South East Coast Ambulance Service NHS Foundation Trust

Inspection report

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Ratings

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

Our reports

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Overall Summary

Our overall rating of well-led went down. We rated it as inadequate and the chief inspector of hospitals has recommended to NHS England and NHS Improvement (NHSEI) that it be placed in the Recovery Support Programme.

A trust may be placed in the Recovery Support Programme for quality reasons when:

- It is rated 'inadequate' in the well-led key question (because there are concerns that the organisation's leadership is unable to make sufficient improvements in a reasonable timeframe without extra support)
- A trust placed in the Recovery Support Programme receives intensive support to help it improve. It must produce an improvement plan setting out what it will do to bring services up to the required standard.

During this inspection we identified further checks we needed to carry out. In the meantime, we have suspended the trust's overall rating. This will be reviewed once the checks are completed.

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) was established on 1 July 2006. On 1 March 2011 SECAmb became a Foundation Trust.

Our findings

The trust covers 3,600 square miles which includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country. It serves a population of over 5 million people.

The trust employs over 4,500 staff working across 110 sites in Kent, Surrey and Sussex. Almost 90 per cent of the workforce is made up of operational staff – those caring for patients either face to face, or over the phone at the trust emergency dispatch centre where the trust receive 999 calls.

Patients range from the critically ill and injured who need specialist treatment, to those with minor healthcare needs who can be treated at home or in the community.

As well as a 999 service, the trust also provides the NHS 111 service across Kent and Sussex. The trust also has a Hazardous Area Response Team (HART) which was not inspected at this time.

During March 2022, we undertook a focused inspection of the Emergency and Urgent Care services as part of a pilot approach of the urgent and emergency care pathway across Kent and Medway. This was to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures. A short notice period was given prior to the inspection. We also undertook an inspection of the Emergency Operations Centre and 111 service using our comprehensive inspection framework and due to concerns about leadership quality and culture in the organisation we inspected the well-led key question for the trust. We did not inspect the resilience core service (HART) on this occasion.

Following this inspection we have suspended the overall ratings for the trust while we carry out further checks on all the provider's locations.

- In 111 the overall rating stayed the same. We rated safe, effective, caring, and well-led as good. We rated responsive as requires improvement.
- In Emergency Operations Centre the overall rating went down. We rated the caring domain as good however, we rated safe, effective, responsive and well-led as requires improvement.
- The Emergency Urgent Care service was unrated due to being part of a system review to ensure consistency with other ambulance trusts.
- The ratings for the well-led inspection went down.
- In rating the trust, we took into account the current ratings of the other core services not inspected this time.

What we found.

111 Service

Our ratings for the service stayed the same. We rated it as Good.

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.

Our findings

- Patients were able to access care and treatment from an integrated service with specialisms to meet their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

However:

- The trust was not meeting the key performance indicators on clinical call back times, call abandonment rates and call response times.
- The trust did not always support the workforce in order to reduce the pressure and improve staff morale.

Emergency Urgent Care. Due to the focused nature of the inspection, we did not rate the core service. The previous rating of outstanding remains.

- The significant rise in numbers of callers to 999, in excess of what the trust was commissioned for combined with crews being delayed at emergency departments meant the trust was unable to reach all patients in a timely way. As a result, the service was not meeting any NHS constitutional ambulance response times, which was a similar picture across the ambulance services nationally.
- The exceptional demand was increasing, and this was becoming unsustainable for staff across the service.
- There were additional risks for patients from handover delays for ambulance crews at emergency departments which were unable to take patients due to their lack of capacity.
- Due to delays in response times as a result of increased demand, there were risks of harm to patients who were in the community.
- The service planned care to meet the needs of local people, however it didn't always take into account patients' individual needs and did not provide people with information on how to give feedback.
- The trust did not always support staff to develop their skills. Managers and staff told us that any additional training courses had to be self-funded and completed in their own time.
- A high proportion of staff had not received an appraisal.
- Not all staff felt connected to other teams and sites within their service and to the organisation as a whole.
- Learning from low level harm and near miss incidents was not embedded and staff often did not get feedback from incidents they had reported.
- Leaders were not always aware of the risks in their service or themes and trends in patients' complaints.
- There was a lack of a clear strategy and consistent approach in the management of ambulance response categories 3 and 4.
- Staff felt there was an overall lack of a strategy and vision for the organisation.

However:

- Staff worked well together for the benefit of patients and focused on the needs of patients receiving care.
- Local leaders ran services well using reliable information systems.
- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.

Our findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs and helped them understand their conditions. They provided emotional support to patients, families and carers.
- There had been some excellent multidisciplinary working and mutual aid to and from the service. For example, an ambulance staffed by a paramedic and police officer to support patients experiencing severe mental ill health.
- Despite the immense pressure faced every day, staff were kind, compassionate and supportive.

Emergency Operation Centre

Our rating for the service went down. We rated the Emergency Operations Centre core service as Requires Improvement.

- The service did not always have enough staff to care for patients and keep them safe.
- There was an expectation on staff to work overtime even though they were exhausted.
- Staff were not up to date with mandatory training and training in key skills. Staff did not receive adequate training on patients who had mental health needs and felt this was a risk to the safety of their service.
- The service did not manage safety incidents well. Incidents were often not investigated in a timely fashion and learning from incidents was not consistently shared with all staff.
- The service did not ensure all staff had an appraisal and appraisal rates for the service were poor.
- Staff understood how to protect patients from abuse, however safeguarding training compliance was worse than the trust target.
- People could not always access the service when they needed it. Since the rise in demand and strain on response times, the service was no longer able to always meet the needs of patients.
- People who did not speak English could sometimes not access the service in a timely way.
- Leadership at a local level was good. However, staff did not feel visible or appreciated by senior leadership.
- Not all staff felt respected, supported and valued. Not all staff felt they could raise concerns without fear, even though there was a freedom to speak up guardian in post that staff were aware of.
- Leaders did not support staff to develop their skills. Opportunities for development were limited and staff were expected to do any continuous professional development in their own time.

However:

- Staff assessed risks to patients, acted on them and kept good care records.
- Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, even when they were under a vast amount of pressure themselves. They were focused on the needs of patients requiring care.
- There were processes in place to ensure the service could continue in the event of a business continuity incident or other events that could stop the service running effectively.
- Staff knew about the values of the service.

Our findings

Trust wide

- Leaders had the experience, capacity and capability to lead effectively. However, the current leadership style and relationships in the executive team were not operating as effectively or cohesively as it should.
- Communication at all levels was poor. Staff provided us with many examples of this during the inspection.
- Leaders were out of touch with what was happening on the front line, and they were not always aware of the challenges in the service.
- Leaders were not visible and did not act in line with the trust's own values when staff raised concerns.
- Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care.
- Not all staff felt they could raise concerns without fear of reprisal.
- Staff reported low levels of satisfaction and high levels of stress and work overload.
- We found high levels of bullying and harassment, inappropriate sexualised behaviour and a high number of open grievances.
- There was insufficient resource allocated to FTSUG, safeguarding and medicine management team.
- The governance systems at the trust were not operating in a way that protected patients or staff from the risk of harm.
- Key reports to board were not prepared in a standardised way.
- Risk, issues and poor performance were not always dealt with appropriately or quickly enough.
- We found a back-log of 1500 incidents on the incident reporting system.

However:

- We found good collaborative working between the FTSUG and union representatives.
- The trust had an award-winning wellbeing hub that provided invaluable cost-effective support to staff.
- The trust was making progress with the equality, diversity and inclusion agenda.
- The trust was well on its way to becoming a digitally mature organisation. There was record investment in IT infrastructure to future proof the organisation
- The trust had used the pandemic to improve its visibility, influence and focus in the local system. We saw improved levels of engagement with other key stakeholders. The trust had become a more outward facing organisation.
- The strategy director work programme was having a positive impact on the trust's ability to translate data into service planning, delivery and organisational strategy.

How we carried out the inspection

- We looked at information such as staffing number and rotas, staff training, clinical stack management.
- We looked at medicines management, checked equipment, medical devices and consumables.
- We reviewed information provided by the service following the inspection.

Our findings

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.

What people who use the service say

Most patients praised the care, treatment and support they received from the service. However, we also saw concerns about the excessive ambulance waiting times and staff attitude.

Outstanding practice

111 Service

- In March 2022, the engagement work undertaken to involve patients and volunteers in the development and procurement of the NHS111 service had received a 'Healthwatch Recognition Award'.
- Having worked with the commissioners and other external organisation to establish a Direct Access Booking (DAB) service, approximately 30% of all triaged patients received a DAB into an external provider. This service improvement had resulted in a Health Service Journal improvement Award was for 'Best Acute Sector Partnership with the NHS'.

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:

- The trust must ensure all staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. (Regulation 18 (2) (a)).
- The trust must improve the culture and ensure all staff are actively encouraged to raise concerns and improve the quality of care. (Regulation 12 (1) (2i)).
- The trust must ensure it takes staff's concerns seriously and takes demonstrable action to address their concerns. Regulation 17 (2)(b).
- The trust must ensure that all incidents investigations are completed in a timely way to allow opportunity for action on learning to be shared and action taken swiftly. Regulation 17 (2) (b) (e)).
- The trust must ensure it works collaboratively with system partners to improve category 2, 3 ,4 response times. (Regulation 12, (1) (2) (a) (I)).
- The trust must ensure the governance and risks processes are fit for purpose and ensure the ongoing assessment, monitoring and improve the quality and safety of the services provided. (Regulation 17, (1) (2) (a) (b)).
- The trust must ensure it seeks and acts on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving services. (Regulation 17, (2) (e)).

Our findings

- The trust must collect and analyse the End of Life (EoL) calls and share the analysis with ICS stakeholders, with the objective of reducing the needs for unanticipated EoL care by emergency and urgent care services (Regulation 17, (1) (2) (a) (b) (c)).

The trust should consider:

- The trust should ensure it provides appraisals and continuous professional development to all staff.
- The trust should ensure blood glucose (sugar) machines are calibrated.
- The trust should consider how to recruit to staff vacancies.
- The trust should consider how to improve communication and relationships between staff and senior leaders.
- The trust should consider a consistent approach in the management of ambulance response to categories 2, 3 and 4 calls.
- The trust should ensure that it continues to work towards meeting the key performance indicators on clinical call back times, call abandonment rates and call response times.
- The trust should ensure it continues working towards supporting the workforce in order to reduce the pressure and improve staff morale.
- The trust should consider how to improve engagement with staff.
- The trust should consider how to improve engagement with patients.
- The trust should better understand the role of the FTSUG to improve the speak up culture.
- The trust should consider how to drive the improvements needed to achieve key performance indicators on clinical call back times, call abandonment rates and call response times in 111.
- The trust should continue working towards supporting the workforce in order to reduce the pressure and improve staff morale.

Is this organisation well-led?

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

Leadership

Leaders had the skills and abilities to run the trust. However, they did not always understand or manage the priorities and issues the trust faced. They were not visible and approachable and did not act in line with the trust's own values when staff raised concerns. Staff were not supported to develop.

Leaders had the experience and abilities to lead effectively. However, the current leadership style and relationships in the executive team were not operating effectively or cohesively. We recognise the significant impact the Covid 19 pandemic had on healthcare organisations. As a result, the trust was operating a control and command style of leadership. However, we were told there was an imminent plan to move away from this leadership style as a result of the known and inherent risks of a command and control culture. The organisation were still trying to address the concerns outlined in the 2017 Lewis report in relation to this leadership model.

Our findings

Staff knew who their leaders were. However, staff did not feel they were empowered to make decisions or lead in a progressive or constructive way. Staff told us decisions were made in isolation by a small number of individuals rather than using the expertise, experience and clinical knowledge in the organisation. Decisions were frequently made outside of the trust's own policies, governance and risk systems.

Communication at all levels was poor. Staff provided us with many examples including email trails showing key decisions and changes were not always communicated effectively in the executive team, or amongst the senior leaders or their teams working at core service level.

Leaders were out of touch with what was happening on the front line, and they were not always aware of the challenges in the service. We found many examples of staff raising concerns relating to the challenges they faced that went unaddressed. Not all executives were able to demonstrate a knowledge of what was happening at core service level.

Leaders were not always clear about their roles and their accountability for quality. There was insufficient challenge at executive and senior levels. We saw a wide range of committee and subcommittee meeting minutes which failed to provide assurance of enough challenge or healthy debate in these forums. There was a perception of a 'power imbalance' at executive level that posed a potential organisational risk. We were aware relationships in the executive team were sometimes fraught. This had an impact on the executive's ability to work as a cohesive team but also had an impact on leaders within their individual core services. Whilst the trust had recently recruited a small number of new executives there was still a risk of legacy behaviours affecting the cohesiveness in the wider executive team.

Staff were not supported to develop. The recent pandemic had a significant impact on the trust's ability to support staff to train and develop. Many staff were promoted into leadership roles but were not provided with the necessary training to support them in that role. Mandatory training rates throughout the trust were low. Annual appraisal rates were also low. There was a recognition that training, development and annual appraisals were important at all levels. As a result the trust were in the process of addressing how to manage this given the current demands on the service. However, a formal recovery plan had yet to be signed off by the board.

CQC carried out an Emergency and Urgent Care and Emergency Operations Unit staff survey before inspecting the trust. Staff were provided with a free text box to make comments about issues important to them. Many staff told us they were worried about the cultural decline in the organisation and referred to the senior leadership as 'dysfunctional'. Most staff we talked with during our inspections gave us a similar message.

Leaders were not visible and did not act in line with the trust's own values when staff raised concerns. Staff told us their senior leadership team were not visible and some went as far to say leaders were not approachable. Many staff described a 'disconnect' between the executive team and the staff delivering care. Staff felt raising concerns was futile and would negatively impact their future careers if they continued to bring concerns to the attention of the senior leadership team.

We reviewed the personnel files for four members of the executive team. Appropriate checks had been carried out in accordance with 'Fit and Proper Person' requirements. The executive team had an appropriate range of skills, knowledge and experience.

During the pandemic some members of the executive team went out to meet staff and support welfare initiatives. This included but was not limited to providing food and drinks to staff who struggled to get meal breaks and the medical director worked alongside crews.

Our findings

Vision and Strategy

The trust had a clear set of values and were developing a new operational change model. The new operational model was not developed with input from staff, patients or other key stakeholders. The operational change model was focused on the sustainability of services and to some degree was aligned to local plans within the wider health economy, however it was not incorporated in the trust strategy.

The trust values were, taking pride, demonstrating compassion and respect, acting with integrity, assuming responsibility and striving for continuous improvement. There were firmly embedded in the trust.

The new operational change model, was known as Better by Design (BDB). The change programme was felt necessary to support improvement to make the trust 'Best placed to care, the best place to work': and to be a better partner in the wider NHS system. BBD had three main aims, the delivery of timely patient care though delivering response targets, becoming an outstanding organisation as measured by CQC and patients and improved long-term resilience. The programme also had three guiding principles to guide change: these were 'getting it right first time, standardisation of tasks and processes and strategic alignment'. The BBD framework also focused on seven additional key areas to drive service improvement. BBD had the potential to bring about positive changes, however, it also carried a significant risk to the organisation due to the potential gaps and weakness that undermined its credibility. For example, people who use the service, staff expected to deliver key changes and trust governors were not engaged in its creation or development. All staff we talked with had heard of BBD. However, we spoke to many staff, at all grades and no one could tell us what Better by Design was, how it would impact them and what it meant for patients. Many staff told us they spent the last 12 months feeling worried about their job security because they simply did not know what BBD would mean in practice. At the time of inspection, the trust had not updated their strategy to incorporate the BBD framework and staff had not received any information about the change programme. The operational change model was only one strand of the better by design programme.

The organisational strategy was due to expire in 2022. The current strategy outlined how the trust ensured the provision of safe, quality care. The pandemic meant service delivery changed and the trust's scope broadened to ensure it could meet the overwhelming demand. The challenges led to an improved focus to system health care delivery. The trust became a vital partner and key support to other stakeholders as a result. It also brought about new and interesting ways of delivering a service. It led to improved healthcare pathways, cohesive system working and career development. However, there was also a potential risk to the trust given the task to meet the vast needs and expectations in the system particularly given the risk related to category three and four response delays. Staff were very proud of what they achieved during the last two years. However, many staff we talked to told us they were unsure of what their roles had become and felt the lack of an updated strategy was problematic.

The trust recently developed an Executive Director of Planning and Business Development role. Whilst in its infancy, this role was having a positive impact on the trust's ability to translate data into real time service planning, delivery and organisational strategy. We found proactive system development to capture live data that could be used for system planning based on population health.

The trust recently launched a Green strategy. The trust had invested in electric vehicles which were already in use. There was a range of other green initiatives all aimed at reducing the trust carbon footprint.

Our findings

Culture

Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. Not all staff felt they could raise concerns without fear of reprisal, and when concerns were raised, staff felt they were not listened to. There were low staff appraisal rates. The service had made some progress in promoting equality and diversity in the organisation.

The executive team told us they ensured a fair and just culture. Executives felt they role modelled a compassionate leadership style. The executive team described the culture of the organisation as 'good'. However, staff did not feel this was the case. It was clear from the trust and CQC surveys and the number of whistle-blowers we talked with there was a potentially closed culture developing. Staff told us they feared reprisal for raising concerns. When we asked staff to describe the culture of the trust the word 'toxic' was frequently used. This was a marked deterioration since our last inspection.

We found low levels of staff satisfaction and high levels of stress and work overload. Much of this related to the burn out from the pandemic. However, this also related to the challenges staff felt when trying to raise concerns. Staff told us about their frustration and disappointment when potentially serious concerns went unheard. Many staff turned to their Freedom to Speech Up Guardian (FTSU) guardian and Union representatives for support. However, it appeared these avenues of escalation were also futile.

We found high levels of bullying and harassment, inappropriate sexualised behaviour and a high number of open grievances. The trust reported reducing the number of grievances from 200 to 70. Staff raised concerns about grievance processes and the introduction of policies that may unfairly discriminate against different groups of staff.

The organisation employed in excess of 4,500 staff but only had one Freedom to Speak up Guardian (FTSUG). This role was greatly under resourced given the number of staff and the volume of contacts. The role of the FTSUG was poorly understood by the executive team. There was a widespread perception the FTSU function only related to patient safety issues. During interviews we were told more than once the FTSU role was a 'victim of its own success' and many of the issues raised 'did not concern' a FTSUG. Staff at all grades told us they contacted the FTSUG to raise concerns when they did not feel listened to or where their concerns were not taken seriously. These concerns related to patient safety, bullying and harassment, lack of meal breaks, inappropriate sexualised behaviour, wellbeing and work-related HR concerns.

As a result of a lack of understanding of the role and remit, many concerns raised by the FTSUG were not addressed.

We found good collaborative working between the FTSUG and union representatives. There were obvious trends and themes in the concerns raised by the unions and FTSUG. These did not appear to be recognised or responded to in line with the trust own polices, values or behaviour framework.

The CQC and trust staff surveys indicated worrying levels of concerns relating to the culture of the organisation. We were concerned the trust was reverting to 'normalising' many of the concerns raised. Staff told us the culture was 'not as bad as it was', which may indicate a potential acceptance of the cultural decline.

The trust recognised the risk of inappropriate sexualised behaviour. In 2021, an audit was undertaken into all allegations following a rise in reported cases. As a response to the report the trust had recently launched a sexual safety at work programme and have sought volunteers to support the development of a campaign. However, at the time of the

inspection many staff were unaware of the programme. Not all staff felt that when concerns relating to inappropriate sexualised behaviours were raised, they were always heard, understood or tackled equally across all levels of the organisation, with the approach being that issues were either 'clumsy, creepy or criminal'. As a result, there was a risk that behaviours judged by those not affected could be deemed 'clumsy' and not appropriately addressed.

The trust had an award-winning wellbeing hub. The hub was established to provide a wide range of support to staff, who all recognised the invaluable support the hub provided. However, many expressed fears about its current capacity and future in the organisation when BBD was launched. Themes from concerns and support provided was not formally monitored. As a result, there was missed opportunities to use the information to from themes and trends to support cultural improvement. For example, high numbers of staff who used the service reported excessive stress and bullying and harassment. This was not formally being captured or used to address the underlying issues. A recent review had been carried out to assess the value of service provision which reported the service provided value for money to the trust through the staff support it delivered.

The trust was making progress with the equality, diversity and inclusion agenda. However, there was a perception not all executives were fully committed to this work. The trust monitored their workforce data in relation to the protected characteristics as defined by the Equalities Act 2010. The trust was in the process of developing a live database capable of monitoring all aspects of diversity for example, training, talent management and turnover. However, we identified an imbalance that meant the work focused more on staff inequalities rather than patient inequalities. The trust acknowledged more work was needed to meet its requirements for staff and patients.

Governance

The trust did not operate effective governance processes. Staff at all levels were unclear about their roles and accountabilities. The weak governance processes meant the trust missed opportunities to learn and improve performance.

The governance systems at the trust were not operating in a way that protected patients or staff. The systems failed to assess, monitor and drive improvement in quality and safety. The processes were complex and poorly understood. There was a range of sub committees that fed into the governance system. However, these systems and processes lacked clarity and did not work effectively. Sub committees were inconsistent and lacked a focus on quality and service improvement. Executives felt there was discussion at board about quality, however a review of board and sub committee papers did not demonstrate this clearly.

We found a lack of clarity about who had the authority to make decisions. The trust was using a 'bridged governance' approach during the pandemic. As a result, key decisions appeared to be made by a few key individuals. This was a potential risk as important decisions were made in isolation of constructive challenge or healthy debate despite the wealth of experience in the trust. Staff were unable to explain how this approach worked. Staff and their managers were not clear about their roles or accountability during this time. Staff were unsure of who's direction to follow when key decisions were made that did not follow the expected scheme of delegation or current trust policies.

The Director of Finance (FD) was supported by an experienced finance team led by the Associate Director of Finance. Whilst the FD reported that the Trust was reviewing its offer to improve retention of finance business partners, the team was generally well staffed and had low turnover. The inspection team noted evidence of good financial governance discipline in respect of financial accounting. The Trust had undertaken significant work over the last five years to improve the financial control environment and had updated its standing orders and standing financial instructions. The business case process had been updated and the Trust was in the process of reviewing it to ensure that it added value without being unnecessarily bureaucratic.

Our findings

The trust had an external company to assist with an independent financial assessment. They issued an unqualified audit opinion and a value for money conclusion in 2021 and did not identify any significant weaknesses in the Trust's financial systems. The trust also had a team to provide internal audit function. There was evidence that the Trust has good and constructive working relationships with both internal and external audit firms.

The Trust developed a draft plan for 22/23 with a stated deficit of £39.9m which is 14.6% of turnover. There was a consistent recognition of the financial challenges. There was evidence of good financial understanding at board level, but the board papers did not fully reflect the financial sustainability challenge and the Trust's response. As a result, it was not possible to be assured of a well-developed plan to return to a financially sustainable position. The Better by Design strategy was frequently cited as a key part of the Trust's response. However, this was in the early stages of development and the external financial environment was frequently referred to as the source of the Trust's financial challenge.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, although there were times when this was not effective. While known risks were identified and high-level risks were escalated with identified actions to reduce their impact, there was variability in the way risks were identified, recorded and mitigated, with some known risks being unmanaged.

The trust operated a risk register. However, the information we reviewed did not provide sufficient assurance the entries reflected the true risk or had appropriate mitigations. The trust had a risk management policy and procedure which covered the process for recording the closure of risks.

However, staff could not confidently tell us the frequency or process used to review risks. Risks were described as having 'disappeared' from the register with no formal record kept of the decision to delete/remove entries. There was no communication with the staff groups the risks affected. The trust operated a Board Assurance Framework (BAF). The BAF should bring together the information on the organisational risks to the trust's strategic objectives. The trust executives felt the BAF risks were linked to the trust strategy. However, the inspection team did not see how BAF was not linked to the trust strategy or objectives, and the BAF did not reflect the true risks in the organisation at the time of the inspection.

Risk, issues and poor performance were not always dealt with appropriately or quickly enough.

We saw many examples of key concerns being raised that were not dealt with or not given necessary priority. For example, in June 2021 the Association of Ambulance Chief Executives (AACE) requested all ambulance trusts in the country to make changes to the management of 999/111 stacks. These changes related to patients presenting with overdoses and the potential threat of suicides being upgraded to a category two call to minimise the risk of a long wait. The AACE request to automatically transfer unvalidated 111 calls to the 999 queues for category three and four call after 30 minutes in the 111 stacks. We asked for assurance this request had been carried out. We were told the trust went live on the 26 October 2021 and the final upgrade to iron out issues was implemented on the 16 March 2022.Computer aided dispatch (CAD) functionality was developed to provide automation of auto-dispatch. The trust told us 95% of all cases were validated within a 30-minute timeframe. However, we were not provided with the audit data or the timeframe the audits were carried out. We requested additional information to show the workaround was reviewed through the trust governance and risks processes. We also asked for a better understanding of the time taken to address the request. However, we were not provided with the necessary assurance that the risks to those waiting were being sufficiently managed. User acceptance testing and full impact analysis within 999 has not been completed at this stage, which is required in accordance with the Trust full Risk Analysis prior to implementation of new CAD functionality.

Our findings

The trust carried out serious incident and harm reviews. However, the quality and learning from these was inconsistent. There were missed opportunities to identify trends and themes. The learning identified was sometimes weak. When learning was identified it was not always shared with staff. There was an absence of audit processes to check if identified changes were embedded or were keeping people safe. We saw some obvious trends and themes relating to medicines management and failed dispatch which had not been identified or addressed. We were also not assured the level of harm was always correctly identified.

There were low levels of confidence in how incidents were managed. The trust was not proactively learning to prevent incidents recurring. There was a back-log of 1500 incidents on the incident reporting system. There were incidents that had been reported but not addressed as not all staff identified as incident handlers had been trained to review them. Some staff did not always report incidents because they felt there was 'no point'. Where staff did report incidents, they did not always receive feedback to evidence that learning had occurred as a result.

The pandemic placed an increased pressure on the trust to manage capacity. We had serious concerns about patients categorised as a three or four call (categorised as those requiring non urgent assistance). The clinical risks of those waiting was not always appropriately managed as there were insufficient numbers of practitioners employed to monitor the clinical risk in the stack. Staff in this role showed high levels of stress due to their inability to manage the risks given the number of patients. Many staff told us how upset and worried they were about patients experiencing long waits. Staff gave us examples of attending calls where patients' conditions had deteriorated whilst waiting. However, this was not always formally recorded as an incident. Staff also told us of calls attended where an ambulance was not necessary. This placed an unnecessary pressure on an already stretched service.

There were insufficient staff in the safeguarding team to manage the safeguarding function. This was identified as a potential risk to the organisation. Safeguarding policies were not in date. There was no risk assessment to mitigate the risk of out of dates policies. However, we saw evidence of functioning safeguarding processes that protected patients from the risk of abuse. Examples included identifying a sudden rise in calls from a care home for patients with breathing difficulties. The trust proactively reviewed all the calls and raised a safeguarding with the local authority.

There were several risks relating to medicines management. The pharmacy team did not have enough resource to manage a service of its size. The Medicines team received approximately 100 incident reports a month relating to medicines management. There were insufficient resources to manage these. Where serious incidents occurred that related to medicines, the team were not always informed in a timely way. A significant number of Oxygen and Entonox cylinders could not be accounted for. The trust was not fulling it's duty to safely manage medical gases.

Paramedics did not have their competencies assessed to supply or administer specific medicines. Patient Group Directions (PGDs) provide a legal framework allowing some registered health professionals to supply and/or administer specified medicine. There were risks associated with the lack of training and competencies-based assessments. The trust was mitigating the risk by using a competency-based questionnaire and had recently introduced an eLearning PGD module. Paramedics could self-assess their own competencies.

During the pandemic the trust recognised a need to adapt service delivery to meet the needs of patients who may require End of Life Care (EoLC). This cohort of patients did not always have advanced care planning in place, and other providers did not have capacity to be responsive to their individual needs in a timely way. The trust ensured these patients received timely care at home. However, the trust was not comprehensively collecting or analysing the End of Life (EoL) calls/attendance and sharing the analysis with ICS stakeholders, with the objective of reducing the need for emergency and urgent care services to deliver predictable EoL care.

Our findings

There was also a risk relating to medicines pouches. The trust held data that showed a potential 10% harm to patients. However, the trust had yet to set out its objectives to address this risk.

The pandemic had affected the trust's audit cycles and schedules, with many being put on hold or stopped. Full auditing processes had only just been recommenced. There was continuous monitoring of national performance statistics, but service quality did not have the same level of scrutiny.

The trust had put in place a strategic and tactical in response to the COVID-19 pandemic. This was focused on three key areas: to manage demand, increase capacity, and system working. The service had been at REAP level 4 (extreme pressure) since July 2021 and this was only reduced to level 3 ('severe pressure) in January 2022. A recovery plan was being developed to show how the trust would support both colleagues and our patients moving forward.

Information Management

The trust collected data and analysed it. Data was used to understand performance and make decisions. However, data was selective and was not always used in a way to improve services, quality or safety.

The trust was well on its way to becoming a digitally mature organisation. There was record investment in IT infrastructure to future proof the organisation. There was an embedded electronic records system. All crews had access to handheld devices which were password protected and designed to capture data in real time. The devices meant staff could report incidents and safeguarding concerns in real time without having to report to their base. Information was kept confidential and stored securely.

The service used a computer-based system to plan to use long-term data and analysis of demand and in response to the changing needs of a system or community.

Engagement

Leaders did not actively and openly engage with patients; However, the trust had changed how it collaborated with partner organisations to help improve services for patients in the wider healthcare system. Staff engagement had notably worsened since our last inspection

The trust had a Patient and Family/Carer Experience Strategy 2020 – 2025 which was developed in collaboration with stakeholders. The strategy helped identify what the trust did well in addition to areas requiring improvement. There was minimal engagement with people who use services in the development of that strategy. However, patient stories were presented at board meetings. This was in line with national guidance and provided a patient's perspective of using services.

Staff engagement had notably worsened since our last inspection. Whilst the challenges during the pandemic will have impacted this, this is not the sole reason for the decline. Staff at all levels reported feeling disconnected from the senior leadership team.

There were twice weekly conference calls open to all staff, on a Monday and Friday. These were used to discuss current and projected operational concerns, trust updates across and any other new and important information. These meetings gave staff the opportunity to ask questions or give feedback. However, staff told us they were not able to attend these as they were too busy. Operational bulletins were also used to communicate with staff.

Our findings

The workforce at the trust was highly unionised. Relationships between the union representatives, Human Resources and the executives appeared strained. There was much work needed to ensure all parties worked collaboratively to ensure fair, transparent and productive ways of working that incorporated staff voice.

The trust had become a more outward facing organisation and had used the pandemic to improve its visibility, influence and focus in the local system. We saw improved levels of engagement with other key stakeholders and greater partnership working, especially in times of extreme system and national pressure.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. The command and control approach in use stifled innovation in the organisation. Staff did not feel empowered to innovate or improve working practice.

Most staff felt unable to engage in improvement or innovation, citing reasons such as the control and command culture coupled with the continued challenges of delivering the service.

The Executive Director of Planning and Business Development work programme was having a positive impact on the trust's ability to translate data into service planning, delivery and organisational strategy. We found proactive system development to capture live data that could be used for system planning based on population health. The trust was using real time data to predict surges in activity. Dual trained staff were then redeployed to the surge areas. The trust was using data to proactively manage high demand.

Some staff had been dual trained in responding to 999 calls and 111 calls. This allowed a more flexible approach to managing the staffing needs of both elements.

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
Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Inadequate ↓↓ Jun 2022	Good Aug 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.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
South East Coast Ambulance Service NHS Trust Headquarters	Good Aug 2019	Requires improvement Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019
Overall trust	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Inadequate ↓↓ Jun 2022	Good Aug 2019

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 South East Coast Ambulance Service NHS Trust Headquarters

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Aug 2019	Requires improvement Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019

Rating for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Emergency operations centre (EOC)	Requires Improvement ↓ Jun 2022	Requires Improvement ↓ Jun 2022	Good → ← Jun 2022	Requires Improvement ↓ Jun 2022	Requires Improvement ↓↓ Jun 2022	Requires Improvement ↓ Jun 2022

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 but did not make sure everyone completed it.

The trust had recently faced extreme, unprecedented operational pressures linked to the impacts of the COVID-19 pandemic. The aim of the Resourcing Escalatory Action Plan (REAP) was to provide the trust with a nationally understood process of escalation in order to provide additional resources in the event of operational pressure being experienced in the system. On the 02 July 2021, the trust took the decision to declare the highest level of escalation and move in to REAP 4. This was due to the significant operational pressures the trust was facing in both 999 and 111, as well as the challenges being felt across the wider NHS. This allowed the trust to take additional further actions to maintain patient care, actions such as abstraction cancelling all non-essential training.

Not all staff received and kept up-to-date with their mandatory training. Figures supplied by the trust showed overall mandatory training at 63% which was worse than the target of 95%. Staff told us much of their training was available online, although they often completed it in their own time at home. Managers told us that staff could be remunerated for training they completed in their own time, however staff we spoke with were not aware of this.

The mandatory training was comprehensive and met the needs of patients and staff. There was a programme of key skills training for all emergency operations centre (EOC) staff which consisted of major incidents, human factors and resilience. However only 6% of staff had received this training. The trust told us that key skills training had been cancelled for the past two years due to the pandemic. The trust advised that key skills training would resume 'imminently' but did not provide a date for this.

Clinical staff completed training on dementia. All EOC staff received mental health training when first appointed to SECAmb. Figures supplied by the trust showed that 82% of staff had completed dementia awareness training. Mental Capacity training was provided to all EOC clinicians when initially recruited and updated every three years. There was no additional training provided on how to deal with patients with mental health needs and learning difficulties. However additional support was available from the mental health and learning difficulties leads. Staff told us that one of their biggest challenges was the sizable increase in calls from younger patients and children under the age of 18 who had mental health problems or suicidal ideation. Staff told us there had been a marked increase in this type of call since the pandemic. Data provided by the trust showed that between September 2021 and February 2022, there were 2880 calls made by children aged 15 and under, with 2881 of these calls requiring a 999 response. The legal definition of a child is those 18 and under, but we were not provided with this data. Staff told us there were times when clinically trained staff had to use their clinical judgement about decisions around young people's mental health care, when there was no mental health care professional on duty.

Data provided by the trust showed that between September 2021 and February 2022, there were 2881 calls made to the service by children aged 15 and under relating to mental health, with 2880 of these calls requiring a response."

Clinicians within the EOC also completed mental capacity training, however only 46% had completed this training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff training was monitored by managers via a digital training system. Staff told us they did not receive emails to advise them when training was due to expire as this was all managed on the digital system.

Safeguarding

Staff understood how to protect patients from abuse. However not all staff were up to date with training on how to recognise and report abuse.

Dispatch staff received training specific for their role on how to recognise and report abuse. All new staff received safeguarding training to the level required for their role on induction. Dispatch staff were trained to level two in safeguarding children and adults. Figures provided by the trust showed that 87% of staff had been trained in level one and two adult safeguarding, for Children's' Safeguarding, 76% of staff had completed their training.

Healthcare professionals received training specific for their role on how to recognise and report abuse. All new staff received safeguarding training to the level required for their role on induction. Healthcare professionals such as paramedics, nurses and midwives were trained to level three in safeguarding. The percentage of staff who had received safeguarding refresher training had fallen during the pandemic and only 65% of staff had completed level three safeguarding training at the time of our inspection.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff worked hard to make sure that peoples safeguarding needs were recognised. Staff who had concerns about a patient or family members welfare, completed an incident report after the call. This was allocated to the safeguarding lead for review and investigation. Staff told us they received an acknowledgement that the safeguarding had been received. However, they did not always get feedback on the outcome of the referral.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they could submit safeguarding concerns and alerts electronically, and they get an email acknowledgment when sent. Staff told us managers encouraged staff to complete safeguarding even if they were unsure of the circumstances constituted a safeguarding referral. Managers advised us that the digital patient assessment system did not have a list of safeguarding questions, the referral was made on the judgement of staff handling the call.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

There were two EOCs across the trust at Crawley, West Sussex, and Coxheath, Kent. Crawley EOC was a new building and met the demands and the needs of the service well. Coxheath EOC was an older building which was small and did not have disabled access into the areas used by the EMAs or dispatchers. A consultation had taken place and the Coxheath EOC was due to move to a new location in Medway which was bigger and met the needs of the organisation better. This had been delayed by Covid-19. Both locations were secure, and all areas were accessed with card entry systems to prevent unauthorised access.

Staff used control measures to protect themselves and others from infection, however infection control training rates were low. The premises were visibly clean. All staff wore a uniform and were well presented. Hand sanitising gel

dispensers were full and available to staff and visitors throughout both EOC sites. Staff had access to disinfectant wipes to clean their desks before and after their shift, which we observed staff using. Staff completed infection prevention and control training as part of their mandatory training, however data provided to us from the trust showed that only 63% of EOC clinicians had completed this.

The trust had put additional measures in place following Covid-19. Measures to mitigate the spread of COVID-19 had been put in place throughout the EOCs, such as separation screens, rooms had been adapted to allow for social distancing and maximum room occupancy numbers were seen on doors and adhered to whilst on the inspection. All staff working within the EOCs were expected to wear masks unless they had an exemption. We saw managers reminding staff if they were not wearing them. Staff working in the EOC were expected to test regularly for COVID-19 however this was not mandatory unless symptomatic. Staff were asked to follow procedure, isolate and provide a negative test before returning to work.

The service had enough suitable and effective equipment to help staff safely care for patients. Staff in the hubs said their electronic equipment generally worked well and the IT systems were up to date. Staff in the hubs knew what to do in the event of a systems failure and gave examples of how they would continue to run the service using paper-based systems. There had been a recent example of this in November 2021 where there had been a significant IT disruption which affected the availability of computer aided dispatch and telephony services. Contingency plans were in place and buddy sites took on the overflow of 999 calls.

The service complied with the Display Screen Equipment (DSE) Regulations 1992 to ensure the provision of a safe environment for staff working in the EOCs. It was individual staff members' responsibility to complete a DSE self-assessment yearly, and this was monitored by managers at their yearly appraisal. At the time of our inspection, the way compliance with DSE assessments was monitored was changing as it had not previously been monitored centrally. Compliance rates for completed DSE assessments were available for the EOC East site which was at 69%.

The estates team conducted cleanliness audits monthly at both sites. Data provided from the trust showed that results were consistently between 91% and 100%. We were not told what the target was or what the audits consisted of. The trust told us that there were no actions identified from these audits and therefore there was no need to 'complete a more thorough assessment'.

There was no multi-faith room on site at the Coxheath EOC. Staff told us that there were quiet rooms that could be used if staff needed.

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. Staff in the EOC used approved triage systems to prioritise calls based on risk and need, using the NHS Pathways system (NHSP). NHSP is a telephone and digital triage clinical decision support system. The triage systems prioritised, and coded calls based on responses to questions asked by the EMAs.

The call takers followed the call handling procedure in line with the requirements laid out by NHS Pathways (NHSP) user licence and training for the safe use of the system. It detailed the local procedures to be used with regard to specific scenarios within NHSP and CAD (Computer Aided Dispatch) functionality.

Emergency operations centre (EOC)

We listened to a number of calls during the inspection. Staff followed triage pathways consistently to determine the right response for the patient. This response was not always to send an ambulance but included a clinician talking with a patient or carer, or asking the caller to contact community healthcare services, including a GP or by direct referral to the NHS 111 Clinical Assessment Service. The calls we observed were complex. Patients were asked about their condition, and staff entered the answers on to the system so that all aspects of patient care were covered such as their current condition and any medications. Staff determined the risk and acuity of the patient to ensure the correct response. Calls were categorised from high risk requiring attendance within seven minutes to lower risk for patients who are unable to get to hospital unaided and the system identifies wait times and urgency of the patient.

There were four categories of response resulting from calls that came into the EOC with category one being for people with life-threatening illnesses or injuries, category two for emergency calls, category three for urgent calls and category four for less urgent calls. The level of urgency identified would then determine how the dispatch team would coordinate a response.

Certain category three and four calls are added to a 'clinical stack' for triage by a clinician. Clinicians would prioritise calls and determine whether a patient's condition required a redirection to another service or for an ambulance response. Clinical staff had access to the stack and calls were colour coded into priority such as red for emergency category 1 calls and grey for calls about mental health issues. Clinical leads reviewed and assessed the calls relevant to them, and when appropriate provided a hear and treat service or support for EOC staff who needed to reassure patients whilst they waited for an ambulance.

Staff triaged each patient during their first contact, and again if they were kept waiting in the clinical stack. Two clinical safety navigators (CSN) were on duty each day and one on each night shift. They were responsible for reviewing the priority of calls. They updated the priority when required and communicated with the clinicians. Clinical safety navigators worked alongside staff assigned to provide welfare checks for patients who had not received an ambulance response within a predetermined timeframe within the Patient Welfare Call Procedure". Welfare checks included an assessment of pain relief, nutrition and hydration and the call handler would provide reassurance and could contact family to ensure patients were not left alone. In some cases, they would upgrade the calls and examples were given of where this had occurred. Clinical safety navigators reviewed a list of low risk patients who had declined the initial advice of seeing their GP or attending urgent care. Welfare check calls were audited to ensure that they followed local guidelines, however there was not enough clinical staff to meet the demand in the stack and this was a risk because patients in the stack were waiting for increasingly long periods of time.

Staff followed surge management procedures at time of increased demand. Staff told us that the service was often in surge management and there were mostly large numbers of patients waiting within the clinical stack. At the time of inspection, the service was in surge management level two but this increased to surge level three during the course of our inspection.

The service did not have 24-hour access to mental health support. A mental health practitioner (MHP) should be on site in the EOC to provide support 24 hours a day, however in the last three months, there was only a MHP on 76% of all shifts. In the event there is no MHP on duty in EOC the MHP's in 111 will review cases in both EOC & 111 clinical queues.

Staffing

Whilst the service actual numbers often met planned numbers, the level of work was so extreme that staff did not feel there was enough of them 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.

Emergency operations centre (EOC)

The service did not always have enough staff to keep patients safe. Information from the trust's integrated performance reports showed that between 27 December 2021 and January 10 2022, the actual staffing compared to target hours was between 104% and 115%, between 28 February and 14 March 2022 the actual staffing compared to target hours ranged between 86% and 90%. All staff we spoke with told us that they felt under enormous pressure which demonstrated that even when the EOCs were at full establishment, the workload was often too high to manage. We spoke to three clinicians on duty on the day of our inspection. They all told us that they were under extreme levels of stress because there were not enough staff to meet the extreme demand.

The number of clinical staff allocated to shifts generally matched the planned numbers, however both clinical and non clinical staff told us this was still not enough. Data provided by the trust indicated that between 7 June 2021 and 31 January 2022, clinical shifts ranged from being 76% filled to 108%. On average, shifts were 99% filled. Staff told us that the demand was so extreme that even with the right number of clinical staff on shift, it still felt understaffed.

To gain feedback from staff in a confidential way the CQC undertook an online staff survey. The online survey ran for ten days from 22 February to 4 March. The survey received 155 responses from staff working in the EOCs throughout the trust. In response to the question: I am able to meet the conflicting demands on my work time; 57% strongly disagreed, 23% neither agreed or disagreed and 21% agreed or strongly agreed.

This was further evidenced by the comments received from the survey completed ahead of our inspection:

Comments from staff regarding the rota and shifts included: "Too much relying on good faith to cover shifts but it is becoming less and less as staff just don't want to be here", "The staffing levels in EOC are currently extremely unsafe. We are asking staff to work beyond their capabilities and what they comfortable doing and the amount of staff currently off sick is concerning", "Staff are working at the end of their tether, are emotionally drained, Exhausted and this is resulting in a negative impact on their own Health and wellbeing. we either go sick or keep working till we have nothing left to give and break. No one listens and nothing will ever get better".

Managers could try and adjust staffing levels daily but this was not always enough to meet the needs of patients. Managers reviewed staffing daily at a "strategic review" meeting where acuity, system updates such as hospital emergency department wait times and emergency or weather issues were openly discussed. Managers used closed social media groups to arrange emergency cover for the service in the event of sickness and low staff rates.

The service had high vacancy rates. The highest number of vacancies sat within the dispatch team staff with a 22% vacancy rate at the time of our inspection. Overall, the service had a 13% vacancy rate.

The service had high turnover rates. Across both EOCs, the turnover rate between April 2021 and February 2022 was on average 3%. The highest turnover of staff was amongst dispatch team leaders, emergency medical advisors (EMA) and senior EMAs, EMA Team Leaders, resource dispatchers, response desk dispatchers at 59% with EOC West.

The service had recently seen a reduction in sickness rates. Within both EOCs, Dispatch Team Leader, EMAs and EMA team leader roles accounted for the highest number of sickness between April 2021 and February 2022. Across both EOCs, the sickness rate between April 2021 and February 2022 was 10%. The sickness rate had risen to 12% in December 2021 and January 2022, but the latest figure had reduced significantly to 7% in February 2022.

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.

Emergency operations centre (EOC)

Patient notes were comprehensive and all staff could access them easily. Staff completed digital patient records. Staff had access to paper templates so they could complete the calls in the event of power failure. The template included decision trees so that staff made sure patients were risk rated and placed on the appropriate care pathway. Once power returned managers allocated staff to input the data into the digital systems and shredded the paper records.

Records were stored securely. Patient records were created and held digitally and could only be accessed by staff with secure passwords. All areas of the EOC had key coded locks to ensure the safety of data. Staff that worked remotely had to complete a risk assessment, which included using secure servers, secure log in details and a secure area in the home.

Staff received training on keeping personal information secure. Data provided by the trust showed that 79% of staff had completed their training which was worse than the trust target of 95%.

Clinical safety navigators also review patient records to ensure staff have completed them correctly.

Medicines

Staff gave advice on medicines in line with national guidance.

The EOC did not store any medication.

Staff followed national guidelines to check patients had the correct medicines. Pharmacy services were available between 7am and midnight for clinical staff. These meant staff could ask pharmacists to prescribe urgent medication, including antibiotics to patients to avoid a hospital attendance. Staff told us that they had seen an increase in people contacting the service who required repeat medication. This was because patients were unable to access their GP. However, clinical leads advised that they asked the GP services to prescribe if they could to ensure the GP had full oversight of their patient's needs.

Incidents

Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents but not always in a timely way, and lessons learned were not always shared with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff used a digital incident reporting application to report incidents. Staff told us they were given an overview of the incident reporting process during their period of membership. Staff could demonstrate how to use it and gave examples of incidents such as safeguarding concerns, loss of contact with patients and health and safety incidents.

Staff survey responses indicated that staff were encouraged to report incidents: In response to the question: My organisation encourages us to report, errors, near misses or incidents, 12% of staff either strongly disagreed or strongly disagreed, 10% neither agreed or disagreed and 78% agreed or strongly agreed.

We reviewed the latest trust wide incident report available focusing on January 2022. During January 1680 incidents were logged on the incident reporting system trust wide which was an increase of 10% from the same reporting month the previous year. The most common incident reported in January 2022 were incidents related to COVID-19 staffing issues which accounted for 21% of incidents reported this month.

Emergency operations centre (EOC)

Staff reported serious incidents clearly and in line with trust policy. There had been six serious incidents declared between November 2021 and January 2022. Staff told us that in the event of a serious incident, managers undertook a rapid review to identify any immediate actions to reduce further risk to patients. Route cause analysis methods were used to investigate and identify actions following serious incidents.

The governance lead and other key managers including the safeguarding lead attended a serious incident group which met every Wednesday to review new incidents and update ongoing incidents when appropriate.

Staff generally received feedback from investigation of incidents. Staff told us that they received feedback from incidents, if it was relevant. However, there was a long delay on the investigation and allocation of incidents, which meant that often this feedback was delayed or forgotten. Comments on the staff survey included: “There is a lot of attitude of 'what’s the point' as when incidents are raised the investigations and responses are minimal and inconclusive and often they are not investigated for a significant amount of time after the incident took place.

Managers did not always investigate incidents in a timely way. At the time of our inspection there were 178 incidents overdue investigation within the EOC. The highest percentage of overdue incidents (40%) sat with the EOC clinical team. We saw that this had been recognised as a risk on the risk register.

Managers debriefed and supported staff after any serious incident. Staff gave us examples of where they had taken distressing calls and team leaders had supported them during and after the call. However some dispatch staff told us they were not invited to debriefs and if they were, they were not given the time to attend them.

Managers did not always share learning with their staff about incidents, other than through bulletins. Staff could not tell us about any learning from recent incidents. The trust told us that historically, key skills training had been a way of sharing learning from incidents. However, key skills training compliance was only at 6% at the time of our inspection. Staff told us that they used to hear about learning from serious incidents in weekly meetings, but that these had not occurred for the last two years. This meant that shared learning relied upon communication from managers to EOC staff, via methods such as through ‘hot topic’ bulletins. This was reflected in the staff survey responses:

In response to the question: I hear about incidents that happen in my part of the organisation, 42% of staff either strongly disagreed or strongly disagreed, 25% neither agreed or disagreed and 32% agreed or strongly agreed.

In response to the question: When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again 38% of staff either strongly disagreed or strongly disagreed, 30% neither agreed or disagreed and 32% agreed or strongly agreed.

There were five comments relating to the management of incidents within the staff survey including: “Issues and incidents are not reported as regularly as they should be and it is certainly not actively encouraged”, “ I feel we should take more time on learning from serious Incidents and what we can do to improve”, “We are told not to flag incidents we are concerned about because staff are too busy”, “Mistakes are made by people in my job role we very rarely see and official communication about learning from it. We often only hear about it through gossip in the control room”.

Is the service effective?

Requires Improvement 

Emergency operations centre (EOC)

Our rating of effective went down. 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. However, some trust policies were overdue for review. Managers checked to make sure staff followed guidance. Staff followed policies to plan and deliver high quality care according to best practice and national guidance.

Several of the policies we reviewed including the call handling procedure, complaints policy and the speaking up policy were overdue review. The trust told us that there was a number of policies that were overdue review due to the pressures of the pandemic and long-term status at REAP 4. The trust told us that risk assessments was undertaken to review policies to assess whether urgent updates or amendments were needed and the majority reviewed had an extension granted between six to 24 months. At the time of our inspection, the final approval for this approach was awaited and if permitted, new expiry dates would be added to the policies to reflect the extension.

Quality indicators and key areas of practice were audited as part of the trust's annual audit plan. The service used the NHS pathways system to triage calls and provide clinical advice. NHS pathways were accredited as a 'safe and appropriate' system for managing 999 calls. The service benchmarked data such as AQI data against other national ambulances with data reported monthly and performance indicators were shared trust wide and to the trust board.

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. All patients were asked if they were experiencing pain and used the NHS pathways triage tool during each call. A body map was used on the dispatch system and EMAs selected the area of the body where the patient was experiencing pain.

Welfare checks included an assessment of pain relief, nutrition and hydration and the call handler would provide reassurance and could contact family to ensure patients were not left alone. In some cases the call handler would escalate or upgrade the calls in line with guidance.

Response times

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

The trust monitored nationally measured NHS Ambulance Quality Indicators (AQI) for a range of indicators including their hear and treat rate and call answer rates.

Calls to emergency operations centres should be answered within a maximum of five seconds on average (mean). Between November 2021 and February 2022, the trust consistently took longer to answer calls than the target of ten seconds, but generally performed as well as or better than other trust's it was benchmarked against. The average (mean) call answer time during this period was 19 seconds. Between November 2021 and January 2022 the trust was ranked 4th or 5th out of the 11 ambulance trust's for call answering times nationally, and 8th for February 2022.

The service monitored abandoned call rates. Between December 2021 and February 2022, the average call abandoned rate was less than 1%.

Emergency operations centre (EOC)

The service was one of the poorest performers nationally for its 'hear and treat' service. These were incidents resolved by staff over the telephone. This was a nationally measured Ambulance Quality Indicator (AQI) standard for which the trust was benchmarked against other NHS ambulance services in England. The national average for November 2021 to February 2022 was 11.65%. For this service, the average rate between November 2021 and February 2022 was 9.3%. The trust was ranked 9th out of the 11 ambulance trust's for 'hear and treat services during this time.

The trust monitored real time performance. On the day of our inspection we saw, on large screens in the EOC areas, the number of calls held in the queue and these calls were colour coded to aid risk management. Since July 2021, as at other times during the COVID-19 pandemic, the trust had been at Resource Escalation Action Plan (REAP) level 4, which meant the service was under 'extreme pressure'. During our inspection, the service upgraded it's surge level response from level three to level four.

Patient outcomes

The service monitored the effectiveness of care. The service participated in relevant local and national clinical audits. There was a programme of audit for EOC activity which was overseen by the practice development team. As part of the NHS pathways contract, EMA staff and clinician led call staff were audited on calls each month, both retrospectively and in real time.

Welfare calls were calls made by clinicians to patients in the clinical stack who were waiting for long periods of time for calls pending dispatch. The trust provided us with audit results of these calls from January 2022 which audited 18 calls. It found that 83% of these calls were compliant, which was worse than the target of 95%. The results stated that 100% of the staff audited were provided with about the results. We were only provided with data for January 2022 and was not clear what the frequency of these audits was. There were also no actions or themes identified in relation to the non-compliance on the data we were provided with.

Competent staff

The service made sure staff were competent for their roles. Managers did not appraise staff's work performance but held supervision meetings with them to provide support.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke to staff that had started working for the service within the last six months. They told us they felt well supported and had opportunities to listen in to other calls and to buddy up with an EMA during their induction period. Staff told us there was an online learning package section that supported new starters in their role.

Managers were not able to support staff to develop through yearly, constructive appraisals of their work. Staff were unaware of the formal process for completing appraisals. Data provided from the trust confirmed that between April 2021 to January 2022, only 18% of staff within the EOC had received an appraisal compared to a trust target of 95%. The trust recognised the poor compliance with appraisals and had an appraisal compliance improvement plan in place. This projected that appraisal rates would be at 85% by April 2022, however data we reviewed did not support this projection.

Managers supported staff to develop through regular, constructive clinical supervision of their work. One to ones were used at regular intervals between yearly appraisal meetings with the aim to check in with staff and discuss a range of topics including but not excluded to health and wellbeing, performance, obstacles and personal development. Staff told us they generally received regular one to ones, and that they were able to get support from their line managers. Data provided to us by the trust showed that one to one compliance was at 78% across both EOC sites.

Emergency operations centre (EOC)

There were staff meetings but it was not clear whether minutes of meetings were made available to staff who could not attend. The service had two shift huddles, one at 7am and one at 8am. Leaders introduced a clinical huddle at 7.45 to ensure they reviewed staffing, acuity, and capacity. The trust told us that minutes of meetings were no longer taken as administration support staff had been re-skilled to support with call-taking. We saw that senior leadership (SLT) and clinical safety navigators (CSN) meetings had taken place from attendance reports, however we did not see any evidence of wider staff meetings involving EMA or dispatch staff.

Managers identified poor staff performance promptly and supported staff to improve. As part of the NHS pathways contract, staff were audited on recorded calls each month. Staff who were not achieving the desired level of competence during call handling were offered additional support and one to one development conversations with their line managers. If staff consistently achieved below the recommended benchmark they would have to retake the NHS pathways training. Staff told us that team leaders did not audit their own staff and they felt this was good as there would be no prejudice or bias.

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 worked across health care disciplines to care for patients. We observed positive working relationships between EMAs, dispatchers and clinicians during our inspection. Clinicians worked with other healthcare professionals to provide cohesive safe care. For example, patients could be signposted to GPs, and mental health charities.

On the day of our inspection there was one nurse working at the Coxheath site although staff could access other healthcare professionals remotely. On the day of our inspection there was no mental health care professional or midwife on site. However, staff could access advice from the other site at Crawley EOC.

The maternity hub continued to provide support and advice to pregnant women. The service was a collaboration between the trust and a local CCG to provide support and advice to pregnant women within Surrey Heartlands area. We observed good working relationships between the midwives and clinicians who provided advice and cover if required. The midwives gave advice to patients who telephoned an emergency advice line although they told us that they often were needed more often for 111 calls than 999, especially for women in early pregnancy who did not have a named midwife at an early stage. We saw that there were 47 calls into the maternity hub between 1 November and 3 March 2022, the majority of which resulted in a category one response.

Health Promotion

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

The frequent callers team gave examples of how they had worked with partner agencies to help patients with long term conditions. This not only helped to ease pressure on the service for EOC staff, but helped identify and support patients in the community with unmet needs.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Emergency operations centre (EOC)

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us they received Mental Capacity Act (MCA) training. Capacity to consent to care was assumed unless staff had concerns during the call. If patients appeared delirious or under the influence of substances, staff would highlight this on the risk assessment.

Staff received but did not keep up to date with training in the Mental Capacity Act. The trust told us that MCA training was delivered both electronically and face to face for relevant staff, however only 46% of staff had completed this training.

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. Emergency medical advisors (EMAs) were observed to be professional, calm, and communicated well to distressed callers.

Patients said staff treated them well and with kindness. We reviewed compliments that the trust provided to us and themes that came through were around the calmness and reassurance that the call handlers provided: “Your calm attitude and good advice helped to save my life”, “call handler remained calm, kind and comforting, giving advice whilst still asking all the questions”, “This wonderful kind person was truly an angel….she not only made me feel better and managed to get all the information I could find. But chatted to me and reassured me until the ambulance crew arrived”, “I’m sure I was hysterical but you kept me going doing compressions until the ambulance arrived. It was only 9 minutes according to my phone but it seemed much longer. You were calm, professional and kind.”, “Last night was one of the worse nights of my life and an image I can never get over. But the 999 operator was amazing. I can honestly say from the bottom of my heart thank you to the lady who took my call, who constantly kept me calm, reassuring me that I was doing the right thing and kept letting me know how far the ambulance was.”

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. Staff we spoke with were concerned about the level of calls that were coming in from patients with mental health needs and felt they did not have sufficient training to deal with these types of calls.

Due to the nature of emergency calls, there was not a system for gaining patient feedback or completing patients surveys during the calls. Staff were aware of a patient social media group and were able to provide patients with the details of the patient advice and liaison service (PALS) if patients wanted to raise a complaint.

Emergency operations centre (EOC)

We reviewed the NHS website where patients and their families could leave feedback about the care they received. The majority of the reviews were in relation to paramedic frontline staff, however we saw two reviews in the last 12 months that were in relation to the EOC, one positive and one negative: “call centre lady was marvellous and got an ambulance to me very quickly” and a negative one where a relative rang 999 for a patient fall but after 5 hours found alternative arrangements to get to the hospital as there was still no ambulance available to dispatch.

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. Staff were offered further support following a distressing or difficult call with counselling through the trauma risk management (TRiM) programme. The TRiM programme offered support to staff following traumatic experiences or calls.

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. We observed a call to a patient who had severe pain, and an underlying condition. The patient was unable to answer the questions coherently. A family member supported them to answer the questions and the call took a long time to complete. We observed the clinician was patient and explained all aspects of care in great detail to ensure they fully understood.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff had access to translators and could use a text talk line for patients who were heard of hearing. However, the access to translation was not always available quickly and we observed one call during the inspection where a caller hung up as it took too long to source the right translator.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw that feedback, complaints and compliments were monitored by the service.

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

Since the national NHS Ambulance Response Programme standards were introduced in 2017, the service had almost always planned and provided care in a way that met the needs of local people and the communities served. However, since the rise in demand and strain on response times, the service was no longer able to always meet the needs of patients.

Emergency operations centre (EOC)

Managers planned and organised services so they met the needs of the local population.

Since the pandemic staff had seen an increase in people who did not require emergency services, and staff gave examples of patients calling 999 who had been unable to access their GP. This was felt to be linked to the high number of calls that were placed into category 4 stacks and the length of time taken for those patients to be attended by an ambulance. The service had used their social media to try and help patients understand other alternatives if they are unwell, such as by attending pharmacies, urgent treatment centres or by calling NHS 111.

Staff could access some third party services and help arrange attendance from patients who may not need emergency dispatch. Clinical leads had access to software that provided information about appropriate third-party organisations such as the same day emergency care centre (SDEC) at a local hospital which provided same day emergency care for patients who would otherwise need to be admitted or an ambulance dispatched. Staff had the option to contact these third-party services to make arrangements for the patient to attend that service as an alternative to a dispatch. There were 'buddy' arrangements with other NHS trust's in the event of service disruption or failures.

The service had systems to help care for patients in need of additional support or specialist intervention. Call takers worked with other emergency services to coordinate a response if support from police or fire and rescue were needed. We observed a dispatch team requesting support from the fire brigade to assist with a patient on scene.

Trained staff could provide a 'hear and treat' service for patients that did not need an ambulance dispatched, however the rates for hear and treat were low.

Clinicians and staff trained in triage systems provided assessment and treatment advice to callers who did not need an ambulance response, a service known as 'hear and treat'. Staff gave callers advice on self-care, making an appointment for a general practitioner (GP) or signposted callers to other services. However, the hear and treat rates for the service were amongst the lowest in the country.

Facilities and premises were appropriate for the services being delivered.

Staff could not always access emergency mental health support for patients with mental health problems, learning disabilities and dementia. [LS1] Staff told us there should be a mental health practitioner on site every day, however there were often none, and there were none on site on the day of our inspection. Staff told us that with the rise in calls from patients with mental health issues, this was a huge concern for them.

Meeting people's individual needs

The service was inclusive and took account of some patients' individual needs and preferences, however there was a lack of training for staff in how to deal with patients that had mental health problems. Staff made reasonable adjustments to help patients access services, however some of these adjustments were reliant on third party support which was not always available quickly.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Dementia awareness training was provided as part of staff mandatory training and data provided by the trust showed that 83% of staff had completed this. However, there was no training for staff around mental health and staff told us that with the increase in number of mental health calls taken, they felt it was a risk to not have enhanced training in these areas, particularly for younger people and children with mental health problems as there had been an increase in the number of these calls.

Emergency operations centre (EOC)

The trust had a frequent caller team who supported patients that made multiple calls to 999. Frequent callers were defined by the Frequent Caller National Network as patients aged 18 or over who made five emergency calls or more relating to individual episodes of care in a month or 12 or more emergency calls relating to individual episodes of care in three months. Some frequent callers had long-term physical and/or mental health conditions and the trust gave examples of where staff worked with partners across the system to try and ensure patient's unmet needs were met, and frequent callers were reduced.

Software used by staff had the ability to flag if a patient had a particular individual need. The trust's electronic data system enabled clinicians to review a patient's care plan to identify complex and vulnerable patients such as those with dementia, learning disabilities, physical disabilities, autism or other mental health conditions.

There was a process for people who were hard of hearing or did not speak English as a first language, however this did not always give people access when they needed it. The service offered text talk for the hard of hearing and a language translation service for non-English speaking patients. Staff told us that if patients call into 999 and English was not their first language, they would try to obtain all clinical details necessary. If the level of English was poor and details could not be obtained, the call handler would flag to their senior emergency advisor. Language line gets tagged in to try and locate a translator. It was not always possible to connect to a translator, in which case the call is designated a high priority. In some circumstances, if there was a staff member fluent in the language spoken and a language line translator was not available, then they would use the staff member to help. When there was difficulty with accessing translators, staff report this as an incident. The trust had been monitoring the number of incidents reported regarding language line issues and data provided showed that there had been a 15% increase in the number of incidents reported regarding language line. Between 1 April 2021 and 31 January 2022, 168 incidents had been reported. Data showed 97% of incidents were no known harm and the remaining 3% were low harm. the majority of which resulted in no or low harm outcomes. Themes from the incidents were that there were no interpreters available in the language needed or that language line did not answer the call. The paper also reported that there had been three incidents where cardiopulmonary resuscitation instructions were given in not the patients first language.

During the inspection, we observed an EMA trying to obtain an interpreter for a 999 call. After 15 minutes of no response from the interpretation service, the call was abandoned and referred to a senior member of the team as an incident. Data provided by the trust showed that between 01 April 2020 – 31 March 2021 a total of 753,630 calls were received in 999 services run by SECAmb and the Language Line was used in [LS2] a total of 2687 of these calls (0.33% of total answered 999 calls).

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Managers monitored waiting times and made sure patients could access emergency services when needed, however wait times often exceeded agreed timeframes and national targets.

Calls were risk assessed using the electronic triage software system, NHS pathways to prioritise calls according to clinical need in line with Ambulance Response Programme (ARP).

Category one calls (calls from people with life threating illness or injury), which related to urgent situations requiring an immediate response, such as cardiac arrest, received the highest priority. The service aimed for a responder to be on the scene within seven minutes for these calls. Calls classified as Category two should be responded to within 18 minutes. Category three (urgent calls) and Category four (less urgent calls) should be responded to within 120 and 180 minutes,

respectively. During high demand the surge management policy was in place. This meant category three and four calls were classed as 'no send' calls and placed in the clinical stack. On reviewing the clinical stack and completing an enhanced assessment the clinician was able to upgrade the category of a patient. During the time of our inspection the surge management level was increased from three to four.

Learning from complaints and concerns

People could give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned.

Patients, relatives and carers knew how to complain or raise concerns. There was information on the trust's website signposting patients and members of the public on how to complain to the service. There was also a link to the complaints policy so that patients wishing to making a complaint could see the timelines in which they could expect a response and how their complaint would be dealt with and by whom, however the linked policy was overdue review. Patients could write, email, telephone or text to make a complaint. The website also directed patients to free support in making their complaints from local advocacy services in each geographical area. The trust published their annual complaints and experience report on their website for patients to see.

Between 01 February 2021 and 31 January 2022, the EOC service received 384 complaints from patients and families. The service received 29 compliments during the same period. Of these complaints the majority (54%) of them related to timeliness for the ambulance to arrive.

Compliment 1: the call handler remained calm, kind and comforting, giving advice whilst still asking all the questions he needed to help and get help arranged for XX. Please pass on our heartfelt thanks

Compliment 2: directed me whilst I delivered my son. gentleman's help as well as his cool demeanour, things could of potentially swayed the other way. Mum herself has stated how at ease he put her during the birth.

Staff understood how the complaints policy worked but the policy was currently overdue review. The trust policy for complaints was that 90% should be responded to within 25 working days, except complaints that were also serious incidents for which 60 working days were allowed. In addition, all complaints should be acknowledged within three working days. The trust told us that although the policy was overdue, there had been a lot of work undertaken to revise it to ensure it was accessible for patients, families and staff members. However, there was no indication of when this would be available.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that if a complaint was received, the patient experience team fed this to the team leaders, who then shared with relevant staff to obtain further details. Once the investigation had been completed, the outcome was fed back to staff, regardless of whether the complaint had been upheld. The trust sent us another example of where learning had been identified following a complaint and the plans to improve and share the process.

Staff could give examples of how they used patient feedback to improve daily practice. Staff gave us an example regarding duplicate call management. A change was made following a complaint where if the same caller rings for updates, they update the initial call log, as opposed to creating a new one and possibly missing a change or deterioration in the patient condition.

Emergency operations centre (EOC)

In the staff survey undertaken by the CQC, in response to the question: in this organisation we are encouraged to be open and honest with service users and staff when things go wrong, 47% said they agreed, 23% neither agree or disagreed, and 30% disagreed.

Is the service well-led?

Requires Improvement ↓↓

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

Leadership

Local leaders had the skills and abilities to run the service. However, staff did not always feel they understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service, however, staff told us that senior leaders were not visible or approachable.

Staff told us that local leadership was good. This was reflected in the CQC staff survey response to the question: how satisfied are you with the support you get from your immediate line manager, 54% said satisfied, 12% neither satisfied or dissatisfied, and 34% said dissatisfied. Emergency medical advisors (EMA) and dispatchers reported to team leaders, who reported to the operations centre managers who reported into the head of operations IUC.

However, staff in the EOC told us that they did not feel the executive team were supportive. Examples given were they felt they did not listen to operational staff concerns, that they were not visible to understand the real issues and that they would like more training but were expected to complete continuous professional development in their own time. Staff told us that a simple “hello” would be appreciated when they are on site. One staff member told us that an executive said hello to them for the first time but felt it was only because the CQC were on site, another staff member said it was the first time they had seen that executive on site and again felt it coincided with the inspection. This was reflected in the CQC staff survey carried out prior to the inspection.

In response to the question: Communication between senior management and staff is effective, 66% of staff disagreed, 12% staff neither agreed or disagreed, and 23% agreed.

In response to the question: The organisation values staff and provides them with effective support to do their jobs to the best of their ability, 62% disagreed, 14% neither agreed nor disagreed, and 25% agreed.

We spoke to a senior executive with operational responsibility who knew the vision and strategy at a high level, but did not appear to have a grasp of the issues at an operational level – for example, they did not know what was on the risk register for the EOC. When asked about the operational demand situation staff are facing, we were told the staff member did not have access to that data.

In response to the question: I am able to meet all the conflicting demands on my time at work, 57% disagreed, 23% neither agreed nor disagreed, and 21% agreed.

Vision and Strategy

Whilst there were trust-wide values that staff understood, the service did not have a clear vision for what it wanted to achieve or a strategy to turn it into action.

Emergency operations centre (EOC)

The trust values were: taking pride, demonstrating compassion and respect, acting with integrity, assuming responsibility and striving for continuous improvement. All staff we spoke to knew what the trust values were.

The trust told us their priorities were: delivering modern healthcare to patients by continuing their focus on core services of 999 and 111 clinical assessment service. This linked in with the trust's strategy which was delivering modern healthcare, a focus on people, system partnership and delivering quality. However, staff were not clear how this was going to be achieved or how this linked in with the trust's improvement journey called 'better by design'. Staff we spoke to had heard of 'better by design' but were unaware of what this meant and some were worried about their job security.

Some staff felt that the focus was on 111 services rather than 999, and told us they did not always feel 'visible' by the wider organisation and senior team.

Culture

Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, but opportunities for career development were limited. Not all staff felt they could raise concerns without fear.

Many staff were working beyond their hours under intense pressure and they told us the morale was extremely low in a very tired workforce. However, staff remained focused on the needs of patients receiving care.

Not all staff felt the trust encouraged openness and honestly at all levels. Most staff we spoke with told us they knew how to raise concerns to managers but some did not feel assured of how raising concerns led to change. This was reflected in the CQC staff survey questions: In response to the question: I feel safe to report concerns without fear of what will happen as a result, 45% disagreed, 15% neither agreed or disagreed, and 40% agreed. There was a freedom to speak up: raising concerns policy, that although was not overdue for review at the time of our inspection, contained details of an executive director with responsibility for whistleblowing that was no longer in the organisation and had not been since December 2021. This could have impacted staff who had wanted to speak up.

None of the staff we spoke to during the inspection raised concerns about bullying or harassment, however in the staff survey we ran, the majority of responders stated they had witnessed bullying and did not feel confident that actions were taken to reduce it:

In response to the question: the organisation treats people with respect and takes action to reduce bullying and harassment, 40% disagreed, 26% neither agreed or disagreed, and 34% agreed.

In response to the question: in the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from colleagues, 66% said never, 34% said at least once.

In response to the question: in the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers, 58% said never, 41% said at least once.

In response to the question: the last time you experienced harassment, bullying or abuse at work, did you report it – 34% said no, 18% said yes, and 47% said they didn't know or it was not applicable.

Emergency operations centre (EOC)

Staff told us that they did not always feel supported when they were unwell or not able to return to work. Examples were given where staff were off sick, had no contact from managers, and no phased return on return to work, and felt unsupported. Staff told us that they do not always feel listened to. An example given was that many of the calls received by the trust did not require an emergency response, and staff felt that GPs could be utilised in the call centre to help reduce the number of stacking patients.

The trust had set up a wellbeing hub and tried to make this accessible to all staff for their health and wellbeing. The wellbeing hub was an in-house support service accessible to all staff. The hub provided access to a variety of support. Some of the support included mental and emotional wellbeing, Trauma Risk Management (TRiM), as well as physiotherapy referrals. The wellbeing team would assess and refer or signpost colleagues to the most appropriate service for their needs. Additionally, managers and peers who may be concerned about a colleague can contact the Wellbeing Hub for support and advice. We saw data that showed between April 2020 and March 2021, 704 mental health referrals were processed by the wellbeing hub trust-wide. The wellbeing hub had adapted its existing wellbeing practitioner pathway, resulting in fast-track access to a psychological assessment for those referred with mental health issues. The usual two-week wait time for assessment was reduced to 24 hours, ensuring colleagues received fast and effective support especially during a time of increased pressure as a result of COVID-19.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The governance structure had changed since our last inspection. The trust-wide clinical governance group was made up of 15 committees and five sub committees, for example, the medicines governance group, infection prevention and control, safeguarding and mental health. These fed into the Executive Management Group. The EOC/111 governance group was one of these 15 committees, however it was unclear whether the minutes we had been sent were for this group or another group. We reviewed minutes from a joint 111/999 quality and patient safety group meeting, and saw that serious incidents, complaints and risks were reviewed as part of this meeting.

Outside of the trust-wide clinical governance structure, meetings were broken down from Teams A to Teams E, each group had a different role and remit and included different members. We saw minutes from the Teams A meetings which included the associate director for integrated care (111 & 999) and saw issues such as training and business continuity were discussed.

We requested minutes for EOC leadership meetings but were advised by the trust that they did not currently minute these meetings due to a shortage in administration staff.

Staff we spoke with were clear about their role and remit, however did not always feel they received feedback from relevant meetings. This was backed up with our CQC staff survey question: In response to the question: The team I work in often meet to discuss the team's effectiveness, 66% of staff disagreed, 12% staff neither agreed or disagreed, and 23% agreed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Emergency operations centre (EOC)

The EOC had 19 risks on the risk register, of which four were rated 'extreme'. The four extreme risks related to emergency preparedness, resilience and response (EPRR) and the future of the 111/999 future operating models. However, when we spoke to a senior executive with operations accountabilities, they were not aware of the main risks for the EOC. We saw that risks were discussed at the joint 111/999 quality and patient safety group meeting.

The trust had put in place a strategic and tactical in response to the COVID-19 pandemic. This was focused on three key areas: to manage demand, increase capacity, and system working. The service had been at REAP level 4 (extreme pressure) since July 2021 and this was only reduced to level 3 ('severe pressure) in January 2022. A recovery plan was being developed to show how the trust will support both colleagues and patients moving forward.

With the exceptional pressure on the system, the risks to a safe and effective performance of the ambulance frontline service was high. The ambulance service was set up to cope with unexpected events but staff were concerned about the ability to manage performance with the current increase demand on urgent and emergency care capacity. A significant IT issue affected operations in November 2021 which added further challenges to a service already under significant pressure.

However, foreseeable risk such as changes in demand generally (known as surge), adverse weather conditions and loss of service were well embedded and planned for.

The service followed the government COVID-19 guidance on safety for ambulance trust's. Staff said the national guidance was not always clear in the early days of the pandemic, but the trust updated them when it changed and those staff we spoke with said they thought it was now well understood. We observed staff following the current guidance and local rules for the service.

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 information systems were integrated and secure.

Staff told us there was good access to information through the trust intranet and the online training resource where they could access key information and resources easily. The trust produced a monthly integrated performance report (IPR) which provided an overview of performance and targets. This was submitted and reviewed at the trust board and was available on the public website for the public to view and download. We attended board meetings before and after the inspection and saw that the IPR was used to help make decisions and improvements.

We observed 'real-time' electronic dashboards that monitored performance in the centre and staff reviewed these throughout the day. This information included the number of calls waiting to be answered, waiting time to dispatch, and the surge level. This information was used by the team leads and senior team to manage capacity, demand and staff responsiveness to calls.

Engagement

Leaders and staff actively and openly engaged with patients, staff and the public. However, staff told us they did not always get feedback on service issues or incidents.

Emergency operations centre (EOC)

The trust had an Inclusion Hub Advisory Group (IHAG) whose role was to advise the trust on effective engagement and involvement relevant to service design. The trust told us that this group met quarterly. This group fed into the Inclusion Working Group (IWG) which monitored and reviewed patient and public involvement and engagement activity. The trust told us they had over 9,000 public members who have identified they would like to be involved.

The trust had an active Patient Experience Group (PEG) which met bi-monthly, although due to operational pressures a number of these meetings have had to be cancelled during the pandemic. Patient stories were shared at board level when possible and this had been via video links during the pandemic.

The trust told us they send out survey links (or via hard copy letter) to patients who have either complained or given a compliment. The trust told us that there had been 552 responses received since April 2021 and the majority of which had been complimentary.

The trust had a Patient and Family/Carer Experience Strategy 2020 - 2025 which was developed in collaboration with patients, their carers and other key stakeholders including members of their council of governors, the inclusion hub advisory group, commissioners and Healthwatch. The strategy helped to identify areas that the trust does well in addition to those where change is needed.

Anyone could become a member of the trust and there were annual members meetings to celebrate all the excellent work the staff and volunteers do and to highlight areas where the trust were working hard to improve. The trust produced quarterly newsletters for staff.

Staff told us they got their meal breaks, and there was a live tracker for the number of staff who had taken their meal breaks. At the time of our inspection 8 out of 131 staff had taken their breaks. If breaks were not taken, staff told us the team leaders would come and check on staff.

The trust had annual award ceremonies to celebrate long service and outstanding achievements. In December 2021 the trust introduced a ‘Christmas star’ campaign which allowed staff to nominate colleagues they felt deserved a special thanks for what they do. The trust told us this had been well received with nearly 100 nominations during December.

To acknowledge their effort through the pandemic, staff were allowed an additional day's annual leave and awarded a specially designed coin, however at the time of our inspection the coins had not yet been received.

Compliments were shared with staff by email or individually. There was a compliments board in the EOC but this had not been updated recently. Staff told us compliments were not shared at team meetings, and that staff no longer got minutes from team meetings.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. However many staff felt they did not have the time or support from managers to access learning and improvement.

The trust had recently become a member of NHS Elect, which provided online learning, webinars and course material for all staff who wished to learn or develop their skills. However, staff told us that they simply did not have time to complete these and that they were expected to do this in their own time without any support.

Some staff had been dual trained in responding to 999 calls and 111 calls.

Emergency operations centre (EOC)

The service had recently introduced a taxi service to assist patients that did not require an urgent dispatch but did require conveying to an emergency or urgent treatment department. Staff reported that this new service was experiencing 'teething' issues, with taxi firms not always acknowledging calls or answering 24/7.

Emergency and urgent care

Inspected but not rated

Is the service safe?

Inspected but not rated

Inspected but not rated.

Mandatory training

The service had not been able to provide mandatory training in all key skills to staff. The COVID-19 pandemic had impacted on face to face training for staff.

Key skills training was given during induction and was detailed and varied to enable staff to meet the needs of patients and staff. Key skills training was broken down into eight different modules, four of which all staff completed which included; information governance, dementia, health safety and welfare and manual handling. Clinical staff completed an additional four modules which included; emergency driving training , infection prevention and control level two, resilience/specialist operations and classroom training.

The trust had recently faced extreme, unprecedented operational pressures linked to the impacts of the COVID-19 pandemic. The aim of the Resourcing Escalatory Action Plan (REAP) was to provide the trust with a nationally understood process of escalation in order to provide additional resources in the event of operational pressure being experienced in the system. On the 02 July 2021 the trust took the decision to declare the highest level of escalation and move in to REAP 4. This was due to the significant operational pressures the trust were facing in both 999 and 111, as well as the challenges being felt across the wider NHS. This allowed the trust to take additional further actions to maintain patient, actions such as abstraction cancelling all non-essential training.

As of 31 January 2022, just under 70% of all staff had completed the four key modules, the lowest compliance was manual handling training with 68% compliance. Overall compliance for clinical staff completing the additional four modules was 68%, the lowest compliance was classroom training with 5% compliance. The trust set a target of 85% compliance with key skill training.

Managers had oversight of compliance with key skills training and had developed plans to ensure staff received training. For example, at the Tangmere make ready centre plans showed that all staff would be compliant by April 2022.

Staff we spoke with confirmed they were not able to keep up to date during the COVID-19 pandemic as they did not have protected time to complete even the via e-learning modules.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had received training on how to recognise and report abuse.

Staff received safeguarding training to the level required for their role on induction and refreshed the training every three years.

Data showed that during 2021/2022 60% of professionally registered front line staff had completed Level 3 training if applicable to their role. Eighty six percent of staff had completed either level 1 or 2 adult safeguarding training and 85% had completed children safeguarding training.

Staff we spoke with were able to demonstrate their knowledge of safeguarding and how to make referrals if required. Staff could seek advice from paramedic practitioners whilst with a patient via the telephone if needed. Staff could make safeguarding referrals by using their handheld tablet computer. We saw there was a noticeboard dedicated to safeguarding information including how to contact the trust's safeguarding network if staff required support or advice.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, some staff reported shortages of equipment and machines used to check patients blood sugar were not calibrated.

Ambulance crews told us that blood glucose (sugar) machines were not calibrated. There is a basic requirement for blood glucose meters to be calibrated regularly. If there are no periodic calibrations the accuracy of the blood glucose meter's measurements may not be accurate. People who are diabetic use blood glucose machines to monitor their blood sugar level.

Vehicles we looked at appeared to be well-stocked and were visibly clean and tidy. The floors, the cab, the equipment and the cupboards were all visibly clean.

We visited five vehicle 'make ready' centres. The make ready operatives were employed by a private contractor. They were responsible for the daily cleaning, checking and stocking vehicles as well as deep cleaning. We saw the operatives working to a comprehensive check list and records showing each stage of the process, a copy of the checklist was left in vehicles for staff to check if any items were missing and they signed the checklist to confirm this process. We noted that the operatives placed signs in the cabin of each vehicle to indicate those waiting for cleaning and the ones ready for use.

A green notice was placed in every ambulance to alert staff that it was ready for use. The ambulances we checked were cleaned internally and externally, restocked and refuelled. Each kit bag within the vehicle was labelled with a green tag to indicate it had been checked and was complete. If something was missing from a kit bag it had a red tag, with what was missing written on the tag.

Some staff told us that there was a shortage of some equipment. For example, blood pressure cuffs, thermometers and inflatable evacuation mattresses. Of the five ambulances we inspected we found the only missing item was one inflatable evacuation mattress. Managers told us that this issue had not been escalated to them and they were unaware of the issue. A manager told us that the inflatable evacuation mattress were often mistakenly left with patients in emergency departments and needed collecting.

We saw broken chairs in the staff rest areas at the Polegate 'make ready' centre.

All vehicles underwent maintenance checks by mechanics employed by the trust. Mechanics told us that there were issues getting replacement parts for the new type of ambulance and they had not received any training on it. In addition, they told us that although the diagnostic software had been purchased for the new type of ambulance there were not any manuals, therefore they could diagnose the problem but could not always fix it.

Emergency and urgent care

Staff were not positive about the replacement of the ambulances to a different make; however, this was a nationwide replacement programme. Staff reported safety concerns relating to the fitting of the seatbelts and a smaller working space in the ambulance. Staff who were affected by the fitting of the seatbelts had undergone a risk assessment and some were exempt from driving these vehicles. For example, of the crew based at the Worthing vehicle 'make ready' centre 38 ambulance staff were exempt from driving them. This created logistical problems with trying to match the right ambulance against staff. Managers were aware of the issue and the trust had commissioned an external review of the ambulances. Ambulances had been moved around the different centres to try and mitigate the concerns, but staff told us that this was a real challenge.

Staff ensured the people they met and cared for were protected from COVID-19 and adhered to national guidelines. All staff were part of a regular testing programme. Staff told us they undertook lateral flow tests at least twice weekly and reported the results onto a database.

We saw ambulance staff attending emergency departments were all wearing the right personal protective equipment (PPE) including masks and gloves at the right time. Staff were issued with their own power assisted filter protection hood to protect them when caring for patients with COVID-19. Staff collected a battery pack for the hood and filters at the start of their shift to ensure it was fit for use. Staff said there was ample PPE available and they were trained to use it effectively.

Routine cleaning of ambulances between patients was the responsibility of the crew. Staff explained that if a vehicle became heavily contaminated, crews would return to base and it would be taken out of service until it had been cleaned.

The ambulances were deep cleaned every 12 weeks or sooner if heavily contaminated. This was done by the dedicated 'make ready' team. Records indicated all ambulances were within date for deep cleaning. These records were audited regularly, and we saw copies of these audits which confirmed this.

Staff swabbed vehicles monthly to ensure the quality of cleaning. Trust staff and make ready operatives undertook monthly joint audits to check the quality of cleaning and stock check of equipment, audit records showed good compliance.

Staff disposed of clinical waste safely. We saw general, infectious and hazardous (including sharps') waste stored safely. Waste was collected once a week from each site but could be collected more frequently if required.

All vehicles we inspected contained essential emergency equipment. Equipment such as defibrillators and suctions on board the vehicles were labelled which showed they were serviced, maintained and safety checked.

The various areas of the 'make ready' centres were only accessible by electronic swipe cards given to authorised staff. Keys to ambulances were stored in key safes and were signed out to ambulance staff at the beginning of their shift and signed back in and stored securely at the end of their shift.

We were told the trust continued to promote and encourage staff to participate in the vaccination programme for Covid-19 and Seasonal Flu. The trust monitored rates of staff vaccinated against flu and COVID-19. The trust was able to provide flu and COVID-19 vaccinations to staff, including the booster, or staff could also use their local NHS service. In addition, staff could pay privately to have the flu vaccination and claim the cost back from the trust.

Assessing and responding to patient risk

Emergency and urgent care

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. However, the delays experienced by patients being handed over to the emergency departments were adding risks to patient safety and welfare.

Ambulance crews treated patients on the scene and if required took them to an emergency department for ongoing care. The risk to the patient would then be handed over to the emergency department teams on arrival. The NHS contract states all handovers between an ambulance service and an emergency department must take place within 15 minutes with none waiting more than 30 minutes. The responsibility for the patient is that of the emergency department when the ambulance arrives. Data showed that in the last 12 months the average time of verbal handover from ambulance staff to hospital staff was 19 minutes. Managers monitored compliance with this standard. For example, managers showed us the day before the inspection handover took place in 16 minutes.

In the last three months 16 patients had experienced low harm,15 of the delays was due to inadequate beds within the receiving hospital and one due to an inadequate number of patient cubicles at the receiving hospital. In the same time period 77 patients experienced no known harm caused by delays in handing patients over to the care of the emergency department. Of these 77 delays, three were caused by documentation issues, 47 were caused by an inadequate number of beds within the receiving hospital, eight were caused by inadequate staffing at the receiving hospital and 16 were caused by inadequate patient cubicles at the receiving hospital.

In terms of assessing and responding to the risks to patients who experienced delays in handover, ambulance crews were required to assess and respond to risk and deteriorating patients in situations and timeframes they had not been trained or expected to manage. However, ambulance crews said the medical and nursing staff at the emergency departments responded quickly if they believed a patient was rapidly or significantly deteriorating.

Some patients waited in ambulances for extended periods. Between March 2021 and March 2022 17,794 patients waited longer than one hour to be handed over to the care of emergency departments. In the same time period, there was 82,722 hours lost through delayed handovers to emergency departments.

There was no routine clinical emergency department support to the crews. However, operational team leaders, operation managers and operating unit managers could visit emergency departments to try and resolve issues. We were given an example of when an operating unit manager went supported by a clinical member of staff to an emergency department where ambulance crew had been delayed for over eight hours and helped the patients being admitted releasing the ambulance crew.

Ambulance crew used the National Early Warning Score (NEWS) tool to monitor and manage deteriorating patients. The NEWS2 score was recorded on the electronic patient care report based on the assessment of patient's clinical observations and vital signs. NEWS2 is a simple scoring system. It used scores based on physiological measurements to help identify patients who are deteriorating and indicate the priority for medical intervention.

When handovers were made to emergency department staff, ambulance staff shared key information with them. We observed handovers which confirmed this.

At some make ready centres, a paramedic practitioner hub was available to answer calls from colleagues for clinical advice and support. The aim of this was to support frontline staff with clinical advice from staff they were familiar with. The guidance provided included shared decision making, help with alternative care pathways, support to crews on

scene, clinical referrals and patient follow ups and discharge advice. This was particularly useful for newly qualified paramedics and for emergency care support workers. Paramedic practitioners was also available to attend the location if face to face support was required. This service also intended to reduce inappropriate conveyances to hospital when patients were better suited to being supported in the community to stay at home.

Paramedic practitioners were able to self-allocate any jobs to themselves and monitored the list of outstanding category 3 (urgent calls) jobs and could call patients back, refer to different healthcare agencies or upgrade or downgrade the urgency category of patients. Paramedic practitioners were able to use their own clinical judgement to make clinical decisions rather than following care pathways.

Ambulance staff provided on scene situation reports to control staff within 30 minutes of arriving on scene. These followed a standardised format using the acronym STEPS. Staff welfare at scene and if additional supports required, transporting to a further facility, expected time on scene, Patients current condition, Support needed for shared decision making.

Care pathways were available for ambulance crews on the hand-held electronic system used. There was a colour coded traffic light system which highlighted level of risk and provided guidance to staff. The trust had worked with other care providers to identify the primary community pathways. These included pathways for patients with frailty, dementia, mental health, end of life care, chest infections, urinary tract infections, catheters and falls.

When people called 999, they were assigned an urgency category based on their condition, which determined the type and time of the response from ambulances. These are category 1- calls from people with life- threatening illness of injuries, category 2- emergency calls, category 3- urgent calls and category 4 less urgent calls. At times there were many outstanding category 3 patients awaiting an ambulance or assessment by a paramedic practitioner. At busy times these patients waited extended lengths for crews and call backs. Therefore, this group of patients were at risk of deterioration whilst they were waiting for a response. Staff told us that there were lots of different people monitoring the category 3 backlog but nobody taking accountability for it.

The trust had up to date policies and procedures to manage patients with disturbed behaviour, we saw a clinical bulletin went to all staff regarding the management of acute behavioural disturbance.

Staffing

In normal circumstances, the service had 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. However, the ambulance handover delays, unplanned absence through sickness or COVID-19 isolation rules, and the pressure from increasing demand meant staff could not always provide the care patients needed. Some staff reported working excessive hours and managers were not aware of what their staffing establishment should be.

The service was under additional pressure from staff sickness and COVID-19-related absence. Data showed from April 2021 and February 2022, the overall sickness rate for staff working in urgent and emergency care was just over 9%.The highest level of sickness was in December 2021 and January 2022 when the overall sickness rate was nearly 12%.This equates to 80,267 staffing hours lost to sickness during the same time period.

Emergency and urgent care

Many staff were working beyond their hours and not always getting breaks on time in what were already long shifts. Staff told us that they often worked excessive hours and were required to drive long distances during their shift which some felt impacted on their ability to drive safely. Staff were required to have a minimum of 11 hours between each shift which meant if their previous shift did not finish on time then they started late on the next shift, which impacted on service delivery.

The trust had offered a number of different financial incentives to reward staff for working overtime to cover the service. Staff had mixed views on these, however at the Tangmere 'make ready' centre the 5am until 11am shift on overtime had been popular with staff.

Managers told us that they did not know if they were staffed to their planned staffing establishment as they did not know what the staffing establishment should be. Managers told us that an external company had been undergoing a review of what staffing establishments should be and that the time frame for this to be concluded kept extending.

Data showed there was an overall vacancy rate of 7% across all staff groups working in urgent and emergency care, this equated to 170 vacant posts. The highest vacancy were amongst Emergency Care Support Workers at Tangmere and Worthing ambulance stations with a 50% vacancy rate. The second and third highest vacancy rates were amongst Ambulance Paramedic, Newly Qualified Paramedic (NQPs) at Chertsey ambulance station (31%) and Tangmere and Worthing ambulance stations (22%). Manager posts were fully staffed to the establishment. The overall month on month turnover rate for all staff groups working in urgent and emergency care was 1% based on people leaving against substantive posts. The highest turnover of staff was amongst NQPs (6.3%) at Dartford and Medway ambulance station. Emergency care support workers had a month on month turnover rate of between 1% and 4%.

There were skill mix rules which managers told us was an issue. The trust had strict criteria about which staff were able to work together dependent on their skill level and there was a matrix to support how this worked practically. However, during the COVID-19 pandemic it was not always possible to achieve the skill mix rules. Managers tried to ensure that ambulances were staffed with the highest level of trained staff with a paramedic in each ambulance. We saw an example during the inspection when an ambulance went out on a category 1 call, a manager looked up what staff had been allocated to the call to assess if any additional support was required.

Each 'make ready' centre had a make ready centre manager who had oversight of the rota, which was compiled by the schedulers. The rota informed staff of shifts indefinitely and the scheduling team then allocated relief duties, which were approximately two weeks in every six weeks, for any unfilled shifts that occur due to leave, sickness, or training.

The operational team leaders (OTLs) made decisions on a daily basis to cover unexpected absences. There was an escalation policy for unsafe staffing but the expectation was that it was the responsibility of the OTLs to resolve issues that occur. OTLs told us that managing staffing was very challenging and often resulted in last minute shift changes for staff.

Ambulance crew members worked a combination of days and nights. Managers told us they believed there were staffing shortages on nights, for example, in one area in Sussex we were told there were sometimes only two vehicles on the road despite the workload being similar to a day shift. The lack of staff on the night shifts in Sussex was an ongoing problem that the trust was attempting to remedy. A third-party provider provided one emergency response ambulance 24 hours a day seven days a week in this location to provide extra support.

The trust also used private ambulance providers to help offset some of its workload and to assist with staffing deficits.

The trust had an induction process for new staff, practice development paramedics and paramedic practitioners supported new staff especially newly qualified paramedics (NQPs).Rotas showed the role of each individual staff member and identified NQPs so they could be supported.

The service uses internal bank staff who were all trained in key skills. The service does not use any agency staff.

To gain feedback from staff in a confidential way the CQC undertook an online staff survey. The online survey ran between 22 February and 04 March 2022. The survey received 337 responses from staff working in urgent and emergency care throughout the trust. In response to the question: I am able to meet the conflicting demands on my work time; 55.2% strongly disagreed, 20.8% neither agreed or disagreed and 23.4% agreed or strongly agreed.

In the same survey staff were asked to leave comments, we received 150 comments from staff. Comments from staff regarding the rota and shifts included; “no flexibility at all in the rotas and people struggle with childcare, “the trust makes staff work 30% of their shifts at short-notice "relief" but does not appreciate this demand and the impact it has on people's work life balance” and “the trust does not make any effort to facilitate flexible working for people within their rotas”. However, there was a minority of positive comments which included “They have never made it difficult for me to take time off to support my partner, they have been wonderful’.

Records

We were not able to review any patient records during the inspection due to social distancing rules.

The trust had moved to an electronic recording system for clinical documentation which was on their handheld tablet computer. Mobile devices were personal issue for substantive staff members, bank staff were able to access a device at each make ready centre. We observed that staff kept these secure at all times.

The trust used an electronic records system called to log details of patient care plans and needs. For example, any special care pathways for patients living with a health condition which meant they often called an ambulance. This enabled ambulance crews to make the best clinical decisions when attending patients as all the relevant information was available. Healthcare professionals in the community advised the trust of patients who might benefit from being added to the system. Patients had to consent to have their details shared and uploaded to the system which was generally carried out in primary care services. Once patients agreed to share their medical records then alerts could be added to the system. A manager showed us an example of this where a patient had an alert for do not attempt cardiopulmonary resuscitation. Other alerts that could be added included, advance care planning and details of patient’s pre-existing conditions and safety risks. Ambulance crews had access to the system through their handheld mobile devices.

Medicines

Generally, staff stored, administered and managed all medicines in line with the provider’s policy.

Medicines in ambulance stations and make ready centres were stored in automated storage systems. Where the automated storage systems were used, access to the room was controlled by use of an authorised swipe card and access to the automated storage systems was by biometric (fingerprint) recognition.

The service stored medical gases safely.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Ambulance crew were supported to administer medicines via trust policies, guidelines and the UK Ambulance Services Clinical Practice Guidelines. Patient group directions and policies were on handheld tablet computer for medicine administration and instruction. Patient group directions authorised paramedics to administer or supply a wider range of medicines depending on their role, additional training and competency.

Ambulance stations and 'make ready' centres used an electronic ambient temperature monitoring system for medicine stores. We saw thermometers in each of the storerooms we visited. These devices were linked to a central control and alarmed if the temperature in the room increased or fell below specified temperature.

We had some concerns relating to Patient Group Directions (PGDs). PGDs provide a legal framework allowing some registered health professionals to supply and/or administer specified medicine. The risks were associated with the lack of training and competencies-based assessments to ensure these staff can safely undertake this aspect of their role. The trust was mitigating the risk by using a competency-based questionnaire so that paramedics could self-assess their own competencies. We were informed this was improving and an eLearning PGD module was recently introduced.

Incidents

The service did not manage patient safety incidents well. Staff recognised incidents and near misses but did not always report them appropriately. Managers did not always investigate incidents and share lessons learned with the whole team, the wider service and partner organisations.

The trust used an electronic incident reporting system, which staff accessed with an electronic tablet or via computers at their base. Staff we spoke with were clear about the reporting system and knew how to access it. Staff told us they reported a wide range of issues including safeguarding incidents, issues with practice and vehicle and equipment issues. However, staff told us that they did not always receive a response or feedback from incidents they raised. Staff told us that learning from incidents was not communicated unless it was a serious incident and they were directly involved in the incident.

This was reflected in the staff survey undertaken by the CQC. There were eight comments relating to the management of incidents. Comments included: "Often incidents are left for months without a response", "incidents just get closed without any discussion, makes it feel pointless in raising concerns as they just get shut down without properly addressing concerns", "incidents are frequently swept under the carpet" and "inexperienced staff report incidents as they are encouraged to do so, but due to a blame culture, they learn to refrain from doing so and they will either receive sanction"

In the same survey in response to the question: I hear about incidents that happen in my part of the organisation, 41.8% of staff either strongly disagreed or strongly disagreed, 23.4% neither agreed or disagreed and 34.7% agreed or strongly agreed.

In response to the question: My organisation encourages us to report, errors, near misses or incidents, 11.3% of staff either strongly disagreed or strongly disagreed, 12.2% neither agreed or disagreed and 76.6% agreed or strongly agreed.

In response to the question: When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again 31.8% of staff either strongly disagreed or strongly disagreed, 29.1% neither agreed or disagreed and 39.2% agreed or strongly agreed.

Emergency and urgent care

Data showed there were 420 incidents overdue for investigation across the urgent and emergency care service, the highest number (79 of all incidents) awaiting investigation were within the Brighton and Mid Sussex Operating Unit, the second highest (63 of all incidents) were within Medway and Dartford Operating Unit. Trust wide as of 23 February 2022 the trust had 537 incidents awaiting an investigator to be allocated, of these 186 were in the overdue category. The number being investigated was 1,361 with 840 in overdue and awaiting closure. The trust told us that due to unprecedented operational pressures linked to the impacts of the COVID-19 pandemic incident investigations had been delayed.

Data showed that from November 2021 and January 2022 eight serious incidents within clinical operations of urgent and emergency care. Managers told us that serious incidents were investigated by a corporate team within the trust and therefore the learning may not be shared for some time.

Staff understood their responsibilities in relation to the duty of candour. Operational team leaders told us they would either phone or write to patients where an incident had occurred, and the duty of candour subsequently applied.

Is the service effective?

Inspected but not rated

Inspected but not rated.

Response to patients

Due to extreme demand, the service was not meeting any NHS constitutional ambulance response times, which was a similar picture across the ambulance services nationally.

The trust was trying significantly reduce conveyance to hospitals and increasing treatment of patients by phone or at the scene to help with pressure on the rest of the urgent and emergency care system.

The NHS constitutional standards are set out in the Handbook to the NHS Constitution. They are these:

All ambulance trusts to:

- respond to Category 1 calls in 7 minutes on average, and respond to 90% of Category 1 calls in 15 minutes
- respond to Category 2 calls in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes
- respond to 90% of Category 3 calls in 120 minutes
- respond to 90% of Category 4 calls in 180 minutes

The times for response are those considered as the most clinically safe for the patient's assessed risk and to send a response to the sickest patients first. The categories are determined by a clinical triage system based on national standards with category 1 being the most seriously ill or injured patients.

In the last 12 months the trust had categorised 54,609 calls as Category 1, this was 8% of all calls and was lower than the England average in the same time period.

Emergency and urgent care

In the most recent NHS published data at the time of writing (October 2021) for ambulance services in England, South East Coast Ambulance Service responded to patients as follows:

Category 1 calls 8mins,26secs (8.26) on average and 15.28 for 90%.The England average was 9.20 and 16:23 respectively. No NHS ambulance trust in England met the 7 minute standard. This measure shows the amount of time taken to reach 90% (9 out of 10) of all category 1 calls- was 15.28 mins.

Category 2 calls 27.02 on average and 53.18 for 90%. The England average was 53:54 and 1:56:13 respectively. No NHS ambulance trust in England met the 18 minute standard. This measure shows the amount of time taken to reach 90% (9 out of 10) of all category 2 calls 53.18 mins.

Category 3 calls 2:19:14 and 5.17.19 for 90%. The England average was 3:09:58 and 7:47:15 respectively. No NHS ambulance trust in England met the 120 minute standard. This measure shows the amount of time taken to reach 90% (9 out of 10) of all category 3 calls 5.17 hours.

Category 4 calls 3:07:32 and 6.59.52 for 90%. The England average was 3:37:00 and 8:01:16 respectively. No NHS ambulance trust in England met the 180 minute standard. This measure shows the amount of time taken to reach 90% (9 out of 10) of all category 4 calls 6.59 minutes.

Between February 2021 and February 2022, the trust recorded a total of 756,543 incidents (requests for ambulances). Of these 57% of patients were transported to an emergency department in a hospital. The trust was trying to reduce conveyancing to hospitals and increasing treatment of patients by phone or at the scene to help with pressure on the rest of the urgent and emergency care system.

The ambulance triage system and clinical intervention by trained staff recommended some patients were treated with clinical advice given remotely – usually by telephone in order to reduce pressure in the system and on crews. Between February 2021 and February 2022 an average of 10% of patients were supported through 'hear and treat'. The number of patients supported through 'hear and treat' had increased throughout the 12-month period. In February 2021 8.4% of patients were supported through 'hear and treat' and by February 2022 11.1% had been supported through 'hear and treat'. However, this was still lower than the national average.

The trust had also implemented 'see and treat' – when a person does not require hospital care but instead a paramedic or another clinician provides treatment at the scene, which could be in someone's home or in the community. Between February 2021 and February 2022 an average of 32% of patients were supported through 'see and treat'. The number of patients supported through 'see and treat' had been roughly the same throughout the 12-month period but were still below the national average. Both these objectives had led to far fewer patients being conveyed to emergency departments. In the last six months 10% of patients re-contacted the service within 24 hours following treatment and discharge at the scene.

Patient outcomes

The service monitored the effectiveness of care and treatment. In times of normal demand patterns, it used the findings to make improvements and achieved mostly good outcomes for patients in line with national averages. However, with the rise in demand alongside the reduction in capacity due to delays, some patients were coming to unintended harm as the ambulance was unable to get to them in a clinically safe time. There was a clear approach to monitoring, auditing and benchmarking of outcomes for people receiving care and treatment.

Emergency and urgent care

Since June 2021 the trust has carried out over 4,700 harm reviews, however, these have related to potential harm caused or not prevented by the service. In the last 12 months 28 patients had suffered severe harm as the result of delays.

The trust reported that in the last 12 months, 28 patients were reported through the incident management system as suffering severe harm due to delays in ambulances. However, these have related to potential harm caused or not prevented by the service. A review by the trust of incidents of serious harm due to delays in ambulances being on scene had been conducted now for several months. The trust has carried out over 4,700 harm reviews. However, we found the quality of the review's poor and learning from potential harm was not always identified.

However, while patient outcomes were adversely affected from delays in response times, other outcome measures recorded against national standards showed some positive clinical indicators. Return of Spontaneous Circulation (ROSC), (e.g. signs of breathing or a pulse) is the main objective for all out of hospital cardiac arrests. The latest data showed (up to September 2021 that 34% of all patients who had resuscitation commenced or continued by ambulance staff had ROSC at the time of arrival at hospital. This was better than the England average of just over 25%.

The outcomes for patients who suffered cardiac arrest (data went up to September 2021) showed that 11.8% of patients survived at 30 days this was above the national mean of 9.6%.

Patients were treated (time period April 2021 to July 2021 in slightly less time than the national average when receiving a catheter insertion for those needing an angiography for a definite myocardial infarction (heart attack). Fewer patients (61%) received an appropriate care bundle with a suspected ST-segment elevation myocardial infarction (STEMI – or serious heart attack) against the national mean for the same period of 77.0%.

Data (time period April 2021 to July 2021) for stroke patients showed slightly better times than average for the time of the call to hospital arrival. However, trust wide performance against the stroke care bundle for April 2021 to August 2021 was 96%, against the national mean for the same period of 98%.

Trust wide performance against compliance with the sepsis care bundle for April 2021 to September 2021 was 84%, against the national mean for the same period of 83%.

Competent staff

The service did not make sure staff were competent for their roles. Managers did not appraise staff's work performance.

From April 2021 to January 2022, 25% of staff within the emergency and urgent care at the trust received an appraisal compared to a trust target of 95%. The trust told us they identified an issue with under-reporting of completed appraisals. To address under reporting of appraisals the learning and development team carried out a validation exercise to ensure that all completed appraisals were accurately recorded and reported. Overall, from the returns received, an additional 400 completed appraisals were identified and reported in the February 2022 appraisal compliance report, but this did not include any staff working in emergency and urgent care. The trust told us that due to services recently facing extreme, unprecedented operational pressures linked to the impacts of the COVID-19 pandemic this had impacted on the ability to undertake appraisals.

The staff survey undertaken by CQC included comments from staff on the development and education of staff. Comments included: "there is little opportunity for staff progression" and "continuing professional development is enforced within our own time and our three allocated study days a year are non-existent".

Emergency and urgent care

Multidisciplinary working

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

Ambulance staff and staff within emergency departments worked closely to support a shared approach to patient care as much as possible.

Staff at the local emergency departments and ambulance crews described a good and friendly working relationship. We observed good natured banter and exchanges between emergency department staff and ambulance staff. Handovers of patients were professional and comprehensive. Emergency department staff had an electronic tracking system to alert ambulance staff when to bring patients to the emergency department. Emergency department staff signed the ambulance staff's record to accept the patient and agree the handover had taken place. Ambulance staff could leave soiled linen and collect fresh linen and could also use the kitchen facilities to make a cup of tea while they were in the department.

There had also been mutual aid given and received by other ambulance services and support from a team of volunteers and first responders. Staff could call on ambulance services from across regional borders to request support if that service could respond more quickly to the trust's most urgent calls.

The trust had contracts with a small number of independent ambulance providers who were closely monitored under clear contractual terms.

Is the service caring?

Inspected but not rated

Inspected but not rated.

Compassionate care

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

Due to restrictions in place at the time of the inspection we were unable to talk to any patients directly. However, we observed staff were professional and demonstrated empathy and reassurance whilst speaking to patients.

Staff were concerned that the newly purchased ambulances made it harder to ensure dignity was maintained. The ambulance cannot accommodate a wheelchair and a trolley inside; this meant having to complete the transfer outside the ambulance before getting onboard with the trolley. We observed patients being covered by blankets when being transported out of the ambulance to the emergency department to maintain their dignity.

With the guidance around COVID-19 safety for staff and patients, it was harder for staff to support patients as family or carers were not able to accompany them in the ambulance. We did not observe any relatives during the inspection, but staff described how they developed friendly relationships and made sure they kept them informed of the plan of care.

Emergency and urgent care

We reviewed the NHS website where patients and their families could leave feedback about the care they received. The last 10 reviews which were all positive and included the comments; “All the ambulance people are so kind, patient, efficient and helpful” and “staff were thorough and professional but took the time to be kind, patient and respectful”. Between 01 February 2021 and 31 January 2022, the urgent and emergency care service received 1994 compliments from patients and families. We reviewed four of these compliments and comments included: “Your staff were caring, sympathetic and comforting - thank you” and “there are not enough words to how we say thank you to you all from when that call was first picked up”.

We also received patient feedback from local Healthwatch branches. This feedback indicated patients experienced very long waits but were satisfied with their care when the crews arrived on scene. However, we also noted a small number of concerns indicating some poor experiences related to staff attitude and behaviour.

Is the service responsive?

Inspected but not rated

Inspected but not rated.

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. However, due to demand on the whole urgent and emergency care pathway, there were unmet needs for patients.

The service used a computer-based system to plan using long-term data and analysis of demand and also in response to the changing needs of a system or community. There were plans drawn up for a change in demand in the service such as major incidents or adverse weather. This meant the service could quickly adapt to support the needs of the community.

The service had a number of different initiatives to try and reduce or limit admissions to hospital and ensuring accurate referrals of patients to other services. There was a community falls team and the trust had designed and delivered a falls package which allowed community first responders (CFRs) to carry out a primary falls response to patients who had fallen in the community. CFRs make a primary assessment of the patient and if not seriously injured can mobilise them again or convey to hospital if required. This service allows a more timely response to patients who otherwise may have to wait a protracted time for an ambulance response and allows not only an early assessment for the patient but allows for comfort measures to be introduced, and if safe moved from the floor.

We saw that the trust worked with others in the wider system and local organisations to plan care and reduce conveyances to emergency departments when not required. The trust was working proactively with system partners on different projects. For example, enhanced health in care homes – enabling systems to identify and support care homes that are frequent callers into the 999/111 services.

The trust is working with system partners to contribute to the national priorities concerning mental health transformation and maternity networks.

Emergency and urgent care

The 111 service leads making direct appointment bookings for patients into emergency departments, primary and community care pathways. For example, same day emergency care pathways for patients.

The trust was working alongside local authority partners to trial educational support for careline responders to risk assess and support callers, whilst reducing 'long-lies' falls through early intervention.

Staff could access a directory of services which was a live database of all services available for patient care, for example GP surgeries, walk-in centres, dental services and district nurses. The services have detailed profiles of who they can see, what they can treat, when they are open and how they are contacted. It is designed to divert patients into other local services rather than calling an ambulance and being transferred to hospital. Managers told us that it was underused by staff and there was a plan relaunch in April 2022 to remind staff of what other services were available and tips on using it.

The service supported the COVID-19 oximetry at home service. This service supported people at home who have been diagnosed with coronavirus and are most at risk of becoming seriously unwell. Patients were given a machine which monitors the oxygen levels in their blood, if their levels drop, they could contact 111 or 999 where trained staff can offer advice and refer to the most appropriate healthcare agency if required.

Ambulance staff recognised and respected the need to provide individualised personal treatment and care as far as they were able. There were processes to engage hard to reach communities and links with various charities. For example, there were designated staff that engaged with the travelling community.

The trust had introduced a wellbeing hub which provided a range of support for staff to stay physically and mentally well as well as provide talking therapy, physiotherapy and many other initiatives.

The service took into account the particular needs and choices of different people.

In order to safely manage incidents where the patient does not speak English, operational staff may contact the trust's approved provider for interpreting services. Between 01 April 2020 and 31 March 2021, a total of 753,630 calls were received in 999 services run by the trust. The interpreting service was used in a total of 2,687 of these calls (0.33% of total answered 999 calls). Sixty-three different languages were accessed during this time, up from 54 the previous year.

The service used the relay UK service which lets deaf, hard of hearing, or speech-impaired people in the UK alert police, ambulance, fire, or coastguard services by either calling via a relay assistant or texting a message to 999.

The trust told us that ambulances carried multilingual emergency phrasebooks for road staff, with phrases in 41 languages plus British Sign Language and pictorial communication booklet to help patients with communication needs. However, staff told us that these were no longer carried on ambulances.

The service used an electronic system whereby other healthcare professionals can inform the ambulance service of any particular patient needs with the patient's consent. A flag is placed on the electronic system which informs staff of any additional needs a patient requires.

The service used a 'history marking' system, where a note can be placed against a patient's address on the electronic patient record system used by staff to include of any useful information about the patient or their condition, such as language needs or directions to a difficult-to-find property.

Emergency and urgent care

The service had specialist bariatric vehicles permanently stationed at the three key locations that could be used to care for patients with a high body mass index.

Access and flow

Due to pressure already described, people were not able to access the service when they needed it at all times or in line with national standards. Not all patients received the right care in a timely way.

Access to the service for patients was severely affected by rising demand and handover delays in hospital emergency departments. This was not an issue exclusive to this trust and many hours were being lost in emergency departments nationally. There was also a growing number of patients calling the ambulance service and the 999 and 111 service being used when another agency would be more appropriate. Patients accessed 999 and 111 when they did not know where else to access support or other alternatives such as GPs, 111 or community services where not responsive. This was a complex picture with many factors.

Many and increasing numbers of hours were being lost while ambulances were held at emergency departments. In the previous 12 months a total of 7119 hours had been lost because of handover delays in emergency departments. Between March 2021 and January 2022, the mean average response time for a hospital to hospital transfer undertaken by the service was just over 9 hours this was equal to the England mean average in the same time period.

Patients categorised as a 3 or a 4 were not receiving care in a timely way. This was identified at our previous inspection. The trust has made little progress in addressing this. However, the situation has been made worse by the COVID-19 pandemic.

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and but sharing of lessons with staff was limited.

We saw there was no information within ambulances explaining to patients how they could make a complaint if they had concerns about their care and treatment. However, patients had made complaints, between 01 February 2021 and 31 January 2022, the urgent and emergency care service received 401 complaints from patients and families. Of these complaints the majority (55%) of them related to staff conduct or attitude.

Managers told us that until recently there had not been a local system of monitoring themes and trends of incidents, however this was now in place, therefore learning from complaints was not shared. One manager told us how they had identified a theme amongst a small proportion of staff that had multiple complaints about their conduct. The manager had addressed this with the members of staff and there had not been any further complaints.

Is the service well-led?

Inspected but not rated

Leadership

Emergency and urgent care

Local leaders had the skills and abilities to run the service. However, staff did not always feel they understood and managed the priorities and issues the service faced. The majority of local leaders were visible and approachable in the service for staff. However, staff told us that senior leaders were not visible or approachable.

The urgent and emergency care service was led by the Executive Director of Operations, they were supported by three Associate Directors and a Head of Community Resilience. The urgent and emergency service was split into two by geographic location; East and West each had five operating unit managers. Operating unit managers were supported by; make ready managers, operations managers and operational team leaders.

The service was under intense pressure. Senior management told us they attended meetings every day to assess the pressure on the system and find ways to ease it.

The trust had engaged with hospital trusts and other care providers to attempt to improve the flow of patients transported to hospital, and lower handover delays. The trust had introduced innovative ways (previously mentioned in report) to ease the need for some patients to be transported to hospital. However, further work was needed to address the current challenges the service faced.

Staff told us that generally their immediate managers were visible and approachable, but they felt managers above were not supportive or visible. Comments from the staff survey undertaken by the CQC included; “I find that the local operational team leaders are very supportive but find the managers above aren’t” and “the trust is in a state of flux with no clear leadership form the top”.

Staff told us that there was a lack of communication between staff and senior managers in the trust regrading matters that affected them. Managers told us that the human resources department was not supportive or consistent in their approach often working outside of the trust's own polices. For example, operational staff on alternative duties because they are at high risk if they contracted COVID-19, cannot be replaced and there is a lack of supporting policies on the management of these staff. Staff also raised concerns about recruitment processes and introduction of policies may unfairly discriminate against different groups of staff.

Vision and Strategy

The service did not have a clear vision for what it wanted to achieve or a strategy to turn it into action.

The trust values were: taking pride, demonstrating compassion and respect, acting with integrity, assuming responsibility and striving for continuous improvement. All staff we spoke to knew what the trust values were.

The trust told us their priorities were: delivering modern healthcare to patients by continuing their focus on core services of 999 and 111 clinical assessment service. This linked in with the trust’s strategy which was delivering modern healthcare, a focus on people, system partnership and delivering quality. However, it was not clear how this was going to be achieved or how this linked in with the trust’s improvement journey called ‘better by design’. Staff we spoke to had heard of ‘better by design’ but had no understanding of what it meant in real terms for them or the patients they cared for. Staff were not involved in its development or engaged with during the design phase. This poses a potential risk to the organisation's ability to deliver this project without staff buy in or understanding.

Staff told us that there was a lack of an overall strategy for the trust. Comments from the staff survey undertaken by the CQC included; “We do not have a clear guidance on the trust’s progression, we are unable to show clear links to our day to day work and the direction of the trust and “leadership is questionable with no clear strategy or direction”.

Staff described the leadership style as a 'control and command' style. Staff accepted that this approach was needed at the height of the pandemic however, they felt there was little will to move away from this.

Culture

Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, but opportunities for career development were limited. Not all staff felt they could raise concerns without fear.

Many staff were working beyond their hours under intense pressure. However, staff remained focused on the needs of patients receiving care.

Not all staff felt respected, supported and valued. This was reflected in the staff survey undertaken by the CQC and the trust's own recent survey. Data we reviewed showed repeated use of the words bullying and toxic when talking about the culture. Comments from staff included: "the job is great, but the bullying culture is starting to return, which is a real shame" and "here is a hideous culture at the moment of micromanagement, intimidation, coercion and bullying".

The trust told us there was strong emphasis on the safety and wellbeing of staff. Some initiatives to support the wellbeing were welfare trolleys and vans which provided hot drinks and snacks, wellbeing advocates and an extra day's annual leave for staff. There was an employee assistance scheme provided around the clock by an external provider with immediate contact with a trained counsellor offered to staff. However, the pressure on staff was taking its toll. Staff said they recognised there was support for them, but many said they did not have time or the energy to use it and in most cases it needed to be accessed outside of work hours. However, some staff expressed concern the support from the wellbeing hub was being stretched during the last two years given the increase in referrals. Staff also raised concerns about the level of support for the wellbeing hub from the current executive team.

The service promoted equality and diversity in daily work. The trust developed a reasonable adjustments passport in partnership with the disability and carers network. This provided a framework for colleagues to approach their managers to discuss how their particular circumstances, disability or health condition impacts them at work. Electronic stethoscopes were available for staff who had a hearing impairment and there was a variety of online tools and guidance to support accessibility in IT systems. However, we were also made aware of concerns where staff were concerned about discrimination in the organisation particularly towards female staff.

Staff told us they felt demoralised by the situation of leaving patients waiting for hours for ambulances to reach them. They told us this had a personal impact on them because they care.

Staff told us that opportunities for career development were limited and anything additional to their role had to be undertaken in their own time and staff were not receiving appraisals

The culture did not encourage, openness and honesty at all levels within the organisation, including in response to incidents. This was reflected in comments made by staff in the staff survey undertaken by the CQC. Comments included: "Reporting errors and mistakes is encouraged but rather than creating a learning culture, there's a widespread blame culture that's more likely to get the reporting person in trouble". Other comments included;" I am scared of speaking up" and "reporting issues fall on deaf ears"

Emergency and urgent care

CQC received a high number of whistleblowing concerns before and during the inspection process. Common concerns were raised about bullying and harassment, inappropriate sexualised behaviour and a combination of raising concerns which were not addressed and a fear to speak up.

Management of risk, issues and performance

Leaders and teams used systems to monitor performance. They generally identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events, although were struggling with how to manage the significant increase in demand in urgent and emergency care.

The trust had put in place a strategic and tactical response to the COVID-19 pandemic. This was focussed on three key areas: to manage demand, increase capacity, and system working. The service had been at REAP level 4 (extreme pressure) since July 2021 and this was only reduced to level 3 ('severe pressure) in January 2022. A recovery plan was being developed to show how the trust will support both colleagues and patients moving forward.

With the exceptional pressure on the system, the risks to a safe and effective performance of the ambulance frontline services was high. The ambulance service was set up to cope with unexpected events but staff at all levels were concerned about the ability to manage performance with the current increase demand on urgent and emergency care capacity. A significant IT issue affected operations in November 2021 which added further challenges to a service already under significant pressure.

The urgent and emergency care service had a comprehensive up-to-date risk register. The highest risks were those outlined throughout this report. These were; as a result of the failure to deliver the key skills to all appropriate staff, there is a risk that that overall staff confidence and competence may reduce, there is a risk that patients will come to harm due to inability to provide a timely response and staff vacancies. All risks had mitigations and had been reviewed within the last 12 months. Managers were able to describe to us the risks that faced their area, except for one location we visited who did not show they knew what the risks were. Not all leaders knew how or where to escalate risks to.

The trust has seen an increase in reported violence and aggression towards staff in the last three years. Therefore, it is trialling body worn cameras in six locations across the region and the footage can be used as evidence in cases of violence or abuse.

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 information systems were integrated and secure. Managers were able to show us how they accessed data on performance and how they monitored it and acted upon it. The service has weekly performance meeting to review and monitor performance across the trust.

All staff had handheld electronic devices that were password protected. Information was kept confidential and stored securely. The devices meant staff could report incidents and safeguarding's in real time without having to report to their base.

Engagement

Emergency and urgent care

Leaders and staff had limited engagement with patients, staff, equality groups and the public to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had a Patient and Family/Carer Experience Strategy 2020 - 2025 which was developed in collaboration with patients, their carers and other key stakeholders including members of our council of governors, the inclusion hub advisory group, commissioners and Health Watch. The strategy helped to identify areas that the trust does well in addition to those where change is needed.

Anyone could become a member of the trust and there were annual members meeting to celebrate all the excellent work the staff and volunteers do and to highlight areas where we the trust were working hard to improve. The trust produced quarterly newsletters for staff.

There were twice weekly conference calls open to all staff, on a Monday and Friday which discusses current and projected operational concerns, wider updates across the trust along with any other new and important information and offers the opportunity for questions. However, staff told us they were not able to attend these as they were too busy.