South Western Ambulance Service NHS Foundation Trust

Emergency and urgent care

Inspection report

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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 and urgent care

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 emergency and urgent care 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

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 patients. The organisation was offering a package of support measures for staff, which staff 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.
- 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. There were also known and unknown risks of harm, some serious, to patients who were in the community and an ambulance was not available to send or was excessively delayed. Although many patients had an effective outcome, not all patients did due to delays in the transfer of their care to the emergency department or from the crew being able to reach them on time.
- The NHS contractual response times for ambulances to attend patients were no longer being met and some were significantly delayed. This was to an extent not previously experienced at any time since these standards were implemented in 2017. It was due almost entirely to ambulances being held at overwhelmed emergency departments because of serious capacity pressures in hospitals and other parts of the urgent and emergency care system.

However:

- Despite the immense pressure faced every day, staff were kind, compassionate and supportive to patients, some of whom were complex and challenging for staff. One of the patients we met said of the staff who had looked after them: “they are truly wonderful.”
- There were good standards of cleanliness and infection prevention and control. Arrangements, equipment and guidance helped staff and patients stay safe.
- There had been some excellent multidisciplinary working and mutual aid to and from the service. The support from the fire and rescue service was highlighted as being exceptional. Volunteers and first responders continued to play a vital role.

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 and urgent care inspection, we met with staff from across the whole organisation. We spoke with operational managers, and the trust’s deputy county commander for Gloucestershire. We talked with paramedics, emergency care assistants and other members of staff at NHS emergency departments and in two ambulance stations in the county of Gloucestershire. This was to learn more of the multidisciplinary approach to urgent and emergency care and how the system supports all parts of this pathway. We spoke with 30 paramedics, emergency care assistants and

Our findings

other support personnel, a hospital ambulance liaison officer (known as a HALO) and two senior doctors working for the ambulance service. We spoke 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 with us.

We talked with seven patients while on site at the emergency departments. Some were still in ambulances and others had arrived by ambulance and taken into the emergency departments. Although we observed care delivered by ambulance staff for a number of other patients, many of these were not well enough to talk with us. Due to rules of safety in the COVID-19 pandemic, and in light of the pressures of demand on the ambulance service, we did not ride out with crews or observe them on the scene with patients.

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 protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.

The trust had made provision to ensure staff and people they met and cared for were protected from COVID-19 and met the national guidance for the pandemic. There was a regular testing programme for staff and those staff we met said they were following the guidance to check their status and reporting this to the organisation.

Ambulance staff attending emergency departments were all wearing the right personal protective equipment (PPE) including masks and gloves at the right time. They said they were equipped with PPE and trained to use it effectively. The vehicles all appeared to be well-stocked and visibly clean and tidy. We saw an empty ambulance when staff were taking the patient into the emergency department, and this was visibly clean and tidy. This included the floors, the cab, the equipment and the cupboards.

We visited two stations in Gloucestershire and all vehicles we saw were visibly clean and well maintained. Records we saw were up-to-date and showed vehicles were cleaned regularly. All vehicles underwent maintenance checks and were booked in for a deep clean every 42 days in line with policy, or sooner if required. For example, if a patient with a diagnosed contagious illness was conveyed, vehicles were scheduled for an emergency deep clean.

The trust had experienced a number of COVID-19 outbreaks in ambulance station bases, but this was limited and quickly addressed. All of these affected a number of staff in single figures – so below 10 in each case. To manage this situation, the trust had an overarching internal outbreak control plan which included action cards to be used and followed by staff when an outbreak or potential outbreak was identified or declared. Actions included restricting access and arranging for a deep clean to be undertaken by an appointed external specialist company.

The infection prevention and control team told us they worked closely with operational staff and built a strong relationship and rapid response to issues. The trust undertook regular briefings on infection prevention and control and had a helpline for staff with questions and problems. Infection prevention and control videos and images were also provided to give additional guidance around cleaning and protection for staff.

Our findings

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

The design, maintenance and use of facilities, premises, vehicles and equipment mostly kept people safe. However, there were some issues with the safety of an area used for cleaning at one station

Staff said they had access to up-to-date communication systems and felt the trust responded well most of the time if there was any equipment failure or fault. Most staff said there had not been any issues they were aware of with faulty equipment or problems with their working environment causing safety risks.

At the start of their shift, ambulance staff carried out daily safety checks of the ambulance on-board specialist equipment. There was a system for recording defective equipment so that the maintenance team could make timely repairs. We were told equipment was regularly serviced and defective equipment was stored separately from useable equipment. Although most equipment was said to be readily available and usually repaired quickly, some staff told us they did not always have access to working electronic blood pressure monitors.

There was a risk to ambulance crews at one of the emergency departments. The ambulances having to queue outside of their entrance to the emergency department were held in an area adjacent to some large-scale building work. However, ambulance crews were very aware of the potential safety issues and were mindful of the risks. Following our inspection, the trust updated us that there had been a review of the safety of ambulances in that location and this had been urgently addressed.

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.

The floor in the bay used for clearing ambulances at Staverton station was not slip proof making this a potentially hazardous work area. There was also an ambulance's electric cable thrown over the top of the vehicle weighted by a rope during deep cleaning. There was a risk of injury to staff and possible damage to vehicles as a result. There was a wall mounted bracket to hold the cable, but this did not hold it high enough and there was no corresponding harness to suspend the cable safely above the vehicle. Staff said they complained about the floor and the mechanism for suspending electric cables over vehicles more than a year ago but were still waiting for this to be addressed.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and where possible minimised risks. Staff identified and quickly acted upon patients in their care at risk of deterioration. However, the extensive delays experienced by a number of patients being handed over to the emergency departments were adding risks to patient safety and welfare.

The role of a paramedic or emergency care assistant was to treat a patient on the scene and if required take 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.

In terms of assessing and responding to the risks to patients within extensive 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. To help with this they used the National Early Warning Score (NEWS) tool to monitor and manage deteriorating patients. Staff we spoke with said due to handover delays they would now be required almost always to care for the patient for far longer than optimal for safety and the best outcome for the patient. Due to delays, the NEWS tool was now being used extensively beyond how it was designed or expected to be used by ambulance crews.

Some patients waited in ambulances for many hours and data showed:

- In October 2019, in Gloucestershire, ambulance crews handed over all but nine of their just under 3,500 patients in less than an hour with around 70% in 15 minutes or less.
- In October 2020, 66% of the 4,200 patients were handed over in 15 minutes or less. This was the first time the handover delay had exceeded 15 minutes on average since records provided to us by the trust started from (April 2018). This rose to 95% in 30 minutes or less.
- In October 2021, of the 3,300 patients, fewer than 25% were handed over in 15 minutes. The average handover time was 56 minutes.
- In the 12 months to October 2021, 1,885 patients waited over two hours. In the 30 months before that only 16 patients had been delayed more than two hours.

Some ambulance staff said at times they waited much longer for handover including some between eight and 12 hours. This required ambulance staff to assess and respond to any deterioration in their health or condition. Staff told us this was particularly challenging for them with patients experiencing a mental health crisis or with cognitive impairment or anxiety. Risks associated with these waits included: possible skin damage; delays in tests, treatment, medicines and nutrition and hydration; and a lack of access to toilet or washing facilities.

Crews did not always start their shift with a new job or call to a patient. For example, on one day in the week of 15 November 2021, 15 crews started their shift at an emergency department to take over from crews standing outside or inside the emergency department looking after (cohorting) patients there. Although there was no evidence of harm, staff said they were concerned this could lead to risks for the patient as they were taking over the management of someone they had not been looking after up until then.

A report from the Association of Ambulance Chief Executives (Delayed hospital handovers: Impact assessment of clinical harm) stated that research showed 80% of patients who experienced a delay of over 60 minutes were assessed as likely to have experienced some level of harm. One out of 10 patients were classified as potentially experiencing severe harm.

Ambulance crews said the medical and nursing staff at the emergency department responded quickly if they believed a patient was rapidly or significantly deteriorating. However, there was no routine clinical emergency department support to the crews with the exception of the coordination and management of the hospital ambulance liaison officer (known as the HALO). They were an employee of the ambulance service and an experienced paramedic. They maintained a live document of all patients remaining in their care either in an ambulance or being cohorted in the department. They risk assessed the patients to liaise with the hospital staff as to the priority and risk of patients either on the ambulances or being brought into the cohorting areas. The work they did was spoken of as highly valued by the ambulance service and the emergency departments, although this role was not recurrently funded.

When handovers were made to emergency department staff, ambulance staff shared key information with them. They also handed the patient over to colleagues if there was a shift change and the patient remained in the ambulance at the time.

Our findings

The risk of harm extended to patients waiting for an ambulance in the community. The section below on response times shows those patients in the lowest category of harm at the point of triage (category 4) were waiting on average over 13 hours. The trust was unable to assess and respond to the risk for this group of patients beyond remote guidance and intervention from the emergency operations centre teams.

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.

Although improved from previous inspections, many staff were working beyond their hours and not always getting breaks on time in what were already long shifts.

Senior trust staff recognised that pressure had been building on the workforce for the two years prior to our inspection. Most staff said the overwhelming demand and pressure in the last three months particularly from handover delays, sickness and vacancies meant staff were unable to provide a safe service at all times. In response to this and the additional pressure resulting from staff choosing to leave the service, the trust had a major recruitment drive. There were around 35 paramedics trained and due to start imminently and a further 15 posts approved.

Staff said they had worked beyond their shifts most of the time. However, staff said this was not always as long as at times in the past and was now around an hour or two – but this was on top of often a 12-hour shift. Most staff said they did not always get breaks or these were delayed. Staff who worked in the cohorting areas said it was sometimes impossible to get proper breaks and told us of staff waiting outside emergency departments for eight hours with no breaks.

However, staff said, the organisation was far more committed to breaks being taken and shifts ending on time which had improved since our last inspection.

The service was under additional pressure from staff sickness and COVID-19-related absence. In August 2021, 8.9% of operational staff were on sick leave against a target of 4%. Of these staff, 5.8% were on long-term sick leave. The impact of this was helped to an extent with the trust taking a decision to have more operational staff on the road than were originally funded. For paramedics and other senior clinical staff, this was achieved in September 2020 and was planned to continue with additional staff coming through following university training. Numbers had risen steadily since April 2019 from 1,614 staff (all numbers whole-time equivalent (WTE)) to around 1,800 by August 2021. The plan was to increase to around 1,875 by March 2022.

For emergency care assistants (ECAs), establishment to planned numbers had yet to be achieved although numbers had risen steadily since April 2019. There were around 1,000 emergency care assistants in April 2019, and this had risen to around 1,230 by August 2021. The plans were to increase by a further 60 WTE by March 2022.

Is the service effective?

Inspected but not rated

Our findings

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.

Pressure had built in the south west in the late summer of 2021 and beyond and performance for the trust had deteriorated further in that time. However, the trust was significantly reducing 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 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 most recent NHS published data at the time of writing (October 2021) for ambulance services in England, South Western Ambulance Service responded to patients as follows:

- Category 1 calls 11mins, 48secs (11:48) on average and 21:12 for 90%. The England average was 9:20 and 16:23 respectively. No NHS ambulance trust in England met the 7 minute standard.
- Category 2 calls 1hour, 24mins, 25secs (1:24:25) on average and 3:04:58 for 90%. The England average was 53:54 and 1:56:13 respectively. No NHS ambulance trust in England met the 18 minute standard.
- Category 3 calls 3:58:59 and 10:33:45 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.
- Category 4 calls 4:37:56 and 13:29:55 for 90%. The England average was 3:37:00 and 8:01:16 respectively. No NHS ambulance in England trust met the 180 minute standard.

For the results in October 2021, alongside exceptional demand and ambulances held at emergency departments, South Western Ambulance Service were the worst performer in England for the category 1 and 2 calls in both standard measures and for 90% of calls in categories 3 and 4. Before the pandemic, the trust were performing well in most categories and close to the England averages. To add pressure, in the last year, the percentage of incidents classed as the most serious category 1 cases were consistently higher for this trust than the national average.

Equally, in demand terms, since March 2021, the trust has had to deal with more clinical incidents each day for each 100,000 of the population than the national average. For Gloucestershire, in October 2019, the trust managed 8,376 clinical incidents and by October 2021 this had risen to 9,586. This was only surpassed in July 2021 when clinical incidents were above 10,000 for the first time.

Our findings

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, this had increased almost three-fold in the last few years. In Gloucestershire in October 2019, 768 patients (11%) were supported through 'hear and treat'. By October 2021 this had increased to 2,541 patients (27%). The national average was 12.3%.

Crews attending people on the scene and not taking them to hospital had also increased (known as 'see and treat'). Both these objectives had led to far fewer patients being conveyed to emergency departments. In Gloucestershire in October 2019, 56.7% of patients were conveyed, and this fell to 42.1% by October 2021. This was significantly below the England average of 51.4% and was replicated in similar reductions in conveyancing across the south west.

The trust had evaluated the impact on patients from not sending an ambulance and advising them on the telephone. There had been what was described as a "smattering" of incidents, but none had led to serious harm.

However, there was a growing number of patients diverted to the ambulance service through the South West 111 services who were found not to then need an emergency ambulance response. The concern from both the senior ambulance staff and the operational crews were with the growing number of calls made to them when a community response was right for the patient. This was reflected in the data from the trust which showed how incidents originating from the 111 services across the South West had been handled:

- In April 2021, 6% of 111-diverted patients could be helped by hear and treat. By October 2021, this had risen to 26%.
- In April 2021, 48% of 111-diverted patients needing to be taken to an emergency department. By October 2021, this had fallen to 35%.

Operational staff also reported how the 111 services were increasingly not able to triage all patients calling them using clinical advice. This was recognised as due to significant growth in the volume of calls to 111 services and the 111 services dealing with their own issues caused by staff shortages and unplanned absence. A senior member of the operational team at the ambulance service told us they saw a rapid increase in demand for 999 services when 111 services were unable to provide all patients with clinical validation due to internal capacity pressures. This meant the triage system used by the 111 call handlers being more likely to advise call takers at 111 to send for an ambulance far more often than when a clinician triaged the patient.

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 handover delays, some patients were coming to unintended harm as the ambulance was unable to get to them in a clinically safe time.

The trust reported that from 22 August to 21 November 2021, 18 patients in Gloucestershire were reported through the incident management system as suffering severe harm or death as a result of delays. A report was published in November 2021 by the Association of Ambulance Chief Executives reporting the national picture of "significant harm to members of the public up and down the country…" from ambulance delays in getting to patients.

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. A report had been produced for clinical commissioners and regulators. These incidents included older people waiting many hours for assistance following falls, and patients in cardiac arrest not being reached in time.

Our findings

Many staff from all across the organisation said how these incidents also had a negative effect on staff morale and wellbeing. This extended also to the staff of the trust in the patient safety team who investigated these incidents. The trust was fully aware of all these issues but was not able to affect change while demand was impossible to manage.

However, while patient outcomes were adversely affected from delays in response times, other outcome measures recorded against national standards showed some positive clinical indicators. A few improvements were also needed. The outcomes for patients who suffered cardiac arrest (data went up to April 2021) showed more patients in the South West than the England average survived at 30 days. More patients than the England average had a return to spontaneous circulation when they arrived at hospital.

Patients were treated in almost the same time as the national average when receiving a catheter insertion for those needing an angiography for a definite myocardial infarction (heart attack). However, data for stroke patients showed slightly longer times than average for the time of the call to hospital arrival. Fewer patients (80%) received an appropriate care bundle with a suspected ST-segment elevation myocardial infarction (STEMI – or serious heart attack) against the trust's standard (90%).

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. There had been fantastic support from the fire and rescue services. However, the principles of cohorting patients by ambulance personnel in an emergency department were not those agreed nationally or locally.

Although the pressures on the ambulance service were unrelenting, the staff in the emergency departments worked closely with them to support a shared approach to patient care as much as possible. We observed an excellent working relationship between the hospital ambulance liaison officer (HALO), other ambulance personnel and the emergency department team.

However, staff from the ambulance service had taken on a role within the emergency department to look after patients in 'cohorting' areas. These were areas set aside in the emergency department for ambulance personnel to hold patients in order to release ambulances back into the community. These arrangements were designed to be a temporary solution in times of crisis – which we were told were now almost all the time.

However, the arrangements did not meet the principles laid down by NHS England and NHS Improvement or the ambulance service. NHS England wrote to NHS trusts to state that leaving patients in an ambulance or a corridor supervised by ambulance personnel was inappropriate. Hospital staff were required to take the lead in supporting patients in these areas, but this was not happening. Cohorting was now a normal occurrence in one of the emergency departments we visited which was continuously staffed by South Western Ambulance Service staff. As well as caring for patients, ambulance staff said there had been times when they had to act as porters and move beds around the hospital as none were available in the emergency department.

This had been raised with the emergency department senior team by the ambulance service to look for alternative arrangements. We understood these were under discussion with a view to an agreed solution for all parties.

Our findings

There had been what was described to us as an exceptional response to support the ambulance service from the fire and rescue service and it's staff. Mutual aid from the fire and rescue service restarted in November 2020 and 7,328 shifts were covered by its staff. There were just under 30,000 patients responded to using fire-service personnel who received additional training from ambulance service staff. In the week of 15 November 2021, for example, 78 vehicles were crewed with fire-service personnel supporting paramedics.

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 (including into Wales) 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

Compassionate care

Staff treated patients with exceptional compassion and kindness, respected their privacy and dignity, and took account of their individual needs in increasingly difficult circumstances.

Despite the pressure on staff from long delays at emergency departments, and delays in ambulances reaching patients, our observations of care found a high level of compassion and kindness. Patients we met made comments such as: "I cannot speak highly enough of them", "they have been marvellous really", and "where do they get such lovely people from?" A patient we met in one of the emergency departments who had arrived by ambulance said the service was "really brilliant."

Staff did their best in difficult circumstances to provide privacy and dignity for patients, and most of the time were able to achieve this. However, this was almost impossible to continue in the crowded cohort spaces organised in one of the emergency departments for some patients to wait. Staff did their best but were very aware of the limitations of this arrangement for patient privacy and dignity. This had been raised by the ambulance service with the trust and arrangements were being made to use other areas in the emergency department to improve privacy and dignity for patients.

Staff took the time to interact with patients and those close to them. With the guidance around COVID-19 safety for staff and patients, it was harder for staff to support patients who almost all came to the emergency departments by ambulance without family or carers. Staff said this had required them to be as sensitive as possible to patient's needs and recognise their discomfort or emotional distress.

Some patients were acutely mentally unwell and staff told us how they had been trained to deal with distress and abuse and reduce aggression where possible. Although this was acknowledged and recognised, this was an increasing area of risk to staff. Those situations we observed saw staff being empathetic and understanding with patients who were experiencing a mental health crisis.

Our findings

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of the local people

The service was designed to meet 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 ambulance service was planned using long-term data and analysis of demand, but also in response to the changing needs of a system or community. For example, adverse weather, major events or incidents had plans drawn up in advance. This enabled the service to adapt quickly to support patient need particularly if these situations were not anticipated or known far in advance.

The increasing demand and reduced resourcing had led to recommendations to the trust board from various different service delivery models, all of which involved both planned, approved and potential increases in staffing numbers and resources. Over the previous few years, the service had adapted and expanded to meet changing patient needs. This was in response to the 2017 Ambulance Response Programme review and new ambulance standards, including response times and the type and number of resources. For South Western Ambulance Service, who piloted this new approach in England, this included more ambulances in the fleet and the move to almost all ambulances on the road being crewed by two staff (retiring the fleet of single-crewed cars).

The service otherwise maintained its other specialist teams such as the hazardous area response team (HART) and the helicopter emergency medical service (HEMS).

The service was part of a number of national and more local working groups looking at ways of reducing or limiting admissions to hospital and ensuring accurate referrals of patients to other services. The local county commanders for the ambulance service worked with commissioners and other providers to contribute to this work through collaboration and local knowledge.

However, one area of increasing complexity was with the system used by the ambulance service to divert patients into other local services. It appeared this system which listed all the alternative providers in a place was difficult to keep updated. It was subject to regular change as providers moved into different areas and added or stopped some service provision. However, we were told this register of providers was more advanced in Gloucestershire with support from commissioners who recognised the importance of the system working well.

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.

The rise in hear and treat numbers was evidence of increased use of the ambulance service rather than alternative community-based services. Many and increasing numbers of hours were being lost while ambulances were held at emergency departments.

Our findings

As described above, the access to the service for patients was severely affected by rising demand, but to a significant extent by handover delays in hospital emergency departments. This was not an issue exclusive to Gloucestershire hospitals and many hours were being lost in emergency departments across the South West and also nationally. There was also a growing number of patients calling the ambulance service. This was either as they perceived they had no other option or could not access the other alternatives such as GPs, 111 or community services. This was a complex picture with many factors. Some patients were also experiencing a mental health crisis and struggling to find urgent help from community services also under exceptional pressure.

Ambulance resources were stretched to a point where at times none were available to send to patients. The 'call stack' is the term used by ambulance services to describe patients who have called 999 and an ambulance is needed, but there is no resource immediately available. For South Western Ambulance Service, the call stack had increased in 2021 at two key times. One was the summer months of 2021, which given the huge influx of tourists was somewhat predictable. However, the other was in and around September 2021, which we were told was not expected in terms of past predictors. This growth in the call stack did reduce in October and November but still not to safe or manageable levels when it continued to be extreme.

At the peak in September 2021 there were more than 500 patients in the call stack. October and November saw towards 450 at times. This was within a resource of 373 ambulances on average on the road for the South West. This call stack was also more than double the position back in April 2021, although the numbers had been steadily in a rising trend since then.

In Gloucestershire, the peak came late October 2021 when there were over 90 patients in the call stack. This rarely rose above 50 in the first half of the year. This was in a resource of around 41 ambulances on average for Gloucestershire. The situation for the South West had improved slightly by the time of our inspection in late November but remained at levels which meant not all patients were receiving timely care.

Data showed the increase in time lost for ambulance crews waiting outside emergency departments. In Gloucestershire in the month of September of each of the last four years the service lost just 72 hours in 2018 and in 2019 it was 124 hours. This rose to 257 in September 2020 and by 2021 it had risen to 2,699 hours. For the service across the South West the trust had 4,500 hours lost each week. On one day in the week of 15 November 2021, the trust reported a loss of 950 hours in just one day. During that week, the service was unable to get to around 2,000 patient requests from around 21,000 in total. In August 2021, the trust reported losing 14,715 hours which was the second highest level in England.

Over the year from September 2020 to August 2021, the service lost just under 90,000 hours in delays at emergency departments.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable to their staff and teams.

Our findings

Each county or sub-divided county (Devon) in the South West had a leadership structure which had been established around three years prior to our inspection. The services were led by county commanders working deputies and a senior team. Senior leadership, officers, paramedics and emergency care practitioners based in Gloucestershire said they felt supported by their leadership and the issues they were facing were understood, even if solutions were very hard for anyone to find. All staff knew who their local leadership were and also staff from the senior executive team.

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.

Many staff were working beyond their hours under intense pressure. Patients and carers were becoming more anxious and staff were being abused at times. However, staff remained focused on the needs of patients receiving care.

Most staff said they felt respected in the service, but the intense pressure was making some feel less valued or supported. Most paramedics and specialist practioners in urgent and emergency care said they still felt proud to work for the organisation and the job they did. Some staff who despite the pressure on their resilience remained positive and said they were determined to do their best for patients.

There was a strong emphasis on the safety and wellbeing of staff in trust policies and its ethos. The trust had a 'Staying Well' service which had recently been awarded additional NHS charity funds. 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. Some said they were grateful it was there, but they were increasingly getting support from their fellow crew members or the staff they worked closely with who were in the same situation.

Staff said they felt there was a culture where they could speak up, but not all said they had either the energy or felt they would be listened to in the midst of the significant increase in demand in the whole urgent and emergency care system. Some staff said they felt "hopeless" and no longer expected anyone to have answers to the increasing demand which all felt was going to get worse over the coming months unless something changed.

Staff told us they felt demoralised by the situation of leaving patients waiting for hours for ambulances to reach them and having to treat patients in queues outside hospitals. However, some of the staff we met told us it they felt it was still a privilege to work as paramedics and emergency care assistants providing emergency care and treatment in their communities.

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.

Leaders had plans to cope with unexpected events, although were clearly struggling with how to manage the significant increase in demand on urgent and emergency care capacity. There was a risk as expressed throughout this report, and from a loss of skills, experience and knowledge from both staff exhaustion and the turnover rate.

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

Our findings

becoming more concerned about the ability to manage performance with the current increase demand on urgent and emergency care capacity. Events such as the G7 conference and two major incidents in the region were events which stretched resources to capacity. The major incidents were unexpected but were planned for strategically as with all emergency services.

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.

In terms of protecting staff, the trust had recently introduced body-worn cameras for crews. Crews we spoke with were very positive about the cameras and took it as a sign the trust invested in ensuring staff were safe at work.

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:

- Continue to influence and play a key role in the increasing demand on urgent and emergency care 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 frontline and support staff.
- Resolve any areas of risk in stations or elsewhere where these have been identified and reported but not yet 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.