North West Ambulance Service NHS Trust

Emergency operations centre (EOC)

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 operations centre (EOC)

Inspected but not rated

North West Ambulance Service NHS Trust serves more than 7.5 million people across the communities of Cumbria, Lancashire, Greater Manchester, Merseyside and Cheshire. The services respond to over one million emergency incidents each year; with the workforce providing pre-hospital care to patients in remote-rural and urban environments.

The trust's vision is to be the best ambulance service in the UK, providing the right care, at the right time, in the right place; every time for patients accessing its urgent and emergency (999) care service, non-emergency patient transport service and NHS 111 service. North West Ambulance Service NHS Trust (NWAS) provides 24 hours, seven days a week, emergency and urgent care services to those in need of emergency medical treatment and transport.

We carried out this unannounced focused inspection of North West Ambulance service (NWAS) emergency operations centre between 11 and 14 April 2022. We had an additional focus on the urgent and emergency care pathway and carried out several inspections of other services across a few weeks. This was to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures.

As this was a focused inspection, and we did not look at every key line of enquiry, we did not re-rate the service this time. At our previous inspection in February 2020 we rated emergency operations centres at the trust as good overall.

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

The trust employs around 6,300 staff in over 300 different roles and is supported by over 1,000 volunteers as members of its patient and public panel, volunteer car driver network and community first responder network. There are 3,686 staff employed in emergency and urgent care services, working across 103 ambulance stations. The service has 616 ambulance vehicles, including 481 emergency vehicles, 10 dedicated see and treat cars, 93 rapid response vehicles, 21 advanced paramedic vehicles and 11 community specialist response cars.

A summary of CQC findings on urgent and emergency care services in Cheshire and Merseyside (Liverpool, Knowsley and South Sefton).

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. We have summarised our findings for Liverpool, Knowsley and South Sefton within the Cheshire and Merseyside ICS below: Cheshire and Merseyside (Liverpool, Knowsley and South Sefton)Provision of urgent and emergency care in Cheshire and Merseyside was supported by services, stakeholders, commissioners and the local authority. We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff had continued to work hard under sustained pressure across health and social care services.

Our findings

Services had put systems in place to support staff with their wellbeing, recognising the pressure they continued to work under, in particular for front line ambulance crews and 111 call handlers. Staff and patients across primary care reported a preference for face to face appointments. Some people reported difficulties when trying to see their GP and preferred not to have telephone appointments. They told us that due to difficulties in making appointments, particularly face to face, they preferred to access urgent care services or go to their nearest Emergency Department. However, appointment availability in Cheshire and Merseyside was in line with national averages.

We identified capacity in extended hours GP services which wasn't being utilised and could be used to reduce the pressure on other services. People and staff also told us of a significant shortage of dental provision, especially for urgent treatment, which resulted in people attending Emergency Departments. Urgent care services, including walk-in centres were very busy and services struggled to assess people in a timely way. Some people using these services told us they accessed these services as they couldn't get a same day, face to face GP appointment. We found some services went into escalation. Whilst system partners met with providers to understand service pressures, we did not always see appropriate action taken to alleviate pressure on services already over capacity.

The NHS 111 service, which covered all of the North West area including Cheshire and Merseyside, were experiencing significant staffing challenges across the whole area. During the COVID-19 pandemic, the service had recruited people from the travel industry. As these staff members returned to their previous roles, turnover was high, and recruitment was particularly challenging. Service leaders worked well with system partners to ensure the local Directory of Services was up to date and working effectively to signpost people to appropriate services. However, due to a combination of high demand and staffing issues people experienced significant delays in accessing the 111 service.

Following initial assessment and if further information or clinical advice was required, people would receive a call back by a clinician at the NHS 111 service or from the clinical assessment service, delivered by out-of-hours (OOH) provider. We found some telephone consultation processes were duplicated and could be streamlined. At peak times, people were waiting 24-48 hours for a call back from the clinical assessment and out of hours services. We identified an opportunity to increase the skill mix in clinicians for both the NHS 111 and the clinical assessment service. For example, pharmacists could support people who need advice on medicines. Following our inspections, out of hours and NHS 111 providers have actively engaged and worked collaboratively to find ways of improving people's experience by providing enhanced triage and signposting. People who called 999 for an ambulance experienced significant delays.

Whilst ambulance crews experienced some long handover delays at the Emergency Departments we inspected, data indicated these departments were performing better than the England average for handovers, although significantly below the national targets. However, crews found it challenging managing different handover arrangements at different hospitals and reported long delays. Service leaders were working with system partners to identify ways of improving performance and to ensure people could access appropriate care in a timely way. For example, the service worked with mental health services to signpost people directly to receive the right care, as quickly as possible.

The ambulance service proactively managed escalation processes which focused on a system wide response when services were under additional pressure. We saw significant levels of demand on emergency departments which, exacerbated by staffing issues, resulted in long delays for patients. People attending these departments reported being signposted by other services, a lack of confidence in GP telephone appointments and a shortage of dental appointments. We inspected some mental health services in Emergency Departments which worked well with system partners to meet people's needs. We found there was poor patient flow across acute services into community and social care services. Discharge planning should be improved to ensure people are discharged in a timely way. Staff working in care homes (services inspected were located in Liverpool and South Sefton)reported poor communication about discharge arrangements which impacted on their ability to meet people's needs.

Our findings

The provision of primary care to social care, including GP and dental services, should be improved to support people to stay in their own homes. Training was being rolled out to support care home staff in managing deteriorating patients to avoid the need to access emergency services. We found some examples of effective community nursing services, but these were not consistently embedded across social care. Staffing across social care services remains a significant challenge and we found a high use of agency staff. For example, in one nursing home, concerns about staff competencies and training impacted on the service's ability to accept and provide care for people who had increased needs. We found some care homes felt pressure to admit people from hospital. On going engagement between healthcare leaders and Local Authorities would be beneficial to improve transfers of care between hospitals and social care services.

In addition, increased collaborative working is needed between service leaders. We found senior leaders from different services some times only communicated during times of escalation.

A summary of CQC findings on urgent and emergency care services in Lancashire and South Cumbria

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. We have summarised our findings for Lancashire and South Cumbria below:

Provision of urgent and emergency care in Lancashire and South Cumbria was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff felt tired and continued to work under sustained pressure across health and social care.

We found demand on urgent care services had increased. Whilst feedback on these services was mostly positive, we found patients were accessing these services instead of seeing their GP. Local stakeholders were aware that people were opting to attend urgent care services and were engaging with local communities to explore the reasons for this.

The NHS 111 service which covered all the North West area, including Lancashire and South Cumbria, were experiencing significant staffing challenges across the whole area. During the COVID-19 pandemic, the service had recruited people from the travel industry. As these staff members returned to their previous roles, turnover was high, and recruitment was particularly challenging. Service leaders worked well with system partners to ensure the local Directory of Services was up to date and working effectively to signpost people to appropriate services. However, due to a combination of high demand and staffing issues people experienced significant delays in accessing the 111 service. Following initial assessment, and if further information or clinical advice was required, people would receive a call back by a clinician at the NHS 111 service or from the clinical assessment service, delivered by out-of-hours providers. The NHS 111 service would benefit from a wide range of clinicians to be available such as dental, GP and pharmacists to negate the need for onward referral to other service providers.

People who called 999 for an ambulance experienced significant delays. Ambulance crews also experienced long handover delays at most Emergency Departments. Crews also found it challenging managing different handover arrangements. Some emergency departments in Lancashire and South Cumbria struggled to manage ambulance handover delays effectively which significantly impacted on the ambulance service's ability to manage the risk in the community. The ambulance service proactively managed escalation processes which focused on a system wide response when services were under additional pressure.

Our findings

We saw significant delays for people accessing care and treatment in emergency departments. Delays in triage and initial treatment put people at risk of harm. We visited mental health services delivered from the Emergency Department and found these to be well run and meeting people's needs. However, patients experienced delays in the Emergency Department as accessing mental health inpatient services remained a significant challenge. This often resulted in people being cared for in out of area placements.

We found discharge wasn't always planned from the point of admission which exacerbated in the poor patient flow seen across services. Discharge was also impacted on by capacity in social care services and the ability to meet people's needs in the community. We also found some patients were admitted from the Emergency Department because they couldn't get discharged back into their own home at night.

Increased communication is needed between leaders in both health and social care, particularly during times of escalation when Local Authorities were not always engaged in action plans.

Summary of North West Ambulance Service NHS Trust

For the emergency operations centres we found:

We did not rate this service at this inspection. The previous rating of good remains. We found:

- The service controlled infection risk well. Staff used equipment and control measures to prevent the spread of infection. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff undertook risk assessments as part of the 999 calls. Staff identified and acted quickly for patients at risk of deterioration or who were known to be deteriorating. 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave temporary staff a full induction.
- The trust performed well in call answering times. The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide safe care and communicated effectively with other agencies.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service planned and worked to provide care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. Most people could access the service when they needed it, in line with national standards, and received the right care in a timely way.
- 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 in the service for staff. Staff mostly felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. 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 the service was under significant pressure to manage the considerable increase in demand.

However:

Our findings

- There were known risks to patients when ambulance resources were not available to respond in a timely way. The trust was not able to resolve all these risks due to exceptional demand and ongoing resource issues.
- Due to the increase in demand and the pressure on resources, the service was not always able to meet the needs of patients. Pressure from increased demand meant some patients waited too long for ambulances to be dispatched to them.

How we carried out the inspection

For our emergency operations centres inspection, we met with staff from across the whole organisation. We spoke with 22 staff including emergency medical advisors, emergency medical dispatchers, paramedics, advanced practitioners, service delivery managers, the strategic head of the emergency operations centre, the medical director, director of quality and the director of operations. We listened to ten 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.

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.

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.

The service was well maintained and visibly clean; in house cleaning teams increased their schedule and standard of cleaning throughout the COVID-19 pandemic. There was an air filtration system in large offices to ensure air flow.

There were bottles of hand sanitiser gel and disinfectant wipes on each desk and in separate offices. We saw staff cleaning desks, keyboards and other equipment in between users. If staff moved away from their desk to take a break, they took their headset with them and the person taking over plugged their own headset in. There were wall mounted hand gel stations at entrances and building exits. Visitors to the emergency operations centres had their forehead temperature recorded on arrival to ensure they did not have a high temperature associated with COVID-19 or other infections.

The call handling suites, dispatch suites and clinical hubs had been adapted to allow for social distancing. Offices had notices on the doors to indicate how many people should be in the room for infection prevention and control (IPC) purposes. Clear plastic screens separated desks in the call handling and dispatch suites. Staff wore face masks when they moved through the buildings and mostly when they were in closer proximity to colleagues.

There was a COVID-19 testing programme for staff who carried out lateral flow tests twice a week. Staff told us the advice from AACE (Association of Ambulance Chief Executives) was not clear. An internal web-based system was used to communicate with staff about COVID-19 testing. The same platform was used to monitor reporting of results.

Our findings

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

There was enough suitable and effective equipment to enable staff to carry out their roles. Each desk in the suites was equipped with several monitors. This enabled staff to focus and be immersed in the task in hand and to be more efficient. All staff had been issued with a touchscreen electronic tablet which supported them in their role. We saw emergency medical advisors look up information about medical conditions whilst they were speaking with patients during 999 calls.

There was a telephony system provided by a national company. It had a number of failsafe 'layers' to ensure continuity of the 999-phone system.

Senior staff told us they tested the whole phone system using desk top exercises and in real time. Senior staff told us the computer systems needed some 'downtime' for servicing in March 2022, so the telephony system resilience was tested without problem. There were contingencies in place in case the computer aided dispatch (CAD) system failed. Staff we spoke with knew what to do in the event of a systems failure and gave examples of how the service could continue.

We saw some vehicles at the Broughton site being charged with external electrical charge cables; the cables were suspended at near head height. This could cause a risk to staff or visitors walking under the cables.

Assessing and responding to patient risk

Staff undertook risk assessments as part of the 999 calls. Staff identified and acted quickly for patients at risk of deterioration or who were known to be deteriorating. However, there were known risks to patients when ambulance resources were not available to respond in a timely way. The trust was not able to resolve all these risks due to exceptional demand and ongoing resource issues.

The service used a national telephone triage system known as NHS Pathways to support the assessment of callers who dialled 999. The system was delivered by NHS Digital.

There had been a recent change from use of the licensed advanced medical priority dispatch system (AMPDS). NHS pathways was in use and this enabled emergency medical advisors to link clinical questions and care advice. Based on the answers given by the caller or patient, the most appropriate clinical response with a specific level of care and the time frame, was reached. We listened to ten calls and saw that questions were asked in a clinical hierarchy; life-threatening questions were asked early in the call, progressing through to questions about less urgent symptoms.

The pathway was used to categorise calls from 1 to 5 depending on the risk and nature of the illness or injury.

Category 1 was for calls about people with life-threatening injuries and illnesses. Category 2 was for other emergencies and serious conditions such as stroke or chest pain which needed rapid assessment. Category 3 was for urgent calls. In some instances, patients might be treated by ambulance staff in the person's own home and did not need taking to a hospital. Category 4 was for less urgent calls. In some instances, patients might be given advice over the telephone or referred to another service such as a GP or pharmacist. Category 5 was for low risk calls and could be further broken down.

Our findings

During the 999 call, the emergency medical advisor advised the caller of an estimated time of arrival if an emergency ambulance was dispatched. The caller was advised to ring 999 again if the patient's condition deteriorated. Emergency medical advisors were able to obtain support from clinicians during a call or pass the call to a clinician if there was a risk to the patient.

Staff recognised and responded if they became aware of a patient deteriorating. For example, we listened to a 999 category 3 call where the patient had rung back after their symptoms worsened; the category was upgraded to a '2'.

Category 1 and 2 incidents calls from health care professionals and interfacility transfers went to the dispatch queue. All other calls went to the clinical support desk for validation. There was a minimum of one clinician per shift in the clinical hub who was identified as a 'clinical navigator'.

Within 15 minutes of the call, category 3, 4 and 5 incidents were assessed by the clinical navigator. They decided if the patient could be assessed by a clinician over the phone or if a face to face response was needed from an ambulance crew. If an ambulance was needed the navigator directed the call to the dispatch queue. If the patient was for clinical assessment, the navigator considered any known risks, issues or flags on the system. If the patient could be assessed over the phone, the call / incident was placed in the call 'stack' for full triage by a clinical hub practitioner. This took place 24 hours a day, seven days a week. Clinicians in the hub had oversight and clinically validated all clinical incidents / calls. There were rotational specialist paramedics, who 'floor walked' in the emergency operations centres to support emergency medical advisors and hear & treat.

The service had a proactive escalation policy known as the 'patient safety plan'. This guided staff around procedures when the service was in high states of escalation, to ensure the service could respond to situations such as an excessive call volume or reduction in staff numbers. The plan included a scheme of delegation and four trigger levels based on the total number of calls and time waiting. There were master action cards for each trigger level which clearly defined the actions required for all staff including the Regional Operational Control Centre (ROCC) tactical commander and emergency operations centres duty manager.

In the dispatch suite, the emergency medical dispatchers followed a methodology 'respond, review, revise'. This meant 999 calls and incidents should be allocated in time, category and risk order. The dispatch queue was for calls / incidents which needed an ambulance response. Emergency medical dispatchers told us that emergency ambulances were sent to less low acuity calls than in previous years. This meant ambulance resources could be prioritised for patients who needed them, and that category 3, 4 and 5 patients were likely to receive advice or signposting more quickly (to help manage any risk to them) rather than waiting a long time for an ambulance.

However, dispatchers were not always able to ensure an emergency ambulance would reach the patient within the standard timeframe because of demand and capacity issues. The same pressures on demand meant that at times, emergency medical dispatchers were not able to ensure crews with the most appropriate skill mix were dispatched to patients. For example, a volunteer community first responder might be needed to get to a patient first, if the double crewed ambulance with a paramedic on board was delayed. This added pressures to the dispatch team and meant patients might be exposed to a risk of harm.

Staff told us they used 'special notes' on the system to help them assess and respond to patient risk. These notes were brief summaries of already known key information about some patients.

Our findings

Within the clinical hubs there were advanced and specialist paramedics, nursing staff, pharmacists and mental health clinicians. These specialist clinicians had access to patient records to support patient centred decision making and to reduce risk to patients. The mental health clinicians worked in partnership with local NHS trusts.

There had been an increase in the number of 999 calls related to mental health; around 15% of all the 999 calls received were from people with mental health issues. Pathways had been developed to reduce the waiting time and risk for patients; this included daily 'huddles' with the mental health trust and public health leaders. The service worked with a charity hosted by the mental health NHS trust to reduce risks to support those who were at risk of suicide.

Senior staff in the clinical hub told us of a recent 999 call originating in the local region asking for an ambulance response for a family in the Ukraine. The service directed the call to a Polish ambulance service who was able to respond to the emergency.

Staffing

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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave temporary staff a full induction.

There had been a continued rise in demand for call handling throughout the pandemic. This meant staff resources were continually stretched. The delay in sending ambulances meant members of the public sometimes called repeatedly to ask for updates on ambulance arrival, or if a patient's condition changed.

Staffing levels were adjusted to respond to resource escalation action plans (REAP) and by use of the patient safety plan. The service had been at REAP 4 (severe pressure) for extended periods of time over recent months. The service had four levels of REAP, one and two were when the service experienced a steady to moderate levels of demand. Levels three and four were when the service experienced severe and extreme levels of demand. The service acted when REAP levels increased such as using senior staff to attend calls.

Staffing levels were planned with appropriate skill mix to ensure there were enough staff throughout the emergency operations centres. The service modelled and predicted increased demand for services and was proactive. In March 2020, around the start of the COVID-19 pandemic, an extra 180 call handlers had been recruited at pace and trained to support increased demand on services. There were over 400 whole time equivalent (WTE) staff in post in the service.

At the end of March 2022 there were 199 agency staff supporting the emergency operations centres call taking. Of those, 75 had been given permanent contracts with the trust. Most of the remaining agency staff were due to be made permanent by the end of April 2022.

The vacancy rate in the emergency operations centres had fallen (improved) from around 12% in June 2021. There were some gaps in substantive emergency operations centres staffing, however the increased recruitment of agency staff during the winter of 2021 to support call handling meant staffing equated to 135%. This meant the service was over established by 35% (194 staff) in order to meet demand. This included an extra 30 WTE staff in the clinical hub.

Our findings

Long term sickness absence had increased from previous years. Senior leaders described how this reflected on the pandemic in terms of staff wellbeing, or delayed elective surgery for individual staff members. Short-term sickness in the service was high which was likely to be as a result of sustained demand on the service combined with a higher prevalence of short term COVID-19 absence.The overall sickness absence rate for the latest reporting month (January 2022) was around 9% including COVID-19 related sickness of around 7%.

We saw that staff turnover had increased steadily over the previous year. Overal staff turnover for the trust was 11.7% in February 2022, within the emergency operations centres service it was 16.1%. This was the highest staff turnover since April 2016. We saw from board papers (March 2022) this was reflected in the loss of staff on fixed term contracts who sought permanent positions elsewhere. However, the overall staffing position in the emergency operations centres was stable as a result of over recruitment measures.

Is the service effective?

Inspected but not rated

Call answering times

The service performed well in call answering times and consistently met national standards.

The service monitored how effective it was using ambulance quality indicator (AQI) measures. It used the information to target improvements. However, the ability to respond to 999 calls and dispatch a response was impacted upon by increased demand. Data we reviewed showed there had been a 32% increase in calls received for March 2022 compared to March 2021.

Trust data showed in the period between October 2020 and March 2022, the ability to answer calls was frequently quicker than the national average.

The emergency operations centres 'call answered' measure was defined as the time in seconds between call connect and call answer. Since September 2021 the trust's mean time to answer calls was quicker than the national average. In March 2022, the mean time to answer calls was six seconds and this was 36 seconds quicker than the national average. The median time to answer calls saw a similar trend and since July 2021 the service was quicker than the national average. In March 2022, the service answered half of all calls in less than one second and this was 13 seconds quicker than the national average.

When looking at the 95th centile performance for 14 of the 18 months, the service was quicker than the national average. In March 2022 the EOC answered 95 out of 100 of calls within 41 seconds. This was the second quickest out of eleven English NHS ambulance providers. The 99th centile performance saw an improving trend with 15 of the 18 months being quicker than the national average. In March 2022, the service answered 99 out of 100 of calls within 118 seconds. This was 178 seconds quicker than the national average.

Patient outcomes

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

Our findings

The service had accomplished a significant rise in the rate of 'hear and treat' for patients. Hear and treat described the scenario when 999 calls were successfully completed without despatching an unnecessary ambulance vehicle response. This included advice, self-care or a referral to other urgent care services. Hear and treat services had been developed over recent years, in response to increasing 999 call demand. For example, in Cumbria and Lancashire, around 12.5% of calls into the service were handled by hear and treat. This was higher than the national average of around 10%. Senior leaders told us the service contributed to avoidance of hospital admissions by being able to treat patients this way. There were plans to increase hear and treat to around 20% of calls by late summer 2022.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide safe care and communicated effectively with other agencies.

We saw that all staff worked well with each other and the systems were used to support this team working approach. For example, we saw and heard specialist clinicians supporting emergency medical advisors during call handling. We also saw and heard emergency medical dispatchers working well to support ambulance crews on the road; we listened to calls where crews thanked dispatchers for stepping them down for a break after a traumatic incident. Dispatchers told us they considered the length of journey time a crew would need to travel under blue lights and sirens which could be stressful for the crew in the ambulance. Dispatchers used radio calls and text messages to communicate with crews on the road. We also overheard dispatchers informing hospital emergency departments of estimated times of arrival for crews conveying trauma patients. Despite the clinical hub being in a separate building at the Broughton emergency operations centre, staff still worked together as a team at the site and linked in with colleagues at Estuary Point emergency operations centre.

Care was coordinated using agreed standard operating procedures and care pathways. The service used national frameworks to manage calls from GPs and other healthcare professionals who requested an ambulance for patients who needed urgent or emergency transportation to hospital or between hospital sites (known as interfacility transfers). This approach supported patients' clinical needs and the service monitored reporting of healthcare professionals and interfacility transfer incidents separately to other 999 activity, to allow them to measure how effective they were.

There was an area within the emergency operations centres for local air ambulance teams. The helicopter emergency response service was used to fly the most advanced medical crew and equipment to patients when and where they needed it most. They worked closely with the emergency operations centres teams and used joint systems to respond to patients across the entire North West region.

The service made good use of 'special notes.' These were in the form of a shared care record from other healthcare services. For example, if a person had additional needs or an advanced care plan, their GP or specialist care team could ask for special notes to be added to the ambulance services care record to support any future care of the patient.

There were good examples of partnership working with a local mental health trust to support patients with mental ill health.

Is the service caring?

Inspected but not rated

Our findings

Compassionate care

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

We sat with emergency medical advisors during live 999 calls and saw that staff were caring, respectful and kind when speaking with patients, their families or members of the public. Staff took time to interact kindly despite being under pressure. We heard emergency medical advisors speaking to callers in a clear and steady manner to get messages across in emergency situations, whilst remaining considerate for the person on the call.

Emergency medical advisors were supportive and reassured patients and their families even when there were extended waits for emergency ambulances to arrive. Patients and families were asked to call back if situations changed and we heard calls where patients expressed their frustration and anxiety.

Staff were non-judgemental when speaking with or discussing patients with mental health needs.

Staff told us they used their training, the NHS pathways system and drew on their own values to remain compassionate to callers.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

The service planned and worked to provide care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, due to the increase in demand and the pressure on resources, the service was not always able to meet the needs of patients.

There was higher demand in more densely populated areas. The team in the dispatch suite focussed on localities within the whole region, to ensure there was a focus on varying nature of demand in different parts of the region.

The EOC worked with other NHS ambulance services for calls that crossed regional boundaries. There was mutual support in times of peak demand. The national ambulance response programme (ARP) was set up for all NHS ambulance trusts to increase operational efficiency whilst maintaining a clear focus on the clinical need of patients. Response times had deteriorated over the last two years throughout the pandemic.

We saw that for February 2022, response time targets were not met for any ARP measures apart from the category 1 90th centile. The main reasons for this were a rise in the acuity of calls (more urgent calls), and the time it took for crews to be 'turned around' after an incident / emergency. An overall increase in handover delays at emergency departments meant crews were delayed for hours at times before they could get back on the road. In February 2022, over 895 hours were lost due to crews being delayed at hospitals.

Our findings

Almost 70% of all calls into the service were in the highest categories and reduced the opportunities for hear and treat or see and treat. The service had worked with the wider system and local organisations to remain responsive. There had been a 'six-point plan' intended to improve performance and maintain patient safety. This focussed on reduction in lost hours, reduction in conveyances to hospitals, reduced handover times, improvements in community access and access to mental health services.

Extra non-recurring finances had been used to increase numbers of 999 call handlers and additional clinical support.

In February 2022, there were five patients in category 1 who waited longer than 60 minutes and 7,349 patients in category 2 who waited longer than 60 minutes for an ambulance. This however had improved since December 2021. In comparison to other ambulance trust emergency operations centres at that time, the service was fourth out of eleven services for category 2 calls.

There was effective use of the directory of services (DOS). The DOS was an urgent and emergency care services clinically focused 'phonebook' of all commissioned healthcare services. It was designed to help staff to be able to refer patients, to the right service, the first time, safely. The emergency operations centres had worked with commissioners and their respective service providers, to create the directory so that staff could make informed decisions regarding the appropriateness of the services for patients. The directory was quality assured by a small team who worked with commissioners, national teams and local organisations to ensure the directory remained up to date.

There were systems in place to meet the needs of people or patients who required other interventions. Emergency medical advisors worked with other emergency services such as Police and Fire services to coordinate a response as needed.

Access and flow

Most people could access the service of the EOC when they needed it, in line with national standards, and received the initial phone response in a timely way. However, pressure from increased demand meant high numbers of people waited too long for ambulances to be dispatched to them.

The week following our inspection, there were 128 occurrences of ambulance crews being delayed for over three hours in hospital emergency departments. Over 300 hours were 'lost'. This meant crews could not respond to patients who were waiting for an emergency ambulance. There were over 800 occurrences of crews being delayed by one to two hours.

Senior leaders told us the service received around 25,000 calls per week; at the busiest times in recent months they received 48,000 calls per week.

Call pick up in the emergency operations centres had been responsive over winter 2021/2022 and the service had achieved both the mean (average) and 90th centile standards. The service was consistently in the upper 25% of English ambulance trusts for 999 call pick up times. In February 2022, the service received 110,736 calls of which 84,645 became incidents which needed an ambulance response.

The call pick up times had improved from 85.7% in January 2022 (and previous months) to 95.4% in February 2022.

- Mean (average) call answer time was 3 seconds (10 second improvement vs January 2022)

Our findings

- 90th centile call answer was 0 seconds (33 second improvement vs January 2022).
- 95th centile call answer 3 seconds (82 second improvement vs January 2022).
- Percentage of calls answered within 5 seconds was 95.4% (9.71% improvement vs January 2022).

The service continued to be first or second out of 11 trusts for weekly call pick up standards.

When we were on site, the average call pick up time for a health care professional to respond was 23 seconds; 12 seconds of that time was within the system re-routing the call.

Senior staff supported call handlers and dispatchers to make sure of the best response for patients. Emergency medical dispatchers made decisions to allocate ambulances and crews according to patient risk and available resources by use of the dispatch process. Staff told us it meant constant reprioritising and balancing of patients who had been waiting, against risks to other patients with a more urgent need.

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 in the service for staff.

There was a comprehensive leadership and governance structure for each part of the service. For example, the advanced and specialist practitioners in the clinical hub were led by the clinical lead; there was a senior clinical lead who had oversight of the whole team. Similarly, there were leaders for the call handling and dispatch suites. The number of supervisors in the call handling suite had been increased by one person to allow them to each supervise six or seven emergency medical advisors. The number of managers in the dispatch suite had also been increased so there was extra flexible support for emergency medical dispatchers. Staff we spoke with knew who their leaders were and told us the leaders supported them.

The service had been under increased and unprecedented pressures for an extended period of time. Senior leaders from the service had worked hard to support staff. Senior leaders described how there had been investment into staff resilience through work with an external company. This had enabled earlier identification of factors which had been found to contribute to staff stress and anxiety. A clinical psychologist had been appointed to support staff. Leaders described wellbeing initiatives and emotional support which was in place. They told us how proud they were of all the teams.

Executive leaders had not been able to be as visible over recent months due to lockdown pressures although they had met virtually with operational staff via online meetings. The chief executive carried out a weekly online briefing, other executive leaders posted personal web logs to communicate with staff. Some face to face meetings with executive leaders had resumed in recent weeks. Leaders told us about structured executive visits which were planned to be part of internal quality assurance visits. They described being authentic and approachable, not just being visible. As part of recent restructuring, area director roles were being introduced to support visibility of leaders.

Our findings

Leaders were clear about the challenges to quality of care and sustainability of the service. The service had been at resource escalation action plan (REAP) 4 since September 2021. Measures had been put in place such as contracts with agency and third-party providers to mitigate against short term sickness. Shift enhancements for staff were in place and the use of estimated time of arrival by emergency medical advisors to minimise the number of duplicate 999 calls.

The trust received additional non recurrent funding from central Government during the pandemic to assist with operational pressures. A large proportion of those funds had been used on recruitment of agency workers to support call handling.

Staff were supported to develop their skills in preparation for the rollout of NHS Pathways. Some staff went to work for 10 weeks in another ambulance trust that was already using the system to enable North West Ambulance Service (NWAS) staff to gain knowledge and skills of how to use NHS pathways.

Culture

Staff mostly felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff had been working under unprecedented pressures for an extended period of time and senior leaders recognised the impact this had on health and well-being of staff. Leaders spoke with us of not wanting to add to operational pressures as staff had been quite despondent at times during the pandemic. Teams had access to a regional resilience hub. Leaders told us about learning and changes put in place after the Manchester arena attack. There was a mental health toolkit in place to support all staff.

The NHS staff survey for 2021 showed around 36% of trust staff responded to the survey. This was the lowest response of ambulance trusts in England. (These response rates were at trust level and could not be broken down to the emergency operations centres service).

The trust's board assurance framework for April 2022 indicated a risk that if the (whole) organisational culture change did not sufficiently develop, it could impact adversely on staff wellbeing and engagement with organisational changes. The board assurance framework noted this in turn could result in poor quality services and staff harm.

There had been additional NHS England and Improvement funding which had been focused on addressing managerial burnout and proactive wellbeing calls for frontline staff. The staff survey results showed some improvement. Leaders told us this provided a foundation to build upon.

Leaders told us as the NHS staff survey was carried out on an annual basis, they wanted to engage with staff feedback more frequently. The trust carried out a quarterly staff survey. This allowed a year-round opportunity for staff to share their views, experiences and feedback. Leaders told us this shaped how they listened, responded and enabled changes to take place.

Staff forums had continued via online meetings; at the time of our inspection face to face forums were restarting. Senior leaders told us they called into face to face training sessions to meet staff as it was an opportunity to thank them and acknowledge the work they were doing.

There was a learning culture and staff spoke up when they felt there was a need. Senior leaders we spoke with told us staff were more willing to raise concerns than in previous times, and they were supported to do so. The timeliness of

incident reporting had improved, as had the response times to incident reporting. Historically, there had been delays in learning from incidents because of the delay in identifying them. We saw that comprehensive audits were completed and fed into quality business groups. Learning was system based and organisation wide rather than being limited to an individual area. Senior leaders told us they engaged with staff side and unions around a 'just culture' to promote and highlight a 'no blame' culture. When things went wrong, the service used 'duty of candour' in order to respond to patients and families.

Staff we spoke with told us that the electronic tablets helped them stay in touch with colleagues. They were looking forward to being able to meet up face to face too.

Senior leaders told us there was a health and wellbeing focus during appraisals. This enabled staff to 'decompress' with colleagues who understood the pressures.

We saw that most senior leaders wore uniform and this supported team building with operational staff.

Operational staff had been involved in consultation and roll out of NHS pathways.

In the Broughton emergency operations centre there was a wall mural, the 'Tree of Life'. 'Leaves' on the tree represented emergency operations centre staff who had either supported delivery of a baby or supported someone to survive a cardiac arrest. Staff were awarded with either a stork or heart badge and received a letter from the leadership team to celebrate their involvement.

The staff room at the Broughton emergency operations centre was being expanded and updated to improve the environment for the staff rest area. Staff told us their 12-hour shifts were long and could be mentally draining, so they appreciated a restful space to have a break. There was also an online 'green room' where staff could give and receive support to and from each other.

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 the service was under significant pressure to manage the considerable increase in demand.

The service understood and managed foreseeable risk. There were proactive plans in place for demand surges related to internal and external events such as disruption to staffing levels or regional hospitals not being able to accept patients.

There had been restructuring at a senior level to reflect the regional planned integrated care systems. We heard from leaders how there was a need for the trust and service to be engaged at system level because of the key role played by the trust.

There was significant risk in some local community areas that due to the excessive handover delays at hospitals across the North West, there may be increased numbers of patients being held on the back of ambulances. This meant the number of available ambulances to respond to 999 calls was diminished and resulted in increased numbers of delayed responses for patients.

Our findings

Senior leaders told us that the week before our inspection, at one time, there had been 20 ambulance crews waiting with patients in corridors at hospitals. The trust had developed an 'every minute matters' plan, however not all hospital trusts in the region had signed up to this, which pushed the risk back onto the ambulance trust. There had been an increased number of serious incidents in April 2022. Senior leaders told us this heightened the focus on quality, safety and patient experience for people who interacted with the emergency operations centres service.

Senior leaders discussed with us how the relationship with commissioners in one of the regions was much more supportive than with other commissioners. System working meant steps had been put in place in acute hospitals to minimise delay to patients being handed over. In other regions patients were being delayed in ambulances outside emergency departments. This meant the ambulance trust carried the risk and this contributed to risks in communities as crews and ambulances were not available to respond in a timely way. This contributed to other risks such as patients waiting for calls to be answered. We saw from trust documents that handover delays were discussed in regional system meetings.

The service mitigated where it could against these risks. For example, the clinical co-ordination desk was in place for clinicians to review patients who were awaiting an emergency ambulance. The implementation of NHS pathways had enabled the service to carry out more hear and treat and signposting to support ambulance resources being used well. The patient safety plan would be utilised along with the scheme of delegation to support business continuity, depending on any level of escalation and risk.

There was a risk that due to increasing operational demand and call volumes, the health and wellbeing of the staff in the service could deteriorate. This in turn could potentially lead to other staff taking time off and could impact on the service. There had been some mitigation such as an extra £6.23 million non-recurring fund to cover short-term increase in resources from September 2021 to the end of March 2022. Senior leaders told us this funding had now ceased. There had been work with NHS England and Improvement and some commissioners to improve hospital delays. There were also 'buddy' arrangements with other NHS ambulance trusts to alleviate pressures on the emergency operations centres when it was needed.

Senior leaders told us the service had struggled to meet demand before the pandemic. The prolonged demand for services, not only in relation to COVID-19 meant the service needed around 10,000 more ambulance hours per week in order to meet the needs of the population. There were currently around 45,000 ambulance hours provided each week for the 999 service.

Risks to staff who worked in close proximity to one another in the call handling and dispatch suites had been addressed by good infection, prevention and control (IPC) processes.

Our findings

Outstanding practice

We found the following outstanding practice:

The trust also supported a national effort to help bring 21 Ukrainian children with cancer to the UK to receive care through the NHS. The children were brought over from Poland to a triage centre in the West Midlands where they were assessed before being transferred to be cared for at appropriate hospitals across the country. A staff team of 13 from the trust's patient transport service, paramedic emergency service and operational commanders took the 180-mile round trip to bring some of the patients and their families to the North West region to continue their care. The extremely fast-moving operation was made possible by the quick and efficient planning and co-ordination of the trusts Regional Operational Control Centre (ROCC) team. The trust told us it was an honour for them to be able to support in this humanitarian effort and do what they do best, which is provide care to those who need them most.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors and a Specialist Advisor. The inspection team was overseen by Karen Knapton Head of Hospital Inspection.