South East Coast Ambulance Service NHS Foundation Trust

Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is part of the National Health Service (NHS). The trust was established on 1 July 2006, with the merger of the former Kent Ambulance Service, Surrey Ambulance Service and Sussex Ambulance Service. On 1 March 2011 SECAmb became a Foundation Trust.

The trust employs approximately 3,500 staff, 85% of whom have direct patient contact, either face to face or over the phone. The staff work across 119 sites in Kent, Surrey and Sussex. This area covers 3,600 square miles which includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country. It has a population of over 5 million people. There are 12 acute hospital trusts, four specialist and mental health trusts and 22 Clinical Commissioning Groups (CCGs) within this area.

The trust responds to 999 calls from the public and urgent calls from healthcare professional across Brighton and Hove, East Sussex, West Sussex, Kent and Medway, Surrey, and parts of North East Hampshire. The trust provides assessment and treatment advice to callers with less serious illnesses and injuries using a service known as “hear and treat”. The trust also has a Hazardous Area Response Team (HART) and provides NHS 111 services across the region.

SECAmb was inspected in both 2016 and 2017 where they were rated as inadequate overall for both inspections. This year we inspected SECAmb as part of our new methodology inspection programme. As part of our inspection we visited trust premises including offices, vehicle ‘make ready’ centres, vehicle fleet maintenance centres, specialist units such as Hazardous Area Response Team (HART), ambulance stations and emergency operations centres. We also observed care on ambulances and visited hospitals and other health care locations to speak with patients and staff about their experiences of the ambulance service.

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Requires improvement

What this trust does

The trust provides a range of services including emergency and urgent care, and handling of calls through the 999 service and the 111 service.

There are two emergency operations centres (EOC), located in Crawley and Coxheath, where 999 calls are received, clinical advice provided and emergency vehicles dispatched if needed. Calls coming into the EOC are responded to using a set form of triage which determines the response time based on a new set of measures called the ambulance response programme (ARP). The four new categories enable call handlers more time to assess 999 calls that are not immediately life threatening, and callers whose needs indicate when a faster response is required.

There are eight vehicle ‘make ready’ centres, 33 ambulance stations and 69 ambulance community response posts out of which ambulance crews may be dispatched. They may also be sent directly to callers from previous call out locations or emergency departments where they take patients to.

The South East Coast Ambulance Service (SECAmb) has a crucial role in the national arrangements for emergency preparedness, resilience and response (EPRR). The trust has two Hazardous Area Response Team (HART) locations, at Ashford and Gatwick. Staff working within these teams have additional training to enable them to work in hazardous environments.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

Summary of findings

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. During the past year we have held regular engagement meetings with the trust and attended a range of meetings. These activities enabled us to have continued oversight of the trust activities and progress it was making on a number of quality improvement initiatives, some of which arose from the previous inspection in 2017. This information was used together with other data to inform our inspection.

This inspection included the core service areas of emergency operations centres (EOC) and emergency and urgent care (E&UC). These core services had a number of areas which were inadequate or required improvement at the previous inspection and our inspection was designed to assess the progress made.

This inspection also included the core service area of resilience. The trust is part of the civil contingency planning for both the NHS and the wider emergency preparedness network. Our inspection was designed to assess whether SECAmb could effectively manage the impact and aftermath of a major incident.

We did not inspect the 111 service during this inspection but we did take into account the current ratings of the 111 service when rating the trust.

In addition, we undertook a well-led inspection. At the previous inspection we rated well-led as inadequate. At the time we were not assured of progress made to remove the trust from special measures, which had been in place since 2016.

What we found

At this inspection, the trust did not respond in a timely way to category 3 and 4 patients, there was inconsistency in the identification and management of safety concerns surrounding patients waiting for an ambulance, learning from incidents and complaints was slow to disseminate, the process for identifying risks and reducing them was inconsistent and low staffing levels had a significant input in the trust's inability to meet national ambulance response targets. We also found the leadership structure within the Hazardous Area Response Team (HART) was unclear.

During the inspection we found a breach of Regulation 12, safe care and treatment. We took action and the trust made substantial and prompt changes to correct the breach and ensure patient safety. As a result, we did not take enforcement action under Regulation 12.

Although the trust was fast to respond to our concerns, their processes to assess, monitor and improve the quality and safety of services and also to assess, monitor and improve the assessment of risk relating to the provision of the service were not always embedded or operating effectively. We therefore found the trust was in breach of Regulation 17, Good governance.

However, we found the trust demonstrated compassionate care and emotional support that took people's needs into account. They had made significant progress in areas including medicines management, safeguarding training, staff understanding and management of incident reporting, the quality of the trust's response to complaints, staff culture and had a number of outstanding areas.

Summary of findings

Overall trust

Our rating of the trust improved. We rated it as requires improvement because:

- In both the emergency operations centre (EOC) and emergency and urgent care (EUC) we rated safe, effective, responsive and well-led as requires improvement and rated well-led in resilience as requires improvement.
- We rated safe, effective and responsive in the trust's resilience core service as good. We rated caring as good across all three core services.
- In rating the trust, we took into account the current ratings of the 111 service, which was not inspected this time.
- We rated well-led for the trust, overall, as requires improvement.

Are services safe?

Our rating of safe improved. We rated it as requires improvement because:

- Staff were not always reporting incidents. For example, during our inspection it was unclear which staff members were responsible for reporting long lying patients. This resulted in incident reports not reflecting the number of patients who were waiting for extended periods of time. However, incident reporting had significantly increased since our last inspection and staff had a better understanding of what their responsibilities were surrounding incident reporting compared with the previous inspection.
- Across the emergency operations centre and emergency and urgent care core services, there were areas of insufficient oversight and understanding of risk. For example, the emergency operations centre had no process or system in place to promptly review patients who had been declined an ambulance as part of the trust's surge management plan. However, following inspection the trust promptly put a system in place to ensure a review of these patients was within 30 minutes. Another example of inconsistency in understanding of risk was among emergency and urgent care staff who did not always carry out comprehensive risk assessments of their patients.
- Learning from incidents, reviews and concerns, across resilience and emergency operations centre core services, was slow. There was improvement on learning from incidents since our last inspection as staff were receiving feedback and actions were created following incidents. However, there was not always follow up to show these actions had been completed or had resulted in improvement.
- Staff shortages across both the emergency operations centre and emergency and urgent care core services had an impact on both staff and patient safety. Staffing concerns were often around recruitment and retention which put pressure on existing members of staff to meet public demand. This had a direct impact on category three and four calls where patients were waiting for an ambulance for extended periods of time. This also put pressure on staff who often could not take their meal breaks which impacted on their well-being.
- The trust did not have clear oversight of the deteriorating health of 'long lying' patients both within emergency operations centre and emergency and urgent care core services. In the emergency operations centre many waiting patients did not receive a clinical review or welfare call in a timely manner. Following our inspection, the trust employed 20 more members of staff to undertake welfare call backs and provided data that showed significant improvement in their welfare calls and clinical review compliance.

However,

- Medicines management was robust and effective across the trust. There had been marked improvement since our previous inspection. Medicines were managed safely and securely, the trust made sure patients received medicines as intended and this was recorded appropriately.

Summary of findings

- Safeguarding training compliance across all three core services had significantly improved since our last inspection. For example, trust data showed that 98% of registered clinicians had been trained to safeguarding level 3.
- The management of incidents had significantly improved since our last inspection. In May 2018 there was a backlog of 80 incidents, an improvement of 97%. In June 2016 there had been a backlog of 2,633 incidents.
- Following inspection, an upgrade to the trust's system – commissioned in May 2018 – was in its final stages. This improved the management, oversight and assessment of patients waiting for an ambulance.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- The trust was not meeting national ambulance response standards. Although category 1 and 2 response times were above the England national average, category 3 and 4 patients remained below average.
- The trust's performance data was consistently below the England average over the reporting period. For example, the trust's call answering performance, the trust's 'hear and treat' performance, patient outcome performance and the number of patients to re contact the service within 24 hours.
- Patient outcome data was broadly in line with or below the England national average in the majority of patient outcomes. For example, the number of patients who survived a cardiac arrest through to discharge was worse than the England average in 10 out of 12 months.
- The Hazardous Area Response Team (HART) was under used by the emergency operations centre and emergency and urgent care teams. This appeared to be down to a lack of understanding and communication across the trust about what a HART member of staff could do. The trust was working to improve staff understanding to ensure the Hazardous Area Response Team (HART) was better used.

However,

- The Hazardous Area Response Team (HART) staff were a group of highly trained individuals whose response to incidents was based on best practice and national clinical guidance. Staff competencies were maintained and staff completed a comprehensive training programme to ensure their skills remained up to date.
- The service made sure staff were competent for their roles. Data showed that appraisal completion was above the trust target of 80% across all three core services and had significantly improved since our last inspection.
- The trust had a comprehensive approach to supporting frequent callers and the operational frequent caller model was followed. Emergency and urgent care teams signposted to appropriate support in the community and a new frequent caller lead was in post within the emergency operations centre.
- People's physical, mental health and social needs were assessed and their care, treatment and support was delivered in line with legislation, standards and evidence based care and treatment across all three core services.
- Care was delivered in a coordinated way between different teams across all three core services. For example, a maternity hub was launched within the emergency operations centre at Crawley that provided support and advice to pregnant women. There were good working relationships between midwives and clinicians in providing advice, support and care.
- Support and understanding of mental health patients was consistent across all three core services. All staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. The mental health 'street triage' service continued to be effective in providing better outcomes for patients.

Summary of findings

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. All staff we spoke with were motivated to deliver the best care possible. Feedback from patients and those close to them was positive.
- Staff cared for patients with a non-judgemental attitude and ensured patient dignity was maintained.
- Staff involved patients and those close to them in their decision making and supported patients to manage their own health.
- Staff provided emotional support to patients to minimise their distress. Support was consistently given with kindness and respect.
- The trust was taking positive steps to show staff they were cared for. Staff had access to a new well-being hub which enabled staff to access support in a variety of areas. Most staff spoke highly of the hub. Managers were trained to complete trauma risk management assessments (TRiM) to help support staff following traumatic events.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People could not always access the service when they needed it in both the emergency and urgent care and emergency operations centre core services. There continued to be serious concerns around delays in responding to category three and category four patients. The emergency operations centre listed these patients in time order, without reference to the needs of the patient. There were also delays, at times, during the handover of patients between ambulance staff and hospital staff. We acknowledge that the trust had demonstrated a reduction in the number of handover delays.
- The emergency operations service did not always take account of patients' individual needs. The service did not audit or review calls that had been initially triaged as not needing an ambulance and then changed by a clinician to needing one. This meant the trust could not learn from these changes to enable them to better respond to calls in the future. Following our feedback, the trust put immediate measures in place to have better oversight and understanding of calls that were triaged as not requiring an ambulance but following a clinical review were sent one.
- Delays in dispatching ambulances to patients gave some of the responding staff the perception that these patients were a low priority and so blue lights were not always used in line with ambulance response programme guidance. We raised this concern with the trust, who put measures in place to monitor the suitability and appropriate use of blue lights.

However,

- The trust treated concerns and complaints seriously, investigated them and learnt lessons from the results. The process for investigating complaints and the quality of the trust's response to complaints had significantly improved since our previous inspection.
- The trust had introduced a new role to give better oversight and management of patients waiting for an ambulance. This role helped support clinicians to review patients based on their needs rather than just the length of time they had been waiting.
- The trust's resilience was developed to meet the needs of the local population and the Hazardous Area Response Team (HART) liaised with many agencies and cross county networks. A special operations response team was in development to support chemical, biological, radioactive and nuclear (CBRN) and marauding terrorist firearms attack (MTFA) operations.

Summary of findings

- The emergency and urgent care service took into account patient's individual needs. Staff recognised and respected the need to provide individualised personal treatment. For example, staff received training about specific patient groups such as patients living with dementia. The trust also employed mental health nurses to provide support and guidance to front line crews.

Are services well-led?

Our rating of well-led improved. We rated it as requires improvement because:

- The trust did not have fully embedded systems for identifying risks, planning to eliminate or reduce them. Managers and operational team leaders were not always aware of what their station's risks were or what was on the trust risk register. We received varied responses in the emergency operations centre to explain why call recording was a top risk.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action but staff values were not embedded across the emergency operations centre among junior staff.
- The perception of managers at all levels across the trust was varied. There was mixed feedback about management above team leaders and below senior management.
- Staff perception of bullying and harassment was still present in some areas across the trust and some members of staff were still affected by previous concerns surrounding bullying and harassment. However, this had improved since our last inspection as the majority of staff felt the senior leadership team took a serious view on bullying and harassment.
- The leadership structure within the resilience core service was unclear.
- The governance processes were not well established and effective within the resilience core service. For example, there was a lack of collation and review of response times within the Hazardous Area Response Team (HART).
- The trust's previous management of private ambulance providers within the reporting period was poor. However, the trust had recently taken steps to improve their management, oversight and monitoring of private ambulance providers and their performance.

However,

- Managers were developed across the trust to ensure they had the right skills and abilities to run a service providing high-quality sustainable care.
- The trust promoted a positive culture that supported and valued staff. The culture across all three core services had improved since our last inspection. Most staff we spoke with felt the culture had improved and felt able to raise concerns to their managers. There were still some areas where culture had not improved but the trust's culture change plan demonstrated a commitment to focusing on these areas.
- The new operational team leader role was highly spoken of across the trust. Most members of staff felt their team leaders were supportive and went out of their way to ensure the welfare of their staff despite the vast and sometimes excessive amount of work they had to do.
- The trust was committed to improving services by learning from when things went well and when they went wrong. Throughout the inspection process, we found the trust was quick to respond to concerns raised by the inspection team. This willingness demonstrated a commitment to improve the service they provided.

Summary of findings

Ratings tables

The ratings tables show the ratings overall and for each key question, for each core service, and for the whole trust. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in the emergency operations centre and emergency and urgent care core services. For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including one breach of a legal requirement that the trust must put right. We found ten things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued one requirement notice to the trust. This meant the trust had to send us a report saying what action it would take to meet this requirement.

For more information, see the sections on Areas for improvement and Regulatory action in this report.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Emergency Operations Centre

- Support for maternity patients was excellent. A new pregnancy advice and triage line for pregnant women had been introduced within the Crawley EOC.

Emergency and Urgent Care

- The Crawley triage scheme, which had led to a reduction in conveyancing to hospital for people with mental health conditions from 53% to 11%.
- We found elements of outstanding medicine management, for example the way the trust handled Controlled Drugs (CD’s). We found suitable audit and quality control processes to ensure the high standards achieved by the organisation were continuously monitored.
- The trust initiative to provide physical and mental health support for staff through the ‘wellbeing hub’ was widely commended by staff during the inspection.
- There was a multidisciplinary multiagency approach to training in the Kent area. This meant staff were training to deal with unexpected situations should they occur.

Summary of findings

- Brighton station had a dedicated homeless lead who took responsibility for and oversight of this vulnerable group. This role included undertaking outreach work, as well as working with local services to meet the needs of these patients.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve services in both the emergency operations centre and in emergency and urgent care.

- The trust **must ensure** that their processes to assess, monitor and improve the quality and safety of services and also to assess, monitor and improve the assessment of risk relating to the provision of the service are operating effectively.

Action the trust SHOULD take to improve the emergency operations centre

- The trust **should ensure** they take action to continue to have effective systems and processes to assess the risk to patients and people using the services and they do all that is reasonably practicable to mitigate those risks, specifically in relation to the risk assessment of patients awaiting the dispatch of an ambulance.
- The trust **should ensure** they continue to monitor the effectiveness of the clinical safety navigator role to ensure continued oversight on the safety of patients waiting for an ambulance.
- The trust **should ensure** there are a sufficient number of clinicians in each EOC to meet the needs of the service.

Action the trust SHOULD take to improve emergency and urgent care

- The trust **should ensure** the processes for providing staff with feedback from safeguarding alerts is improved to strengthen and develop learning.
- The trust **should ensure** that maps in all vehicles are current, up to date and replaced regularly.
- The trust **should ensure** that all staff adhere to the trust policy on carrying personal equipment and the regular servicing of such equipment.
- The trust **should ensure** that pain assessments are carried out and recorded in line with best practice guidance.
- The trust **should ensure** response times for category three and four calls is improved.
- The trust **should consider** producing training data split by staff group and core service area for better oversight of training compliance.

Action the trust SHOULD take to improve Resilience

- The trust **should ensure** they collect, analyse, manage and use data on meeting response times for Hazardous Area Response Team (HART) incidents.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as requires improvement because:

- Although the trust had a new executive leadership team with the skills, abilities, and commitment to provide high quality services, they had not been in post for long enough to be able to demonstrate sustainable outcomes arising from improvements.
- The availability of middle and senior managers with the right skills and abilities to run a service providing high-quality sustainable care was not consistent across all regions within the organisation. Staff reported poor management practices in several areas. However, the executive team understood that further development was needed to ensure that all managers demonstrated behaviours which were fully aligned with the trust's values and a development programme was in place.
- Equality and diversity was not consistently promoted within and beyond the organisation. There were no BME representatives at board level and no action planned to address this shortcoming. Board members recognised that they had work to do to improve diversity and equality across the trust and at board level but this had not been prioritised.
- The trust did not have assurance that work on inclusion was running through all aspects of its organisation's policies and practices, and further work was needed to engage with and identify key issues for diverse groups, especially women and BME staff.
- There was inconsistency in how senior management across the organisation was able to implement the strategic objectives allocated to them, and a risk that the executive team would be diverted to supporting the implementation of operational changes instead of being able to focus on driving the necessary strategic changes.
- The trust had taken action to address behaviours and performance that were not consistent with their values and vision and staff reported an improvement in the level of bullying within the organisation. However, senior staff identified inconsistent knowledge around the trust on what constituted unacceptable behaviours, and a lack of visibility of the processes which existed to address this. Staff across the organisation commented on the slow pace of change to address this and some believed that there was insufficient recognition of the severity of the problem.
- In some areas, morale was still low. Staff reported a lack of knowledge of action taken by the leadership team to resolve long-standing cases of bullying and harassment and this led them to form the view that the trust was not reviewing its previous investigations.
- The pace of change within the organisation was inconsistent. Whilst the executive team was aware of the need to deliver improvement by balancing the implementation of solid governance systems with swift and sustainable action, some staff felt that their concerns were being ignored and that there was a layer of managers who were obstructing the delivery of change.

Summary of findings

- The nature of the governance structure did not always support the board's ability to have clear oversight and was held by some to slow down the pace of change. The trust had a lengthy and detailed structure for overseeing performance, quality and risk, with board members represented across the divisions. At times this led to slow progress in the approval of new policies and practices. However, we saw an improvement on governance processes and increased understanding of governance since the last inspection.
- The trust did not have effective or consistent systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Not all risks had fully been identified to the board or by managers and control measures did not consistently provide sufficient detail to have assurance that they would be effective.
- The trust had limited engagement with patients and received very little feedback on the quality or experience of those who used the service. The Patient Experience Group had not been fully operational since the previous inspection as it had prioritised work on the trust's response to complaints. There was a lack of strategic focus to community engagement and to ensuring that the voices of patients from different equality groups were all heard.

However:

- The trust had a vision for what it wanted to achieve and had recently reviewed its plans to turn it into action. The newly revised trust strategy was directly linked to the vision and values of the trust and linked to identified risks and key areas where improvement was needed. The trust involved staff in the development of the strategy and from this had a clear five-year plan with objectives set out for the next two years to deliver high-quality care and sustainable change.
- The new executive leadership team recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation. This included a board development programme, executive coaching and buddying with a local NHS acute trust. Steps had been taken to address succession planning and this was in the process of being extended to other senior leaders.
- A training programme had been developed for managers below the executive team to ensure that they had the skills and abilities to provide support and development for their teams, including the provision of high quality appraisal and career development conversations.
- Senior leaders, including both executive and non-executive directors, worked hard to improve their visibility across the organisation and made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced.
- The newly agreed Demand and Capacity Plan had been drawn up after extensive consultation with commissioners and other partners in the wider health care economy to ensure that the trust would be able to meet the needs of its communities and achieve its performance targets. There were clear plans to monitor performance against the plan once it had been signed off.
- They demonstrated improved engagement with local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively
- The executive team understood their role in promoting a positive culture that supported and valued staff, and worked hard to create a sense of common purpose based on shared values. The creation of a Well-Being Hub provided staff with a single point of access to a range of resources for support around both physical and mental health.
- The trust had a culture change plan which demonstrated an understanding of the challenges facing the organisation and included specific outcome measures to monitor its impact. The HR department was working closely with union representatives to resolve issues arising from historic investigations into bullying and they had a clear understanding of the importance of modelling behaviours and recruitment processes which were aligned with the trust's values.

Summary of findings

- The executive team understood the importance of underpinning improvement with clear lines of accountability and effective governance. There had been significant improvements in the trust's processes and systems for medicines management with a comprehensive external review recognising the impressive turnaround in performance.
- The executive team responded swiftly and effectively to address risks which we identified during our inspection and provided detailed evidence to demonstrate their action and how this had resolved our concerns.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The board reviewed performance reports that included data about the services and results from national audits were used to develop improvement plans relating to patient outcomes.
- A new Business Intelligence system allowed managers to apply real time data to challenges to be able to identify solutions, such as understanding and addressing challenges with road crews not being able to take their meal breaks in a timely manner.
- Staff engagement had improved. The executive team used a range of innovative methods to communicate with staff across the whole region and had established staff engagement leads to make it easier for staff to get involved.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. The management of complaints had improved since the previous inspection, with more timely responses demonstrating compassion, and transparency in acknowledging when things had gone wrong.
- There was a new quality assurance and improvement framework and the trust had established a clinical innovations and service change fund for staff to pursue service improvement projects aligned with the trust's strategy.
- Operational, finance and clinical leads worked well together to deliver high standards of care.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↑ Oct 2018	Requires improvement →← Oct 2018	Good →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement ↑ Oct 2018	Requires improvement ↑ Oct 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement ↑ Oct 2018	Requires improvement →← Oct 2018	Good →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement ↑ Oct 2018	Requires improvement ↑ Oct 2018
Emergency operations centre	Requires improvement ↑ Oct 2018	Requires improvement →← Oct 2018	Good →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement ↑
Resilience	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018
NHS 111 Service	Good May 2017	Good May 2017	Good May 2017	Good May 2017	Outstanding May 2017	Good May 2017
Overall	Requires improvement ↑ Oct 2018	Requires improvement →← Oct 2018	Good →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement ↑ Oct 2018	Requires improvement ↑ Oct 2018

Overall ratings are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Emergency and urgent care

Requires improvement

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) provides emergency and urgent care services to the population of southeast England. The trust operates in a diverse geographical area of 3,600 square miles including densely populated urban areas, sparsely inhabited rural areas and some of the busiest parts of the motorway network in the country.

Like other NHS ambulance services, SECAmb has little influence over the number of '999' emergency calls it receives, but has a statutory obligation to resolve a call, once it arrives. In addition to emergency calls, ambulance services are required to take patients to hospital where a doctor, midwife or other healthcare professional identifies the need as urgent.

To help meet demand, telephone triage and advice services have been developed nationally. This is called 'hear and treat' and this aspect of the service is dealt with in the emergency operations centre section of this report.

As part of the 'assess and treat' and 'assess and convey' roles of the ambulance trust, the emergency and urgent care service provides a rapid response to calls made to the emergency 999 service or to NHS 111. Providing this service 24 hours a day all year round, SECAmb works closely with the police and the fire service to provide emergency services at accidents and incidents throughout the region.

Key facts and figures

SECAmb has over 3,300 staff working across 119 sites in Kent, Surrey and Sussex, making it one of the largest ambulance trusts in the country. The trust headquarters is in Crawley with a regional office in Coxheath, Maidstone.

The trust has qualified ambulance staff including paramedics and technicians on all front-line services. SECAmb also employs advanced practitioners such as consultant paramedics, community paramedics and paramedic practitioners. These are experienced paramedics who have undertaken extended training to enable them to 'assess and treat' patients and discharge them 'at scene' as appropriate. All these roles are supported by associate practitioners, emergency care support workers and community first responders.

The service has two emergency operations centres where 999 calls are received, clinical advice provided and emergency vehicles dispatched if needed. These are located at the headquarters building and at Coxheath. In addition to the 999 service, the trust also provides the NHS 111 service across the region. The 111 service was not inspected on this occasion.

The ambulance service facilities operated by the trust included:

- Eight vehicle 'make ready' centres
- 33 ambulance stations
- 69 ambulance community response posts
- Two vehicle fleet maintenance centres

The emergency and urgent care service undertook 703,354 journeys between April 2017 and March 2018.

During inspection, we visited 30 ambulance stations or make ready centres across Kent, Surrey and Sussex. Some sites were visited on more than one occasion during the inspection. At the ambulance stations we reviewed the facilities provided for staff, vehicles and stores for medical equipment and consumable items. We checked 37 ambulances in detail and reviewed 88 patient care records.

Emergency and urgent care

Our inspectors and specialist advisors accompanied ambulance crews during day and night shifts to see the care provided. In addition, we visited 10 hospital emergency departments where we observed interactions between ambulance crews and hospital staff. We watched 12 patient handovers and spoke with 14 patients and relatives who used the service. We also spoke with 21 emergency department staff and three police officers to get feedback on the service provided by the ambulance trust.

As part of our inspection, we talked with 136 staff in various roles including managers, clinical team leaders, paramedics and paramedic practitioners, emergency medical technicians, associate practitioners, trainees, students and administrators. Prior to our visits, we facilitated organised and led focus group discussions, attended by over 36 frontline and support staff to hear their views about the service. We also held telephone interviews with six community first responders.

We also reviewed trust policies and protocols along with a variety of performance data, including incidents, complaints, and national ambulance quality indicator reports.

The trust had contracted with commercial providers to 'make ready' their vehicles and premises. We did not inspect these parts of the service.

Summary of this service

Our rating of this service improved. We rated it as requires improvement because:

- We found the trust made significant improvements since our last inspection. The commitment of the EUC staff and senior leadership team to improve was notable. We recognised a positive shift in organisational culture, and many new systems and processes having an improved and measurable impact on the service. However, at the time of the inspection many of these changes were still very new and required additional time to become embedded practice.
- While we saw improvements to the way in which equipment was managed and maintained we identified one member of staff using personal issue equipment with no assurance that these items were in good working order. We also received three contacts from staff making us aware of their concerns with the accuracy of the asset register. We made the trust aware of the concerns we received as the inspection process was unable to prove or disprove the concerns.
- Manual handling equipment was not consistently used, resulting in observed unsafe manual handling practices. Comprehensive risk assessments were not always carried out as clinical observations were not consistently undertaken. Not all patients, where applicable, had their blood glucose level checked in accord with policy and a second set of clinical observations was not consistently carried out even when patients had been administered morphine.
- People's individual care records, including clinical data, were not always written and managed in a way that kept people safe as there were entries that were not sufficiently completed. We acknowledge the trust was reviewing the patient clinical record to make improvements and we saw that records were routinely audited by team leaders.
- Staff did not always report delays where patients who had fallen at home may be waiting for several hours and staff did not report an incident relating to a lack of consumable equipment at the time of our inspection.
- While some staff told us they were encouraged and given opportunities to develop, others told us they believed that internal processes made it difficult for other staff to progress. Some paramedic practitioners told us that there were improved opportunities in hospitals and primary care but that the trust needed to take more action to support development opportunities internally.

Emergency and urgent care

- There were significant delays in handing over of patients at emergency departments, which meant ambulance staff needed to stay with their patients to deliver care and support them until they were handed over to hospital staff, which in turn reduced the capacity of front line staff to respond to emergencies.
- Although ambulance crews had access to specialist ambulances that could be used to transport bariatric patients, these were not always available. One crew described being refused the use of the specialist ambulance, which staff felt was unnecessarily undignified for the patient.
- We identified inconsistencies in station managers and Operational Team Leader's insight into their own stations risks and the Emergency and Urgent Care core service as a whole. Managers were not always aware of what was on the trust risk register. This meant that local managers were not always aware of the risks in the service which meant that action could not be taken to reduce risk and improve patient care, staff and the wider organisation.
- We were made aware of an inconsistent approach to the delivery of regular staff meetings across the three counties. Some stations could demonstrate regular staff meetings with a set agenda while others didn't. This meant that some staff did not have a forum to raise concerns or comments, or catch up on organisational learning and key communications
- At our last inspection staff told us they were not able to have regular meal breaks. Whilst we found this had improved, we were still aware that some crews were unable to have a meal break and experienced shift over runs.

However:

- One of the concerns from the last inspection related to a culture of bullying and harassment. The trust had taken steps to address this. We received positive feedback from staff who recognised a change in culture. However, others told us they were still affected by it.
- The trust had improved its systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, these processes were still being developed and not fully embedded in practice.
- It was clear there was a significant improvement required to help staff understand the governance systems and processes. We received mixed feedback which indicated that governance processes and the importance of such processes, was not widely understood by staff.
- We saw better staff training in safety systems, processes and practices. There were systems and processes in place to protect people from abuse and harm. Staff understood their responsibilities and the process to follow in the event of any safeguarding concerns and we found that overall compliance with mandatory training had increased from 85% at our last inspection to 93.2%.
- There were good standards of cleanliness and hygiene were maintained throughout the vehicle fleet and we found reliable systems in place to prevent and protect people from infection. The trust had implemented an infection prevention improvement plan since the last inspection and staff demonstrated good infection control practices.
- Staffing levels and crew skill mixes were routinely planned and reviewed. Information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way with the introduction of electronic mobile devices which contained patient information as well as trust protocols and procedures.
- Medicines were managed safely and securely. The trust made sure that patients received their medicines as intended and that this was recorded appropriately. An automated medicines management system had been implemented in larger ambulance stations to improve the safety of medicines.

- Lessons were learned and improvements made when things went wrong. Staff reported a learning focus around incident reporting and there were effective arrangements to respond to relevant external safety alerts and when things went wrong. Staff understood their responsibilities to raise concerns, to record and report safety incidents, concerns and near misses.
- People's physical, mental health and social needs were holistically assessed, and their care, treatment and support was delivered in line with legislation, standards and evidence-based guidance. The trust had care pathways and protocols in place that incorporated guidance from the National Institute for Health and Care Excellence and other expert professional bodies. Staff demonstrated familiarity with the guidance and we observed this being followed.
- Patient outcomes and comparators varied, but were broadly similar to other trusts and showed improvements since our last inspection. The service had enhanced clinical and other audits through increased resourcing of front line leadership.
- The learning needs of staff were identified and there was appropriate training and support available to meet those needs. There was protected time for training and experienced staff available to provide clinical supervision and support in decision making.
- Care was delivered and reviewed in a coordinated way between different teams, services and organisations. Staff within the trust worked collaboratively with other services to develop and improve care pathways for patients. This included working collaboratively with hospital staff to reduce the waiting times for patients in accident and emergency departments and ensure that patients who did not need to be conveyed to hospital had the appropriate support.
- Patients who needed extra support were identified. The trust had a comprehensive approach to supporting frequent callers that included signposting them to other services and liaising directly with primary care services to ensure that appropriate support was available in the community.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Mental capacity assessments were consistently carried out and staff had relevant guidance and support available for this.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them with dignity and respect. Staff involved patients and those close to them in decisions about their care and treatment. Patients confirmed their care had been discussed with them; they were able to ask questions and felt included in the decisions about their care. All staff we spoke with were passionate about their roles and were dedicated to making sure patients received the best patient-centred care possible.
- The service treated complaints seriously, investigated them and learned lessons from the results, which were shared with staff.
- The trust planned and provided services in a way that met the needs of local people. They developed ways to ensure the service was as responsive as possible given the demands on the service. The trust worked well with commissioners and local stakeholders to meet the needs of the local populations. The service also took account of patient’s individual needs.
- There were processes in place to ensure the needs of people with a mental health illness were met. The trust employed mental health nurses to provide support and guidance to frontline crew.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust had improved the way it engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Emergency and urgent care

Is the service safe?

Requires improvement

Our rating of safe improved. We rated it as requires improvement because:

- Overall, there was improvement to the safety domain. The trust had implemented systems and process to improve patient safety. However, the systems and process were newly implemented and required further development to have an effective and consistent impact.
- While we saw improvements to the way in which equipment was managed and maintained we identified one member of staff using personal issue equipment with no assurance that these items were in good working order. We also received three contacts from staff making us aware of their concerns with the accuracy of the asset register. We made the trust aware of the concerns we received. Manual handling equipment was not consistently used, resulting in observed unsafe manual handling practices.
- Comprehensive risk assessments were not always carried out as clinical observations were not consistently undertaken. Not all patients had their blood glucose level checked in accord with policy and a second set of clinical observations was not consistently carried out even when patients had been administered morphine.
- People's individual care records, including clinical data, were not always written and managed in a way that kept people safe as there were entries that were not sufficiently completed. We acknowledge the trust was reviewing the patient clinical record to make improvements and we saw that records were routinely audited by team leaders.
- While we acknowledge that incident reporting had improved generally, however, staff did not always report delayed calls to patients who had fallen at home and could wait for some hours. We also observed one occasion where staff did not report an incident relating to a lack of consumable equipment.
- The trust was not able to provide mandatory training information by staff group as this was not how they collated or monitored their data. We were provided with additional data at operational unit level which showed the trust training target of 95% was not achieved by any unit, for any training module. During the inspection we saw team scorecards that indicated 100% of staff were up to date with mandatory training. This meant there was a discrepancy between local and organisational training compliance records.

However:

- There were improved systems and processes in place to protect people from abuse and harm. This was an area of concern from our last inspection, when we found only 14% of frontline ambulance staff had received the training. On this occasion, we saw evidence that training rates and overall focus was much better. For example, trust data showed 98% of registered clinicians had been trained to child safeguarding level 3. Staff we spoke with clearly understood their responsibilities and the process to follow in the event of any safeguarding concerns.
- Standards of cleanliness and hygiene were maintained and there were reliable systems in place to prevent and protect people from a healthcare-associated infection. The trust had implemented an infection prevention improvement plan since the last inspection and staff demonstrated good infection control practices.
- Staffing levels and crew skill mixes were routinely planned and reviewed. Information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way by using electronic mobile devices which contained patient information as well as trust protocols and procedures.

Emergency and urgent care

- The trust made sure that patients received their medicines as intended and that this was recorded appropriately. An automated medicines management system had been implemented in some ambulance stations to improve the safety of medicines.
- Medicines were managed safely and securely, including medicines related consumables which were seen to be accessible and within their expiry date except for one consumable item seen during inspection. This was an improvement from the 2017 inspection.
- Lessons were learned and improvements made when things went wrong. Staff reported a learning focus around incident reporting where action was taken to make improvements. Changes to staff training were made to incorporate learning from when things went wrong
- There were effective arrangements to respond to relevant external safety alerts and we saw information about this was shared with relevant staff and changes were made to practice where appropriate.

Is the service effective?

Requires improvement

Our rating of effective stayed the same. We rated it as requires improvement because:

- The trust did not achieve the Ambulance Response Programme targets under the previous and current new metrics. Performance was consistently worse than the England Average and the National Standard for both the Category three and four calls. We recognise improvements in category one and two calls since December 2018.
- From February 2017 to January 2018 the trust's overall proportion of patients who had return of spontaneous circulation (ROSC) was worse than the England average for ten out of 12 months.
- In the same period, the trust's proportion of patients with a pre-hospital diagnosis of suspected myocardial infraction confirmed on electrocardiogram (ECG) who received an appropriate care bundle was consistently worse than the England average.
- While some staff told us they were encouraged and given opportunities to develop, others told us they believed that internal processes made it difficult for other staff to progress. Some paramedic practitioners told us that there were improved opportunities in hospitals and primary care but that the trust needed to take more action to support development opportunities internally.

However:

- From December 2017 to May 2018 the trust consistently managed a higher proportion of face-to-face calls without the need for transport compared to the England average. The trust's performance was consistent ranging from 33% to 34%.
- The trust's proportion of Face Arm Speech Test (FAST) positive patients assessed face to face that arrived at hospitals with a stroke centre within 60 minutes was better than the England average for eight months out of the nine-month period between February to October 2017.
- People's physical, mental health and social needs were holistically assessed, and their care, treatment and support was delivered in line with legislation, standards and evidence-based guidance. The trust had care pathways and protocols in place that incorporated guidance from the National Institute for Health and Care Excellence and other expert professional bodies. Staff demonstrated familiarity with the guidance and we observed this being followed.

Emergency and urgent care

- Patients in pain were assessed using tools incorporated into the patient clinical record, including tools for use when patients had difficulty communicating. We observed ambulance crews effectively managing patient's pain, however records of pain assessments were not always completed.
- The learning needs of staff were identified and there was appropriate training and support available to meet those needs. There was protected time for training and experienced staff available to provide clinical supervision and support in decision making.
- Staff were supported and managed to deliver effective care and treatment. Most staff had received an annual appraisal and had access to clinical supervision. Newly qualitied paramedics were mentored by more senior staff until they were confident and competent.
- Care was delivered and reviewed in a coordinated way between different teams, services and organisations. Staff within the trust worked collaboratively with other services to develop and improve care pathways for patients. This included working collaboratively with hospital staff to reduce the waiting times for patients in accident and emergency departments and ensure that patients who did not need to be conveyed to hospital had the appropriate support.
- Patients who may need extra support were identified. The trust had a comprehensive approach to supporting frequent callers that included signposting them to other services and liaising directly with primary care services to ensure that appropriate support was available in the community.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Mental capacity assessments were consistently carried out and staff had relevant guidance and support available for this.

Is the service caring?

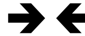
Good

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them with dignity and respect. We saw staff introduced themselves, and asked patients how they wanted to be addressed.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients confirmed their care had been discussed with them; they were able to ask questions and felt included in the decisions about their care, or being taken to hospital.
- Staff provided emotional support to patients to minimise their distress. We saw support was consistently provided with kindness and respect and crews acted to reduce the distress experienced where possible.
- All staff we spoke with were passionate about their roles and were dedicated to making sure patients received the best patient-centred care possible. For example, we saw staff providing distraction techniques when a child required a procedure that may be painful or upsetting.
- Staff made sure patients from vulnerable groups, such as those suffering from mental ill health, had had their dignity maintained. We saw interactions were non-judgmental and patients were treated as individuals.
- Patients gave positive feedback about their experience. Patients told us staff were "very caring", "excellent", and "professional". However, of the 463 complaints made in the inspection time frame, just over half (238) related to complaints about staff.

Emergency and urgent care

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People could not always access the service when they needed it. There were some significant delays in handing over of patients at emergency departments, which meant ambulance staff needed to stay with their patients to deliver care and support them until they were handed over to hospital staff, which in turn reduced the capacity of front line staff to respond to emergencies. Between 3 July 2017 and 2 April 2018, handovers were delayed 179,714 occasions. The average number of delays per week was 3,456.
- Delays in dispatching ambulances to patients gave some of the responding staff the perception that these patients were a low priority and so blue lights were not always used in line with ambulance response programme guidance. The guidance says all Category one, two, and three calls should be responded to on 'blue light' regardless of the time of call was received. This meant there could be delays in getting to patients.
- A new process was in place for the trust to manage the handing over of patients from the South East Coast Ambulance NHS Foundation Trust to the care of the hospital, by introducing a 'PIN number'. The handover PIN ensures that there is an agreed point of handover, which enables the Trust to manage individuals against their 'Handover to Clear' performance and is only generated once a crew confirms that they are en-route to a specific emergency department. This was a new process which was not fully embedded at the time of the inspection. This meant, the reliability on the data obtained by this system may not be reliable.
- Although the ambulance crews had access to specialist ambulances that can be used to transport bariatric patients, this was not always available to staff. One crew described being refused the use of the specialist ambulance that led to care the crew felt was unnecessarily undignified for the patient.

However:

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff. We saw in February and March 2018 98% of complaints were answered within the trusts own target of 25 working days. In addition, the trust had trained extra staff to investigate complaints and concerns.
- The trust planned and provided services in a way that met the needs of local people. They developed ways to ensure the service was as responsive as possible given the demands on the service. The trust worked well with commissioners and local stakeholders to meet the needs of the local populations. This included working with general practitioners, in community settings and patients own homes.
- The service took account of patient's individual needs. Ambulance staff recognised and respected the need to provide individualised personal treatment and care as far as they were able.
- Staff told us they received training about specific patient groups, such as patients living with dementia. Dementia training was part of the key skills training which was undertaken annually for two twelve-hour days.
- There were processes to ensure the needs of people with a mental health illness are met. The trust employed mental health nurses to provide support and guidance to frontline crew. In addition, Kent were piloting a Joint Response Unit (JRU) service in conjunction with Kent Police. One paramedic and one police officer staffed a response vehicle on Friday and Saturday evenings.

Emergency and urgent care

Is the service well-led?

Requires improvement

Our rating of well-led improved. We rated it as requires improvement because:

- Overall, there was improvement to the leadership in the service. The trust had managers at all levels with the right skills and abilities to run a service providing quality care. However, staff told us that not all the leaders in the service were aligned with the values and behaviours of the organisation.
- One of the concerns from the last inspection related to a culture of bullying and harassment. During this inspection, staff used the following statements to summarise the culture within Emergency and Urgent Care: Staff told us “we are not in the same place anymore”, “it’s more difficult to get away with bad behaviour, and we are empowered to call it out”. Most staff told us they felt the senior leadership team took a serious view on bullying and harassment and addressed it accordingly.
- However, we also spoke with some staff who were still affected by bullying and harassment, and were not as confident the inappropriate behaviour was being addressed. We were also told by staff that the executive team ran anti-bullying workshops but they were not well attended. When we asked why that might be we were told ‘people didn’t feel safe to talk about bullying and harassment – cards would be marked if staff spoke up’. The trust provided assurance of an awareness and oversight of individual staff/managers who failed to live the organisational values. The trust was taking continued steps to address unacceptable behaviour.
- Some female staff raised concerns about inclusion and diversity in, in front line teams, in what they regarded as a predominantly male working environment. The trust subsequently provided data showing that 49.9% of the workforce, across the whole trust, were female.
- The trust had improved its systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, these processes were still being developed and not fully embedded in practice. We received mixed feedback which indicated that governance processes and the importance of such processes was not widely understood by staff.
- We identified inconsistencies in station managers and Operational Team Leader’s insight into their own station’s risks and the Emergency and Urgent Care core service. Managers were not always aware of what was on the trust risk register. This meant that local managers were not always aware of the risks in the service which meant that action could not be taken to reduce risk and improve patient care, staff and the wider organisation.
- Staff told us of an inconsistent approach to the delivery of regular staff meetings across the three counties. Some stations could demonstrate regular staff meetings with a set agenda while others didn’t. This meant that some staff did not have a forum to raise concerns or comments, or catch up on organisational learning and key communications.
- At our last inspection staff told us they were not able to have regular meal breaks. Whilst we found this had improved, staff told us that some crews were unable to have a meal break and experienced shift over runs.
- At our last inspection we found evidence of false assurance the trust had in relation to the servicing of equipment. The trust presented CQC with the most up to date data that suggested this concern had been resolved. We received three contacts from staff making us aware of their concerns with the accuracy of the asset register during the inspection process. We made the trust aware of the concerns we received as the inspection process was unable to prove or disprove the concerns.

However:

- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust had improved the way it engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- There was a wellbeing hub at the Crawley headquarters with staff at desks and quiet rooms, admin staff take calls and answer emails and refer on to one of two mental health practitioners (MHP) as required. Staff who used the service told us it was very responsive to their needs.
- Our previous inspection identified serious concerns with how medicines were stored, handled and administered and we took enforcement action as a result. At this inspection, we saw significant improvement which meant that patients were protected from the risk associated with poor medicines management. There was suitable audit and quality control processes to ensure the high standards achieved by the organisation was continually monitored.
- We asked staff if they could give one message to the senior leadership team what it would be. We were given a range of responses which included "We have a restored sense of pride to work for South East Coast Ambulance NHS Foundation Trust", "We are proud of how far we have come", "Develop mental health pathways to help us", "It's good our focus is back on patient care and staff". Some staff also commented on their fears about what would happen to the pace of change if the organisation came out of 'special measures'.

Outstanding practice

The use of the Crawley triage scheme, composed of paramedics and mental health nurses, reduced the number of people conveyed to hospital with mental health conditions from 53% to 11%.

Our previous inspection identified serious concerns with how medication was stored, handled and administered and we took enforcement action as a result. At this inspection, we saw significant improvement which meant that patients were protected from the risk associated with poor medicines management. We found suitable audit and quality control processes to ensure the high standards achieved by the organisation was continually monitored. We found elements of outstanding medicine management, for example the way the trust handled controlled Drugs (CD's).

Trust initiative to provide physical and mental health support for staff through the 'wellbeing hub' has been widely commented by staff during the inspection. There was a range of resources available to staff, as well as a physical, staffed wellbeing hub in the Crawley headquarters.

There was a multidisciplinary multiagency approach to training in the Kent area. This meant staff were training to deal with unexpected situations should they occur.

Brighton station had a dedicated homeless lead who took responsibility and oversight of this vulnerable group. This role included undertaking outreach work, as well as working with local services to meet the needs of these patients.

Areas for improvement

The trust **MUST** ensure their processes to assess, monitor and improve the quality and safety of services, and to assess, monitor and improve the assessment of risk relating to the provision of the service are operating effectively.

The trust **should ensure** the processes for providing staff with feedback from safeguarding alerts is improved to strengthen and develop learning.

Emergency and urgent care

The trust **should ensure** that maps in all vehicles are current, up to date and replaced regularly.

The trust **should ensure** that all staff adhere to the trust policy on carrying personal equipment and the regular servicing of such equipment.

The trust **should ensure** that pain assessments are carried out and recorded in line with best practice guidance.

The trust **should ensure** response times for category three and four calls is improved.

The trust **should consider** producing training data split by staff group and core service area for better oversight of training compliance.

Emergency operations centre

Requires improvement

Key facts and figures

SECAmb operates the emergency operations centre (EOC) which is a central command and control facility responsible for carrying out the triage, assessment and response of 999 calls from members of the public and other emergency services. It provides advice and dispatches ambulances and crew according to need. Category one calls are for people with immediately life-threatening and time critical injuries and illnesses.

The EOC provides assessment and treatment advice to callers who do not need an ambulance response using a service known as “hear and treat”. Callers receive advice on how to care for themselves and direct or refer to other services that could be of assistance, such as a pharmacist, GP, community services or social care professionals. The EOC also manage requests from healthcare professionals to convey people between hospitals or from community services into hospital.

At the time of our inspection, the trust had merged the EOC from three locations into two. The two locations inspected were in their regional office in Coxheath and at the trust headquarters in Crawley.

Additionally, the trust also provides the NHS 111 service across the region, however NHS 111 was not inspected on this occasion.

We spoke with staff including call handlers, dispatchers, clinicians and operational unit managers. We observed 999 calls, EOC policies and a variety of performance data, including incidents, complaints and national ambulance quality indicators (AQI).

The EOC consists of call handlers, dispatchers, paramedic trained clinicians, nurses, midwives and administrative staff. The service receives nearly 862,000 calls every year.

A computer system called NHS Pathways was used to triage calls and identify the response a patient needs. NHS pathways is a clinical tool used to triage, assess and direct contact from the public to urgency and emergency services.

When a 999 call is received it is prioritised by call handlers using NHS Pathways depending on the information provided by the caller.

The categories are as follows:

- Category one: For calls to people with immediately life-threatening and time critical injuries and illnesses. These should be responded to in an average time of seven minutes.
- Category two: For emergency calls, including stroke patients fall into this category. These should be responded to in an average time of 18 minutes.
- Category three: For urgent calls including patients treated by ambulance staff in their own home. These types of calls should be responded to before 120 minutes.
- Category four: For less urgent calls and patients may be given advice over the telephone or referred to another service. These less urgent calls should be responded 180 minutes.

To manage the demand of the service when there was an operational challenge, the trust had a surge management plan. This consisted of an escalation process ranging from category green to black.

Category green demonstrated no concerns and provided a normal level of service to response times. Following the EOC being placed into category green, there would be triggers in place to escalate demand and capacity through stages

amber, red, purple and black. This enabled the EOC to prioritise resources for those patients with the greatest clinical need but did mean increased waiting times for patients requiring a clinical review. Patients requiring a clinician review were placed into a 'clinical stack' for mainly category three calls. The 'clinical stack' was a list of calls waiting to be reviewed by a clinician. Clinicians are level three registered health care professionals.

Summary of this service

At our previous inspection we rated this service as requires improvement.

Our rating of this service stayed the same. We rated it as requires improvement because:

- We found a lack of systems and processes to effectively identify and manage the level and severity of risk for calls waiting in the stack. This was despite the introduction of a clinical navigator role. Following our inspection, the trust had updated the clinical safety navigator guidelines and shared with the clinical teams. A working group had been established to provide a bi weekly update to provide intensive support to clinicians and the 'clinical stack' to reduce waiting times for callers.
- Patients classified as category three (elderly fallers and long lying patients) were at high risk of deterioration as a result of experiencing long delays. Staff did not report this through the incident reporting system. However, this was raised with the trust who took immediate action to audit and improve incident reporting as a result.
- Calls could not be audited in line with the NHS pathways contract. We identified concerns with the call recording system which resulted in poor audit quality, calls merged together, and partially recorded calls. We raised this with the trust who put systems and processes in place to audit the frequently of these calls as well as a paper record of all conjoined calls to help future retrieval.
- Sickness rates within the emergency operation centre (EOC) exceeded trust target despite the trust having raised sickness rate targets since our last inspection. The trust had introduced a human resources advisor to provide support to the EOC staff to reduced absence. However, it was too early to comment on the impact of the initiative.
- The national Ambulance Response Programme introduced by the trust in November 2017, measured the time it took from receiving a 999 call to a vehicle arriving at a patient's location. The trusts performance from December 2017 to May 2018, time in which 50% of calls were answered were 29.8 seconds longer in December, and 2.6 seconds longer for the remaining five months than the England average.
- The trust consistently performed worse than the England average between December 2017 to May 2018, when looking at the data of time within which 95% of calls were answered. The trust were 251 seconds longer than the England average in December and 62.7 seconds longer than the England average in May. However, under the new metrics the trust showed a steady improvement.
- Data measured showed us the proportion of patients re-contacting 999 within 24 hours of original emergency call closed with telephone advice, had a consistently higher proportion of patients than the England average from June 2017 to November 2017. A decline in trust performance, from 6.2% in June 2017, compared to the England average of 6.4%, to 13.9% in November 2017 compared to the England average of 10.7% was shown. This could mean patients receiving initial telephone advice were either unhappy with the advice given or their symptoms or complaint had worsened.
- Mental Capacity Act training compliance was reported as 81.4%, which was less than the trust target of 95%. However, we found staff were aware of the processes to ensure people with mental health issues were well supported. Call takers followed NHS pathways and clinicians to assess for mental health needs or risk behaviours. Clinicians completed capacity assessments and ambulances were sent to patients assessed as lacking capacity.

Emergency operations centre

- People could not always access the service when needed. A surge management policy was used within the EOC when demand for the service outweighed available resource capacity. This meant patients who were not classed as a category one or two were not sent ambulance assistance (no-send) but directed to other services or placed within the clinical stack for a clinician review.
- Clinicians felt that the computer aided dispatch system did not provide enough information to be able to determine patients' priority or risk severity. This contributed to the long delays we observed in patients receiving a clinical review. Since our inspection a free text field had been added allowing clinicians to record additional clinical details and priority indicators.
- Staff lacked insight into when 'no-send' calls should be reviewed when the surge management policy was activated. Staff were unable to determine if a patient's condition had deteriorated and escalated to category one or two. However, following our inspection the trust had amended the surge management policy to include defined clinical review timeframes.
- During the inspection we identified nine out of 73 patients received the required number of welfare calls in line with trust policy. EOC data showed us that during that time the patient should have received 10 welfare calls. We found no welfare calls were made despite the patients recorded risk score of eight. Data showed the longest wait for a response was six hours and eight minutes.
- EOC received 593 complaints in 2017/2018 and were worse than the previous year where 432 complaints were recorded. The most common complaint related to ambulance response times. The trust received 415 complaints received this year, compared to 204 the previous year.
- We found a lack of insight from senior leaders into the quality of the 999 call voice recordings. Senior managers were unclear as to whether recorded calls could be quickly retrieved should there be an urgent need to get details from the call recording quickly. However, following the inspection we found the trust had been monitoring call recordings far greater than five other ambulance trusts. The trust told us there had been no incidence of recorded calls where information could not be immediately retrievable. There was clear executive oversight with call recordings being listed on the standard agenda on the executive management board.
- Our last inspection identified concerns with a culture of bullying and harassment. At this inspection staff told us that this had mostly improved because there was better support to raise concerns about poor behaviour. However, some staff told us there were still members of the team whom made it difficult for others. They told us about concerns about individuals moving to other parts of the organisation which did not deal directly with poor behaviour.
- Call takers and dispatchers felt well supported and spoke highly of the senior team leaders. However, we observed different cultures between the two EOC sites. Staff based at Coxheath felt less valued than their colleagues at Crawley.

However:

- Data showed 98% of registered healthcare professionals had completed safeguarding level three adult and children training. This was a significant improvement on our previous inspection findings.
- A joint working project was in place between the trust and Kent police. Staff reported this was working well and hoped would continue. The project was in operation on Friday and Saturday nights and was to jointly respond to any incidences which involved alcohol related injuries, domestic disputes and mental health incidents
- A mental health 'street triage' service was starting to be trialled within Coxheath EOC during our last inspection. Recent data showed a reduction in the proportion of patients attending accident and emergency departments for a mental health condition from an average of 53% to 7%.

Emergency operations centre

- Patients were treated with dignity and compassion. We observed staff give reassurance to callers and stayed calm during difficult and distressing situations. During cardiac arrests we observed call takers staying on the telephone line to offer support until an ambulance crew arrived.
- Staff provided emotional support to patients to minimise their distress. We listened to call takers providing callers and patients with reassurance, speaking calmly and clearly to emotionally distressed patients.
- The trust had not completed a patient survey over the last 12 months, however the trust website had a 'contact us' tab and a 'we'd like to know what you think' leaflet. Notice boards were seen in both EOC sites with patient feedback and positive comments displayed. Positive comments such as 'we are sincerely grateful to you all' and 'they were very thorough and their passion and dedication really shone through'
- The trust amended the surge management policy immediately after the inspection. The update included the introduction of formal timeframes for reviewing the 'no send' calls. To gain further insight into 'no send' calls the trust will complete an audit each month to be reviewed by the surge management review group.
- 'Hear and treat' patients had increased from 64,000 to 69,000 each month. The 'hear and treat' service did not require ambulance transportation to accident and emergency.
- Dementia training was provided to all staff. Any patients identified as living with dementia had an ambulance automatically dispatched to allow crews to carry out a full, face-to-face assessment and respond to the patient's individual needs.
- Most staff told us they felt valued, listened to and respected and there had been a significant change in leadership style since our previous inspections. We saw positive examples of leadership from the EOC managers at both EOC locations. Staff told us team leaders would support them during difficult or concerning calls and arrange support from the clinician if necessary.
- There was a trust vision and strategy that was developed collaboratively with staff. New values were developed to support and drive a change in organisation culture.
- The systems and processes to report, investigate and learn from incidents had significantly improved. Staff felt actively encouraged to be open, candid and learn from incidents. Reporting of near misses and no harm had increased by 40% since our previous inspection, identifying that staff were compliant in reporting incidents. However, we identified concerns for patients who experienced excessive delays, as this was not reported formally as an incident.

Is the service safe?

Requires improvement

Our rating of safe improved. We rated it as requires improvement because:

- We found a lack of systems and processes to effectively identify and manage the level and severity of risk for calls waiting in the stack. This was despite the introduction of a clinical navigator role. Following our inspection, the trust had updated the clinical safety navigator guidelines and shared with the clinical teams. A working group had been established to provide a bi weekly update to provide intensive support to clinicians and the 'clinical stack' to reduce waiting times for callers.
- Patients classified as category three (elderly fallers and long lying patients) were at high risk of deterioration because of experiencing long delays. Staff did not report this through the incident reporting system, However, this was raised with the trust who took immediate action to audit and improve incident reporting as a result.

Emergency operations centre

- We found the majority of patients had waited a number of hours before receiving a welfare call which was not in line with the trust policy and 30-minute timeframe. This meant the risk of harm to patients was not being mitigated or managed effectively.
- We identified concerns with the call recording system which resulted in poor audit quality, calls being merged together, and partially recorded calls. This meant these calls could not be audited in line with the NHS pathways contract. We raised this with the trust who put systems and process in place to audit the frequently of these calls as well as a paper record of all conjoined calls to help future retrieval.
- There were inadequate numbers of staff to meet the needs of the EOC service. Staff told us they were concerned about the impact of poor retention and a high sickness rate. This risk was identified and recorded on the trust risk register. At the time of our inspection a business case was in development to recruit 24 support call takers to support the development of the welfare check policy.
- Sickness rates within the emergency operation centre (EOC) exceeded trust target despite the trust having raised sickness rate targets since our last inspection. The trust had introduced a human resources advisor to provide support to the EOC staff to reduced absence. However, it was too early to comment on the impact of the initiative.
- Mandatory training data showed a compliance rate of 90.47% which did not meet the trusts own target of 95%. This compliance rate was lower than when we previously inspected.

However:

- Staff reported that they were provided with supportive learning opportunities. Call takers completed an accredited NHS pathways course which identified how to triage calls in line with evidence-based guidance. Staff felt confident in identifying when a caller may be unable to speak or to recognise concerns such a domestic violence incident or safety concern.
- Data showed 98% of registered health care professionals had completed safeguarding level three adult and children training. This was a significant improvement on our previous inspection findings.
- People's individual care records, including clinical data, were stored within the Intelligence Based Information System (IBIS).
- Staff understood their responsibilities to raise concerns and to report incidents. Reporting of near misses and no harm had increased by 40% since our previous inspection, identifying that staff were compliant in reporting incidents. However, we identified concerns for patients who experienced excessive delays, as this was not reported formally as an incident

Is the service effective?

Requires improvement

Our rating of effective stayed the same. We rated it as requires improvement because:

- Under the national ambulance response programme introduced by the trust in November 2017 the trust measures the time it takes from receiving a 999 call to a vehicle arriving at a patient's location. The trusts performance from December 2017 to May 2018, time in which 50% of calls were answered were 29.8 seconds longer in December and 2.6 seconds longer for the remaining five months than the England average.

Emergency operations centre

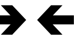
- The trust consistently performed worse than the England average when looking at the data of time within which 95% of calls were answered between December 2017 to May 2018. The trust was 251 seconds longer than the England average in December and 62.7 seconds than the England average in May. However, the trust had consistently improved compared to their previous results.
- Data measured showed us the proportion of patients re-contacting 999 within 24 hours of original emergency call closed with telephone advice, had a consistently higher proportion of patients than the England average from June 2017 to November 2017. A decline in trust performance, from 6.2% in June 2017, compared to the England average of 6.4%, to 13.9% in November 2017 compared to the England average of 10.7% was shown. This meant patients receiving initial telephone advice were either unhappy with the advice given or their symptoms or complaint had worsened.
- Mental Capacity Act training compliance was reported as 81.4%, which was less than the trust target of 95%. However, we found staff were aware of the processes to ensure people with mental health issues were well supported. Call takers followed NHS pathways and clinicians to assess for mental health needs or risk behaviours. Clinicians completed capacity assessments and ambulances were sent to patients assessed as lacking capacity.
- There was no current audit in place to determine when 'non-clinical' welfare call was carried out. Information on welfare call backs were only collected and collated if there had been a complaint or incident. This meant that the trust had no oversight on monitoring patient risk.

However:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. An audit lead was in place at both sites. Guidance and procedures were updated every Wednesday and managers took responsibility to make sure staff on their shift were updated.
- The trust had recruited a 'frequent caller' lead based within EOC to deliver the operational frequent caller model, which was in line with national guidance set by the UK ambulance services Frequent Caller National Network (FreCaNN). The trust found that since introducing the model, frequent caller calls had reduced by 40%.
- Staff were competent to undertake their roles. Managers appraised staff's work performance with 90.5% of staff from April 2017 to March 2018 receiving an appraisal. This was better than the trust target of 80% and an improvement from our last inspection.
- EOC managers proactively encouraged staff to develop and gain additional training. A dual role operator position had been developed to enhance skills, working in both call handling and dispatch. At the time of our inspection EOC were looking at a business case to increase the salary banding for this position, to encourage more staff to apply.
- The trust was auditing three to five calls taken by call takers each month as part of the NHS Pathways contract. This was a significant improvement since our last inspection.
- A joint working project was in place between the trust and Kent police and staff reported this was working well and hoped would continue. The project was in operation on Friday and Saturday nights and was to jointly respond to any incidences which involved alcohol related injuries, domestic disputes and mental health incidents.
- A maternity hub offering a pregnancy advice line was launched within the EOC at Crawley. The hub was a collaboration between SECAmb and three acute NHS trusts. The advice line provided support and advice to pregnant women and the initiative is part of the National NHS Better Births plan. We observed good working relationships between the midwives and clinicians who provided advice and cover if required.
- A mental health 'street triage' service was starting to be trialled within Coxheath EOC during our last inspection. Data demonstrated a reduction in the proportion of patients attending accident and emergency departments for a mental health condition from an average of 53% to 7%.

Emergency operations centre

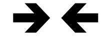
Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Patients were treated with dignity and compassion**.** We observed staff give reassurance to callers and stayed calm during difficult and distressing situations. During cardiac arrests we observed call takers staying on the telephone line to offer support until an ambulance crew arrived.
- Staff provided emotional support to patients to minimise their distress. We listened to call takers providing callers and patients with reassurance, speaking calmly and clearly to emotionally distressed patients.
- Managers received training in debriefing staff following a difficult or disturbing call. Staff could be sign posted to other specialist support, such as counselling or the well-being hub. Managers were trained to complete Trauma Risk Management assessments (TRiM), which aimed to support staff following exposure to traumatic events.
- Patients were supported through the ‘hear and treat’ service to support patients to manage their own health. This included signposting patients to alternative services where they could access more appropriate care and treatment, for example GP surgeries and walk-in centres.
- The trust had not completed a patient survey over the last 12 months, however the trust website had a ‘contact us’ tab and a ‘we’d like to know what you think’ leaflet. Notice boards were seen in both EOC sites with patient feedback and positive comments displayed. Positive comments such as ‘we are sincerely grateful to you all’ and ‘they were very thorough and their passion and dedication really shone through’.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People could not always access the service when needed. A surge management policy was used within the EOC when demand for the service outweighed available resource capacity. This meant patients who were not classed as a category one or two were not sent ambulance assistance (no-send) but directed to other services or placed within the clinical stack for a clinician review.
- Staff lacked insight into when ‘no-send’ calls should be reviewed when the surge management policy was activated. Staff were unable to determine if a patient’s condition had deteriorated and escalated to category one or two. However, following our inspection the trust had amended the surge management policy to include clearly defined clinical review timeframes.
- Category three patients were placed in a clinical stack for clinician review. Calls were organised by the length of time since the call was received and did not take into consideration the severity of the patient’s condition.
- There were delays in reviewing patients within the clinical stack. Clinicians felt the computer aided dispatch offered limited information as to the priority or severity of the patient. Therefore, we observed long lying patients and elderly fallers waiting for long periods of time before being reviewed by a clinician or ambulance crew. The computer aided dispatch system since our inspection has been updated to give free text. This meant information in regarding the patients age and complaint was now visible, enabling clinicians to prioritise patients.

- The trust was not meeting the needs of elderly fallers. Elderly fallers were classed as category three patients and were placed into the clinical stack. This meant waiting times for a clinician review or ambulance response were long and often led to increased risk of health deteriorating or long last health issues.
- During the inspection, we identified 73 elderly patients who had a fall. Only nine of the 73 patients had received the required number of welfare calls. EOC data showed us that during that time the patient should have received 10 welfare calls. We found no welfare calls were made despite the patients recorded risk score of eight. Data showed the longest wait for a response was six hours and eight minutes.
- EOC received 593 complaints in 2017/2018 and were worse than the previous year where 432 complaints were recorded. The biggest contributing factor to complaints had been ambulance response times, with 415 complaints received this year compared to 204 the previous year.

However:

- The trust following our inspection had made an amendment to the surge management policy to formulise timeframes for reviewing the 'no send' calls. To gain further insight into 'no send' calls the trust will complete an audit each month to be reviewed by the surge management review group.
- The frequent caller management report identified a decline in calls made to 999 by frequent callers. The frequent caller lead felt this was attributed to stage one of the management programme. Stage one of the programme meant the caller received a clinician review and a trust letter was sent to their GP advising for the caller to have a GP health review.
- From 2017 to 2018, 377,501 patients reviewed through the 'hear and treat' service did not require ambulance transportation to accident and emergency. 'Hear and treat' patients had increased from 64,000 to 69,000 each month.
- Staff told us they had received specific training on dementia and all staff we spoke to were aware of trust guidelines. Staff told us that an ambulance would be automatically dispatched to any patient living with dementia to allow crews to carry out a full, face-to-face assessment and respond to the patient's individual needs.
- Patients and callers with hearing or physical disabilities preventing them from using a telephone could contact 999 via the SMS emergency service system. We saw the trust's patient call handling and pre-dispatch policy, which stated that the default response for calls originating from this service was to dispatch an emergency ambulance. This was to ensure a safer service for hearing impaired patients who could not be fully assessed by a call handler via an SMS message.

Is the service well-led?

Requires improvement

Our rating of well-led improved. We rated it as requires improvement because:

- We found a lack of insight from senior leaders into the quality of the 999 call voice recordings. Senior managers were unclear as to whether recorded calls could be quickly retrieved should there be an urgent need to get details from the call recording quickly. However, following the inspection we found the trust had been monitoring call recordings far greater than five other ambulance trusts. The trust told us there had been no incidence of recorded calls where information could not be immediately retrievable. There was now clear executive oversight with call recordings being listed on the standard agenda on the executive management board.

- Our last inspection identified concerns with a culture of bullying and harassment. At this inspection, staff told us that this had mostly improved because they were better support to raise concerns about poor behaviour. However, some staff told us there were still members of the team whom made it difficult for others. They told us about concerns about individuals moving to other parts of the organisation which did not deal directly with behaviour problems.
- Call takers and dispatchers felt well supported and spoke highly of the senior team leaders in regard to the support and guidance they gave. However, we observed different attitudes of staff between the two EOC sites. With staff based at Coxheath feeling less valued than their colleagues at Crawley, which we were told was due to Crawley being a larger and newer location with more senior leadership based there and showing more in that site.
- There was a clear lack of governance processes around auditing of welfare calls and long lying patients. There was a lack of insight into monitoring the clinical stack and the 'no send' calls waiting during the surge management plan. However, the trust has since responded and have formulated a timeframe of when no send calls will be reviewed.
- Incidents relating to long lying patients were not being reported. Senior members of staff did not know who was responsible for reporting long lying patients, and neither did staff which lacked oversight into the ongoing risks to long lying patients. With the service unable to monitor themes and trends.
- Staff raised concerns during our last inspection that they were not able to have regular meal breaks and following this the trust produced a meal break policy. Whilst we found this had improved and a coordinator was in place within the EOC monitoring crew's welfare. However, dispatchers told us that some crews continued to miss meal breaks due to restraints found within the meal break window. During busier times and depending on the number of crews available meant that at times crews could not be sent for their meal break at specific times.

However:

- Overall there was an improvement with the leadership within the EOC, the trust continued to develop managers to ensure they had the right skills and abilities to run the service. A new executive team had been in place since 2017 and they shared with us their vision of how they were addressing concerns identified in previous inspections.
- Staff told us that the culture within the EOC felt very different from when our last inspection took place. There was a more optimistic and positive approach from the leadership team and developing down to ground level.
- Since our previous inspection there had been significant changes within the department with three locations at Coxheath, Banstead and Lewis merging into two locations these being Coxheath and Crawley. We spoke with staff about the merge of the three teams and they were positive and felt the transition had gone well.
- Our previous inspection had highlighted instability and poor governance systems and processes that were not consistently applied. During this inspection we found that there was a positive approach from managers and staff with a clear focus to improve the services for patients.
- Most staff told us they felt valued, listened to and respected and there had been a significant change in leadership style since our previous inspections. We saw positive examples of leadership from the EOC managers at both EOC locations. Staff told us team leaders would support them during difficult or concerning calls and arrange support from the clinician if necessary.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action. New values were developed to support their change in leadership and culture within the service. The values were developed through focus groups and engagement with staff. Staff were involved in the development of the strategy and asked to attend working groups and give feedback at various stages of its development.

Emergency operations centre

- We found the incident reporting culture had significantly improved and the service now encouraged transparency and openness amongst all staff groups. Staff told us they were actively encouraged by managers to report incidents and all received feedback via an email to inform the staff member of the outcome. Staff could give us examples of incidents as well as learning and outcomes. We observed display boards around both EOC locations where incidents and outcomes had been displayed.
- Throughout the inspection process, we found the service was quick to respond to concerns raised by the inspection team. This willingness demonstrated a commitment to improve the service they provided.

Outstanding practice

The pregnancy advice and triage line for pregnant women introduced within the Crawley EOC we found to highlight outstanding practice within the department. The maternity hub was part of a joint collaboration between SECAmb and three acute NHS trusts and part of the National NHS Better Births plan to transform maternity services for pregnant women and families with new born babies. The service provided 24-hour advice, with midwives from three trusts. We observed good working relationships between midwives and clinicians who worked closely together to provide advice and cover if required.

Areas for improvement

The Trust MUST:

- The trust **must ensure** that their processes to assess, monitor and improve the quality and safety of services and also to assess, monitor and improve the assessment of risk relating to the provision of the service are operating effectively.

The Trust SHOULD:

- The trust **should ensure** they continue to take action to ensure they have effective systems and processes to assess the risk to patients and people using the services and they do all that is reasonably practicable to mitigate those risks, specifically in relation to the risk assessment of patients awaiting the dispatch of an ambulance.
- The trust **should ensure** there are a sufficient number of clinicians in each EOC to meet the needs of the service.
- The trust **should ensure** they continue to monitor the effectiveness of the clinical safety navigator role to ensure continued oversight on the safety of patients waiting for an ambulance.

Resilience

Good

Key facts and figures

Since June 2011, responsibility for the delivery of emergency preparedness policy in NHS ambulance services in England has been delegated to the National Ambulance Resilience Unit (NARU).

From April 2013, all NHS organisations have been required to contribute to co-ordinated planning for both emergency preparedness and service resilience through their local health resilience partnerships (LHRPs).

The South East Coast ambulance service (SECamb) has a crucial role in the national arrangements for emergency preparedness, resilience and response (EPRR). The service is part of the civil contingency planning for both the NHS and the wider emergency preparedness network, and as such must be in a position to demonstrate it can effectively manage the impact and aftermath of a major incident.

We inspected this service over three days between July 15 and July 17, 2018. We visited two HART sites at Ashford and Gatwick. We interviewed the director of operations, paramedics, team leaders, administration staff, operations managers, CP&R (Contingency Planning and Resilience) managers and training managers. Resilience has not been inspected and reported on as a core service until this inspection so has no previous rating.

Summary of this service

We rated it as good because:

- Much progress had been made since the last CQC inspection to ensure the service met national standards and SECamb was able to provide an effective and timely response to planned events and catastrophic incidents.
- The number of paramedics in the HART had increased, 'all technicians had undergone the required training and qualified as paramedics' and this was in line with the National Ambulance Resilience Unit (NARU) guidance. There was a dedicated and skilled team of the Hazardous Area Response Team (HART) paramedics who cared strongly about the work they did.
- Hazardous Area Response Team (HART) specific training was well attended, well managed and they were an accredited training centre for water rescue and rope rescue.
- Security at the team sites was robust and staff had received up-to-date training in all safety systems, processes and practices.
- Appraisal rates were higher than the trust's benchmark and staff were positive about the training they had attended.
- There was effective partnership working with organisations across Kent, Surrey and Sussex for major events along with multiagency training.
- Staff were using evidence based practice and working to national guidance for HART/CBRN/Marauding Terrorist Fire Arms Attacks (MTFA).
- Although we were unable to observe EPRR providing care, SECamb provided us with examples of positive feedback from patients/public about care delivered by EPRR staff.
- Staff were positive about their immediate line and local managers but some still felt more could be done to improve communication and take action in response to feedback from staff.

Resilience

However:

- Safety concerns were not addressed quickly enough. Learning from significant events attended by EPRR staff was sometimes shared but learning was slow to disseminate and the trust was slow to act on responses from national incidents such as the Kerslake Report, Grenfell and their own operational exercises.
- The trust business continuity plan was not aligned with other trust policies and plans. There was no collaboration across the trust to ensure that widespread organisational business continuity management was effective.
- Response times were not monitored for Hazardous Area Response Team (HART) operations so the trust had no assurance that national targets were being met.
- The leadership structure was confusing, staff felt demoralised by changes that had occurred and when asked struggled to explain the reporting lines.

Is the service safe?

Good

We rated it as good because:

- Mandatory training was completed above trust targets. Staff received effective training in safety systems, processes and practices.
- Staffing levels were routinely planned and reviewed Staffing levels in the Hazardous Area Response Teams (HART) had been increased. There was a recruitment pool for potential new Hazardous Area Response Team (HART) staff and all operational staff were qualified paramedics.
- There were systems and processes to protect people from abuse and harm. Staff understood their responsibilities and the process to follow in the event of any safeguarding concerns. Security at the team sites was effective and equipment was looked after well.
- The trust had a system for reporting incidents and staff were aware and understood their role in reporting incidents, raising concerns and near misses.
- Medicines management was robust and effective. All medicines were stored securely and medicine audits showed compliance with medicine management. An automated medicines management system had been implemented in both team sites to improve the safety of medicines.

However

- Although staff were reporting incidents and learning was identified, the trust needed to share learning in a quicker and more timely manner across the organisation so that all staff were advised of what had changed following investigations and reviews.
- The trust's business continuity plan needed to be aligned with other trust policies.

Resilience

Is the service effective?

Good

We rated it as good because:

- There was compliance with national standards for the Hazardous Area Response Team (HART), Chemical, Biological Radioactive or Nuclear incidents (CBRN) and Marauding Terrorist Firearms Attack (MTFA). There were standard operating procedures (SOPs) such as core training competencies. These aligned with the national Hazardous Area Response Team (HART) standard operating procedures.
- Response to incidents was informed by best practice and staff followed national clinical guidance. To test responses, there was a communication exercise every six months, a yearly tabletop exercise and a live exercise every three years. The trust last had the major incident live exercise in May 2018.
- Staff competencies were maintained and tested in accordance with the National Ambulance Resilience Unit (NARU) recommendations. Over 95% of staff had a completed appraisal and there was a comprehensive training programme to ensure skills were revalidated.
- There was effective co-ordination with other emergency organisations and staff engaged in joint planning and exercises.
- Staff knew and told us how to gain consent and assess the decision-making capacity of patients.

However:

- There was no clarity or available data on meeting response times for HART incidents. There were set target response times to meet but these were not evident for scrutiny. Although, HART staff responded swiftly and without delay to emergency calls we heard whilst on site.

Is the service caring?

Good

We rated it as good because:

- Staff we spoke with were highly motivated and wanted to deliver the best care possible using technical and enhanced skills as well as using their clinical knowledge.
- Feedback from patients was positive and patients were grateful for the specialist help they received in difficult situations.
- Staff had the opportunity to debrief after an incident and managers were supportive of staff welfare.
- Care of patients was paramount and staff went out of the way to deal with casualties and to look after each other.

However,

- We were not able to directly observe care being provided.

Resilience

Is the service responsive?

Good

We rated it as good because:

- The Hazardous Area Response Team (HART) had become a fully staffed team since our last inspection.
- The trust planned and provided services in a way that met the needs of local people. During our inspection, staff based at the emergency operations centre at Crawley prepared for an aircraft emergency landing at Gatwick airport. All members of the team were well prepared, equipped and organised to respond to the needs of local people.
- Complaints were investigated in a timely way and learning identified and shared with relevant staff. The team had protocols to respond to severe or catastrophic disruptions to normal activities in the community.
- Services were developed to meet the needs of the local population and the team liaised with many agencies and cross county networks. The team had been instrumental in providing a specialist presence at a major chemical incident in a bordering county whilst still maintaining local capabilities.
- A Special Operations Response Team was in development to support Chemical, biological, radioactive and nuclear (CBRN) and Marauding Terrorist Firearms Attack (MTFA) operations. This gave the trust added staffing capacity for specific operational incidents.
- The team dialled into the daily morning call to update the trust on its capacity, availability and assets in use.

However,

- We could not determine if patients had timely access to the Hazardous Area Response Team (HART) services as there was no available data on meeting response times for HART incidents.

Is the service well-led?

Requires improvement

We rated it as requires improvement because:

- The leadership structure was confusing as there were two management lines sitting within Resilience. The Hazardous Area Response Team (HART) and special operations were in a different team to Contingency Planning & Resilience. Staff found it difficult to understand the structure or why there was a divide.
- Resilience did not have robust, well established and effective governance processes. The EPRR self-assessment undertaken by managers without staff we spoke to knowing what this was or having seen the assessment.
- Further work was needed on the business continuity plan. The policy was not updated on business continuity management and business continuity plans were not integrated trust wide.
- Learning was not embedded into the structure from national issues or major incident exercises. There was no dissemination of learning from a major incident training exercise in May 2018 nor any actions seen from the Kerslake Report March 2018.

Resilience

- The trust did not collect, analyse, manage or use information well to support the team. This meant they did not have the data to improve response times if they were poor or by learning from them if they were good.

However:

- The culture within the team was positive, inclusive and collaborative.
- Technology and information was improved and there were various software packages available on staff electronic tablets to make tasks easier to manage and achieve.
- Staff were engaged within the wider geographical community in joint working partnerships and as trainers within their own trust to teach ambulance staff enhanced skills.

Outstanding practice

See guidance note ICS 5 then replace this text with your report content (if required); otherwise, delete this section and its heading.

Areas for improvement

The Trust SHOULD:

- The trust **should ensure** they collect, analyse, manage and use data on meeting response times for Hazardous Area Response Team (HART) incidents.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Elizabeth Kershaw, inspection manager, and Catherine Campbell, head of hospitals, led this inspection. An executive reviewer, Anthony Marsh, supported our inspection of well-led for the trust overall.

The team included a further three inspection managers, 12 inspectors, four assistant inspectors and 12 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections on the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.