South Western Ambulance Service NHS Foundation Trust

Emergency operations centre (EOC)

Inspection report

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Date of inspection visit: 23 to 25 November 2021
Date of publication: 17/03/2022

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Emergency operations centre (EOC)

Inspected but not rated

South Western Ambulance Service NHS Foundation Trust works across the whole of the south west of England from Gloucestershire in the north to Cornwall and the Isles of Scilly in the south. This is an area of around 10,000 square miles and 20% of mainland England. The trust serves a population of around 5.6 million people. The south west also has in the region of 23 million tourist visitors each year.

The trust employs around 4,000 staff, runs 94 ambulance stations, six air ambulance bases and two hazardous area response teams. The team of staff includes paramedics, specialist practioners in urgent and emergency care, clinicians including doctors, advanced technicians, ambulance care assistants and nurse practitioners. The trust is also supported by GPs, the fire and rescue services (co-responders), community first responders, and volunteers.

We carried out this short-notice announced inspection in November 2021. We had an additional focus on the urgent and emergency care pathway for patients across the integrated care system in Gloucestershire. As the trust serves the whole of the South West of England, not all information relates to Gloucestershire, but we have included specific data and evidence where we can.

As this was a focused inspection, and we did not look at every question in our key lines of enquiry, we did not re-rate the service this time.

On this inspection we reviewed emergency and urgent care services (the ambulance crews responding to emergency 999 calls) and the emergency operations centres (known in the trust as the clinical hubs). For both services we looked at elements of the safety, effectiveness, caring, responsiveness and leadership of the staff and teams in the clinical hubs, responding to 999 calls, and those supporting the emergency departments on site.

At our previous inspection published in September 2018, we rated emergency and urgent care services at the trust as good overall, although the key question 'Is the service Safe' was rated as requires improvement. Caring was rated as outstanding and the other key questions as good. We rated the emergency operations centres as good overall.

As this was a focused inspection around system pathways focused on Gloucestershire, we did not inspect Resilience (previously rated in 2016 as outstanding) or Urgent and Emergency Care (for which the trust runs an urgent treatment centre in Tiverton – previously rated in 2016 as good). We continue to monitor these services and will inspect them in the course of our programme of inspections.

A summary of CQC findings on urgent and emergency care services in Gloucestershire

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. On this occasion we did not inspect any GPs as part of this approach. However, we recognise the pressures faced by general practice during the COVID-19 pandemic and the impact on urgent and emergency care. We have summarised our findings for Gloucestershire below:

Our findings

Provision of urgent and emergency care in Gloucestershire was supported by health and social care services, stakeholders, commissioners and the local authority. Leaders we spoke with across a range of services told us of their commitment and determination to improve access and care for patients and to reduce pressure on staff. However, Gloucestershire had a significant number of patients unable to leave hospital which meant the hospitals were full and new patients had long delays waiting to be admitted.

The 111 service was generally performing well but performance had been impacted by high call volumes causing longer delays in giving clinical advice than were seen before the pandemic. Health and social care leaders had recently invested in a 24 hour a day, seven day a week Clinical Assessment Service (CAS). This was supported by GPs, advanced nurse practitioners, pharmacists and paramedics to ensure patients were appropriately signposted to the services across Gloucestershire.

At times, patients experienced long delays in a response from 999 services as well as delays in handover from the ambulance crew at hospital due to a lack of beds available and further, prolonged waits in emergency departments. Patients were also remaining in hospital for longer than they required acute medical care due to delays in their discharge home or to community care. These delays exposed people to the risk of harm especially at times of high demand. The reasons for these delays were complex and involved many different sectors and providers of health and social care.

Health and social care services had responded to the challenges across urgent and emergency care by implementing a range of same day emergency care services. While some were alleviating the pressure on the emergency department, the system had become complicated. Staff and patients were not always able to articulate and understand urgent and emergency care pathways.

The local directory of services used by staff in urgent and emergency care to direct patients to appropriate treatment and support was found to have inaccuracies and out of date information. This resulted in some patients being inappropriately referred to services or additional triage processes being implemented which delayed access to services. For example, the local directory of services had not been updated to ensure children were signposted to an emergency department with a paediatric service and an additional triage process had been implemented for patients accessing the minor illness and injury units to avoid inappropriate referrals. Staff from services across Gloucestershire were working to review how the directory of services was updated and continuing to strengthen how this would be used in the future.

We found urgent and emergency care pathways could be simplified to ensure the public and staff could better understand the services available and ensure people access the appropriate care. Health and social care leaders also welcomed this as an opportunity for improvement. We also identified opportunities to improve patient flow through community services in Gloucestershire. These were well run and could be developed further to increase the community provision of urgent care and prevent inappropriate attendance in the emergency departments.

There was also capacity reported in care homes across Gloucestershire which could also be used to support patients to leave hospital in a timely way. The local authority should be closely involved with all decision-making due to its extensive experience in admission avoidance and community-based pathways.

Summary of South Western Ambulance Service NHS Foundation Trust

For the emergency operations centres (clinical hubs) we found:

- The service was under immense and unrelenting pressure from demand with ambulances being held at emergency departments (which were also full). The service was staffed and resourced safely to meet people's needs in most

Our findings

areas for commissioned and planned levels of demand. However, the recent significant rise in numbers of callers to 999, and the inability to release ambulances from emergency departments meant the service was unable to reach all patients who needed an ambulance safely and effectively much of the time. There was evidence that the trust had done almost everything it was able to do to manage the increasing demand on urgent and emergency care capacity. Incidents of exceptional demand were increasing to occur most days, and this was becoming unsustainable for staff across the service. Staffing levels had been increased to deal with some of the anticipated rise in demand the service had predicted, but not to cope with the pressures and capacity shortages now experienced. However, additional recruitment was underway with some having already happened.

- There was evidence of staff under such pressure that it was having a detrimental effect on both their mental and physical wellbeing. This included staff feeling pressure from dealing with anxious, upset and abusive members of the public, patients and sometimes other stressed healthcare professionals. Most of the staff described feeling exhausted, demoralised and stressed at times by the job with the current pressures. This was entirely recognised and acknowledged by the senior management and the executive team at the trust. Some staff remained as positive as they could and we saw and heard how this helped in their response to callers. The organisation was offering a package of support measures for staff, which staff in the clinical hubs acknowledged they were aware of and had used at times. However, some staff told us they struggled to find the time to prioritise their own wellbeing over that of the workload.
- The expected time for emergency 999 calls to be answered (under 20 seconds for the 90th centile) was no longer being met and since autumn 2021, were now much above (worse than) the England average. This situation was not previously experienced at any time over the previous few years. Although the number of clinical incidents were not significantly higher in number, the call volume had risen with people making additional calls asking, usually, for an update on the ambulance arriving. This delay was due almost entirely to ambulances being held at emergency departments with serious capacity pressures in that and other parts of the urgent and emergency care system. As a result, they were not readily available to swiftly turn around and be back in the community to help other patients. This resulted in people calling more often for an update or if a situation had changed.

However:

- Despite the immense pressure faced every day, staff were kind, compassionate and supportive to patients, some of whom had complex needs and may be challenging for staff. They knew how to remain calm and respectful when dealing with distressed or abusive callers.
- In order to keep staff safe in the clinical hubs, there were good provisions to minimise the risk of the spread of infection and the trust and staff adhered to national guidance.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

For our emergency operations centres inspection, we met with staff from across the whole organisation. We talked with 14 emergency medical dispatchers (the staff trained to take the 999 calls) and six dispatchers (staff who managed the dispatch of ambulances and other resources). We met and talked with four trained clinicians who assess and give advice to the emergency medical dispatchers, patients and carers. These included doctors, nurses and paramedics. We listened to 28 calls coming into the service from the public and other healthcare professionals and heard how these were handled by the emergency medical dispatchers and clinical teams. We met and talked with 16 of the trust's senior operational managers and executives. We were also contacted by over 30 staff after our inspection on site following our usual offer for staff who we had not been able to speak with to get in touch – or staff we had met who wanted to share more concerns.

Our findings

We visited both clinical hubs in Exeter (within the trust's headquarters) and in Bristol.

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to prevent the spread of infection.

Facilities and equipment were visibly clean and well-maintained with in-house cleaning staff having increased the standard and type of cleaning through the pandemic. Staff had access to disinfectant wipes and hand sanitiser gel at their desks and around the building in other offices and communal areas.

The facilities at both hubs had been adapted to ensure social distancing between staff desks or in meeting areas. This was in accordance with national guidance. Staff were seated at desks two metres away from each other and clear safety screens were used to separate desks. Staff followed infection control principles including their own use of PPE. At both emergency operations centres we visited, staff maintained the two-metre distance from one another. They wore masks when it was not possible to maintain distance or when moving around the building.

The trust had a testing programme for COVID-19 and staff had access to lateral flow tests and PCR tests as needed. The trust provided staff with a swabbing service and they could also access tests through the NHS services for the public. The trust monitored staff test results through an online portal. However, at the time of inspection, reporting of twice weekly lateral flow testing was 27% and the trust was working to improve staff reporting their results.

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.

Environment and equipment

Overall, the design, maintenance and use of facilities, premises and equipment kept people safe. However, some maintenance and issues with heating had not been dealt with and not all risk assessments around staff workstations had been responded to.

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. The clinical staff were able to use video calls with patients, which they said improved their ability to triage, particularly with unwell children.

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 which were tried and tested.

The service had mostly suitable facilities to meet the needs of staff, but some issues had yet to be resolved following safety assessments. In the Bristol hub, some desks could rise and fall so staff had the choice of sitting or standing during their shift which had a number of physical health advantages. However, some staff told us their desks did not conform with the Health and Safety Executive Display Screen Equipment (DSE) regulations following risk assessments. These

staff had moved work area to comply with social distancing regulations brought in at the height of the pandemic. They had been told their new workstations would receive the necessary adjustments to comply with the DSE regulations. Staff said this was over a year ago and no workstation improvements had been made. We fed these concerns from staff back to the trust executive team to further investigate after our inspection.

There were some issues with the fabric of the clinical hub in Bristol, which was a relatively new revamped office building. Dispatch staff told us that up until the day we inspected there were four leaks in their ceiling and they had used buckets to collect the rainwater leaking through. Some staff reported having made a series of complaints last winter about the air temperature in their room. At times it was either too hot or too cold. When it had been too cold last winter, they had worn hats, gloves and scarfs at their desk and some days also used blankets and hot water bottles to keep warm at work. They were anxious about this coming winter. We fed these concerns back to the trust executive team to investigate further.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration or who were known to be deteriorating. However, there was a known risk to patients from a deterioration in their health when an ambulance resource was not available to send on time. The trust was unable to resolve all these issues with the exceptional pressure on demand.

Staff used a nationally recognised tool to identify risk and deteriorating patients and escalated them appropriately. The service used the licenced advanced medical priority dispatch system (known as AMPDS) to assess and evaluate (triage) 999 calls. In calls we listened to we heard how the dispatch system enabled staff to follow a consistent triage pathway 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 NHS 111.

Staff recognised and responded when they became aware of a patient rapidly deteriorating. For example, we listened to a 999 call where the response was changed from a category 2 to a category 1 call (raising the emergency level) when the patient's breathing further deteriorated during the call.

The call takers had a standard operating procedure to guide escalation of patients and manage clinical safety which had been issued in November 2021. This procedure was to enable to trust to provide the safest service possible within the resources available. This included continuing to deliver high-risk emergency care where it was most needed, but signposting other patients to alternative pathways. This approach was used when the trust was in the highest level of escalation and approved by the duty strategic commander. There were two levels of safety management depending on specific parameters. Both included exclusions to any redirection of patients such as children under the age of two years, high-risk patients, those unable to get help or get to hospital themselves, and major incidents.

In these circumstances, staff taking calls were given an override option to the triage system and a script to use for all other patients to explain why they were being diverted to other services. Alongside the guidance, a role within the call handling team had been established to provide support to call takers where they needed additional advice. This was for both times of intense pressure, but also more general support.

The trust's emergency operations centres' clinical team (doctors, paramedics and nurses) were based in another part of the clinical hub for COVID-19 safety reasons. However, the trust had arranged for a clinician also to be based with the call

takers to offer face-to-face guidance and support. The call takers were also able to obtain support directly by phone with the clinicians. These clinicians were also able to monitor the incoming calls remotely and would sometimes interject on the call to offer guidance to the call taker or suggest it was diverted to them. There were triggers in the triage system to alert the clinicians to certain situations they should become involved with.

Demand pressures on the service meant at times, dispatchers were not able to ensure crews with the best skill mix were dispatched to meet the care and treatment needs of patients. This option was only used in circumstances where no other option was available but added pressure to the dispatch team and the staff treating the patient. Paramedic crews told us this meant the patient concerned was more likely to be taken to an emergency department than treated at the scene.

One area of concern raised with us from call-taking staff was, due to demand pressures, they were not always able to get timely support from a clinician. This was particularly for complex triage or to validate decisions such as standing down a crew. Therefore, some crews were arriving on scene to find they were no longer needed or the patient had made alternative arrangements, but the job not having been stood down.

Staff made use of 'special notes'. These were notes held on the electronic patient record system to identify patients who had certain welfare needs, or there was a possibility they might be complex for crews on the scene to manage. This was designed to keep both patients and crews safe by anticipating issues in advance.

The service had 24-hour access to mental health liaison and specialist mental health support. A mental health clinician was available in the operations centre to triage, assess and arrange appropriate support for callers. The mental health side of the work of the ambulance service used a high proportion of the trust's resources due to the complex nature of patients' problems. An upgraded service was launched in April 2021 from the Bristol clinical hub which was providing a specially commissioned enhanced clinical service from 9am to 10pm each day. This had resulted in a significant rise in the numbers of patients supported with a mental health crisis over the phone and signposted to community support services if that was the right course of action.

The trust had introduced a 'safety cell' consisting of a team of staff (mostly agency workers) who had responsibility for making welfare calls to patients/carers who had been waiting for an ambulance to arrive. These staff were required to find out if the patient had deteriorated or perhaps improved and no longer needed an ambulance and to escalate their findings to the clinical team for further triage.

Staffing

Due to the pressure and rapid growth in 999 calls, the service did not have enough staff to provide the safest service at all times.

Vacancy and sickness rates were relatively high in the emergency operations centres. However, some recruitment particularly in call-takers had improved staffing numbers. Recruitment was an ongoing challenge which was hard to resolve in both the highly competitive market and the limited pool of resources from where to find staff. It was also a challenge for training and development teams. A decline in overall experience was also a challenge to the trust and its staff with many newly recruited staff and the need to be constantly training new people. There was a high and unplanned number of agency staff used who, due to market forces, were often earning far higher rates of pay than many of their counterparts in the trust.

Our findings

The ability to staff the service safely and effectively was compromised in a number of ways. The rising demand for call handling (around a third higher than planned) meant staff resources were being stretched continuously. The delay in sending ambulances meant people were calling to the service a number of times to ask for updates or provide new information if the patient's condition changed. There was also the difficult and stressful nature of the role, and competition from other employers, which meant turnover of staff was higher than similar roles in the NHS.

Due to these high staff turnover rates in the emergency operations centres, the trust recruited call takers on an ongoing basis. However, this was among the practical limitations on the numbers of staff the trust could recruit at any one time. Senior managers were also trying to reach communities or people who did not typically apply to work in the emergency services with adverts in unusual places and the introduction of an apprentice scheme. The training and induction programme was also changing in order to bring more live scenarios into the programme so call-takers were far more attuned to what they might experience and hopefully well prepared. New staff said the induction, training and mentoring prepared them well for their new role, they felt supported and knew how to ask for more help

Most call takers at both hubs had been employed in the service for less than two years. The experience and skill mix were therefore difficult to maintain due to the high turnover and reliance on recently trained staff.

There had been an increased number of agency staff used in the trust at this time. The trust board report stated spending on agency staff since April 2021 (for the whole organisation) was between 300% and 500% above plan. Staff told us the use of agency staff was understandable in the circumstances but could be demoralising to some staff due to the rates of pay being higher due to a supply and demand imbalance in available temporary staff.

In August 2021, the clinical hubs had a combined sickness rate for staff of 10.4% (against a target of 4%) and additionally, 4.7% of staff away due to COVID-19 requirements to self-isolate. Of these staff, 6.9% were on long-term sick leave.

The trust had taken a decision to have more call-takers in the team than originally funded. This was achieved originally in December 2019 with planned numbers of staff required having been stepped up from June 2019 and for a second time in April 2021. Numbers had risen slightly with these increases since April 2019 from 145 staff (all numbers whole-time equivalent hours) to 161 by August 2021. The staff numbers were to be significantly increased with around 100 new call takers funded for recruitment, which was underway. The service was aiming for 30 of these to be in post by the end of December 2021.

For dispatchers, establishment was mostly against planned numbers in the period of April 2019 to August 2021. However, the step up in establishment from April 2021 had yet to be realised with a vacancy rate of around 8.9% in August 2021.

The clinical staff numbers were also not achieving targets for employed staff and carried a vacancy rate in August of 9.3%. However, the trust had recently increased establishment numbers, which temporarily increased the vacancy rate.

Additional specialist paramedics were working in the clinical hub and the specialist service was provided over 20 hours each day. Learning and development staff also worked in the clinical hubs to provide support and training with staff at their workstations.

These increases in staffing had placed the trust at financial risk from exceeding expenditure budgets on staffing costs, but this was something the trust board had approved within the exceptional circumstances of the increasing demand on urgent and emergency care capacity.

Our findings

Is the service effective?

Inspected but not rated

Call-answering times

The trust had always performed relatively well in call answering times, but recent rises in demand had found the service among the worst performers among the English NHS ambulance providers by the start of autumn 2021.

Trust data showed in the period between April 2020 and September 2021, the ability to answer calls deteriorated with rising demand. When looking at the measure to answer almost all calls (the 95th centile performance), for 15 of the 18 months of the period, the trust was either quicker or about the same as the national mean average. The expectation is for 999 calls to be answered in a maximum of 10 seconds for the mean call answering time and 20 seconds for the 90th centile.

The situation deteriorated significantly starting in July 2021 when the call answering average jumped from generally always under 60 seconds to 3 minutes 20 seconds and then to 5 minutes 10 seconds in September 2021. This was worse than but alongside a similar trend in the England average with call answering for all ambulance trusts in July up at just over 3 minutes and at 3 minutes 14 seconds by September 2021.

This was in circumstances of rising demand on calls-takers of between 10% and 28% more calls over expected levels in the months from April to October 2021. Since March 2021, the service had to deal with more clinical incidents for each 100,000 people in the population than the national average. Although multiple calls were expected in the circumstances, there also been an increase in these over the time period with ambulances being increasingly delayed in arrival on the scene.

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service had achieved a significant marked rise in the rate of 'hear and treat' for patients. These were incidents resolved by staff over the telephone. This was a nationally measured Ambulance Quality Indicator standard for which the trust was benchmarked against other NHS ambulance services in England. The national average for April to September 2021 was 10.6%. For South Western Ambulance Service, the rate increased from April at 5.8% to 10.3% by September 2021. This was a key reason why the number of patients conveyed to emergency departments in the South West had fallen significantly by around 10% in the same period. The trust monitored whether there were any adverse incidents from far more patients being supported over the telephone, and the numbers reported were small, and similar to usual percentages.

Multidisciplinary working

All those responsible for delivering care worked together as a team as much as possible to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. However, the high demand and the changing landscape of provider services meant it was not always easy to find the right service for the patient.

Our findings

All the necessary staff, including those in different teams were involved in assessing, planning and delivering care and treatment. For example, dispatch staff worked well as a team with the emergency ambulance crews. There was often good feedback to call takers from the crews on scene. For example, a call taker told us of how a crew had praised them for ensuring and helping a caller to promptly locate an automated external defibrillator. This support had led to a positive outcome for the patient once the crew arrived on the scene.

Care was delivered and reviewed in a coordinated way linked with agreed standard operating procedures and care pathways. For example, if a patient was in a residential care home, the call taker requested the staff to locate and hand over to crews any important information relating to the patient. This included advanced care plans or medication records. This helped save time and in making the right decisions for the patient. The trust had a record of decisions around end of life care and treatment within patient records if this had been previously provided or was available through connection with other systems.

Staff liaised with other services such as GPs, community teams and others to direct callers to the most appropriate service when an emergency response was not needed. For patients with a mental health illness, staff could use mental health liaison services from community crisis teams and support of their own clinicians. They also recommend patients to minor injury and illness units and urgent treatment centres in their location.

One area of concern for staff in call centres, particularly the clinical teams, was having access to up-to-date service provision for health and social care in a patient's area. Service provision was often changing and it was not always easy to get access to or know the right provider. There was a register held or maintained for health and social care providers for the local area (known as the directory of services) maintained by commissioners. The accuracy of the directory was variable across different commissioning areas. Also, there was no single point of access in any integrated care system managed clinically to avoid patients being passed around and the right service being found first time.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness.

Staff were respectful and considerate when talking with patients, carers or members of the public contacting them by phone. Staff took the time even with high levels of demand to interact kindly with patients and those close to them in a caring way. Staff were also clear and firm with callers in order to get their message across, but this was done with respect and consideration for the person on the phone.

We found staff to be consistently patient, supportive and reassuring to patients and those trying to get help. Where people had to wait extended periods for a response for the emergency ambulance crew, the call taker clearly explained this to the person on the phone. Where a category 1 emergency response had been arranged, the call taker offered reassurance that crews would be on the scene as soon as possible.

In certain situations, the triage system needed call takers to stay on the line with the caller until help arrived. However, this standard operating procedure had been changed with this happening less often due to the demand pressures from other calls. Staff said this contributed to increasing demand from callers at times, when people in situations causing

Our findings

high levels of anxiety called back. However, staff felt needing to close calls was inevitable when under pressure and gave them chance to help other patients who were waiting. During the calls we listened to callers often gave positive feedback to the call takers when talking with them. We could hear reassurance being given and accepted and many times the caller thanked the staff for their help.

Staff were trained to remain calm and respectful when speaking with callers who may be distressed or abusive. Call takers were all familiar with the procedure for managing abusive callers. Staff explained sensitively to us how they empathised with callers' frustrations when waiting for an ambulance response. They appreciated and recognised that members of the public sometimes reacted with strong emotions when in a stressful situation. Call takers told us managers were supportive of call takers when they needed to use the abusive caller policy to go through a process of giving a caller three warnings before ending the call if necessary.

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, for example, mental health needs. We listened to calls from patients with mental health needs and heard staff being compassionate and understanding in their manner. One call taker told us how he had received positive feedback from a patient who was experiencing suicidal thoughts but had been helped and supported by the call taker.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of 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.

There was no immediate indication this situation would change through the winter of 2021/22 despite efforts being made. Nevertheless, the trust worked with others in the wider system and local organisations to plan care and seek support. Managers planned and organised services so they met the changing needs of the local population. The planned capacity for the clinical hubs would have met the needs of the local population had the increasing demand on urgent and emergency care capacity not arisen. The executive team and the trust's forecasting tools were predicting this failure to meet the needs of people at all times was likely to continue throughout the expected difficult winter months of 2021/22.

Although the clinical hubs were not designed for any patients to attend on site, facilities and premises were appropriate for the services being delivered. The trust had also adapted quickly to provide a safer working environment for staff during the pandemic and introduction of social distancing. Both the clinical hubs in Bristol and Exeter had the physical office space to manage the service with staff needing an extensive range of equipment on their desks. Although the service had needed to expand and reorganise to manage social distancing rules and extra staff, there were still rooms available and set-up for immediate response to major incidents. The specialist services such as teams supporting hazardous incidents and managing the air ambulances were still accommodated as always on site alongside their colleagues.

Our findings

During the pandemic, South Western Ambulance Service provided mutual aid (support to other ambulance services) as it did in other times when needed. For example, just before our inspection, the service took calls to assist the ambulance service in Yorkshire. Mutual support was also provided where possible into the service by other ambulance trusts when capacity problems meant it was requested. The initial call handler organisation, BT, also managed the flow of calls to divert these when the response times were rising to pre-agreed levels where they became unmanageable.

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, fire and rescue, coastguard, caving or local rescue services were needed.

Access and flow

Up until the recent increase in demand on urgent and emergency care capacity, most patients got help when they needed it in line with national standards and received the right care in a timely way. However, the pressure from excessive demand meant many patients were now waiting too long for their call to be taken or to get a timely response after assessment.

The service was aware of the status of calls made from patients, members of the public and healthcare professionals to make sure the right response was arranged. The managerial teams and coordinators in the clinical hubs made decisions almost constantly about how to respond to excess demand for both incoming calls and to dispatch ambulances. Decisions were taken around redirecting ambulance resources by dispatchers when new calls needed to take priority and plans had to change at immediate notice. Dispatchers managed their own local allocation of ambulances and took decisions about where to send or redirect resources in terms of patient risk. This was a constant role of balancing risks with resources and managing patients who had been waiting a long time.

Is the service well-led?

Inspected but not rated

Leadership

Most leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Most were visible and approachable in the service. However, alongside exceptional pressure on everyone in the organisation, some staff said they did not feel supported by managers and leaders at all times.

The service was under intense pressure and this had not helped with maintaining supportive and productive relationships between staff at all times. The COVID-19 pandemic had also led to staff being less able to meet face-to-face, and system pressure meant some staff welfare had not had the attention that was hoped for by senior leaders.

The leadership of the clinical hubs had recently undergone a programme of change and restructure which was being worked through to be completed by the end of 2021. As with all change, this was taking time to embed and become clear to all staff. We were told this recent restructuring of management roles meant some staff were in interim posts and not all roles were substantively filled as yet. Alongside this, some call handling staff in the clinical hub in Bristol said they were unsure who their line manager was. Some also felt under-supported at times by team leaders particularly at night and over the weekends. For example, we were told of a shift one evening in the Bristol hub where the most senior member of staff was a band 4 and not a band 7 as required by trust policy.

Our findings

Staff in the Exeter clinical hub told us senior leaders were visible and approachable, as were their direct line managers and operational senior staff. However, a few of the staff in the Bristol hub said they rarely saw or had never seen senior management before the day of our inspection. There was a variable response to our questions of senior staff being approachable and staff in the hubs had different experiences. Some staff said their line managers were visible and approachable and they could share their concerns with them, other staff told us following a recent restructure, managers were inexperienced and some were difficult to approach.

Culture

Some but not all staff felt respected, supported and valued. There had been considerable progress around culture and much had been achieved. However, there was more to do.

Staff were working under intense pressure and dealing with far more anxiety from callers and crews they dispatched than ever before. This was having a detrimental effect on mental and physical wellbeing, although this was recognised by the organisation. Not all staff felt able to speak up and some spoke about fearing retribution. There was considerable anxiety among staff about rota changes and being able to work shifts which fitted with caring or other responsibilities.

There were some staff who felt valued and positive about their roles and the future. However, in the clinical hubs, although not exclusively, this tended to be more among the senior or managerial staff than those in the call taker or dispatch roles. There were some positive staff who felt proud to work for the organisation at all levels, but others who felt anxious, particularly about change. They were also working under pressure at levels which had not been experienced by the organisation before.

The trust described to us a proposed major reform of shift patterns and a reconfiguration of 'stations within zones' for teams dispatching ambulances (rather than roughly in counties). There was a high level of anxiety with staff about these changes and most of the dispatchers raised this issue. Staff felt strongly about being consulted more widely and their anxieties not being heard.

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. They told us they knew how to speak up and most knew about the trust's freedom to speak up guardian role and its purpose. However, some staff told us they were fearful of repercussions or confidentiality if they spoke out. A number came to us with this concern after the inspection and raised it anonymously. Staff talked about a belief that some colleagues were given 'supported practice' (having a higher level of supervision from a manager during shifts) when they raised concerns. They said they were aware this belief had discouraged others from speaking up.

In terms of coping with demand and capacity pressures, staff in the clinical hubs reported the frequency of being able to take breaks varied greatly. Dispatch staff said they covered one another's breaks when there was no designated team member available, as was otherwise planned, to cover break times. They said at busy times covering an additional large geographical area was stressful and they were not always able to get a break themselves. Caller handlers in both hubs described some working conditions that at times felt "inflexible", "undignified" and, as one person said, at times "unkind". Although we recognised a service under intense pressure to perform, staff we spoke with gave examples of:

- Managers monitoring the length of time call handling staff spent on toilet breaks.
- The trust not finding ways to be supportive of staff with children, including children with special educational needs, requesting shifts that worked for their caring responsibilities.
- Managers not allowing staff to attend wellbeing events run by the trust due to pressures on the service.

Our findings

The human resources (people) team recognised the need to look at more flexible working patterns to allow for staff to enter the workforce, and others to remain within it in order to support staff and their wellbeing. This was also mentioned as an action by the director of operations in a separate conversation about staff retention and recruitment.

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, although were struggling with how to manage the significant increase in demand in urgent and emergency care.

There was a risk to the service and patients from the loss of skills, experience and knowledge arising from staff exhaustion and the turnover rate. With the exceptional pressure on the system, the risks to a safe and effective performance of the ambulance emergency operations centres was high. The ambulance service was set up to cope with unexpected events but staff at all levels were becoming more concerned about the ability to manage performance with the increasing demand on urgent and emergency care capacity. Significant events such as the G7 summit and two major incidents this year stretched resources to capacity. The major incidents were unexpected but were planned for strategically as with all emergency services.

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. All events were escalated through clear structures and processes which had always been part of the emergency response.

The service followed the government COVID-19 guidance on safety for ambulance trusts. 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. The staff we asked said they would speak up if they felt infection prevention and control protocols or practices were not being followed by colleagues.

Our findings

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 Should take to improve:

- Improve or renew systems and processes to ensure the service is assessed, monitored and improved for quality and safety for all those who use the service and those in its employment. The trust should:
  - consider the culture in the clinical hubs and the organisation more widely;
  - listen to staff concerns and seek to involve them more closely in how to take the organisation forwards and when making changes;
  - find practical ways for senior staff to be more visible and approachable with all staff and to support morale;
  - take action to be sure staff feel supported and valued;
  - consider the leadership provided to staff across the organisation so staff receive support from accountable managers.
- Continue to influence and play a key role in the increasing demand on capacity, patient harm, and unmet patient needs throughout urgent and emergency care along with system partners and others. This should include a focus on improving the safety and effectiveness of services for patients and of its clinical hub and support staff.
- Maintain premises where staff work so they are safe, and comfortable working conditions. Respond more urgently when these issues are raised.
- Look for a different and innovative approach to the issues with recruitment and retention seeking staff input from those who already do the job.
- Describe to commissioners the consequence of not having accurate or up-to-date directories of services to signpost patients with a view to this finally being addressed and resolved.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a specialist professional advisor and two CQC inspectors. We were joined for an interview with the executive team by a CQC Deputy Chief Inspector. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.