South East Coast Ambulance Service NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	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?	**Inadequate**

Our findings

Our reports

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.

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.

Overall summary

What we found

Overall trust

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) provides services to Brighton & Hove, East Sussex, West Sussex, Kent, Surrey, and North East Hampshire. This diverse geographical area includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country.

The trust employs over 4,500 staff working across 110 sites in Kent, Surrey and Sussex. Almost 90% of the workforce is made up of operational staff who care for patients either face to face, or over the phone at the emergency dispatch centre where 999 calls are received.

Patients range from the critically ill and injured who need specialist treatment, to those with minor healthcare needs who can be treated at home or in the community.

As well as a 999 service, the trust also provides the NHS 111 service across Sussex, Kent and Medway.

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

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

The 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 must be able to demonstrate it can effectively manage the impact and aftermath of a major incident.

Our findings

How we carried out the inspection

At our last inspection in February 2022, the overall rating of trust well-led went down. We rated it as inadequate and the chief inspector of hospitals recommended to NHS England and NHS Improvement (NHSEI) that SECAmb be placed in the Recovery Support Programme. During the previous inspection we identified further checks we needed to be carried out. Therefore, we suspended the trust's overall rating. During this current inspection we reviewed the trust's overall rating following inspection of the two remaining core services.

We inspected emergency and urgent care services. We visited the make ready centres at Paddock Wood and Ashford. We also visited three NHS hospital emergency departments to observe care and talk to staff. We spoke to over 50 members of staff which included; paramedics, emergency care support workers, student paramedics, operational managers, operational team leaders, a driving training manager, pharmacy support staff, associate ambulance practitioners, trainee associate ambulance practitioners and a practice development lead. We spoke to three patients and one relative and reviewed a variety of data.

We carried out a comprehensive inspection of the Resilience core service. Resilience services were located at Gatwick and Ashford Made Ready Centres. We inspected both locations on two occasions between the 22 July and the 2 August 2022. During the inspection process, we spoke with the director of the service, two operations managers, three operational team leaders and 10 Hazardous Area Response Team (HART) operatives across both sites.

You can find information about how we carry out our inspections and previous ratings for this service on our website: https://www.cqc.org.uk/what-we-do/ how-we-do-our-job/what-we-do-inspection.

We conducted this comprehensive short notice unannounced inspection of the emergency and urgent care and resilience core services. We inspected emergency and urgent care on 26 July 2022 and resilience on 26 July 2022 and 02 August 2022. We rated both emergency and urgent care and resilience as requires improvement overall.

What we found

Emergency and urgent care

Our rating of this service went down. We rated the service as requires improvement because:

- The service provided mandatory training in key skills to all staff but not everyone had completed it. The service did not share learning from incidents with staff and staff often did not get feedback from incidents they had reported.
- There was a lack of training for medicines management, specifically for patient group directions.
- The service did not always support staff to develop their skills. Managers and staff told us that any additional training courses had to be self-funded and completed in their own time.
- Managers did not routinely appraise staff's work performance or hold supervision meetings with them to provide support and development. Managers did not always make sure staff were competent.
- Staff did not receive training in patient restraint techniques. The trust did not have oversight regarding how often restraint was used and whether it was done safely. The trust did not have a restraint policy.
- The service did not always make it easy for people to give feedback. People could not always access the service when they needed it and patients often experienced delays in receiving treatment.

Our findings

- There were additional risks for patients from handover delays for ambulance crews at emergency departments which were unable to take patients due to their lack of capacity.
- The NHS contractual response times for ambulances to attend patients were not being met and some were exceptionally long, ambulances were waiting at emergency departments due to the increased demands and capacity pressures in hospitals and other parts of the health and social care system.
- Leaders did not have the capacity or support to run the service well. Not all staff felt respected, supported and valued.
- Staff felt there was an overall lack of a strategy and vision for the service. Staff felt there was a lack of urgency and ownership of responsibilities within the service.
- There was not an effective communications system to ensure staff had read and understood key information.
- Staff were not clear on the roles and responsibilities of managers. For concerns requiring action from senior leaders in the organisation there were often delays in getting a response impacting on the ability of local leaders to deal with issues and concerns at a local level in a timely way.
- Managers did not have enough time to dedicate to the welfare, professional development and training of the staff they managed. There was conflicting and changing demands placed on all levels of managers from the senior leadership team and there was a lack of cohesive working.
- There was evidence of staff under such pressure that it was having a detrimental effect on both their mental and physical wellbeing. Most of the staff described feeling exhausted and burnt-out by the job with the current pressures. Not all staff felt that staff welfare was given sufficient priority.

However:

- The service controlled infection risk well. Staff assessed risks to patients and acted on them. Staff generally managed medicines well.
- Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care.
- Staff provided care and treatment based on national guidance and evidence-based practice. The service monitored the effectiveness of care and treatment.
- Staff treated patients with compassion and kindness, they provided emotional support to patients, families and carers to minimise their distress. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- Staff worked well together for the benefit of patients, for example with staff in emergency departments. Despite the immense pressure faced every day, staff were kind, compassionate and supportive to patients.

Resilience

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

- Not all staff had completed safeguarding training at a level appropriate to their role.
- The service were not always able to demonstrate how they measured IPC effectiveness and infection control risk.
- The service did not always keep equipment and vehicles in line with their documented policies and processes.
- The service had limited learning from safety incidents and incident reporting was low for the service.

Our findings

- Staff were not always clear about information communicated through the meeting structure of the service.
- Some staff did not always feel respected, supported and valued.
- Managers showed limited strategies and systems to improve the service using quality improvement techniques.

However:

- Staff had training in key skills and understood how to protect patients from abuse. Staff assessed risks to patients, acted on them and kept good care records. The service managed medicines well.
- Staff provided good care and treatment to patients and gave them pain relief when they needed it. Managers checked the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Staff showed knowledge of consent and the considerations of patients who lacked capacity to make decisions. Staff worked with other services to ensure best outcomes; key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Staff engaged well with patients and were focused on the needs of patients receiving care.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders supported staff to develop their skills. This included highly specialised training which was monitored effectively.

Our inspection team

Emergency and urgent care

The team that carried out the inspection comprised an inspection manager, lead inspector, two other CQC inspectors and two specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Resilience

The team that carried out the inspection comprised a lead inspector, one other CQC inspector and one specialist advisors. The additional visit had a team of two CQC inspection managers and two CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Outstanding practice

We found the following outstanding practice:

Resilience

- Staff gave several examples of exceptional care in challenging situations that showed compassion and bravery.

Our findings

Areas for improvement

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

Action the trust MUST take to improve:

Emergency and urgent care

- The trust must ensure all staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. (Regulation 18 (2) (a)).
- The trust must ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform their role. (Regulation 18 (2) (a) (b)).
- The trust must ensure they seek and act on feedback from relevant persons. (Regulation 17, (1) (2) (a) (d)).
- The trust must ensure it investigates incidents in a timely fashion and share the learning to improve safety and quality of the service. (Regulation 17 (2) (b)).
- The trust must ensure there is a mechanism to provide assurance that staff had read and understood any changes to policies and national guidance. (Regulation 17, (1) (2) (a) (d)).
- The trust must ensure it continues to work collaboratively with system partners to improve category 2, 3 ,4 response times. (Regulation 12, (1) (2) (a) (l)).
- The trust must ensure that staff administering medicines under a patient group directive have the required training and competency. (Regulation 12, (1) (2) (a) (g)).
- The trust must ensure that blood glucose monitors are calibrated in line with manufacturers guidelines. (Regulation 12, (1) (2) (a) (e)).

Resilience

- The trust must ensure that vehicle equipment used by the service provider is fit for use and accurately accounted for through an up-to-date asset register for the service. (Regulation 15 (1) (f)).
- The trust must ensure that effective systems and processes to ensure good governance in accordance with the fundamental standards of care. (Regulation 17 (1)).
- The trust must ensure that enough numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment. (Regulation 18 (1)).

Action the trust SHOULD take to improve:

Emergency and urgent care

- The trust should continue to focus on staff engagement and welfare.

Our findings

- The trust should consider how to improve engagement with patients.
- The trust should consider how to ensure all staff attend regular meetings or have access to information discussed at meetings.
- The trust should consider how to recruit to staff vacancies.
- The trust should consider how to improve communication and relationships between staff and senior leaders.
- The trust should consider how to engage with and seek the views of operational managers with regard to improvements within the service.
- The trust should consider how to embed a culture where everyone is valued for who they are and what they contribute.
- The trust should consider how to promote and sustain innovations within the service.

Resilience

- The trust should ensure that vehicle checklists are updated to reflect the changes to standard equipment carried on the emergency preparedness, resilience and response (EPRR) response vehicles.
- The trust should ensure that completion rates for level three safeguarding training are improved.
- The trust should ensure that tactical command staff receive updated training within the timeframes specified by the trust.
- The trust should consider how they audit outcomes for the service to measure outcome and monitor improvements.
- The trust should ensure that effective policies and procedures for the management and deployment of NARU owned vehicles are implemented effectively.
- The trust should ensure that formal meetings are recorded and that all staff have access to information discussed if unavailable to attend.
- The trust should ensure that staff filling in for operational team leader positions are given suitable training for undertaking their role.
- The trust should ensure that staff appraisal rates are improved.
- The trust should consider the cleaning arrangements for sluice rooms at both locations and provide documentation to support governance processes.
- The trust should consider the oversight arrangements of documenting deep cleaning for EPRR vehicles at both registered locations.

Is this organisation well-led?

Please see our June 2022 published report.

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 2022	Requires Improvement ↓ Oct 2022	Good ➔➔ Oct 2022	Requires Improvement ↓ Oct 2022	Inadequate ↓↓ Oct 2022	Requires Improvement ↓ Oct 2022

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.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
South East Coast Ambulance Service NHS Trust Headquarters	Good Jun 2022	Good Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Good Jun 2022	Good Jun 2022
Overall trust	Requires Improvement ↓ Oct 2022	Requires Improvement ↓ Oct 2022	Good →← Oct 2022	Requires Improvement ↓ Oct 2022	Inadequate ↓↓ Oct 2022	Requires Improvement ↓ Oct 2022

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

Rating for South East Coast Ambulance Service NHS Trust Headquarters

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Jun 2022	Good Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Good Jun 2022	Good Jun 2022

Rating for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires Improvement ↓ Oct 2022	Requires Improvement ↓ Oct 2022	Good ↓ Oct 2022	Requires Improvement ↓ Oct 2022	Requires Improvement ↓↓ Oct 2022	Requires Improvement ↓↓ Oct 2022
Emergency operations centre (EOC)	Requires improvement Jun 2022	Requires improvement Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022
Resilience	Requires Improvement ↓ Oct 2022	Good →← Oct 2022	Good →← Oct 2022	Good →← Oct 2022	Requires Improvement →← Oct 2022	Requires Improvement ↓ Oct 2022

Overall ratings for ambulance services 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 ↓↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service had not been able to provide mandatory training in all key skills to staff. The COVID-19 pandemic had impacted on face to face training for staff. Not all staff felt the training provided was sufficient to meet their needs.

Staff did not always receive and keep up to date with their mandatory training. Training completion rates had been impacted by the COVID-19 pandemic. Face to face training was suspended and operational pressures meant staff could not access training. However, key skills training had recommenced, and the trust were trying to address the backlog of staff requiring key skills training. The trust had a target to ensure all staff had received key skills training by the end of April 2023.

Staff we spoke with confirmed they were not able to keep up to date with training during the COVID-19 pandemic. They did not have protected time to complete training including the e-learning modules.

Key skills training was given during induction and was detailed and varied to enable staff to meet the needs of patients. There were eight different modules, four of which all staff completed which included; information governance, dementia, health, safety and welfare and manual handling. Registered staff completed an additional four modules which included; emergency driving training, infection prevention and control level two, resilience/specialist operations and classroom training. The classroom training included practical training such as resuscitation.

As of 12 August 2022 , 70% of all staff were compliant with key skills training, the lowest compliance (43%) was prevent training. Prevent training explains how it aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves. The trust set a target of 85% compliance with key skill training.

Not all local managers felt they had oversight of compliance with key skills training as this was managed by the scheduling team. However, local managers were aware that the service was not meeting trust targets for completion of key skills training.

Not all staff felt mandatory training was comprehensive enough to meet the needs of patients and staff. Not all staff could recall having completed refresher training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Some staff told us that they did not feel that they received sufficient training on recognising and responding to patients with mental health needs who they frequently cared for. In addition, some registered staff felt they would benefit from more practical training such as “skills and drills training”.

The scheduling team alerted staff when they had been booked onto key skills training eight weeks in advance.

Staff had to complete a four-week blue light driver training course or hold a certificate in Emergency Response Ambulance Driving. The refresher for this course was seven and a half hours of training which included nearly four hours of theory training and a test. Staff confirmed they had received training and knew when they were due for refresher training. Records confirmed there was oversight of compliance and when staff were due refresher training.

The service had a plan to ensure it was compliant with changes in relation to Section 19 of the Road Safety Act 2006. The service had completed 306 driving assessment from the start of year to date. The service had RAG (red, amber green) rated all staff to become compliant with changes to the Section 19 of the Road Safety Act 2006. Red were staff who had their last assessment over five years ago (909 staff) amber (63 staff) for staff within six months of expiry of their last assessment and green (1359) for staff who were compliant. We saw that based on the current trajectory all staff would be complaint within the next nine months.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had received training on how to recognise and report abuse. Not all staff received feedback on safeguarding referrals they had made.

Staff received safeguarding training level 1 and 2 in line with the Royal College of Nursing's intercollegiate document. Data showed the overall compliance for both adult and children level 1 and 2 safeguarding adults was 85%. The trust target for compliance was 85%.

Staff demonstrated their knowledge of safeguarding and how to make referrals if required. Staff could seek advice from paramedic practitioners whilst with a patient via the telephone if needed. Staff could make safeguarding referrals by using their handheld mobile device. Staff gave examples of making safeguarding referrals and receiving feedback. However, some staff said they did not receive any feedback following making a safeguarding referral.

There was a noticeboard dedicated to safeguarding information including how to contact the trust's safeguarding network if staff required support or advice.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Disclosure and Barring service (DBS) checks were undertaken. Staff were informed when an update was due. Data showed nearly 100% compliance with DBS checks completed in line with trust policy.

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 the premises visibly clean. However, infection prevention and control audit compliance was varied.

All areas we inspected were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and showed that all areas were cleaned regularly. Make ready centres and ambulances were cleaned by dedicated make ready teams provided by an external contractor.

The make ready team undertook ambulances, equipment and station infection, prevention and control (IPC) audits. Audit data reviewed after the inspection showed varied compliance with standards of vehicle cleanliness visual audits, from November 2021 and June 2022 compliance was between 63% and 68%. The trust target was 90%.

Emergency and urgent care

Routine cleaning of ambulances between patients was the responsibility of the crew. Staff explained that if an ambulance became heavily contaminated, crews would return to base and it would be taken out of service until it had been cleaned. However, at one hospital we visited it was not clear who had responsibility for cleaning the wheelchairs that belonged to the hospital after use and these were not consistently cleaned after patient use.

The ambulances were deep cleaned every 12 weeks or sooner if heavily contaminated. This was done by the dedicated make ready team. Records showed all ambulances had had a deep clean within the last 12 weeks. We saw these records were audited regularly. Local managers had oversight of the deep cleaning schedule so they knew when ambulances would not be available for use.

Staff swabbed ambulances monthly to assess the quality of cleaning. For example, from April 2022 and July 2022, 260 ambulances were swabbed. Hand hygiene audit showed varied but improving compliance, between March and May 2022 compliance was over 86% and the latest data for June 2022 showed 90% compliance compared to 73% compliance in December 2021. The number of hand hygiene audits completed had also increased with just over 100 completed in March 2021 this had increased to over 250 in June 2022.

We checked four emergency ambulances. All ambulances we inspected were equipped with visibly clean equipment, clean and available linen, hand gel, personal protective equipment (PPE) such as aprons and gloves, and decontamination wipes. Sharps boxes were all signed and dated and not overfilled.

The trust encouraged all staff to undertake twice weekly lateral flow tests to test for COVID-19, testing kits were available from the central stores to every location for staff to access or from the government website.

Operational team leaders had recently been instructed to complete IPC audits. However, the guidance on how to conduct these audits was not clear.

Crew attending emergency departments were all wearing the correct PPE including masks, aprons and gloves at the right time. Staff demonstrated good hand hygiene practice in line with national guidance.

Staff maintained the cleanliness of their own uniform and explained if their uniform became severely soiled or contaminated it would be disposed of in the appropriate waste bin and a replacement requested.

Staff could obtain advice and support regarding infection control matters from operational team leaders or paramedic practitioners who staffed “the hub.”

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, there was not evidence to show that machines used to check patients blood sugar levels were calibrated.

The design of the environment followed national guidance. The Ashford make ready centre was well designed and large enough for the staff and ambulances that operated from there. However, the Paddock Wood make ready centre was more restricted in size and layout. It also had repair workshops for ambulances and electrical equipment and a secure medicines preparation area.

Staff had communal areas to eat and relax, separate toilet and shower facilities and a dedicated wellbeing room.

Emergency and urgent care

We visited two make ready centres. The make ready operatives were employed by a private contractor. They were responsible for the daily checking and stocking of ambulances. We saw the operatives working to a comprehensive check list. Records showed each stage of the process, a copy of the checklist was left in ambulances for staff to check if any items were missing and they signed the checklist to confirm this process. The service monitored turnaround times against key performance indicators agreed with the private contractor. The latest data for June 2022 showed 88% compliance against turnaround times.

The ambulances we checked were restocked and refuelled. Each kit bag within the ambulances was labelled with a green tag to indicate it had been checked and was complete. If something was missing from a kit bag it had a red tag labelled with what was missing. Sterile consumables such as syringes and dressings were stored correctly on ambulances and at stations.

A check of randomly selected consumable stock at the stations and on the ambulances showed all stock was in good condition and within their expiry date.

All ambulances we inspected had harnesses, chairs, and trollies available for the safe transportation of patients, this included equipment for the safe transportation of children.

All ambulances underwent maintenance checks by mechanics employed by the trust. A mechanic told us there were issues getting replacement parts for the new type of ambulance. In addition, they told us that although the diagnostic software had been purchased for the new type of ambulance there were not any manuals, therefore they could diagnose the problem but could not always fix it. However, the trust told us this was due to be rectified shortly.

The trust told us it was the ambulance crew's responsibility to calibrate the blood glucose (sugar) machines at the start of the shift, but this was not formally documented. This meant there was no assurance the machines were calibrated regularly. There is a basic requirement for blood glucose meters to be calibrated regularly. If there are no periodic calibrations, the blood glucose meter's measurements may not be accurate. People who are diabetic use blood glucose machines to monitor their blood sugar level. The trust told us that they were in the process of developing a trust wide system for the calibration of the machines in line with manufacturers guidelines.

Some staff were not positive about the replacement of the ambulances to a different make as part of the nationwide replacement programme. Staff reported safety concerns relating to the fitting of the seatbelts and a smaller working space in the ambulance. Staff who were affected by the fitting of the seatbelts had undergone a risk assessment and some were exempt from driving these ambulances. This created logistical problems with trying to match the right ambulance against staff. Managers were aware of the issue and the trust had commissioned an external review of the ambulances which had been concluded with recommendations made.

All ambulances we inspected contained essential emergency equipment. Equipment such as defibrillators and suctioning machines on board the ambulances were labelled which showed they were serviced, maintained and safety checked. Ambulance crews had access to up to date satellite navigation systems.

The trust maintained all equipment and there was an effective process to replace any defected equipment. Each make ready centre held replacement medical equipment. For example, the Paddock Wood make ready centre stocked enough replacement equipment for two ambulances. There were records of equipment maintenance schedules. All equipment was marked with a sticker to show when electrical safety testing was due.

The various areas of the make ready centres were only accessible by electronic swipe cards given to authorised staff. Keys to ambulances were stored in key safes and were signed out to ambulance staff at the beginning of their shift and signed back in and stored securely at the end of their shift.

Staff disposed of clinical waste safely. Staff disposed of clinical waste in the secure clinical waste compound when returning the ambulance to the station. The clinical waste bins at the Paddock Wood make ready centre were locked. The locking of clinical waste bins ensured clinical waste was secure and posed less of a risk to anyone handling it. Clinical waste was collected and disposed of by an independent contractor.

All products subject to the Control of Substances Hazardous to Health regulations were stored securely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

When people called 999, they were assigned an urgency category based on their condition, which determined the type and time of the response from ambulances. These are category 1- calls from people with life- threatening illness of injuries, category 2- emergency calls, category 3- urgent calls and category 4 less urgent calls. At times there were many outstanding category 3 patients awaiting an ambulance or assessment by a paramedic practitioner. At busy times, these patients waited extended lengths of time for crews and call backs. Therefore, this group of patients were at risk of

deterioration whilst they were waiting for a response. On the day of inspection, the highest numbers of calls awaiting were; two life threatening calls, 53 emergency calls, 123 urgent, and six less urgent.

Data from 01 February 2022 to 31 July 2022 showed that there were 3932 occasions when a non-paramedic crew were assigned a category 1 call. However, the trust monitored the outcome of these to ensure that no harm was caused to patients.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff monitored each patient's condition using the National Early Warning Score (NEWS2) in line with Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines. Staff accessed this through their handheld mobile device which was regularly updated with new guidance. The NEWS2 score was recorded on the electronic patient care record based on the assessment of the patient's clinical observations and vital signs. NEWS2 is a simple scoring system. It uses scores based on physiological measurements to help identify patients who are deteriorating and indicate the priority for medical intervention. We asked the trust to provide audits which showed compliance with NEWS2, but none were provided.

Care pathways were available for ambulance crews on their handheld mobile device. There was a colour coded traffic light system which highlighted level of risk and provided guidance to staff. The trust had worked with other care providers to identify the primary community pathways. These included pathways for patients with frailty, dementia, mental health, end of life care, chest infections, urinary tract infections, indwelling urinary catheters and falls.

Staff shared key information to keep patients safe when handing over their care to others. Patient handovers in the emergency department was thorough and concise. The electronic notes were printed off and given to hospital staff and filed in each patient's notes.

Ambulance crews treated patients on the scene and if required took them to an emergency department for ongoing care. The patient would then be handed over to the emergency department teams on arrival. The NHS contract states all

handovers between an ambulance service and an emergency department must take place within 15 minutes with none waiting more than 30 minutes. The responsibility for the patient is that of the emergency department when the ambulance arrives. Managers monitored compliance with this standard. The trust held local arrangements for handovers with some NHS trusts, for example there was an enforced handover at 45 minutes at one emergency department. This meant ambulance crews handed over patients to the emergency department staff 45 minutes after arriving.

For patients experiencing handover delays, ambulance crews undertook clinical observations such as blood pressure and pulse every 15 minutes to identify any patients at risk of deteriorating.

A paramedic practitioner hub was available to answer calls from colleagues for clinical advice and support. The support provided included shared decision making, help with alternative care pathways, support to crews on scene, clinical referrals and patient follow ups and discharge advice. This was particularly useful for newly qualified paramedics and for emergency care support workers. Paramedic practitioners were also available to attend the location if face to face support was required. This service also intended to reduce inappropriate conveyances to hospital when patients were better suited to being supported in the community to stay at home. Ambulance crew who were junior (below a band 5) had to contact the hub to be able to discharge patients at the scene after discussion with a senior paramedic. Operational team leaders and operating unit managers could also visit emergency departments to try and resolve any issues.

Paramedic practitioners were able to self-allocate any jobs to themselves and monitored the list of outstanding category 3 (urgent calls) calls. They could call patients back, refer to different healthcare agencies or upgrade or downgrade the urgency category of patients. Paramedic practitioners were able to use their own clinical judgement to make clinical decisions rather than following care pathways.

Ambulance crew provided on scene situation reports to control room staff within 30 minutes of arriving on scene. These followed a standardised format using the acronym STEPS. This stood for: staff welfare at scene and if additional support was required, transporting to a further facility, expected time on scene, patients current condition, and support needed for shared decision making.

The trust had up to date policies and procedures to manage patients with disturbed behaviour. However, some staff felt they did not have enough training to care for patients with disturbed behaviour. Critical care paramedics were available to offer remote or on-site support and advice to ambulance crew caring for patients with disturbed behaviour.

Staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This was contributed to by ambulance handover delays, unplanned absence through sickness and the pressure from increasing demand meant staff could not always provide the care patients needed. Some staff reported working excessive hours and managers were not aware of what their staffing establishment should be.

The service had been under additional pressure from staff sickness and COVID-19-related absence. Data showed from February and July 2022, the overall sickness rate for staff working in urgent and emergency care was just over 10%. This equates to 43,879.92 staffing hours lost to sickness during the same time period.

Emergency and urgent care

Many staff were working beyond their hours and not always getting breaks on time in what were already long shifts. Data showed from February to July 2022, 86% of ambulance crew took their break from their own dispatch location and 41% of crew actually took their break in their allotted break time. In the same time period just over 1% of staff did not have a break in their shift. In the previous six months 10% of staff finished their shift an hour after their shift finished.

Staff were required to have a minimum of 11 hours between each shift, if their previous shift did not finish on time, then they started late on the next shift, which impacted on service delivery. Staff confirmed they always had a minimum of 11 hours between each shift. The trust had offered several different financial incentives to reward staff for working overtime.

Managers at all levels told us that they did not know if they met their planned staffing establishment. They did not know what the staffing establishment should be or what their vacancies were. Core service leaders told us that there were three different establishment figures. One which they were commissioned for which did not meet the needs of the service and two other figures which had not been agreed by the executive team.

Data showed there was an overall budgeted vacancy rate of 7% across all staff groups working in urgent and emergency care, this equated to 164 vacant posts. The highest vacancy were amongst associate ambulance practitioners with a 48% vacancy rate. However, the service had over recruited emergency care support workers to offset the high vacancy rate. Manager posts were fully staffed and met the establishment.

The overall month on month turnover rate for all staff groups working in urgent and emergency care was just over 4% based on people leaving against substantive posts. The highest turnover of staff was amongst ambulance technicians and paramedics (both just over 8%). In the last three months 292 staff had left the service, of these 46% had an exit interview, the service did not gather information on how many staff were offered an exit interview. The top reason for leaving was new job/promotion, then work/life balance and thirdly lack of opportunities.

Managers aimed to achieve the gold standard of double staffed ambulance crews made up of two qualified staff; or as a minimum one qualified and one unqualified, however this was often not possible. When operational needs required managers to adjust staffing, they would often have to evoke the matrix guidance. This guidance allowed managers to maintain ambulance availability but had an impact on the skill mix of the staff.

Each ‘make ready’ centre had a make ready centre manager who had oversight of the rota, which was compiled by the schedulers. The schedulers had a matrix for staff planning which included skill mix requirements. They managed annual leave, abstractions for training, relief, and planning for the front-line ambulances. The rota informed staff of shifts indefinitely and the scheduling team then allocated relief duties, which were approximately two weeks in every six weeks, for any unfilled shifts that occur due to leave, sickness, or training.

The operational team leaders made decisions daily to cover unexpected absences. There was an escalation policy for unsafe staffing, but the expectation was that it was the responsibility of the operational team leaders to resolve issues that occur.

The service analysed previous data to predict demand and tried to schedule enough staff to meet the demand. Data showed that for a seven day period commencing on 25 July 2022 that there was on average 10% less actual staff compared to the planned level.

The trust used third-party providers for emergency response ambulances to help offset some of its workload and to assist with staffing shortages.

The trust had an induction process for new staff. Practice development paramedics and paramedic practitioners supported new staff especially newly qualified paramedics (NQPs). Rotas showed the role of each individual staff member and identified NQPs so they could be supported.

Managers used bank staff familiar with the service. Managers made sure all bank staff had a full induction and understood the service. Operational pressures required the service to use bank staff. The service did not use any agency staff.

Staff told us that it was very difficult to gain approval for annual leave requests. Staff could not see what annual leave had already been booked and was available. All requests for annual leave were made and reviewed and approved or not approved by the scheduling team. Ambulance crew gave us examples of having five requests for annual leave refused. This had a negative impact on the wellbeing of staff. Data showed that in the previous six months 64% of annual leave requests for operational staff had been approved and 60% for medical staff.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The trust had moved to an electronic recording system for clinical documentation which was on their handheld electronic devices. The electronic system had all relevant protocols and pathways available for staff to access. Mobile devices were personally issued to substantive staff, but bank staff were able to access a mobile device at each make ready centre. Staff kept these secure.

The trust had not secured an audit tool to enable oversight of the quality of the electronic patient records. However, we saw there were plans in place to remedy this by a planned date of April 2023.

The trust used a different electronic records system to log details of patient care plans and needs. For example, there were specific care plans for patients living with a health condition which meant they often called an ambulance. This enabled ambulance crews to make the best clinical decisions when attending patients as all the relevant information was available. Healthcare professionals in the community advised the trust of patients who might benefit from being added to the system. Patients had to consent to have their details shared and uploaded to the system which was generally carried out in primary care services. Once patients agreed to share their medical records then alerts could be added to the system. Other alerts that could be added included, advance care planning and details of patient's pre-existing conditions and safety risks. Ambulance crews had access to the system through their handheld mobile device.

Medicines

The service generally used systems and processes to safely prescribe, administer, record and store medicines. However, there was a lack of training and competency assessments for patient group directions.

Staff followed systems and processes to prescribe and administer medicines safely. The handheld mobile device allowed staff to accurately record any medicines administered to a patient and to record any medicines the patient may have already been prescribed.

Emergency and urgent care

Ambulance crews were supported to administer medicines via trust policies, guidelines and the UK Ambulance Services Clinical Practice Guidelines. Ambulance crews had patient group directions (PGDs) for the administration of medicines. PGDs and policies were on handheld mobile device for medicine administration and instruction. PGDs authorised paramedics to administer or supply a wider range of medicines depending on their role, additional training and competency.

We had some concerns relating to PGDs which included just in case medicines. The risks were associated with the lack of training and competencies-based assessments to ensure these staff can safely undertake this aspect of their role. The trust was mitigating the risk by using a competency-based questionnaire so that paramedics could self-assess their own competency. We were informed this was improving and an eLearning PGD module was recently introduced.

The trust had developed end of life care guidance and procedures in June 2022, which provided a framework in how and when paramedics could administer a patient's own just in case medicines. Critical care paramedics and paramedic practitioners carried their own supply of just in case medicines but followed the same process for administration outlined within the guidance and was further supported by the symptom control of patients at the end of life procedure. Just in case medicines are medicines that can be given quickly if someone has sudden distressing symptoms such as pain or agitation.

Staff stored and managed all medicines and prescribing documents safely. Medicines storage in stations and on ambulances was secure.

Medicines in ambulance stations and make ready centres were stored in automated storage systems. Where the automated storage systems were used, access to the room was controlled by use of an authorised swipe card and access to the automated storage systems was by biometric (fingerprint) recognition.

Ambulance stations and make ready centres used an electronic ambient temperature monitoring system for medicine stores. We saw thermometers in each of the storerooms we visited. These devices were linked to a central control and alarmed if the temperature in the room increased or fell below specified temperature.

The medicine pouches were signed out by paramedics at the start of their shift and signed in at the end of their shift on a register.

The standard medicine bags had a tag system to indicate if the bag was ready to go. If a bag was closed and had a green tag it was ready to go. There was a separate storage area for bags, which were not ready.

Medicine and compressed gas storage facilities on ambulances was secure. There were compressed gas storage areas at each station. These were well maintained, ventilated and secure.

Staff provided advice to patients and explained what they were for before giving medicines to patients.

Staff learned from safety alerts and incidents to improve practice. Ambulance crews told us any updates or safety alerts involving medicines were shared via email and emails were marked as important. However, staff also told us that they received a high volume of emails marked as important and they did not have time to read them all.

Medicines governance audits were carried out weekly by OTLs and monthly by operational unit managers and by medicines governance team every six months. We saw records which confirmed these audits were completed. Weekly audits for the last three months showed good compliance (mean average 98%).

Controlled Drugs (CDs) stocks were checked every time a transaction took place at the CD register and CD cabinet. If there was a discrepancy this was raised to the OTLs immediately and an incident form completed. CD checks were performed once weekly by the OTLs.

Trust wide staff report over 100 medicines incidents a month via the incident system. The majority of these incidents (approximately 650 yearly) were controlled drugs (CDs) as these were a mandatory requirement in policy for any discrepancies. The second highest category was medicine pouch paperwork and incorrect tagging of pouches (approximately 300 incidents yearly). The third highest category was breaks/spillages of CDs in the pouch system.

Incidents

The service did not manage patient safety incidents well. Staff recognised incidents and near misses but did not always report them appropriately. Managers did not always investigate incidents and share lessons learned with the whole team, the wider service and partner organisations. There was a backlog of incidents awaiting investigation.

The trust used an electronic incident reporting system, which staff accessed with a handheld mobile device or via computers at their base. Staff we spoke with were clear about the reporting system and knew how to access it. Staff told us they reported a wide range of issues including safeguarding incidents, issues with practice and ambulance and equipment issues. However, staff told us that they did not always receive a response or feedback from incidents they raised. Staff told us that learning from incidents was not communicated unless it was a serious incident and they were directly involved in the incident.

Data showed that in the previous six months there had been 35 serious incidents within clinical operations of urgent and emergency care. Local managers told us serious incidents were investigated by a corporate team within the trust and therefore the learning may not be shared for some time.

There were 8352 incidents recorded from 01 February 2022 until 31 July 2022. The majority of these incidents (12%) were related to the 111 service, 107 related to Covid-19 related staff sickness and 8% related to vehicle issues. Data showed as of 02 August 2022 there were 313 incidents overdue for investigation across the urgent and emergency care service.

The trust issued clinical bulletins and staff newsletters to share learning with staff from incidents and we saw examples of these. However, there was not a process to ensure staff had read and understood the bulletins.

Staff generally knew what incidents to report and how to report them. However, staff told us that they would not report when they used restraint on a patient as an incident. Therefore, the service did not have oversight on how often restraint was used and if it was done safely.

Staff did not always meet to discuss incident feedback and look at improvements to patient care. At the Paddock Wood station there were biweekly meetings when staff were able to discuss learning from incidents and provided support and training for staff as a result. However, this was a localised practice and was not standardised across the service.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed three root cause analysis investigation reports, all identified a root cause and had associated actions with deadlines for completion and a responsible person for each action, one action had expired the deadline. The root cause analysis reports did not include details on how learning would be shared with staff.

Emergency and urgent care

Local managers did not always debrief and support staff after any serious incident. There was an inconsistent approach to providing debriefs and support to staff after a distressing incident. Local managers told us that they tried to undertake an informal debrief with staff after a distressing incident but there was not a formalised process with staff trained to undertake debriefs with staff. One staff member attended a very distressing incident and tried to approach their manager for support and their manager was very dismissive. Managers at one make ready centre had implemented a scorecard for staff which included a wellbeing section, but this was a local practice and was not standardised across the service.

Managers at all levels did not always share learning with their staff about serious incidents. Managers told us that systems and processes for learning lessons from incidents for staff working across stations could be improved.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with were aware of the duty of candour regulation and could reference the trust policy for this.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The handheld mobile device held current care plans, flow charts and policies for patient care and treatment. Policies reviewed were comprehensive, in date and version controlled. The practice education team were responsible for ensuring policies were updated with any changes to practice. For example, an update to a policy involving pregnant women was passed to the consultant midwife to review and make any updates. There was a policy tracker which tracked any changes required to policies which provided oversight to ensure all relevant policies were updated.

Staff had access to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and were able to demonstrate how they could access them on their handheld mobile device.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff explained how they conveyed patients in the manner that preserved their dignity and privacy whilst managing risk to their health and safety or to other people. Ambulance crew could request help and support from the critical care paramedics when caring for a patient subject to the Mental Health Act or could call the police for support if they felt they were at risk of harm.

Emergency and urgent care

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The handheld mobile device prompted staff to record patient pain scores as part of the patient record. The staff used a zero (no pain) to 10 (extreme pain) numerical pain scale to assess pain levels.

We saw staff asking patients if they were in pain and handing over to hospital staff what the patient's pain score was, and any pain relief given by the crew.

Staff used the Wong Baker sliding pain scoring system to assess pain. The Wong Baker tool uses a series of 10 faces, from smiling to crying to identify pain levels. This tool is especially useful for assessing pain in children, young people and those with learning disabilities.

Staff prescribed, administered and recorded pain relief accurately. Staff had access to pain relief in the form of compressed gases such as nitrous oxide and medicines such as paracetamol. All medicines were documented on the electronic patient record.

Patients told us that they received pain relief soon after they needed it, or after they requested it.

The service had not undertaken any pain audits since 2020, which meant there was no assurance that pain management was managed well consistently. The trust told us that there was a pain audit scheduled for 2022/23.

Response times

The service monitored but did not meet agreed response times so that they could facilitate good outcomes for patients.

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

The trust was trying significantly to reduce conveyance to hospitals and increasing treatment of patients by phone or at the scene to help with pressure on the rest of the urgent and emergency care system.

The NHS constitutional standards are set out in the Handbook to the NHS Constitution:

All ambulance trusts to:

respond to category 1 calls in 7 minutes on average and respond to 90% of category 1 calls in 15 minutes.

respond to category 2 calls in 18 minutes on average and respond to 90% of category 2 calls in 40 minutes.

respond to 90% of category 3 calls in 120 minutes.

respond to 90% of category 4 calls in 180 minutes.

Emergency and urgent care

The times for response are those considered as the most clinically safe for the patient's assessed risk and to send a response to the sickest patients first. The categories are determined by a clinical triage system based on national standards with category 1 being the most seriously ill or injured patients.

In the last 12 months, the trust only achieved the NHS constitutional standards on one occasion.

In June 2022 data showed:

The average time for attendance to category 1 calls was nine minutes four seconds on average and 16 minutes 28 seconds for 90% (This measure shows the amount of time taken to reach 90% (9 out of 10) of all category 1 calls). This was in line with the England average which was eight minutes 36 seconds and 15 minutes 15 seconds, respectively. No NHS ambulance trust in England met the seven-minute standard.

The average time for attendance to category 2 calls was 35 minutes 31 seconds and one hour 14 minutes for 90%. This was better than the England average.

The average time for attendance to category 3 calls was two hours 46 minutes and six hours 33 minutes for 90%. This was better than the England average.

The average time for attendance to category 4 calls was three hours 38 minutes (worse than England average) and eight hours 46 minutes for 90% (better than the England average).

The latest data for June 2022 showed that nearly 3% of patients were conveyed to a location other than an emergency department. This was worse than the England average.

Data from January 2022 to June 2022 showed that 53% of patients were conveyed to an emergency department. This was slightly worse than the England average (51%).

The ambulance triage system and clinical intervention by trained staff recommended some patients were treated with clinical advice given remotely – usually by telephone in order to reduce pressure in the system and on crews. Data from January 2022 to June 2022 showed an average of 10.5% of patients were supported through 'hear and treat'. This was lower than the England average (12%).

The trust had also implemented 'see and treat.' This is when a person does not require hospital care but instead a paramedic or another clinician provides treatment at the scene, which could be in someone's home or in the community. Data from January 2022 to June 2022 showed an average of 33% of patients were supported through 'see and treat'. This was equal to the England average. Both these objectives had led to far fewer patients being conveyed to emergency departments. In the last three months, 2% of patients re-contacted the service within 24 hours following treatment and discharge at the scene.

Patient outcomes

The service monitored the effectiveness of care and treatment. In times of normal demand, it used the findings to make improvements and achieved mostly good outcomes for patients in line with national averages. However, with the rise in demand alongside the reduction in capacity due to delays, some patients were coming to unintended harm as the ambulance was unable to get to them in a clinically safe time. There was a clear approach to monitoring, auditing and benchmarking of outcomes for people receiving care and treatment.

Emergency and urgent care

The trust reported that in the last 12 months, 26 patients were reported through the incident management system as suffering severe harm due to delays in ambulances. However, these have related to potential harm caused or not prevented by the service. A review by the trust of incidents of serious harm due to delays in ambulances being on scene had been conducted.

The service participated in relevant national clinical audits. All ambulance trusts in England have been measuring and reporting against 11 ambulance quality indicators (AQIs), which allows performance to be compared with that of other services across the country.

AQIs included the conditions stroke (which occurs when the supply of blood to the brain is reduced or blocked completely, which prevents brain tissue from getting oxygen and nutrients), sepsis and ST-Segment Elevation Myocardial Infarction STEMI (which is a type of heart attack).

Outcomes for patients were positive and met expectations, such as national standards.

AQIs measured outcomes in the return of spontaneous circulation (ROSC), (e.g. signs of breathing or a pulse) for all out of hospital cardiac arrests. The latest data showed (February 2022) that 28.6% of all patients who had resuscitation commenced or continued by ambulance staff had ROSC at the time of arrival at hospital. This was equal to the England average. In the same time frame, data for the service showed 12.3% of patients who had an out of hospital cardiac arrest survived 30 days or more after the cardiac arrest. This was better than the England average of 9.9%.

In the same time frame patients were treated in slightly less time than the national average when receiving a catheter insertion for those needing an angiography for a definite myocardial infarction (heart attack). Angiography is a medical imaging technique used to visualise blood vessels and organs of the body.

In the same time frame data for stroke patients showed slightly better times than average for the time of the call and hospital arrival. Performance against the stroke care bundle was 96.8%. This was slightly better than the national mean for the same period of 95.8%.

The service performed well in the management of sepsis (severe infection) audit findings for January, February and March 2022 showed full compliance against the sepsis care bundle, no more recent data was provided by the trust.

Managers monitored patient outcomes on a monthly basis and shared this information with commissioners but not staff. The service produced a yearly quality account which included information on participation in national and local clinical audits, and the actions that have been taken consequently to improve the services provided. Improvement was checked and monitored by repeat audits at regular intervals.

Competent staff

The service did not always ensure staff were competent for their roles. Managers did not always appraise staff's work performance and hold supervision meetings with them to provide support and development. Ambulance crew were not provided with restraint training.

The trust did not ensure staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The trust did not ensure staff received all the specialist training for their role. Although the service had processes to ensure staff had the right skills and competencies, due to operational pressures, this was not applied. Clinical skills updates were not being consistently completed which impacted mandatory compliance.

Managers ensured that all professionally staff registered were registered with the relevant organisation which set and maintain standards for those professions, with the objective of protecting the public.

Staff told us that they did not receive refresher training in key areas such as supporting a patient experiencing a mental health crisis and restraining patients. The trust told us that they did not provide restraint training and ambulance crew would always look to deploy the least restrictive option and escalate to the trust's on call operational and tactical managers, senior clinicians and the police where required in a life-threatening scenario. The trust did not have a restraint policy.

Managers gave all new staff a full induction tailored to their role before they started work. The trust had a corporate and local induction process for all new staff. We spoke to a newly employed member of staff who confirmed they had received a full induction which met their needs to fulfil their role.

The trust did not always support staff to develop through yearly, constructive appraisals of their work. The service had a yearly appraisal process. This was a formal process to facilitate staff development, progress, training needs and career goals. Data provided by the trust showed that between 01July 2021 and 30 June 2022, 47% of staff had received a yearly appraisal. The service's target was 95% of staff to have had their appraisal completed. Registered staff were meant to have clinical supervision as part of the appraisal process. This included two shifts a year where their manager worked with them for a shift. However, local managers told us there was insufficient time to achieve this and it was a struggle to undertake even one shift a year. Data showed that in the last 12 months 42% of staff had completed a supervised shift with their line manager known as a 'ride out'. The trust told us there was a project linked to the clinical quality strategy looking at clinical supervision led by a consultant paramedic with the formation of the clinical supervision implementation task and finish group.

Managers at all levels informed us the COVID-19 pandemic and operational pressures had impacted the appraisal programme and that there was an action plan to complete staff appraisals. However, some managers shared concerns that the capacity of the managers and ability to release staff to complete the programme of appraisals and clinical supervision was not achievable.

The service had clinical educators who were part of the clinical education team and supported the learning and development needs of staff. However, some local managers were not sure what the role and responsibilities were of the clinical education team. For example, local managers would attend 'train the trainer' sessions and would then be expected to deliver local training to their teams but did not always feel competent to do so.

Staff told us it was very difficult to access training and courses for professional and career development and often had to be self-funded or completed in their own time.

Not all staff received training in how to care for a patient at the end of their life, data showed 24% of staff had received training. However, the trust told us that the training is delivered at every new starters induction and was included in the current year's key skills training for registered staff.

Local managers identified poor staff performance promptly and supported staff to improve. Local managers were responsible for staff support and for actions required to improve staff performance, for example, training needs or management of behaviours. Local managers told us that there was a process to manage and escalate poor performance and behaviour. We were given examples during the inspection which confirmed this.

Emergency and urgent care

Multidisciplinary working

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

Managers attended daily bed meetings with local NHS trusts and worked as a point of contact between staff conveying patients to hospital and emergency staff in hospitals. This helped to reduce staff waiting times in emergency departments, and enabled a smooth transfer of care, and released staff to attend their next call.

Senior leaders attended twice daily system calls where an overview was given of the current risks system wide. All providers were experiencing capacity issues including the acute hospitals, community hospitals, mental health and adult social care services.

We observed staff handing over effectively to hospital staff. The exchange of information was comprehensive and prompt.

Staff could access a directory of services which was a live database of all services available for patient care, for example GP surgeries, walk-in centres, dental services and district nurses.

Ambulance staff told us that team working between hospital and ambulance staff was good. All staff worked together to prioritise access for high acuity patients and deliver the best care possible to their patients.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The trust had a frequent caller team who supported patients that made multiple calls to 999. Frequent callers were defined by the Frequent Caller National Network as patients aged 18 or over who made five emergency calls or more relating to individual episodes of care in a month or 12 or more emergency calls relating to individual episodes of care in three months. Some frequent callers had long-term physical and/or mental health conditions and the trust gave examples of where staff worked with partners across the system to try and ensure patient's unmet needs were met, and frequent callers were reduced. Managers could make referrals to the frequent caller team via email.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, staff had not received training on restraint and there was no oversight of the use of restraint.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood their responsibilities in obtaining consent from their patients before any care or treatment.

We saw capacity to consent was a mandatory field on the patient record and the electronic system would not allow staff to complete a record unless this assessment was completed. There was also links to policies and guidance on consent processes to support staff.

Staff told us that they had not received training in patient restraint. This meant staff may not have the skills and knowledge to promote practice that avoids the need for restraint. In addition, the service did not have assurance that when restraint was necessary that it was used in a safe and proportionate way. This is because staff did not complete incident reports when restraint was used. The trust did not have a restraint policy.

Staff made decisions in patient's best interests when they could not give consent, considering patients' wishes, based on all the information they had available including information from families and carers.

We saw staff gained verbal consent from patients before taking observations or moving them.

Staff described and knew how to access policy and get accurate advice on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. However, not all staff had received MCA training, the latest data showed 56% compliance. The trust told us that MCA training was also included in safeguarding training in less detail. This meant staff may not have the skills and knowledge to undertake a mental capacity assessment on patients to ascertain if they had capacity to consent to care and treatment and act in the best interests of patients.

Is the service caring?

Good 

Our rating of caring went down. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. Throughout our inspection we saw staff caring for patients who were waiting in emergency departments. Staff maintained the dignity of their patients by ensuring they were kept covered and had clean sheets and gowns available.

All patients we spoke with could not praise the ambulance service and the staff enough. They felt safe, well looked after and supported by the staff. All staff were friendly and approachable, and all their needs were catered for despite any delays they experienced. For example, one patient told us "staff were amazing and caring."

Staff followed policy to keep patient care and treatment confidential. All staff we spoke with understood patient confidentiality.

We reviewed the NHS website where patients and their families could leave feedback about the care they received. We reviewed the last 10 reviews of which eight were positive and included "nothing but praise for the 3 that attended quickly and took him to hospital. professional kind and reassuring" and "The team was fantastic, caring and reassuring."

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff told us that COVID-19 guidance had now changed and it was easier for staff to support patients as family or carers could accompany them in the ambulance. We spoke to one relative during the inspection, who confirmed they were kept informed of their relatives' condition and were informed of the plan of care.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients who were feeling anxious or were agitated were taken to a quieter area.

Staff explained patients would be cared for in the privacy of the ambulance whenever appropriate, to maintain dignity.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. We saw staff talk to patients and provide reassurance during the time they were waiting in the emergency department.

Staff confirmed they undertook training on breaking bad news and gave an example of going above and beyond for a patient at the end of their life.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff told us patients had treatment options explained to them and signposted them to where they could access additional information. This was confirmed by a comment left by a relative on the NHS website which said "information available for both the patients and staff. One of them (ambulance crew) provided a lot of really helpful information regarding services for the elderly."

Staff talked to patients in a way they could understand, using communication aids where necessary. We saw staff talking and interacting with patients in a way they could understand. Staff explained that they did not use medical jargon when talking to patients and got to the same level as the patients when talking to them. For example, they would kneel when speaking to a patient using a wheelchair.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was a 'tell us what you think' page on the website which patients could access to give feedback. Patients could also feedback in writing or via email and there was a freephone number available Monday to Friday from 10am to 4pm. However, we saw there was no information on ambulances advising patients and their families how to give feedback on the service. Staff told us that they verbally told anyone who asked how they could give feedback.

Staff supported patients to make informed decisions about their care. Staff explained how patients were always involved in care decisions, for example, patients were involved in non-conveyance decisions. Patients who were discharged on scene and not conveyed to hospital were given information on what to do if their condition got worse.

Is the service responsive?

Requires Improvement ↓

Our rating of responsive went down. We rated it as requires improvement.

Emergency and urgent care

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, due to demand on the whole urgent and emergency care pathway, there were unmet needs for patients.

The service used a computer-based system to plan, using long-term data and analysis of demand and in response to the changing needs of a system or community. There were plans to cope with a change in demand in the service such as major incidents or adverse weather. The trust plans were flexible to accommodate increased demand, by increasing the number of emergency ambulances on the road and using the services of independent ambulances. This meant the service could quickly adapt to support the needs of the community.

The service had several different initiatives to try and reduce or limit admissions to hospital and ensure accurate referrals of patients to other services. There was a community falls team and the trust had designed and delivered a falls package which allowed community first responders (CFRs) to carry out a primary falls response to patients who had fallen in the community. CFRs make a primary assessment of the patient and if not seriously injured can mobilise them again or convey to hospital if required. This service allows a timely response to patients who otherwise may have to wait a long time for an ambulance. It also allows not only an early assessment for the patient but also early intervention such as making the patient comfortable, and if safe moved from the floor.

There was a frailty pathway which was a collaborative pathway with community teams, taking community therapists to frail patients at the time they call 999. The trust had a dedicated frailty team which was made up of GPs, occupational therapists, nurses and pharmacists. The role of the team was to assess frail patients in the community and offer support, for example after a fall, in order to avoid a hospital admission. Occupational therapists could undertake an assessment of the home environment to reduce the risk of falls. The service had a dedicated bed in nearby hospitals for frail patients who needed to be admitted to hospital. However, ambulance crews told us that this bed was often not available.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients living with mental health problems, learning disabilities and dementia. Staff had the support of a single point of contact to raise concerns or to leave notes for the patient's GP.

We saw the trust worked with others in the wider system and local organisations to plan care and reduce conveyances to emergency departments when not required. For example, the service could make referrals 24 hours, seven days a week to a community home treatment service to avoid a hospital admission. This service was for patients experiencing a deterioration in their health and were unable to manage at home without additional support.

The 111-service made direct appointment bookings for patients into emergency departments, primary and community care pathways. For example, the service had a joint same day emergency care (SDEC) pathway with nearby hospitals. SDEC provided specialist care for patients in designated areas within the hospital without the need for hospital admission. Ambulance crews phoned a dedicated phone number to make referrals prior to conveying patients.

Ambulance crews told us that patients were triaged incorrectly, and they attended a huge number of people who did not require an ambulance. This led to other patients who need the service experiencing a delay.

Staff could access a directory of services which was a live database of all services available for patient care, for example GP surgeries, walk-in centres, dental services and district nurses. The services have detailed profiles of who they can see, what they can treat, when they are open and how they are contacted. It is designed to divert patients into other local services rather than calling an ambulance and being transferred to hospital.

The region had specialist support from the helicopter emergency medical service and the hazardous area response team.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

Ambulance staff recognised and respected the need to provide individualised personal treatment and care as far as they were able. There were processes to engage hard to reach communities and links with various charities. For example, there were designated staff that engaged with the travelling community.

The service was fully accessible for deaf and British Sign Language (BSL) users, by using a remote BSL interpreter when calling 999. However, the trust did not provide data on how often this service was accessed.

The service used an electronic system whereby other healthcare professionals can inform the ambulance service of any particular patient needs with the patient's consent. A flag is placed on the electronic system which informs staff of any additional needs a patient has. The service used a 'history marking' system, where a note can be placed against a patient's address on the electronic patient record system used by staff to include of any useful information about the patient or their condition, such as language needs or directions to a difficult-to-find property.

The service had specialist bariatric ambulances permanently stationed at the three key locations that could be used to care for patients with a high body mass index. However, staff told us that there could be a delay whilst waiting for a specialist bariatric ambulances. For example, we were told of a recent delay of 45 minutes and the patient was at risk of deterioration in that time.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff understood how to support patients with specific needs such as those with mental health difficulties and those living with dementia. Staff who had experience had shared strategies for reassuring patients, for example, writing things down or drawing a picture. Staff explained, when appropriate or necessary, the patient's primary carer could accompany the patient.

The clinical notice boards displayed information and guidance for staff, for example, on the Paddock Wood notice board we saw information on basic medical Makaton signs that could be used for patients who had a hearing impairment. Makaton is a unique language programme that uses symbols, signs and speech to enable people to communicate.

A supporting transgender people leaflet had been produced to help operational ambulance staff when supporting transsexual people.

Not all staff were equipped to deal with violent or aggressive patients. This was because they had not received conflict resolution training. However, staff told us they were supported by local police forces when attending to patients with known histories of violence. A member of staff gave an example of when they had activated their personal alarm and the police were in attendance within two minutes.

Staff told us that translation services were available. However, staff said it could take a long time to get a translator and it was often quicker to convey patients to hospital where staff spoke a lot of different languages. We saw an example of this during the inspection when during handover to hospital staff a member of hospital staff said they spoke that language and could help to translate. Staff used a national tool known as the Wong Baker pain scale available on their electronic devices to aid communication.

Access and flow

Due to pressure already described, people were not able to access the service when they needed it at all times or in line with national standards. Not all patients received the right care in a timely way.

Handover delays

The service was struggling to meet national targets for response times and there were many instances when there were no ambulances to attend to high risk patients due to crews waiting patient handovers at emergency departments.

The trust measured the number of hours lost when patients waited on ambulances outside of emergency departments (ED), known as delayed admissions. They also measured the time it took for crews to hand patients over at emergency departments.

Handover start time is defined as the time the ambulance arrives at the ED, with the end time defined as the time the patient is handed over to the care of ED staff. National ambulance standards indicate handover should take place within 15 minutes of arrival at the ED. Data from 01 February 2022 to 31 July 2022 showed there were 6253 handovers of 60 minutes or more. In the same time period on average 38% of all handovers were completed within 15 minutes and the average handover time was 21 minutes.

Data showed for the previous three months a total of 4208 hours were lost due to delayed handovers.

Access to the service for patients was severely affected by rising demand and handover delays in emergency departments. This was not an issue exclusive to this trust and many hours were being lost nationally. Data showed from February 2022 to July 2022 at total of 38,665 hours were lost due to handover delays. There was also a growing number of patients calling the ambulance service and the 999 and 111 service being used when another agency would be more appropriate. Patients accessed 999 and 111 when they did not know where else to access support or other alternatives such as GPs, 111 or community services were not responsive.

The trust set a target of 15 minutes for staff to “wrap up” after they had finished caring for a patient to be ready to respond to the next patient. Data from February 2022 and July 2022 showed the average “wrap up” time was 17 minutes.

Data showed from May 2022 to July 2022, 660 patients who were category 3 patients were escalated to category 1. The category assigned to patients was upgraded due to the patients deteriorating condition; a clinician call back through patient pathways, clinician manual upgrade, operational upgrade, welfare call-back, length of time waiting and if the patient called back with a worsening condition.

Staff supported patients when they were transferred between services. Managers provided an interface between ambulance crews and staff at hospitals. The role facilitated the handover of patients and kept staff and patients informed of any delays. Staff told us that managers would attend when requested.

Emergency and urgent care

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them but sharing of lessons with staff was limited.

We saw there was no information within ambulances explaining to patients how they could make a complaint if they had concerns about their care and treatment. However, patients had made complaints. Between February and July 2022, the urgent and emergency care service received 502 complaints from patients and families. Of these complaints the majority (30%) of them related to staff conduct or attitude.

Local managers investigated complaints and identified themes. There was a local system of monitoring themes and trends of incidents. Local managers told us that the main themes of complaints related to the behaviour and attitude of staff. Local managers addressed these individually with the staff member involved and a record of this was kept on the staff member's personal file.

Managers did not share feedback from complaints with staff, therefore learning was not used to improve the service. No members of staff could give us examples of any learning from complaints.

Is the service well-led?

Requires Improvement ↓↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Local leaders had the skills and abilities to run the service. The majority of local leaders were visible and approachable in the service for staff. However, staff told us that senior leaders were not visible or approachable and did not feel they understood and managed the priorities and issues the service faced. Staff were not supported to develop.

Throughout this section when referring to a particular grade of managers we will refer to operational teams' leaders and make ready managers as local managers, operating unit managers as local senior managers and managers above this grade as core service leaders.

The urgent and emergency care service was led by the executive director of operations, they were supported by a deputy director and two associate directors and a head of community resilience. The urgent and emergency service was split into two geographic locations; East and West. Each had five operating unit managers. Operating unit managers were supported by make ready managers and operational team leaders.

The service was under intense pressure. Local senior managers and core service leaders told us they attended meetings every day to assess the pressure on the system and find ways to ease it. However, they told us that they were constantly "firefighting" and managing different and complex issues. They felt if they had the correct support from other areas within the trust they could focus on finding permanent solutions to some of the challenges the service faced.

Local senior managers and core service leaders told us that they did not have the autonomy to make decisions within their service. In addition, they did not feel the executive team trusted them to make decisions regarding their service.

This was due to a control and command style of leadership by the executive team during the pandemic. This had impacted negatively on the culture, cohesiveness of the service and patient safety. However, some of this group of managers told us that there were early signs of a move away from this style of leadership. They had noticed newly formed effective relationships and were working better as a leadership team.

Communication at all levels was poor. Staff provided us with examples of when changes made were not always communicated effectively. Staff explained that this was in part due to the number of emails they received daily and that almost every email was marked as important. Due to operational challenges, they did not have time to read every email so important emails such as change to practice or policy might be missed. In addition, not all stations had regular staff meetings where information could be communicated. The reasons for not having regular meetings was complex but included poor attendance and managers not having answers to questions and concerns raised by staff at meetings. Core service leaders told us that regular station meetings were being restarted and if staff came in to attend them in their own time, they could claim overtime.

Managers at all grades within the core service demonstrated that they were aware of what was happening on the front line and recognised the challenges staff faced. However, they lacked capacity to invest in staff engagement and finding long term solutions to the issues staff faced daily. In addition, they told us that there was a one-way dialogue with the executive team. Staff felt they were told what to do by the executive team despite operational decisions made by the executive team that impacted them directly.

Managers of all grades within the service voiced frustrations of having to sort out issues which were not within their core responsibilities and a lack of clarity on trust policies. In addition, they told us that the human resources department was not supportive or consistent in their approach. For example, there was not a clear and consistent approach to the management of sickness absence.

The trust had engaged with hospital trusts and other care providers to attempt to improve the flow of patients transported to hospital and reduce handover delays. The trust had introduced innovative ways (previously mentioned in report) to ease the need for some patients to be transported to hospital. However, further work was needed to address the current challenges the service faced.

Staff told us that generally their immediate managers and local senior managers were visible, supportive and approachable, but there were mixed views on how supportive and visible managers were above that level.

Core service leaders and local senior managers told us that for issues requiring action from the executive team there was often delays in getting a response. This impacted on their ability to deal with issues and concerns at a local level in a timely way. They were concerned about the impact the delays were having on staff wellbeing when they were waiting for outcomes. This in turn led to a perception by staff that they were not being listened to and their concerns were not taken seriously.

The service did not have a clear local leadership strategy or development programme, and there was no succession plan. There were limited opportunities for staff to develop their skills and take on more senior roles. Most managers at all grades had not received any formal management or leadership training. However, a trust leadership course had just commenced.

Core service leaders told us that the trust had identified staff development and training as a key focus and that a new strategy to support staff development at all levels had been developed and was underway, with a trajectory for completion by April 2023.

There was a disconnect between all grades of managers of the service and the executive team. Staff told us there was limited visibility of the executive team. However, some had seen relationships and communication improving recently and were positive about the appointment of the interim chief executive officer.

Core service leaders told us that due to limited capacity in the human resources department there were delays in recruitment processes. This meant managers at all levels were trying to facilitate recruitment within the service which took time away from managing other priorities such as staff development.

We were given examples of service leaders visiting make ready centres and sending emails to staff on the frontline to acknowledge the pressures staff were under and to thank staff for the hard work they were doing.

Vision and Strategy

The service had identified four key areas it wanted to achieve and a strategy to turn it into action. The service had developed alternative patient pathways with relevant stakeholders. The vision and strategy were not focused on sustainability of services and further work was needed to align local plans within the wider health economy.

The trust values were: taking pride, demonstrating compassion and respect, acting with integrity, assuming responsibility and striving for continuous improvement. All staff we spoke to knew what the trust values were.

The trust had an improvement journey which included trust priorities for 2022/2023.The priorities were: people and culture, quality, leadership and engagement, responsive care and improvement journey. Oversight and monitoring of delivery of the priorities was through, weekly, fortnightly and monthly meetings.

Staff and managers at all grades told us that there was a lack of an overall strategy for the trust. Managers at all grades were unaware of what the vision and strategy of their service was and there was a lack of clarity on areas the service should focus on. Core service leaders told us that there was a lack of a long-term vision or strategy for the service as they were constantly “firefighting” and the trust had a reactive not proactive approach to challenges. There was a lack of insight or succession planning for the service as this had not been communicated by the executive team.

Culture

Not all staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work but did not provide opportunities for career development. Not all staff felt they could raise concerns without fear.

A lack of effective communication within the trust drove a poor culture within the service. Staff described feeling frustrated and burnout and that senior leaders did not understand or respond to the challenges or concerns they raised.

Some local senior managers described that harm to patients, caused by delays in reaching them, had become normalised as a culture.

Due to operational pressures, long waits outside emergency departments, late finishes and limited access to training and development was impacting on staff morale and feelings of not being valued by the organisation.

Staff were committed to delivering the best care possible to their patients and demonstrated these values in all patient interactions we observed.

Staff did not always feel positive and proud to work in the organisation. Capacity issues were impacting on staff welfare. They expressed concerns around their ability to deliver the best care to the patients due to delays at and attending patients who did not need an ambulance reducing their ability to support patients in the community. Delays meant that staff frequently finished late and missed meal breaks and crew skill mix was all impacting on staff morale.

Actions were being taken to address behaviour and performance that was inconsistent with the values of the organisation. However, issues within the HR department and delays in action from the executive team meant there were delays in decision making. Staff were not confident of the application of HR policies and processes.

The service encouraged, openness and honesty at all levels within the organisation. Managers at all levels and staff understood the importance of staff being able to raise concerns. However, not all staff felt safe to raise concerns. For example, staff told us that they did not approach the freedom to speak up guardian as they were not assured their concerns raised would remain confidential.

There were not effective mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. Staff appraisal levels were low, training opportunities and opportunities for progression were limited.

Staff were not assured that core service leaders were aware of safety and well-being issues. However, we found that operational pressures were impacting on their ability to take action to address concerns raised.

The trust had initiatives to support the wellbeing of staff. There were welfare trolleys and vans which provided hot drinks and snacks, wellbeing advocates and an extra day's annual leave for staff. There was an employee assistance scheme provided around the clock by an external provider with immediate contact with a trained counsellor offered to staff. However, the pressure on staff was taking its toll. Staff said they recognised there was support for them, but many said they did not have time or the energy to use it and, in most cases, it needed to be accessed outside of work hours.

In the most recent staff survey (2021), 71% of staff trust wide said they would feel secure raising concerns about unsafe clinical practice (65% in 2020 survey). Twenty nine percent of staff said they were confident that the organisation would address their concern if they spoke up about anything that concerned them. The trust scored slightly lower when compared to other ambulance trusts overall for the we each have a voice that counts section of the survey.

In the same staff survey, trust wide the percentage of staff experiencing harassment, bullying or abuse from patients service users, relatives or the public in last 12 months, was 54% for white members of staff (worse than national average) and 45% for black, ethnic and minority staff members (worse than national average).

In the same staff survey the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months, was 31% (worse than national average) for white members of staff and 34% (worse than national average) for black, ethnic and minority staff.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Not all levels of staff were clear about their roles and accountabilities. Staff and leaders did not have regular opportunities to meet, discuss and learn from the performance of the service.

Emergency and urgent care

The trust had put in place a strategic and tactical response to the COVID-19 pandemic. This was focussed on three key areas: to manage demand, increase capacity, and system working. The service had been at REAP level 4 (extreme pressure) since July 2021 and this was only reduced to level 3 (severe pressure) in January 2022.

Core service leaders told us that they were focussing on three key areas: staff appraisals, key skills training completion and patient care. Recently the leads of the two different geographical locations, East and West, had formed effective relationships, had joint meetings and met regularly with the executive lead to monitor progress against these three areas. This also meant a more consistent approach across the core service and the expectations were the same of all managers across the service. However, we found silo working across the service and good initiatives were not shared. For example, one station had a system where each member of staff had a score card which included information such as welfare checks, clinical supervision, feedback on performance and key skills compliance, however this had not been implemented across the service.

Not all levels of staff were clear about their roles and accountabilities. Some local managers told us that there had been a "role creep" on their role, and they were often asked to undertake tasks which they had not had sufficient knowledge or training to undertake. For example, local managers were asked to undertake infection prevention and control audits without specific guidance to do so. There was frustration amongst local managers that they were being asked to carry out responsibilities that should sit with other functions of the trust such as HR or scheduling as this took time away from supporting staff.

Staff and leaders did not have regular opportunities to meet, discuss and learn from the performance of the service. We found staff meetings were inconsistent across the service. Some stations had regular meetings and a briefing folder with information discussed at meetings for staff to review if they were not able to attend the meeting. Staff could join meetings virtually and listen back to the meeting. Core service leaders recognised the importance of staff meetings and supported staff to claim overtime to attend the meeting in their own time.

The team B (core service leader meetings) and C (local senior lead meetings) covered governance issues such as risk and compliance, clinical updates, infection control and staffing. We reviewed meetings minutes from these meetings. The minutes did not follow a standardised format and agenda items were not consistent. Therefore, we were not assured that there was standardised and robust oversight of governance across the different operational areas.

Management of risk, issues and performance

Leaders and teams used systems to monitor performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events although were struggling with how to manage the significant increase in demand in urgent and emergency care.

With the exceptional pressure on the system, the risks to a safe and effective performance of the ambulance frontline service was high. The ambulance service was set up to cope with unexpected events but staff at all levels were concerned about the ability to manage performance with the current increase demand on urgent and emergency care capacity.

The trust had developed a comprehensive action plan following our focussed inspection of the service in February 2022. We saw each action had an assigned owner and timeline for completion. However, senior local managers told us that they had not seen the action plan and had not been involved in developing the action plan. They described not seeing any action or direction since the inspection.

Emergency and urgent care

The urgent and emergency care service had a comprehensive up-to-date risk registers. The highest risks were those outlined throughout this report. These were; because of the failure to deliver the key skills to all appropriate staff, there is a risk that that overall staff confidence and competence may reduce, there is a risk that patients will come to harm due to inability to provide a timely response and staff vacancies. All risks had mitigations and had been reviewed within the last 12 months. Managers at all levels were able to describe to us the risks that faced their area. The trust had a risk management policy and procedure which covered the process for recording the closure of risks.

Managers of all grades were aware of the risks for their areas. Core service leaders had oversight of the risk register and worked closely with the executive lead of the service to monitor and mitigate risks. There were effective governance arrangements for the oversight of third-party providers. There was a dedicated manager to oversee third party providers, who met regularly to discuss performance, staffing, incidents and complaints. A yearly compliance audit was undertaken to check that staff were qualified, skilled and competent to undertake their role.

There was a programme of clinical and internal audit to monitor quality and operational processes and systems to identify where action should be taken. For example, the service undertook an audit of inter facility transfers (when a person is taken to another hospital by ambulance) to assess if the transfers were appropriate and if any improvements could be made.

The service used monthly scorecards for each of its operations areas. These scorecards provided oversight of several aspects of service performance such as response times and operational productivity, key performance indicators (such as numbers of journeys undertaken complaints, incidents and safeguarding data), and workforce data.

The trust had seen an increase in reported violence and aggression towards staff in the last three years. Therefore, staff could wear a body worn camera if they wished and the footage could be used as evidence in cases of violence or abuse.

The trust carried out serious incident and harm reviews. However, the quality and learning from these was inconsistent. There were missed opportunities to identify trends and themes. When learning was identified, it was not always shared with staff. There was a lack of audit processes to check if identified changes were embedded or were keeping people safe.

There were low levels of confidence in how incidents were managed. The service was not proactively learning to prevent incidents reoccurring. However, this was a trust wide issue and not specific to this core service. Some staff did not always report incidents and when they did, they did not always receive feedback to evidence that learning had occurred as a result.

The pandemic placed an increased pressure on the service to manage capacity. We had serious concerns about patients categorised as a 3 or 4 call (categorised as those requiring non-urgent assistance). The clinical risks of those waiting was not always appropriately managed as there were insufficient numbers of practitioners employed to monitor the clinical risk in the backlog of patients awaiting an ambulance. Ambulance crews told us how upset and worried they were about patients experiencing long waits. Staff gave us examples of attending calls where patients' conditions had deteriorated whilst waiting. Staff also told us of calls attended where an ambulance was not necessary. This placed an unnecessary pressure on an already stretched service.

There were several risks relating to medicines management. Paramedics did not have their competencies assessed to supply or administer specific medicines. The trust was mitigating the risk by using a competency-based questionnaire and had recently introduced an eLearning patient group directions module. Paramedics could self-assess their own competency. However, core service leads told us that this had been slow to roll out because of the number of paramedics that needed to complete the training module.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

There were clear and effective service performance measures, which were reported and monitored. These performance measures were shared internally and with external stakeholders.

Managers at all levels understood performance targets including quality and data from audits. Information was shared across the service to key committees and oversight groups to provide assurances on the quality, risk and performance within the service.

IT systems were integrated and secure. There was an electronic records system. All crews had access to handheld mobile devices which were password protected and designed to capture data in real time. The devices meant staff could report incidents and safeguarding concerns in real time without having to report to their base. Information was kept confidential and stored securely. However, there was no audit tool for the electronic patient record system, therefore the service had no assurance on the quality of information inputted.

The service used a computer-based system to plan to use long-term data and analysis of demand and in response to the changing needs of a system or community.

Engagement

Leaders and staff had limited engagement with patients, staff, equality groups and the public to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Information was shared with staff by email and newsletters. However, staff told us that they did not have time to read all the emails they were sent. Staff felt that information flow was one way and there were limited opportunities to feedback through meaningful staff engagement.

The trust had a patient and family/carer experience strategy dated 2020 to 2025 which was developed in collaboration with patients, their carers and other key stakeholders including members of the council of governors, the inclusion hub advisory group, commissioners and Healthwatch. The strategy helped to identify areas that the trust does well in addition to those where change is needed. However, the service did not complete any patient satisfaction audits or surveys from patients conveyed to hospital.

Anyone could become a member of the trust and there were ‘annual members’ meeting to celebrate all the excellent work the staff and volunteers did and to highlight areas where the trust were working hard to improve. The trust produced quarterly newsletters for staff.

There were twice weekly conference calls open to all staff which discussed current and projected operational concerns, wider updates across the trust, new and important information and offered the opportunity for questions. However, staff told us they were not able to attend these as they were too busy.

Make ready centres had a virtual and paper-based suggestion box, where staff could make suggestions on improving issues that impacted them. We reviewed the electronic log for the suggestions that staff made and saw some actions had been taken and if it was not possible to make any changes a full rationale was provided to staff.

The service used value cards, these were cards with the values of the trust which staff could complete and give to a staff member in recognition of how they had demonstrated the trust values.

Staff participated in a staff survey to gauge their feedback on the delivery of services and in shaping the culture of the organisation. The most recent staff survey (2021) had a response rate of 61% for the trust. Planned areas of focus identified from the survey response was appraisal, development and access to training as well as recognition for work and feeling valued.

In the same staff survey 40%, of staff trust wide said they looked forward to going to work, (52% in 2020 survey). Thirty six percent said they would recommend the trust as a place to work (50% in 2020 survey). The overall staff engagement score was slightly less when compared to other ambulance trusts.

In the same staff survey the percentage of staff experiencing discrimination at work from manager or team leader or other colleagues in last 12 months was 12% (worse than national average) for white members of staff and 34% (worse than national average) for black, ethnic and minority staff members.

The service promoted equality and diversity in daily work. The trust developed a reasonable adjustments passport in partnership with the disability and carers network. This provided a framework for colleagues to approach their managers to discuss how their particular circumstances, disability or health condition impacts them at work. Electronic stethoscopes were available for staff who had a hearing impairment and there was a variety of online tools and guidance to support accessibility in IT systems. Staff with a hearing impairment could wear a special badge on their uniform which alerted staff and patients. We were given other examples of reasonable adjustments made for staff to ensure they could fulfil their role.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population. For example, the service worked collaboratively with hospitals to develop new pathways to avoid hospital admissions.

Information was shared daily with the wider system to identify performance and escalate delays and extended waits at the emergency departments to discharge patients.

For the first time, the trust honoured the achievements of paramedics around the world on 08July 2022 the birth date of Dominique-Jean Larrey, the man who was considered to be the father of modern-day ambulance services. In support of the event, the trust shared stories from paramedics across social media channels.

The trust had an inclusion hub advisory group (IHAG) who advised the trust on effective engagement and involvement relevant to service design during both development and delivery of services. The IHAG met quarterly, two nominated

representatives of the IHAG were members of the inclusion working group (IWG) which provided a two-way flow of information. The IWG monitored and reviewed patient and public involvement and engagement activity and received regular updates on progress. Simple engagement took place virtually by email or survey, a single or series of focus groups, bespoke workshops or large-scale engagement events were organised as appropriate.

We saw an example of staff engagement when the kit bag staff carried containing all the equipment was changed. The trust provided rationale to staff why the bags needed to be changed, then gained feedback from staff via a survey once the bags had been changed to check they met the needs of staff.

The trust presented staff with either a coin or medal in recognition of their work to support the Covid-19 pandemic.

Some make ready centres had introduced staff engagement sessions, these were less formal events with chat, information, updates, discussion, and pizza.

Each make ready centre had a different approach to undertaking staff meetings or opportunities for staff engagement, these were decided by local managers taking into account the specific needs of the staff or based on how well they had previously been attended. For example, the Thanet and Paddock Wood make ready centres undertook fortnightly meetings virtually which were recorded for staff to listen back to if they wished. Polegate and Hastings make ready centres undertook staff engagement meetings once every three months. The Chertsey make ready centre produced a monthly newsletter that went out to all staff with updates for the previous month.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

All staff were committed to continually learning and improving services. The command and control approach in use prevented innovation in the service. Senior local managers told us that they felt they were not trusted to try new innovations or when they did these were stopped, the reason given by the executive team was that any innovations had to be consistent across the trust. We were given many examples of innovations that had been stopped. For example, one make ready centre employed a mental health practitioner, staff feedback about the support they provided was overwhelmingly positive particularly during the pandemic. The current post holder was leaving, and the funding had now been withdrawn for the post.

We found that the different stations worked in silos, we found examples of innovation, but these were not shared and replicated across the service.

The trust was undertaking a new study to investigate live streaming video from accident scenes. The study is set to examine the impacts on decision making of NHS 999 emergency service staff being able to see live streamed footage of trauma incidents through the smartphones of people calling the service. The study will test the use of state-of-the-art technology, for trauma incidents. The technology provides the ability for those calling emergency services to instantly share live video from their mobile device. The current study will examine if the technology works in different conditions,if the general public are willing and able to use the technology and if using the technology causes any psychological harm to either callers or dispatchers.

Resilience

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Staff received suitable training for their job roles which included enhanced training for HART operatives. Managers provided records which showed good compliance with the training schedule. However, physical competency assessments had been delayed due to a new curriculum being released from the national body that over sees this.

The mandatory training was comprehensive and met the needs of patients and staff. Staff needed to complete more training for their HART role and there was a scheduled week for this training to be performed every seven weeks. Managers ensured that rotas were completed in advance so that staff had the protected time to complete their training.

Staff completed added training courses required to become a HART operative. This included:

Training in the use of Personal Protective Equipment (PPE) such as Powered Respirator Protective Suit (PRPS), Civilian Responder 1 (CR1) suits, Breathing Apparatus and Gas Tight Suits.

A three-week residential Incident response unit (IRU) training module which covered clinical training, Chemical, Biological, Radiological, Nuclear and Explosives (CBRNe), equipment, vehicles, team building, welfare and command & control.

A three-week residential Urban Search and Rescue (USAR) training module which covered issues such as safe working at height; specialist clinical training such as crush and blast injuries, suspension trauma, triage and confined space medicine.

A three-day Inland Water Operations course featuring flood theory, water incident organisation, multi-agency working, self-rescue techniques, bank-based rescues, river crossing, wading techniques, working in boats and specific clinical issues related to water.

Staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff completed training modules which featured these topics as part of the trust's mandatory training programme.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept records to demonstrate that staff were qualified to perform their roles. The Head of Resilience and Specialist Operations handled the oversight of enhanced training for HART operatives and they shared this with operational managers when

needed. Managers supplied records which showed that staff had completed most modules to the internal targets of the the trust. When the target was not achieved in certain modules, managers expressed it was due to the next national course not being available for staff to be enrolled on. All modules had over 85% completion except for physical competency assessments which were outside the service's control.

Senior managers monitored the service's command training records. The matrix showed that the service had suitable cover for tactical command and national incident liaison officers. NARU guidance does not specify a requirement for training to be renewed for command and tactical courses. The trust key performance indicator for the renewal of training of command and tactical staff was three years. The matrix showed that six of the eleven trained tactical command staff had received an update to their training within this.

Some staff we spoke with expressed that they had been asked to be a back-up for an operational team leader and had not been given the required training to perform the role. Records shown did not list these staff members as part of the matrix.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, but the training was not always at the right level for their role.

Staff received training specific for their role on how to recognise and report abuse. Staff were trained at level two for adult and children safeguarding. Records for both sites showed a 100% completion rate.

However, there was a low completion rate for level three safeguarding training which is a requirement for paramedics. At the Ashford site 56% of staff had completed the training and 48% of staff at the Gatwick site.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff reported all concerns to the NHS duty safeguarding lead and the safeguarding lead for the service. Managers and staff told us that safeguarding referrals were rare due to the unique remit of the service.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Managers and staff, we spoke with understood the process. However, they had not needed to make a safeguarding referral in the last 12 months.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment clean, however some areas of the premises were not visibly clean.

Areas and equipment were mostly clean and well-maintained, however there were areas that were not visibly clean. Staff kept their vehicles clean to meet Infection, prevention and control (IPC) standards set by the trust. 10 vehicles were inspected during the inspection visits. All vehicles we saw were clean and well kept, however we did not see evidence of a deep cleaning schedule for the vehicles and signage on some vehicles did not show when they were last deep cleaned. The garages of both sites were mostly clean. However, both sluice rooms had cleaning equipment, which was not stored correctly, and the sluice rooms were visibly unclean. Staff told us that the cleaning for the sluice areas was conducted on a weekly basis but there was not a paper record to support this being completed. The Gatwick site also had cluttered areas of unused equipment in the main garage area. Staff told us that this was due to space restrictions. Observations from the inspection were not seen to impact directly on patient safety

Resilience

The service performed well for cleanliness. Staff had training in IPC which formed part of their mandatory training. Staff had access to washing facilities. Managers said that IPC audits were limited to hand hygiene audits only due to the specialised nature of the service. Managers had an agreement with the IPC department of the trust to limit this activity. However, managers could not supply these audits when we requested IPC audits after our inspection. Managers explained that the application of this was difficult for managers to perform. Managers had reported this to the trust and a compromise was reached where managers were asked to talk with staff members regarding hand hygiene when at base. Managers were unable to show us evidence that this had been completed.

Managers were sometimes unable to provide us with audit data we requested. For example, we asked staff for deep cleaning records associated with all vehicles used by the fleet. This information was unavailable, and we queried IPC audits with managers following our inspection. Senior managers of the service told us that IPC audits had been reduced with board approval. Senior managers also said that audits associated with patient records were also not conducted. Managers told us that this was due to the limited number of records available for an audit.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff showed awareness of IPC principles but expressed that the specialised nature of their job meant that at times it was difficult to apply in emergencies. Staff showed the enhanced PPE that was used by the resilience team and the checks associated with the equipment. Equipment was in a good condition and staff were expected to maintain this equipment, reporting faults if identified to their line manager.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe. However, equipment was not always managed well. Staff were trained to use equipment where needed. Staff managed clinical waste well.

Staff did not always carry out safety checks of equipment and vehicles. Staff checked equipment on vehicles twice a week on a Monday and Friday. However, staff were not always able to complete the checks if a response call was received. Staff showed the process of setting up a vehicle and the checklist used to check equipment. Staff used an electronic checklist which asked a series of questions to ensure equipment needed for the vehicle was available. Managers could run a report to see which items were missing.

We saw 10 vehicles across both sites. Staff showed five vehicle equipment checklists and completed the process for us. There were two vehicles that did not hold the required equipment when matched to the electronic checklist. Staff could give valid reasons for why some equipment was missing, but there was no written evidence that this had been shared with managers. For example, all vehicles reviewed did not have incident ground tech equipment. Managers agreed with staff that the vehicles did not need incident ground tech equipment. However, the vehicle checklists still included this.

Equipment was also seen on some vehicles that wasn't on the electronic checklist. For example, gas monitors were seen on one vehicle. Some equipment in bags lacked individual checklists that confirmed what should be inside. Staff were also not given prompts to check the expiry dates of some items such as saline flushes and pots of water on their vehicles.

Vehicles had primary and secondary grab bags which had equipment that staff checked using a coloured tag system to ensure they were ready for deployment. Staff completing a grab bag check would place a green tag on the bag and write an expiry date which would show when the bag should next be checked. However, we did not see an audit system or electronic breakdown of items that should be in the bags. Staff we spoke with felt this was ok and that there had not been any incidents which had been reported from the tag system.

Resilience

Managers were required under NARU standards to complete an asset register of all equipment and vehicles at the resilience service across the two locations of the trust. Managers told us that the asset register had been under development for the past two years and that two staff members were given responsibility for this. Managers showed us the system but acknowledged that it wasn't currently accurate. Managers told us that the asset system ran using electronic barcodes, but we saw large amounts of equipment which had not been assigned a barcode yet. Managers also confirmed that equipment data from the electronic checklist was used to update the system. Due to the checklists not being correct, we could not be assured that managers had the oversight of what equipment they had and where is was located.

Managers explained to us the oversight processes for NARU vehicles held at both locations. One vehicle was found not to be in operational working order and was taken off the road during our visit. Managers and staff expressed that they did not hold responsibility for the vehicles but we did not see arrangements or policies that clearly identified who was responsible for the vehicles and who held responsibility for their maintenance and upkeep.

Senior managers expressed that following our observations, they were developing policies and procedures around this aspect of the NARU assets.

The design of the environment followed national guidance. Staff were able to explain the layout of both sites and could explain where equipment and vehicles were stored. Both sites were secure and could only be accessed by staff cleared to enter the area. However, visitor passes could access the HART garage at Gatwick, which managers expressed was checked through staff intervention.

The service had suitable facilities. Both sites were suitable for the activities of staff. Staff told us they were happy with their facilities and praised managers for allowing them to develop gym spaces to ensure they could support their training for physical competency assessments. The senior manager said that the Ashford site still lacked space for some activities, but they were satisfied with the present arrangements.

The service had enough suitable equipment to help them to safely care for patients. Staff felt they had enough equipment to perform their roles.

Staff disposed of clinical waste safely. Staff could explain clinical waste processes at both locations. Managers provided information on the multi-disciplinary approach to unique clinical waste encountered by the service. For example, managers expressed that police would normally keep contaminated clothing so that it could be forensically explored. Managers said that all clinical waste would be managed in consultation with their partner organisations and they had access to a department of environment, food and rural affairs (DEFRA) and Chemical, Biological, Radiological and Nuclear (CBRN) team line for advice.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff identified deteriorating patients and escalated them appropriately. Staff were able to give examples of care where they took suitable action and escalated care where needed. Managers had policies for the safe and effective escalation of risk, however some of these policies were under review. Staff widely adopted the current policies where practical due to the specialised nature of the service. However, we did not see any examples of recorded risk assessments.

Resilience

Staff shared key information to keep patients safe when handing over their care to others. Staff gave examples of working closely with other first responders who represented the ambulance trust or other emergency services. The transfer of patients to other locations such as hospitals was not handled by the HART team as other vehicles would be available to do this. Staff would hand over relevant information to other staff members at the incident where needed prior to a transfer occurring.

Staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave staff a full induction.

The service did not have enough staff to keep patients safe. Managers were open about the staffing challenges that the department had faced. HART teams were expected to be made up of six HART operatives which included an Operational Team Leader. This was based on the NARU recommendations for resilience services. The trust had made a decision to allow teams to continue to operate with a minimum of four HART operatives when required and these teams would be backed up by a second team, which provided a safer system of work.

Between the date range from January 2022 to July 2022 for the Ashford and Gatwick locations. Managers breached their policy on 10 occasions with 6 occasions in Ashford and 4 occasions at Gatwick.

Senior managers told us that the trust had identified staffing as a concern on their risk register for the trust and that the decision to reduce the HART teams to four had also been risk assessed. Senior managers told us that this was a temporary arrangement and that funding from NARU would be available next year to improve the staffing levels. Managers had made advanced strategic plans regarding how this money would be invested in the HART service.

Managers accurately calculated and reviewed the number of staff needed for each shift in accordance with national guidance. Managers prepared rotas six months in advance. Managers were concerned with staffing capacity due to staff sickness and time owned in lieu for staff who were available. Managers at the Gatwick site were concerned as they expressed they were working to capacity and if one HART operative became unwell or unable to attend their shift, it would not be possible for the department to meet NARU's recommended team size of six.

The number of staff matched the planned numbers. Managers felt that despite the shortage of staff, they were encouraged to take overtime shifts when available. However, staff and managers expressed that this was becoming harder due to the stress on healthcare services. Staff also expressed that they would be more motivated to work for normal operational ambulances as the rates of pay were better and their clinical skills would also be used more frequently which aided their own professional development.

The service had low vacancy rates. Staff vacancy rates for Gatwick were 3%. Staff vacancy rates at Ashford were 0.3%. Senior managers expected these rates to increase once funding was confirmed and implemented with NARU for more staff.

The service had reducing sickness rates. Staff sickness rates for Gatwick were 8%. Staff sickness rates at Ashford were 10%. Managers did not have flexibility with staffing because of these rates of sickness.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Resilience

Staff completed patient records after being called to an incident and used a patient electronic record system to update their actions. Due to the limitations of the inspection and the specialised function of the service, we were unable to review patient records when we visited the service.

Managers confirmed there was not a specific audit process for the HART service patient records. Managers expressed that patient records were low in quantity and would have been combined with the operational unit data of Gatwick and Ashford where the trust concentrated their audit programme.

Medicines

The service used systems and processes to safely administer and store medicines.

Staff followed systems and processes to administer medicines safely. Staff received assistance from the make ready centre staff where they were based when preparing primary and secondary grab bags for medicines. Staff used a tag system for grab bags that prompted them to know whether the medication in the bags was in date. Staff reviewed two grab bags with our inspection team and all medicines were in date. Staff used a date written on the security tags as a reference for when medications needed to be renewed.

Staff stored and managed all medicines safely. Staff stored medicines securely in a locked room that required fingerprint verification to access. Controlled drugs were kept securely in a separate room for critical care paramedics and staff told us that it would be unusual for the HART team to carry this medication as a first response service. Pain medication was available and prepared in the grab bags.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service.

Staff mostly knew what incidents to report and how to report them. Staff were able to explain the process for recording an incident using the electronic recording system for incidents. Most staff felt they understood what incidents should be recorded but there was some variation in the answers given.

Staff raised concerns and reported incidents and near misses in line with trust policy. There were four incidents recorded in the past 12 months that included the HART team. However, no incidents had been created by the HART team. Managers said that incident reporting was low as the service was used in combination with other ambulance services.

Managers did not share learning with their staff about never events that happened elsewhere. Managers relied on their team leaders for each HART team to conduct safety huddles and handover key messages. Staff did not minute their meetings. Managers could not provide any learning from incidents that the HART team were involved with but did express that the number of incidents encountered by the team was low.

Staff understood the duty of candour. Staff could describe what the duty of candour was and how it should be applied. No incidents had been reported by the service and therefore we could not see any examples of the duty of candour in use. The electronic system for incidents did prompt managers who were reviewing the incident to consider and act if the duty of candour process was needed.

Resilience

Staff did not always receive feedback from investigation of incidents. There were no examples in the last 12 months of incidents that required feedback from managers to their team. Managers said that if there was, relevant feedback for the team following an investigation of an incident would be sent by email. There was not a meeting structure at the service for the review of incidents and no meeting agendas where incidents were a regular item.

Staff did not meet to discuss the feedback and look at improvements to patient care. Staff could recall incidents being discussed informally but as they did not meet the threshold for reporting, no learning was considered. Managers did not have formal structures to look at improvements from incidents. Managers said that due to the small number of incidents the service encountered, this did not feel needed.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff and managers followed national guidance when planning and preparing the service. However, they were not always able to meet NARU recommendations for equipment and staffing.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff showed awareness of the Mental Health Act and the associated code of practice. Staff could explain how they assessed whether patients had capacity and how they supported patients with decision making.

Nutrition and hydration

Staff gave patients enough to drink to meet their needs.

Staff had drinking water available to patients when they arrived at a location. Food was not supplied due to the remit of the service.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. Staff and managers could give examples where pain relief was both assessed and administered. For example, a patient who had suffered a fracture to both of their legs required immediate pain relief. Staff administered pain medication through a rapid inhaler device which provided fast acting pain relief.

Patients received pain relief soon after it was identified they needed it or they requested it. Staff had pain medication available with quick access to ensure that patients received pain relief when it was requested.

Resilience

Response Times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

During our last inspection, we found that response times were not being monitored by the trust for the service. During this inspection, we saw two key performance indicators (KPIs) that had been developed. Managers checked a response target for incidents of 15 minutes and a 25-minute safe system of work target.

Both targets were checked on a monthly basis. The most recent data available from the trust was between June to December 2021. During this time period both targets were met with over 95% being achieved for all months.

Patient outcomes

Staff did monitor the effectiveness of care and treatment. They did not use the findings to make improvements and could not show how they measured good outcomes for patients.

The service did take part in audits but the results from these audits were difficult to show for the service. Managers provided us with some audit activity related to how the service performed and managing the requirements for the service. However, the data was not always specific to the service.

Managers expressed that most data used for the service to measure performance was embedded into the operational unit data streams for Ashford and Gatwick. This made it difficult for managers to show the effectiveness of the service and the limited documentation of meetings also meant that any learning taken from the data was limited.

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. Staff did not know of continuous audits that measured improvement in the service over time. Managers had introduced response time audits since our last inspection which showed positive performance for the service but there was limited audit information available that was specific to the service other than this.

Managers used information from the audits to improve care and treatment. Managers reviewed performance data as part of their role. However, this was not specific to the service and we were unclear on the purpose of the performance data they reviewed.

Managers shared and made sure staff understood information from the audits. Meeting minutes at the service were limited and not always recorded. Meeting minutes provided after our inspection from Ashford did not show how improvements in the service were communicated to staff.

Improvement was not checked and monitored. Managers did not show evidence that improvement had occurred in the service due to audit activity.

Competent staff

The service made sure staff were competent for their roles. Supervision meetings were held with staff following an event to provide support and development. However, managers did not always appraise staff work performance.

Resilience

Most staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were trained at the right level to complete their roles. However, some staff did say that they had been asked to fill operational team leader positions on a temporary basis without receiving the needed training. These arrangements lasted up to 12 months without any action being taken.

Managers gave all new staff a full induction tailored to their role before they started work. Managers recruited staff from within the ambulance trust and externally. Staff were required to undertake an extensive training programme before being operationally available to work at the service which formed a large proportion of their induction.

Managers did not support staff to develop through yearly, constructive appraisals of their work. Staff appraisal rates for the resilience service were low for the year. Data for July 2021 to June 2022 showed only 48% of staff had received an appraisal. Only two members of staff had received an appraisal since April 2022 this year.

Managers made sure staff attended team meetings but did not provide access to the full notes when they could not attend. Managers and staff conducted team meetings, but managers did not always record them. Managers were expected to send meeting minutes to staff by email, but staff told us that this did not always happen. Staff were therefore not always up to date with the latest messages from managers which impacted on their ability to perform their role correctly.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had protected time for their required learning and mandatory training. Staff expressed that they felt they had suitable time to complete the courses required by NARU and that the exercises and courses were enjoyable. Staff praised their trainers and gave excellent feedback about the quality of their experiences with training and this formed a motivational aspect of the role.

Staff did not always have the opportunity to discuss training needs with their line manager and were not always supported to develop their skills and knowledge. Some staff told us that promotion to higher positions within the service was challenging. Some staff expressed that some managers were difficult to approach. Appraisal rates for the service were low and there were examples where some staff were acting as team leaders without being given the training needed for the role.

Multidisciplinary working

HART team members and other professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across emergency disciplines and with other agencies when required to care for patients. Staff and managers gave an overview of incident management and how they would be integrated into an incident with other emergency services. This included how communication would be structured through their tactical command setup. This included the fire and police services, but also included services such as water rescue or military services.

Managers had previously arranged joint exercises with the local airport and other emergency services, but this had been cancelled since the Covid 19 pandemic. Staff had conducted joint responses with the police including terrorist activity investigations. Staff also conducted fire service joint exercises including working with the technical rescue unit and road closure incidents.

Seven-day services

Key services were available seven days a week to support timely patient care.

Resilience

Staff were available for support 24 hours a day, seven days a week. The service responded to category one calls and therefore were always required to be operational.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could explain and give examples for how they would assess consent. Staff gave examples that involved difficult communication and subject matter with patients. For example, a patient had suffered a broken leg and needed help to be freed. But staff held awareness of the potential consequences that could occur from the movement. Staff expressed that it would be important that patients were aware of the risks before anything was tried. Staff assessed mental capacity to respond to decisions when patients became very unwell or where there were in significant pain that disrupted their ability to understand the risks and benefits of a proposed intervention. In these situations, staff made decisions in a patient's best interests to preserve life or reduce the risk of serious complications.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We did not see records that showed consent was gained but staff showed a good knowledge of the subject and understanding of how they would document complex consent.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were trained in the Mental Capacity Act by the trust. 84% of staff from the Ashford site and 88% from Gatwick site had completed this training.

Is the service caring?

Good 

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

Compassionate care

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

Staff within the trust were passionate about their jobs and gave several examples of bravery and professionalism which stood out to our inspection team. Staff gave details of unique approaches to ambulatory care that traditional ambulatory response units would have been unable to attend. This included challenges associated with the geography of incident locations that required specialist vehicles and unique scenarios where their enhanced training was essential in ensuring patients received safe care while addressing their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff described an incident working with the police in a very difficult setting where the patient died from serious injuries. The incident was very distressing for the crew but they remained with the

patient for several hours until they died. Staff were proud that they put themselves in that situation and that the patient did not die alone. Staff reflected following the incident and supported each other with several team members requiring time away from their role. One staff member expressed to us that "HART has an ability to get to anyone" and that they were proud of the part they played in the patient's final moments.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for patients with mental health needs. Staff spoke about an incident with us. A patient suffered serious injuries which required complex treatment in an unusual setting which successfully kept the patient alive. Staff felt the incident showed their attitude as a team and they were proud to have been able to reach the patient where a normal ambulance crew would not be able to achieve this.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, needs.

Staff supported patients who became distressed in an open environment and helped them keep their privacy and dignity. For example, staff attended to a bariatric patient as they were requested by an ambulance road crew and the fire service. The HART team took over the care of the patient to help carry the patient out of the house. Staff expressed this was very traumatic for the patient as it took eight people to carry them out. Staff talked through the process with the patient and supported them to reduce their embarrassment.

Managers expressed that at incidents, patients could be taken to an incident response unit vehicle which could allow patients privacy and a hot drink if it was requested.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff gave an example of an incident and described their approach to not only the patient but family members and the emotional support they offered to them during and after the incident.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff recalled an incident where a patient was very confused, could not recall words they spoke and didn't know where they were. Staff assessed the person as not having capacity using their assessment process detailed in the trust Mental Capacity Act (2005) policy. When the person became distressed, they worked with the patient's partner to encourage and support them to make the decision to travel in the ambulance. The patient was much calmer and was able to be taken to hospital for a full assessment and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff and managers confirmed the ways that patients were able to raise a concern or complaint. However, no complaints had been received about the service in the past 12 months.

Is the service responsive?

Good 

Resilience

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service locations were positioned at two locations which considered potential national response priorities for the local airport and sea-based incidents.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Managers and staff at the service showed a knowledge of services available and policies which concentrated on equality and diversity. This included adjustments for patients which included picture cards, translation services and adaptions for care to those that had both physical and psychological needs.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to interpreter services to safely manage incidents where the patient spoke another language other than English. The service was widely used by Field Operations staff, Emergency Operations Centre staff and 111 staff within the Trust. Staff were aware that this was available to them.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored response times and made sure patients received treatment within agreed timeframes and national targets. Managers developed KPIs for the service following our last inspection. Figures showed that the trust met these new targets. Staff frequently assisted the emergency operations centre of the ambulance service by attending calls that were not traditionally within the remit of the service. This included attending category two and three calls where the service could contribute to a response due to potentially challenging situations. However, the service was still expected to be available if a national incident occurred due to their response remit.

Staff did express that there were calls processed by the emergency operations centre where they should not have been asked to attend which caused them frustration. Managers had placed HART operatives in the operations centre to help triage which calls required the support of the HART team. This did improve areas of triage for the service.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. However, there were no complaints for the service to review.

Staff understood the policy on complaints and knew how to handle them. Staff said that if they received negative feedback or patients wanted to speak with someone regarding a complaint, they would be referred to the Patient Advice and Liaison Service (PALS) complaints team at the trust.

Resilience

Managers investigated complaints and found themes. Managers explained the complaints process they would follow when a complaint was received which would involve working closely with the PALS team. There were no complaints for the service in the last 12 months for the inspection team to review whether this process was working well.

Is the service well-led?

Requires Improvement  

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for staff. They supported staff to develop their skills and take on more senior roles.

The HART element of the resilience service had a leadership structure which consisted of one head of resilience and specialist operations, two operational managers based at separate sites, and 15 operational team leaders who were responsible for teams of HART operative paramedics. The leadership of the service understood some of the issues and challenges the service faced but did not always have solutions to these concerns. This included staffing and equipment concerns that leadership had acknowledged and brought to the wider trust's attention through their risk register.

Staff told us that leaders were visible up to the operational team leader level and there was good feedback about the operational team leaders.

The Operational leaders shared the current priorities and any important information with the team leaders each day. The team leaders then shared this information at the safety huddle meetings. The meetings were not documented so there was a potential that some staff would not see the updates and not know about changes that happened when they were unable to attend the meetings. Staff commented that operational mangers were not visible to the HART teams and that they felt there are very little cover provided from a leadership standpoint at weekends. Senior managers told us that operational managers were not expected to be visible to HART operatives and that the remit of their role was more focused on the quality of the service. It was expected that the operational team leaders handled the relationship management of the team. However, they acknowledged that a recent staff survey had raised these concerns and that managers were going to be recruited who had a larger responsibility for relationship management with the HART teams.

Staff did feel they had opportunities to develop their skills for their role and had opportunities to carry out management duties. However, staff also expressed that they were expected to take on these duties without any expectation that it could lead to a promotion in the service. Staff felt that at times, they had been placed in unofficial roles to provide cover for the shortfalls in staffing.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to trust plans. However, the performance of the strategy did not have data streams that could accurately assess this.

Resilience

Managers at senior levels of the service had a vision and strategy for how they wanted to improve the service. Managers had awareness of the staffing concerns associated with the department and had plans to increase the workforce significantly using funding from NARU which was due in April 2023. With the funding, they planned to increase the workforce with 23 HART operatives, two operational managers and one training manager.

Managers had a strategy for tracking their progress and success across the ambulance trust. However, there was a limited strategy for this service. Data used to calculate success was not available for the service and most available data was blended into the operational unit performance data of Gatwick and Ashford. This did not give a clear picture regarding how the service reassured itself that they were meeting the strategic aims of the service.

Culture

Staff were focused on the needs of patients receiving care, but did not feel respected, supported and valued. The service provided opportunities for career development but did not always provide support when needed. The service had a culture where staff felt raising concerns held consequences at a particular level of the management chain of command.

Staff we spoke with were frustrated and did not feel respected, valued and supported. There was poor morale within the service. Staff did not feel appreciated by management at a senior level. The key themes we found were poor messaging from meetings held with operational team leaders resulted in confusion for HART operatives and unfair treatment, displacement due to staff limitations which meant that staff were asked to go to a different service site at short notice, a poor culture within some HART teams, staff being asked to step into team leadership positions without the suitable training, and poor accessibility or approachability to senior managers.

Meetings at the service had a mixed opinion among the staff we spoke with. Staff felt that team leaders were unable to deliver messages from their meetings as senior managers were reluctant to hear this. Staff also felt that team leaders were asked to give messages from senior management and did not have a strong voice in the governance processes. However, team leaders we spoke with did not agree with this and felt they were able to raise issues with their teams and that they were acted upon. Staff were also frustrated at managers not being visible at weekends and not appearing operationally ready if they were needed to support or attend an incident.

Staff were often frustrated with their role within the trust and did not feel valued outside of the service for their contribution to the trust. For example, a display board was put up in the Ashford site thanking the staff for their contribution during Covid 19, HART staff members were not mentioned on this board for either their contribution or the contribution of the service as a whole which led to reduced morale among the workforce and reinforced to them that the trust leadership did not understand what they did and why it was important.

Staff appraisal rates for the last 12 months were low, and staff were feeling burnt out from an extended period of understaffing and the added pressures that the Covid 19 pandemic had created. Staff had challenging experiences with the human resources department where both pay, conditions and returning to work processes were not followed or were disregarded by managers despite promises being made to staff in the first instance that they would be followed. Staff gave us several examples where return to work processes following absences generated by stress were not followed or acknowledged.

Managers were receptive to our feedback and showed a genuine desire to improve. Following our inspection, they did provide us with one set of meeting minutes from the Ashford site and they expressed that they would be returning to recording operational team leader meetings. Senior managers had also started creating drop-in sessions for staff to approach them in a safe space to voice their concerns. Managers expressed that the lack of recorded meetings was due

to staff concerns regarding the confidentiality of some subjects which were discussed in meetings. Managers did confirm that their policies do expect meetings to be recorded. Managers also acknowledged that managers were not always available but expressed that their jobs are not directly related to this due to a previous structure which had not been reviewed since a senior management change occurred.

Managers from the human resources department and the trust had an awareness of most of these concerns following a staff survey and had developed an action plan prior to our visit to address and improve the relationship between staff and the trust. There was a named individual within the human resources team working on a live document with senior management to outline and respond to staff concerns. This is currently in the early stages from the copy we reviewed as part of the inspection process.

The trust had a freedom to speak up guardian who had been approached by staff regarding some of these concerns. Staff reported that this did not always feel useful and that their concerns from this process were brushed aside.

Governance

Leaders operated governance processes which were not always effective, throughout the service. Staff were clear about their roles and accountabilities. Staff had regular opportunities to meet and discuss operational processes but there was limited evidence of the meetings being documented and learning being gained from the performance of the service.

Senior managers could outline the meeting structure for the service. However, staff did not always understand or receive messages promptly which affected the operational performance of the service. For example, staff expressed that they were not always told important information prior to coming on shift. If they missed a meeting, they felt confused and were asked to both take additional responsibility and travel to different locations of the service at short notice to accommodate staff shortfalls.

Managers had awareness of their equipment and had an asset register for the service which was required under NARU. However, the asset register was incomplete despite being in development for two years and did not provide managers with accurate information of where their equipment was stored. This information was also sourced by out of date checklists which were being used by HART staff conducting vehicle equipment checks to identify equipment available on HART vehicles.

Senior managers and operational managers had a good knowledge of other systems and processes for the service. Managers showed a good understanding of the processes for safeguarding, IPC, incident management, staff competency and complaints. However, the service did not have a strong record for recording incidents with no incidents being reported by the service in the last 12 months.

Managers demonstrated limited evidence regarding learning in the service. Meeting minutes did not highlight learning and we were provided evidence following the inspection which showed some learning but a lack of evidence regarding how this was handed over to staff.

Financial governance for the service was managed at a senior level and managers were operating under financial pressures which restricted their ability to recruit more staff to the service. Managers did have long term plans for the spending of financial support which was expected from NARU in 2023.

Resilience

Management of risk, issues and performance

Leaders and teams did use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.. They had plans to cope with unexpected events taking into account all risks.

Managers checked training risks effectively and spreadsheet matrixes were seen which looked at training from both command staff and an operational staffing capability. Managers were aware of the current risks the service had and these were documented on a trust wide risk register. Managers expressed that their main concern was the staffing level of the service and senior managers had approved a plan with the trust's board to reduce the minimum team numbers to ensure the operational reliability of the service. Senior managers also approved an interim policy to support this.

Managers used staff in a flexible manner to cover the staffing requirements of the service. Staff were asked to attend both locations to ensure that safe staffing levels in line with the trust's policy were maintained.

The service was discussed in wider trust level meetings that focused on risk. Senior Managers attended the calls and the department did assist with the enhanced demand being placed on the emergency operations centre when it was suitable to do so.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure. But staff could not always find the data they needed to understand performance, make decisions and improvements.

Managers collected data that was relevant to the service for performance purposes.. Some data for areas such as vehicle equipment was not always up to date and led to reports being unreliable for managers at operational team level to review.

The information systems used by the service were secure and the trust had policies and processes for the safe and secure storage of data. This included password protected staff accounts. Staff were conscious of data security and the trust had a named Caldicott guardian if they had any queries with data and confidentiality.

Engagement

Leaders did not always actively engage with staff to plan and manage services but were starting processes to improve this. They collaborated with partner organisations.

Senior managers had recently started a consultation piece of work with staff at the service in conjunction with the human resources department of the trust. The latest staff survey had started this piece of work and managers acknowledged that there was a lot of improvement that was needed to address and understand the strength of staff feeling.

Staff expressed their frustrations to us which have been outlined in this report and most staff felt that managers were now starting to acknowledge and take action on their concerns but felt a sense of frustration that it had taken this long for the trust to acknowledge and take action to support them.

Managers were in regular contact with other partner organisations who responded to national emergencies and despite joint exercises being postponed since Covid 19, there was still good communication between organisations such as the police and fire services. Managers felt the joint training will resume soon and that this will enhance their working relationship further.

Resilience

Learning, continuous improvement and innovation

Staff were engaged by leaders to continually learn and improve services. But there was not evidence of training in or understanding of quality improvement methods and the skills to use them. Leaders did not encourage innovation.

Staff engaged with leaders to improve services. For example, placing a HART operative in the emergency operations centre to triage and consult on job suitability for the HART team was considered a successful innovation. However, managers did not demonstrate a clear approach to quality improvement, and we did not see evidence of managers prompting or motivating staff to look at innovative measures to problems the service faced.