West Midlands Ambulance Service University NHS Foundation Trust

Emergency and urgent care

Inspection report

Unit 9
Waterfront Business Park, Dudley Road
Brierley Hill
DY5 1LX
Tel: 01384215555
www.wmas.nhs.uk

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Ratings

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

Our findings

Emergency and urgent care

Inspected but not rated

We carried out this short notice announced inspection on 21, 22 and 23 November 2022. We had an additional focus on the urgent and emergency care pathway for patients across the integrated care system in Worcestershire.

A summary of CQC findings for the overall urgent and emergency care services in Worcestershire.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective, and timely care.

Summary of West Midlands Ambulance Service University NHS Foundation Trust

As this was a focused inspection, we did not look at every question in our key lines of enquiry, we did not re-rate the service, at this time. This inspection was focused around system pathways and attendance at local hospitals. We did not visit any other regions during this inspection.

There is a process in place to continue monitoring services provided by West Midlands Ambulance Service University NHS Foundation Trust (WMAS).

At our previous inspection published in 2019, we rated emergency and urgent care services at the trust as Outstanding overall with safety rated as good and all other key questions as outstanding.

On this inspection we reviewed emergency and urgent care services. For this core service we looked at elements of the safety, effectiveness, caring, responsiveness, and leadership of the staff and those supporting the emergency departments on site.

For emergency and urgent care, we found:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, especially when moving them long distances from ambulance to the emergency department.
- We saw an example of good patient care where an agitated vulnerable patient was taken from an ambulance to a quieter area.
- Infection, prevention and control was good, and staff were ensuring equipment and personal hygiene were of a high standard.
- Communication and multi-disciplinary team working were good. Staff maintained a focus on patient care and shared information appropriately.
- Patients praised ambulance crews for the care and compassion given, particularly during the lengthy waits at hospital.

Our findings

- WMAS was supporting the system by supplying paramedics to aid in the care of patients in the emergency department.

However:

- Response times and handover targets were not being met. Delays in handing patients over at hospitals meant that ambulances and crews could not be made available to attend other calls.
- Lengthy delays at hospitals increased risk to patients, particularly those that had been lying on trolleys or stretchers in ambulances, for longer periods.
- It was unclear who was responsible for the personal care of patients whilst waiting in the ambulance. Ambulance staff were not trained in personal care or to use some personal care equipment, even though they performed these tasks.
- Alternative pathways, to avoid conveyance to hospital, were not always available or known to staff from outside the area.
- Ambulance staff told us that communication about processes, like cohorting patients and sourcing nutrition for a patient waiting in an ambulance, was not clear.

How we carried out the inspection

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

For our emergency and urgent care inspection, we met with staff operating in Worcestershire. We spoke with operational managers, paramedics, emergency care assistants, ambulance technicians and other members of staff on duty at the emergency department at local hospitals.

We spoke with 42 paramedics in total, 2 trainees, emergency care assistants and other support personnel, and the operational Manager and hospital ambulance liaison officer.

We spoke with 15 patients that had been brought in by ambulance, while on site at the emergency department.

We spoke with 13 paramedics, emergency care assistants and other support personnel, and 10 patients at another local hospital.

Is the service safe?

Inspected but not rated

Mandatory training

Staff told us that mandatory training was sometimes difficult to complete due to time constraints. The administration team at the hub ensured that training was monitored and advertised, but difficult to consistently meet compliance.

Our findings

Data for November 2022 showed that Immediate Life Support (ILS) training for the Worcester team was at 75% compliance.

Overall trust compliance for ILS was 82.5% against the trust target of 90%.

Data for November 2022 showed that paediatric immediate life support training for the Worcester team was at 96.5% compliance.

De-escalation training and restraint training were part of the mandatory training programme and supported by an external training team. Mandatory training compliance for staff at the Worcester hub was 92% which was better than the trust wide data showing 69.5%. In January 2023 the rate for online mandatory training for staff at the Worcester hub was at 97%.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment, vehicles, and premises visibly clean.

We visited 1 ambulance hub and 2 emergency departments (EDs) at local hospitals.

Ambulance staff attending emergency departments were wearing appropriate personal protective equipment (PPE), including masks and gloves. Staff told us they had access to equipment and were issued with PPE and trained to use it effectively.

We saw staff cleaning and making vehicles ready for the next patient. They had access to sterilised wipes, hand gel and products to clean the vehicle interior. At the Worcester hub we saw vehicles that were prepared ready for use and 1 vehicle that had returned for the crew to restock equipment and to complete basic checks. We saw vehicle records that were up-to-date and showed vehicles were cleaned regularly.

Used or dirty equipment, such as blankets and covers, could be dropped into the ED for washing and crews could pick up clean ones. There were also facilities to store and dispose of used equipment, at the hub.

Staff wore masks to help prevent the spread of COVID-19 and we observed ambulance crews washing their hands or sanitising with gel, before entering and leaving the ED.

Staff told us they had access to revised guidance for the use of PPE and were updated appropriately by managers, of any changes. Information was displayed at the ambulance hub to help keep staff informed.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles, and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, we found that mattresses on ambulance trolleys were not suitable for longer waits, even though the waiting times on vehicles had consistently increased.

We found the Worcester ambulance hub to be well managed and visibly clean and tidy.

There were good systems in place to re-stock an ambulance as required.

Our findings

We observed a crew returning to the hub to check and replenish stocks, following an emergency admission to hospital. The crew had access to all equipment and medications to fully re-stock the vehicle and could access facilities to ensure the vehicle and crew were ready to be back on duty.

We spoke with support staff at the hub who could explain processes for managing vehicles and ensuring equipment was available to ambulance crews. All vehicles underwent regular maintenance checks and recommended servicing.

Clinical waste was managed well, and replacement equipment was checked and ready for issue. Waste was stored safely and disposed of on a regular basis.

The hub had facilities for staff to take a break, eat meals and rest during official breaks. There were good facilities for staff to store personal belongings safely and all areas were visibly clean and tidy. There was also office space and areas for staff training and meetings.

We found that mattresses on ambulance trolleys were not ideal for patients lying for long periods. They were not designed to provide support for patients for long periods of time. This became a risk due to the increasing wait times outside of ED.

Medicines

The management of medicines was good.

Controlled drugs (CD) and oxygen cylinders were stored safely and access to them managed well. Access to CD store was controlled by a keypad and swipe card access. Temperature was controlled to allow safe storage of medicines.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Staff identified patients in their care at risk of deterioration. However, the delays to patients being handed over to the emergency department were increasing risk to patients.

Time limits and measurements were put in place by the NHS to monitor the transportation of patients to hospitals. Handover of patients between an ambulance service and an emergency department must take place within 15 minutes, with none waiting more than 30 minutes. Currently most patients were not being assessed and admitted within these timeframes.

Trust data shows that between April 2019 and March 2022, the number of hours lost due to delayed handover, increased from approximately 6,000 hours per month to approximately 33,000 hours per month. There was a peak in August 2022 of 43,758 hours lost due to waiting to handover patients. Data for November 2022 was not available during inspection.

On the day of inspection, we saw 1 patient had waited over 19 hours outside the ED and we were told the average waiting time for the day was approximately 6.5 hours.

Ambulance crews had additional pressures around assessing and responding to the risks to patients, due to extensive delays in handover. This resulted in additional assessments and treatment being administered whilst waiting for a place in hospital.

Ambulance crews used recognised assessment tools to monitor and escalate concerns for patients. They used National Early Warning Score (NEWS2) tool and sepsis assessments, to monitor and manage deteriorating patients.

Our findings

We were told that paramedics were relying on Joint Royal Colleges Ambulance Liaison Committee online applications more often, to assist with obtaining information on assessing patients.

Due to longer waits, staff were monitoring blood pressure and heart rates regularly and recording results on electronic devices appropriate to the trust process. Notes from the electronic records were shared with the triage nurse in ED that visited each patient on the vehicles.

We saw good communication of patient details between all staff. However, at peak times when there were more ambulances waiting outside ED, communication was less effective and ambulance crews told us they had concerns that the risk to patients increased.

Some patients were taken from the ambulance to have tests or X-rays completed but returned to the vehicle to wait for admission to the department. In most of these cases the ED consultant would review the patient on the ambulance prior to a decision being made. Ambulance crews documented this electronically, along with notes taken by the ED staff.

We were told that the risk of pressure injuries had increased due to the increased waiting and patients having to sit or lie on trolleys designed for transportation only. We saw that the mattresses and padding on ambulance trolleys was not suitable for extended periods of use. Patients could not be turned or manoeuvred easily to help relieve the pressure injuries. There were no incidents reported for pressure injuries, but the risk had been identified by staff. We were told that high risk patients were triaged by ED staff and prioritised for care in the department.

Ambulance crews had access to incident report forms, and they were submitted on the handheld devices. We were told that feedback after submission of incidents was available and generally good. However, safeguarding referrals were done on the telephone and feed from these was rare.

Staffing

The service had staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, the ambulance handover delays and the pressure from increasing demand for emergency services, meant staff could not always provide care appropriately. Additional training for enhanced patient care was not provided.

There were delays in responding to emergency calls due to the increasing demand for emergency services. Ambulance crews from outside of Worcestershire were often used to respond to calls.

On occasions we saw that crew members were working beyond their normal finish times due to waiting outside of EDs, for prolonged periods.

During our visit the longest a patient had been waiting to be admitted to an NHS hospital, was approaching 20 hours. During this time the crew had been changed over to allow them to finish their shift. We were told this is a regular occurrence, especially at the particular hospital.

Due to long delays, we were told that crews were required to take patients from the vehicle to use the toilets. On occasions patients could not be moved and mobile toilets or bed pans would be required. Staff told us that this was often embarrassing for patients of a different gender to the crew and that the crews felt they had no training or facilities to accomplish the task.

Our findings

Due to longer waiting times, ambulance staff were performing personal care tasks. However, we were told that ambulance crews did not receive training in turning patients, to avoid pressure injuries and similarly, for patient use of bed pans. Staff said that previous care experience was useful in some situations but not all staff had qualifications or experience in personal care for patients.

Assistance was sought from hospital staff, however, this was not always available at busy times.

Staff could access support for clinical decisions and had access to critical care paramedics and the trauma desk. Some paramedics told us that this was sometimes a better option than speaking to an operations manager, as they were generally the same level of knowledge and experience.

We found that staffing levels for the Worcester hub were as planned with no vacancies in any of the required posts, including trainee paramedics. Sickness rates were recorded as 4.65% at the time of inspection. This compared to a trust wide sickness rate of 5.04%.

Ambulances had at least 1 paramedic as part of the crew, which met the standard of no emergency vehicle should attend a patient without a paramedic present, set by the trust.

Paramedics, that were mentoring students, told us that students were not being exposed to the numbers or variety of calls, because they would be waiting outside of hospital for extended periods. We spoke with trainee paramedics that said they were being supervised well but often not exposed to procedures or incidents that supported their training. A paramedic told us that it had been over a week since they last cannulated a patient. This is a procedure that would generally be completed several times in a shift.

WMAS had supported the local trust in supplying paramedics to support the care of patients that were waiting in ED. They were to be based on site and available as a permanent member of staff in the ED team and were available to support the and flow in the department to relieve ambulance waiting times.

Is the service effective?

Inspected but not rated

Response times

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

There are nationally set standards for performance of ambulance services when responding to emergency calls. Emergency calls are categorised in to help prioritise responses. The categories are determined by a clinical triage system based on national standards, with category 1 being the most seriously ill or injured patients.

All ambulance trusts are required to:

Our findings

- Respond to Category 1 calls in 7 minutes, on average and respond to 90% of Category 1 calls in 15 minutes. Response times recorded for WMAS in October 2022 showed Category 1 calls were responded to on average, at 10.36 minutes and 90% responded to on average at 18.59 minutes.
- Respond to Category 2 calls in 18 minutes on average and respond to 90% of Category 2 calls in 40 minutes. Response times recorded for WMAS in October 2022 showed Category 2 calls were responded to on average, at 1 hour and 9 minutes and 90% responded to on average at 2 hours and 32 minutes.
- Respond to 90% of Category 3 calls in 120 minutes. Response times recorded for WMAS in October 2022 showed Cat 3 calls were responded to on average, at 5 hours and 42 minutes and 90% responded to on average at 14 hours and 2 minutes.

Data for Worcestershire shows noncompliance for all category of calls between June and October 2022.

The number of calls for the October 2022 show there were 880 Category 1 calls, 4,229 Category 2 calls, 1,001 Category 3 calls and 39 Category 4 calls.

At the time of inspection there were no changes to the trend shown and response times remained higher than the national target.

There was a decrease in incidents from the previous year, with year to date being 529,167 calls compared with the previous year of 599,537.

The data showed emergency calls were lower than the previous year, with year to date figures at 509,119 compared with the previous year of 567,708. Data in October 2022 shows that the incident demand was reduced compared to previous year.

Patient outcomes

The service monitored the effectiveness of care and treatment. However, with the rise in delays at hospital and the reduction in capacity, some patients were not having the expected outcomes.

There were clear processes in place to monitor and record patient outcomes. Electronic notes and patient information were used by the trust to review patient outcomes. This included times waiting and triage information to risk assess patient needs.

We were told that patients were sometimes deteriorating before an ambulance arrived. Longer waiting times for an ambulance often meant that lower priority calls became more urgent as time passed and led to calls being made a higher priority. These calls would be reassessed by clinicians at the call centre and escalated.

In some cases, patients were seen and treated without conveyance to hospital. A number of these patients would deteriorate and require another ambulance crew to attend. The data showing what proportion of patients that recontacted the service within 24 hours of initial call, was supplied for the whole trust and not Worcestershire specifically.

However, a trust report was completed to communicate patient outcomes along with other national benchmarking standards. Operational managers had access to trust data and specific information for the Worcester hub. Comparisons and benchmarking of the quality of services was completed and audits done to identify areas for improvement.

Our findings

Data we saw shows that across the trust, over half (50%) of patients seen were conveyed to hospital. On inspection we reviewed patients that were taken to local hospitals in Worcestershire. However, local community response teams supported the ambulance service in providing rapid responses to patients, where an ambulance would be delayed.

Access to clinicians remotely had been improved and during October 2022 the number of patients spoken to increased to 128. This further increased to 233 in December 2022.

See and convey to hospital figures, for year to date, show that 52.1% of all patients seen were taken to a hospital for further assessment or treatment.

Hear and treat figures show 16.6% of patients that called for support were given verbal advice or signposted to treatment without an ambulance being sent.

Data shows that 31.3% of patients were seen and treated without being taken to hospital.

Multidisciplinary working

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

We observed an extremely busy emergency department (ED) with 16 ambulances waiting outside, with patients on vehicles and a full waiting room. There were ambulance staff supporting patients in the ED and we saw positive interactions with the staff in the hospital. Staff in the hospital said that they worked closely with the ambulance crews and we saw handover of patients taking place.

The hospital ambulance liaison officer (HALO) supported the admission of patients and helped the ED staff prioritise these to ensure patients were seen appropriately and within the specified time scales. Ambulance handover time should be below 15 minutes, when this does not occur there is an agreement that ED staff triage the patient waiting within 30 minutes of arrival. We saw professional and patient focussed communication between ED and ambulance staff. A consultant was available to assist the ED triage nurse in assessing patients.

We saw the regular HALO supporting the ED staff in treating patients and prioritising their care. There was good communication between the services and regular updates about the patients waiting on ambulances. Escalation processes were in place for patients that were deteriorating, and we saw patients being discussed by a team that included the HALO.

The ED staff were kept informed of ambulances that were on the way to hospital and we saw 2 examples of patients that required immediate admission, due to the severity of their condition, were managed efficiently.

Some ambulance crews we spoke to were from outside of the Worcestershire area. They said that often there were no alternative pathways or services available as an alternative to taking a patient to hospital, that they were not aware of. However, improvements were being made to increase the number of referrals made through the electronic system, to support ambulance crews in making decisions. This supports crews from outside of the Worcestershire area.

Our findings

Is the service caring?

Inspected but not rated

Compassionate care

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

Patients told us that the ambulance crews treated them well. We spoke with 15 patients and all said that they were treated very well despite having to wait for admission to the emergency department (ED). We saw patients having observations completed and ambulance staff communicating compassionately with them. The patients were kept up to date with their situation and crews regularly checked the progress of admission.

When patients were required to use the bathroom, crews had no other alternative but to transfer the patient on to the trolley to use the bathroom within the ED and then transfer the patient back to the ambulance. We observed patients were covered appropriately and protected from the rain as they were taken into the hospital.

Staff understood and respected the individual patients needs and showed understanding when caring for or discussing patients with mental health needs.

We saw ambulance staff caring for and consistently checking patients' wellbeing, in terms of physical pain and discomfort, and emotional wellbeing. Patients were kept informed of the situation to help keep them calm during the lengthy wait to be admitted.

We observed a particular case of good patient care where an agitated vulnerable patient was taken from an ambulance to a quieter area. This helped the patient to reduce anxiety and distress caused by waiting in the ambulance.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

The service was designed to meet the needs of local people and the communities served. However, due to delay in hospital handover, the needs of patients were not always met.

Patients were waiting longer than usual for ambulances to attend, following initial calls to the service. We were told that they had been waiting for long periods before the ambulance crews attended and that once transported to hospital, the wait continued. However, we were told that the staff supported patients well, on the journey to hospital and whilst waiting for admission to the emergency department (ED).

The trust reviewed all calls and were able to use rapid response crews to attend incidents when patient risk was high or when care could be provided without sending an ambulance and crew. This supported response times but did not alleviate the pressure completely. We were told that the control centre and call handlers worked closely with ambulance crews to ensure the right care was provided to patients.

Our findings

The ambulance service supported the hospital by treating patients at home or using alternative pathways for individuals, that did not require an admission to hospital. However, ambulance crews said that Worcestershire did not have as many alternative pathways as some areas and that meant more conveyance to local NHS hospitals.

The ambulance service had established “hear and treat” and “see and treat” policies which supported patients that did not require conveyance to hospital. Signposting to other services was a way to reduce the numbers of patients transported to hospital, but the local ED had between 12 and 16 ambulances and crews waiting outside on the days we visited.

We saw the introduction onto vehicles of a warming devices for premature babies. This was a recommendation to support newly born babies when being transported to hospital, to prevent a reduction in temperature and promote better outcomes for patients.

Access and flow

Due to pressures within the system, people were not always able to access the service when they needed it or in line with national standards. Not all patients received the right care in a timely way.

Many factors applied to the delay in admitting patients to hospital. As part of the inspection, other services were being assessed to review the situation.

We found patients were waiting longer for ambulances to attend after they had called for assistance. Patients told us they had waited up to 12 hours before an ambulance attended.

Once seen by ambulance crews there was another delay in admitting patients to the ED, during our inspection the longest wait we saw was nearly 20 hours.

Data indicated that there were differences between different local hospitals, with 1 having noticeable increases in waiting times compared with others.

On 22 November 2022 at 1 local hospital, WMAS data indicated that there were 40 delays, of 30 minutes or more, totalling 215 hours and 18 minutes. The longest individual wait was 12 hours and 51 minutes.

On 22 November 2022 at a second local hospital, WMAS data indicated that there were 32 delays, of 30 minutes or more, totalling 64 hours and 27 minutes. The longest individual wait was 6 hours and 37 minutes.

On 23 November 2022 at o1 local hospital, WMAS data indicated that there were 48 delays, of 30 minutes or more, totalling 244 hours. The longest individual wait was 18 hours and 48 minutes.

On 23 November 2022 at a second local hospital, WMAS data indicated that there were 17 delays, of 30 minutes or more, totalling 20 hours and 37 minutes. The longest individual wait was 2 hours and 36 minutes.

Is the service well-led?

Inspected but not rated

Our findings

Leadership

Leaders understood the pressures of the ambulance crews and their challenges, leaders were trying to manage priorities and issues that were raised. They were visible and approachable to staff at the hospital.

Managers were onsite during our visit, including late in the evening. We spoke with operational managers that said they were there to support staff with patients and help relieve them to take breaks. This helped but, due to the high numbers of crews waiting outside of the emergency department (ED), did not fully alleviate the issues staff were having.

Managers told us they would support staff in getting a relief crew if their shift was ending. However, crews would often liaise with each other to ensure they could finish on time. Some staff said that they were regularly finishing later than the shift had ended.

We saw that there was support from a hospital ambulance liaison officer (HALO), for ambulance crews at the ED at the local trust. However, due to staff sickness, on the second day of inspection a HALO from another area had to be used to cover at the hospital.

Feedback regarding the senior leadership team was mostly positive and staff felt that leaders took pride in the service. However, following an extended period of issues identified and long delays, staff were negative about the prospect of change to the situation.

Operational managers told us that whilst the executive team were not always visible due to the large geographical area of the trust, access to advice and support was readily available when required. We met a senior leader when visiting the Worcester hub.

Ambulance staff working in the Worcestershire area had been sent complimentary feedback from senior leaders within the local integrated care system, as recognition of continued support provided to patients.

Culture

Staff mostly felt respected, supported, and valued. However, some were disappointed with senior leadership support.

Most staff told us that they felt supported and could approach a manager with concerns.

We saw that senior staff were present at the local hospital and could support at busy times. Some managers and the HALO would relieve staff on the vehicles to allow for a short break.

However, we were told that some more senior leaders were often not available at busy times and this led to lack of leadership support and some staff feeling disheartened about the prospect of improvement.

We were told that a negative culture had developed because of the constant difficulties experienced at local hospitals. Staff suggested that the long waits and difficulties had been occurring for many years and were worsened with COVID-19. On previous inspections there had been a positive attitude and job satisfaction was important, but we found on this inspection this had now reduced considerably. We found there was not a specific workforce retention policy to mitigate the numbers of staff moving to other work or leaving the trust. Some staff told us they were considering leaving or knew of staff that had left.

Our findings

Staff told us that the long waits were impacting on their wellbeing because they felt they were letting down other patients waiting for ambulances. The impact of waiting was also affecting finish times for staff. This could lead to family concerns around childcare or other non-work arrangements. Often meal breaks were difficult to plan and at peak times there was no relief for staff to take a break.

WMAS ambulance crews from other areas told us that it was accepted that there would be longer waits at some local hospitals than other hospitals. This was described to us as “frustrating” and meant that crews could attend less calls during a shift. We were told that crews felt they were being used to supervise low acuity patients in ambulances and were an extra cubicle for the ED. This added to lower morale and frustration in not being able to respond to more calls.

We saw examples where ambulance crews were offered support following traumatic events. We were told that debriefing and learning from incidents was always completed to support staff in their work.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, there were some inconsistencies with the use of tools to triage and escalate concerns.

Workforce policies were in place to support flexible working, career breaks and other workforce strategies.

Staff told us that they would be asked to join crews from different areas to make up the correct staffing levels. An example given was that a paramedic had to travel over an hour to another hub before starting their shift and then return at the end of the shift. This could add 2 to 3 hours on a 12-hour shift. This also provided some difficulties when different hospitals have different systems or procedures that were changing regularly, making it difficult to “keep up to date” as staff were redeployed across areas.

We found some inconsistencies in how patients were triaged and how alternative pathways were accessed to avoid transportation to ED. Some staff told us that the handheld devices provided the only tool to triage a patient. Others said that they could access an online tool to support decisions made for patients.

Escalation processes whilst waiting outside of ED, were in place, however, staff approached them differently. This depended on factors, such as which HALO was working and how busy the ED was at a given time. Although we observed appropriate care and responses to patient needs, staff told us that sometimes they just had to “find someone” to help with a patient.

Staff told us they were often required to “cohort” a patient.

Patients handed over from the ambulance service are managed in a clinical setting that reflects their acuity, as assessed by prompt triage. This action is often referred to as 'cohorting'., “The safest form of cohorting is after assessment to ensure departments are fully aware of the patients and their risk. Any area used for cohorting must have appropriate equipment and facilities, together with appropriate privacy. Plans for the required extra staffing of any cohort area should be included in escalation plans, ensuring that all patients handed over from the ambulance service are managed in a clinical setting that reflects their acuity as assessed by prompt triage.”

Ambulance crews told us they often felt that they were an “extra pair of hands” for the ED and were not sure of what was required of them.

Our findings

We were told there was little guidance available in how to cohort a patient. Some staff told us that they would seek guidance from hospital staff, if available. Other hospitals managed this system differently and some ambulance crews did not understand the process for cohorting a patient at all local hospitals. This was a higher risk at busy times.

Concerns were expressed by crews, that there was an increase in cost of fuel and an excess of fumes produced by vehicles, having to run for extended periods. The vehicles often ran overnight to maintain suitable conditions inside the ambulance for looking after a patient waiting outside of ED. We were told that this had been escalated to the trust by ambulance crews and the trust were assessing risks.

Our findings

Areas for improvement

Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

SHOULDS

The trust should continue to work with partners to reduce the waiting times for ambulances outside of hospital.

The trust should consider exploring the alternative pathways for care available in Worcestershire and communicate to all staff.

The trust should consider reviewing process for cohorting patients at hospitals and communicate process to all staff.

The trust should consider offering staff training to ensure personal care is provided for patients waiting in ambulance.

The trust should review equipment, such as trolley mattresses, or processes to mitigate risks caused by extended waits. (Regulation 12).

The trust should consider the support available to staff whilst at local hospitals and the access to leaders.