South Central Ambulance Service NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Good**
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.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

We carried out this announced inspection of South Central Ambulance Service NHS Foundation Trust as part of our continual checks on the safety and quality of healthcare services and because we had recent concerns about the quality of governance and training.

We also inspected the well-led key question for the trust leadership.

We inspected two core services, the Emergency Operations Centre and Urgent and Emergency Care.

The Emergency Operations Centre (EOC) receives and triages 999 calls from members of the public, as well as other emergency services. It provides advice and dispatches an ambulance to the scene as appropriate. The EOC also provides assessment and treatment advice to callers who do not need an ambulance response, a service known as "hear and treat".

The EOC manages requests by healthcare professionals to convey people either from the community into hospital or between hospitals. It also receives and triages 999 calls relating to major incidents, and other major emergencies, and dispatches the appropriate response as a Category 1 provider under the Civil Contingencies Act 2004 (Part 1); this can include hazardous area response teams.

The Urgent and Emergency Care core service covers the assessment, treatment and care of patients at the scene by ambulance crews with transport to hospital, as well as the assessment, treatment and discharge from the care of the service.

Our findings

It covers the provider's major incident planning and response as a Category 1 provider under the Civil Contingencies Act 2004 (Part 1), as well as planning for and responses to other major emergencies.

It also includes preparedness for, and the support of, events and mass gatherings. Special operations such as serious sand protracted incidents use many of the resources and techniques used in major incidents such as hazardous area response teams and these are considered as part of this core service.

Emergency response from community first responder schemes involving members of the public is also included. High dependency and intensive care transport between hospitals or other care settings is included, as well as other specialist transport that requires an emergency ambulance. This might be from hospital for end-of-life care at home, or mental health patients requiring specialist care.

To understand how services were being delivered, we reviewed information that we hold on this provider and sought feedback from stakeholders including the clinical commissioning groups, Healthwatch and GP practices within the area served by the trust. We spoke with staff and people using the service, spoke with leaders at all levels and reviewed both national data and data that the trust supplied to us. We carried out an anonymous survey of staff.

We did not inspect the core service Patient Transport Services, nor the 111 service. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

It is recognised that the inspection took place at a time when the NHS was under pressure because of the effects of Coronavirus. Some of the shortcomings identified pre-date the pandemic but others have been exacerbated because of restrictions and the impact of Coronavirus.

Our rating of services went down. We rated them as inadequate because:

We rated effective and caring as good. We rated responsive as requires improvement. Safe and well-led were rated as inadequate

In rating the trust, we considered the current ratings of the resilience and patient transport services that were not inspected this time.

- Safeguarding was not given enough priority. There was insufficient assurance that processes were protecting people, despite the Commission raising concerns with the trust in November 2021.
- The identification, reporting, investigation and sharing of learning from serious incidents was not in accordance with the NHS Serious Incident Framework.
- Trends in incidents, when identified, were not investigated or responded to in a way that mitigated future risks to patients.
- Essential equipment was not always available and working, when needed.
- The trust was not meeting the statutory Duty of Candour requirements
- The trust leaders were dismissive of people raising concerns and did not adhere to its own policy for whistle blowers. Sometimes staff who raised concerns were treated badly.
- Allegations against staff and leaders were not always followed up appropriately.

Our findings

- Medicines were not always managed safely or effectively.
- The trust was not meeting key performance standards for call and response times.
- Delays in reaching people who had requested emergency assistance were frequent and prolonged. This resulted in poor outcomes for some people.
- Some of the calls were not handled in line with trust processes and this resulted in delays to people receiving help, sometimes leading to poor outcomes.
- There were no formal appraisals and not all staff were completing mandatory training.
- Emergency ambulances were not always staffed by crews with the skills to provide a full complement of emergency care to people with life threatening conditions.
- Some people were not given the necessary pain relieving medicines.
- There was insufficient attention to infection prevention and control measures.
- Staffing and resources were not able to meet the demands put upon the service.
- The governance and risk processes were not working to protect people and improve services.
- At the time of the inspection, the provider was not meeting the requirements of the Health and Safety at Work (General Risk and Workplace Management) Regulations 2016 because of a pigeon infestation that had not been resolved effectively.
- There was poor understanding of the Mental Capacity Act (2005) and how this impacted on the work of frontline staff.

However

- Frontline staff were working hard to deliver compassionate care to people with whom they had contact. They were proud of their work and how they had managed throughout the pandemic.
- We saw and heard about examples where staff had been particularly kind and 'gone the extra mile to meet the needs of patients and their families.
- There were numerous examples of innovative practice that supported people getting the right care, in the right place.

How we carried out the inspection

In order to understand the experience of patients and quality of service being provided, our comprehensive inspection consisted of;

- Visits to nine sites managed by the trust.
- Observation at one of the Emergency Operations Centers.
- Discussions with staff of all grades, including middle managers, administrative staff, call handlers, clinicians, volunteers, make ready staff and staff working in specialist roles such as the Hospital Ambulance Liaison Officers.
- Visited four acute hospital emergency departments to observe care, handovers and to speak with emergency department staff about the interface between the acute hospital and the ambulance trust.
- Conducted an anonymous survey of trust staff.
- Invited feedback from 20 GP practices across the region serviced by the trust.

Our findings

- Spoke with representatives from the clinical commissioning groups, the local authority and invited comments from Healthwatch.
- Spoke with nineteen patients who had been brought to the acute hospitals by ambulance and six relatives of people who were unable to tell us about their experience
- Spoke with staff from the emergency departments in the acute hospitals including three consultants, two emergency nurse practitioners, four registered nurses and a senior nurse manager.
- Observed care of patients in waiting ambulances, whilst being moved into the emergency department and during handovers.
- Reviewed information held about the trust and provided by the trust.
- Reviewed board papers and interviewed board members and senior leaders.
- A pharmacy inspector reviewed the medicines management.

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

What people who use the service said

Most patients were positive about the care and support they received from the service. Some felt the crews were indifferent and said they "just did their job and no more" whilst others fed back about individual crews who had gone beyond expectations. There were two instances where relatives felt that patients had not had appropriate analgesia, although this was accepted by the patient as "one of those things".

However, we also heard concerns about the excessive waiting times for calls to be answered, for an ambulance to arrive and then for admission to the emergency department when the ambulance arrived at the hospital. Most felt it was not the fault of the ambulance crews but were very unhappy about the consequences of delays.

In addition to our discussion with key trust staff, we received a commentary about the management of resources from NHSIE.

The trust was managing resources well with the commentary saying that;

- The audit committee had clear terms of reference.
- Roles and responsibilities were delegated via the standing financial instructions (issued April 2021) which are available to all staff.
- Finance partners worked with operational teams to ensure that they receive the required financial management support and guidance.
- There were established, regular processes for finance staff to review financial performance.
- Responsibilities for budget holders were clearly laid out in the trust's standing financial instructions.
- The audit committee (which has delegated authority from the board) received the Board Assurance Framework and strategic risk register at each meeting, with the purpose of seeking assurance that effective risk management was in place.

Our findings

- The executive team received and reviewed updates from all directorates relating to risk management in addition to the Board Assurance Framework and strategic risk register. The Executive Director of Finance had responsibility for financial risk management.
- The trust had also established a risk assurance and compliance committee which comprised the executive directors and the company secretary. This carried out a deep-dive review of the trust's biggest risks and ensured that appropriate mechanisms were in place to provide assurance over the management of those risks.
- The board considered risks faced by the trust on a regular basis. For example, it received the Board Assurance Framework at each public board meeting.
- The trust's financial position was reviewed at the executive team and the board. The trust's position was included within the Hampshire & Isle of Wight ICS finance report which was reviewed by the Integrated care System's finance director group.
- The financial information received by the board included a balance of board and divisional level and covered both actual and future-looking projections.
- Financial performance was reviewed and challenged at the executive team and board
- Investment business cases included costs and considered financial and non-financial returns on investment.
- The trust maintained a corporate risk register which was reviewed through the risk, assurance and compliance committee and audit committee.
- The finance function engaged with operational management at all levels within the organisation.
- The trust had an anti-fraud and bribery policy which was issued in December 2021 (to be reviewed December 2025). This was led by the nominated Local Counter Fraud Specialist (LCFS).
- The trust communicated its financial plan and position throughout the organisation.
- Staff were encouraged to be open and honest through key trust policies and procedures, notably the anti-fraud and bribery policy, standards of business conduct and conflict of interest policy and anti-bribery policy. These were covered as part of the staff induction process.
- All cost improvement programmes (CIPs) went through a quality impact assessment process including sign off by executive clinicians.
- The trust used benchmarking data to identify potential efficiencies. The trust also benchmarked sickness and recruitment and retention rates with other providers.
- The finance function had a clear plan for improving financial management processes.
- The executive director of finance participated in the ambulance sector Finance Directors Network, which discussed emerging issues and shared best practice.

Outstanding practice

We found the following outstanding practice:

- SCAS were the first ambulance service to work with an acute NHS trust and introduce pulse oximetry to monitor the oxygen levels of patients with COVID-19 whilst they remained at home, to reduce the need for admission and improve both the patient experience and the burden of high admission rates on the NHS.

Our findings

- A trial of paramedic-led home blood testing for frail and elderly patients who required an ambulance helped to prevent the need for transfer to hospital in more than half of cases. In a pilot study led by SCAS and an acute NHS Foundation Trust, 52% of patients who were initially identified as requiring hospital admission were successfully managed at home. It was made possible by using specialist paramedics to take blood samples at the scene and discuss the results with hospital doctors remotely to determine the next steps.
- An initiative developed by SCAS was seeing research paramedics arrive rapidly on scene to deliver a new trial treatment for head injuries in older adults. Led at SCAS by the assistant medical director, the move is part of a study into the use of a drug which may prevent life-threatening or life-changing bleeds on the brain, known as intracranial bleeding. Although traumatic brain injury (TBI) accounts for half of all trauma admissions in the over 50s in the UK, and is mostly due to falls, more than 90% of the 1.4 million TBIs seen in emergency departments each year are initially classed as 'mild'.
- SCAS worked with Buckinghamshire New University, in partnership and the London Ambulance Service NHS Trust (LAS), to provide a new BSc (Hons) Paramedic Science course which started in September 2021.

Areas for improvement

As we had identified widespread concerns about the effectiveness of the trust governance and impact of this on the services provided, we served a warning notice under section 29A of the Care Act 2014. This notice is issued where it appears to the Commission that the quality of healthcare provided by an NHS trust or NHS foundation trust "requires significant improvement". This report is supplementary to the warning notice.

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.

Trust wide

Action the trust MUST take to improve:

- The trust must ensure all staff complete safeguarding training at the role appropriate level and any additional role specific training in line with the trust target. Regulation 18 (2) (a).
- The trust must ensure it takes staff's concerns seriously and takes demonstrable action to address their concerns. This to include where staff have raised concerns relating to bullying, harassment and sexually inappropriate behaviours. Regulation 17(2)(b).
- The trust must ensure that incidents are identified, reported and investigated in line with the NHS Serious Incident Reporting Framework, that action is taken to mitigate risks and that learning is shared across the organisation. Regulation 17 (2)(b)(e).
- The board must be sighted on accurate information about serious incidents occurring at the trust to enable strategic oversight and planning. Regulation 17 (2)(b)(e).
- The trust must ensure that where trends in adverse incidents are known that these are fully investigated, and action is taken to reduce future risks. 17 (2)(b)(e).
- The trust must ensure that it meets the statutory requirements of the duty of candour. Regulation 20.

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- The trust must ensure that it listens and responds to staff who raise concerns in line with their own policy and the Public Interest Disclosure Act (1998)
- The trust must ensure the governance and risks processes are fit for purpose and ensure the ongoing assessment, monitoring and improve the quality and safety of the services provided. Regulation 17, (1) (2) (a) (b).
- The trust must provide a separate Mental Capacity Act (2005) Policy and ensure that staff understand the principles and application of the Mental Capacity Act (2005) Regulation 17(1)
- The trust must ensure medicines are managed in accordance with the national guidance and that only authorised persons have access to controlled drugs. Regulation 12(2)(7)
- The provider must ensure that systems and processes for managing safeguarding within the trust are adequately resourced, effective and monitored by the board. Regulation 13 (1)(2)(3)

Action the trust SHOULD take to improve:

- The trust should ensure it provides appraisals and continuous professional development to all staff.
- The trust should ensure that staff complete mandatory training appropriate to their roles and responsibilities.
- The trust should consider how to improve communication and relationships between staff and senior leaders.
- The trust should ensure it continues working towards supporting the workforce in order to reduce the pressure and improve staff morale.
- The trust should ensure that it continues to work towards meeting the key performance indicators on clinical call back times, call abandonment rates and call response times.
- The trust should review the arrangements for the role of the FTSUG to improve the speak up culture.
- The trust should consider asking staff and patients with less positive experiences to present to the board to allow more opportunities for learning.
- The trust should consider ways to monitor outcomes for patients who are not transferred to hospital to ensure the pathways are used effectively and that decisions are made in the patients' best interest.
- The trust should consider revising their diversion policy to ensure they are transferred to hospital care in a timely way.

Urgent and emergency care core service

Action the trust SHOULD take to improve:

- The trust should ensure that medicines are always kept safely, whether in stations or on vehicles.
- The trust should ensure that any shortfalls in infection prevention and control are reviewed, and action taken where needed.
- The trust should ensure ambulances are staffed by appropriately skilled crews.
- The trust should ensure that staff have enough time to report adverse incidents.
- The trust should ensure that staff, particularly newly qualified staff, receive appropriate clinical support and supervision to enable them to provide safe patient care.

Emergency Operations Centre

Our findings

Action the trust SHOULD take to improve:

- The trust should continue to identify ways to recruit staff according to their current strategy in order to improve the call handling times.
- The trust should ensure all staff receive a timely appraisal to assure leaders that competency is maintained.
- The trust should improve response times in line with the Ambulance Response Programme.
- The trust should act to ensure the clinical welfare call are completed within the targeted timeframes.
- The trust should optimise information systems to make less labour intensive for staff and improve efficiency in reporting.
- The trust should review methods of communication between senior executives and call takers in the EOC to ensure important information is received and understood.

Is this organisation well-led?

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

Leadership

Some leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced but the board was not always aware of risks that were not shared at board level. Some executives were visible and approachable in the service for patients and staff, but many staff reported a disconnect and did not know who their senior leaders were. They supported staff to develop their skills and take on more senior roles.

Most leaders had the experience and abilities to lead effectively however this was not consistent across all leadership which increased risk.

There was a board that included a mix of skilled and knowledgeable members. However, there was not always enough challenge. There was also a mixture of established non-executive directors and very well qualified newly appointed board members. The chair was newly appointed, having started in April 2022, but had significant senior leadership experience in the NHS.

Similarly, the executives were a balance of very established and newer members, with an interim Director of Patient Care and Service Transformation. There were some credible executives who knew their area well and who provided clear and visible leadership to their own teams and those they interfaced with. Notably, the Executive Director of Finance and the Chief Operating Office, along with the Chief Executive offered confidence and a strong sense of direction of travel to the organisation. The variance of skills and visibility cascaded throughout the organisation with some middle managers being reported as particularly skilled and supportive. We saw some middle-grade leaders who were undoubtedly committed and knew their area of control well.

The Assistant Director of Organisational Development was new in post but brought an enthusiasm for leadership development as a way of driving improvement. They had good ideas, although it was too soon to see how these impacted on culture and quality.

Our findings

Some executives and senior leaders were less aware of their roles and responsibilities. This meant that the focus of their work, their decision making, and their priorities may not always have been in the interests of patients and the staff they managed.

Some staff talked about a disconnect with the senior leaders but were generally far more positive about their local leaders; they felt their part of the organisation worked well but that they were removed from the wider trust, to an extent. There were clearly good relationships with local leaders, but there was also an admission that some managers 'swept things under the carpet' or didn't respond to concerns.

There were no designated deputies for the executive roles. The organisation had no succession planning but did manage contingency cover. They considered themselves an organisation that developed their staff and who were committed to learning, but the opportunity to build and practice the skills required for executive posts was not made available in a planned way.

Patient safety was the area most affected by increased demand and shortcomings in governance. There had been several changes of senior management over a short period. We were told after the inspection that there had been an internal backfill arrangement. We were not made aware of the cover arrangements during either the core service or well-led inspections.

At local level, increased demands and staffing vacancies also meant that patient safety was the area most affected when the system escalation levels increased. Middle managers and clinical educators were covering an increased number of shifts and this resulted in their core leadership, supervision and educational roles taking a back seat. It is acknowledged that the service and local NHS system had been operating at high levels of demand and this was an attempt to mitigate the risks.

We met many staff who were benefitting and enjoying developmental opportunities across the trust; this left their posts unfilled. Many staff were 'acting up' and there was a risk that some were insufficiently experienced or skilled to fulfil the responsibilities of their posts. Some staff told us they were not confident and did not feel supported in their role. Others did not understand the work they were responsible for and were unable to answer basic questions relating to their sphere of responsibility. We saw examples of this at executive, senior and middle management levels and following the inspection, shared our feedback with the trust.

Staff did not always know who their leaders were. Local leaders and two individual executives were visible. There were individual leaders who were less visible and less engaged with the trust staff.

Frontline staff understood who their immediate team leader and the station leaders were, but few could name members of the board. Some knew the Director of Operations who they said, "Got out and about" and some knew the name of the CEO (but said they had never met him).

Staff generally felt they worked for their local leaders and that was all that was required to get the job done. Many people named the consultant pre-hospital care practitioner as the leader they went to with any questions or ideas and said they were the person that 'held the service together'. It was clear they were very well respected by staff at all levels.

Most, but not all, staff reported a positive relationship with their station leaders. Staff were generally positive about their team leaders and most felt supported and able to raise concerns. Generally, staff teams were seen as the key place for support and assistance. There was a cohesiveness and camaraderie in the ambulance stations, although a few people spoke to us privately and said this sometimes tipped over into inappropriate behaviours.

Our findings

The Board of Directors Meeting minutes dated 25 November 2021 showed a non-executive director had commented that it was, “good to hear that the Executive Directors were getting out and about and becoming increasingly visible”. This is at odds with information provided by the trust which showed only the Director of Operational Services and the Chief Executive Officer had been onto the ambulance station bases. The last visit by the Director of Operational Services was in December 2021. The Chief Executive Officer had visited the main operational centres and some ambulance bases seven times in the preceding year.

Following the inspection, we were told that other executives had visited sites. It was acknowledged that, due to the impact of COVID-19 on routine processes there had been no visits to trust sites by non-executive directors.

The trust board had agreed to follow the national infection prevention and control guidance and reducing footfall at their operational sites to try and control transmission of the Coronavirus.

Leaders were not entirely clear about their roles and their accountability for quality. There was sometimes insufficient challenge at executive and senior levels.

The board were not always presented with accurate information which made it very difficult to provide appropriate challenge and to have genuine assurance. They were engaged and committed non-executives who were not always seeing a clear picture of performance and risks. More recently appointed non-executive directors did offer appropriate challenge and clearly understood their remit well.

The executive leaders wanted to present a very positive image of SCAS and shared information that was supporting that image rather than a more accurate picture of how the trust was doing. For example, the trust invited patients to share stories, which is best practice, however upon examination of the stories shared since 2019, seven of the nine were positive stories, leading to concern that this could be offering false assurance rather than a more balanced approach developed to promote learning. Whilst lovely to hear such nice stories, there was a risk of limited learning for the organisation if it does not listen more widely to stories about when they got things wrong. This forum could have been used more effectively to show learning and improvements after things went wrong.

Within safeguarding there was still a line management structure that included a senior leader who had very limited understanding of their responsibilities for safeguarding at the trust. They had the view that the consultant brought in needed to ‘understand ambulances’ rather than accepting the ambulance trust leaders needed to understand safeguarding responsibilities.

The line leadership of safeguarding was unclear.

Despite a letter of intent issued following an inspection in November 2021, there remained poor and unclear leadership of safeguarding at SCAS.

The Serious Incident reporting was an issue the board was not sighted on. Information presented to the board was not an accurate reflection of the level of incidents occurring and so they were not in a position to be clear about their responsibilities regarding action to mitigate the risks. Their ability to provide challenge was limited because they were not provided with accurate information.

Vision and Strategy

Our findings

The trust had a clear set of values and a new strategy. The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had set the organisational vision; To be an outstanding team, innovative and partnering, to deliver world leading outcomes. The strategy was focused on moving towards excellence – saving lives and enabling people to get the care they needed by delivering the right care, first time, every time.

The trust strategy for 2022 – 2027 had recently been published. The strategy starts to talk about the trust as a care navigator service that eases access to care for patients and enabling a seamless link between providers. SCAS talk about getting people to the "right door" to meet their needs; this is very much a change to the historic core purpose of ambulance services simply transporting people to emergency departments. It reflects support to help people avoid being taken to emergency departments unnecessarily, instead treating people at home or seeking alternative care and treatment from other providers.

The leadership were united and positive about the new strategy, but discussions with staff before it was drafted were minimised due to the inability to hold face to face engagement events, although some were held with stakeholders virtually. As a result, the board agreed that feedback would be collected as part of the annual planning process being introduced in quarter two 2022/2023 reflecting the desire to have a plan that evolved over time reflecting changes in the health economy and environment. Some staff therefore felt it had been created with minimal input and discussion before it was drafted. Consultation was taking place after publication with a feeling from some that it had been, "created in a darkened room".

The trust ability to adapt is being challenged by planned change driven by the NHS Long Term Plan and unexpected changes resulting from COVID-19. This has left the trust setting plans for recovery. They believe that the strategy will not only achieve the recovery plan but deliver new targets in patient care and performance.

Key stakeholders were engaged in developing the strategy through identification of key priorities in 2019. The strategic focus is to operate as a clinically led provider committed to integrating safe, high quality care within their own systems, whilst also being a collaborative partner to the other stakeholders within each of those systems.

A core theme of the trust strategic development was to fill in the gaps and provide, or link, services within a developing health care system. They believe that they play a pivotal role in integrating care, as they are the interface with every part of the local care systems and offer themselves as a care navigator service. They intend to do this by;

- Simplifying access to care
- Assessing more people remotely
- Enhancing mobile diagnostics and care
- Integrating care pathways
- Sharing learning across systems

There were clear organisational values that were displayed in all bases that we visited. Organisational values were underpinned by an explicit statement of expected behaviours that demonstrated the values. The core values were;

- Teamwork – delivering high performance through an inclusive, and collaborative approach which values diversity.

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- Innovation – continuous improvement through empowerment of the trust people.
- Professionalism – setting high standards and delivering what was promised.
- Caring – for patients and each other.

Culture

Frontline staff were focused on the needs of patients receiving care. They were usually supportive of each other and kind to patients. Sometimes they felt overwhelmed and described 'compassion fatigue' but they still said they did the job because it made a difference to people using the service. Frontline operational and call centre staff were doing their utmost to provide good care in challenging circumstances.

Organisational leaders gave a united and very positive perspective of the organisational culture. Staff usually felt respected, supported and valued and were focused on the needs of patients receiving care, but felt capacity affected their ability to deliver to the standard they would want. Some staff said they were not listened to when they raised concerns and felt things were "brushed under the carpet". This impacted on their morale.

There was evidence that the organisation did not respond well when people shared concerns internally, or outside the trust because serious issues had not been addressed internally. People who raised concerns were not treated well and we saw evidence of executive leaders attempting to discredit people raising valid concerns.

The service usually promoted equality and diversity in the organisation but there were some concerns raised by staff and some areas for improvement highlighted by the Workplace Race Equality Standards survey data. Several people raised concerns about the treatment of women working at SCAS, particularly younger, or more junior, women.

The board saw the culture as a strength of the organisation. It was sold with positivity, with many examples of forward thinking, innovation and high profile projects. There was undoubtedly much good work taking place and a genuine desire to be the very best. The risk of such extreme positivity was that this could feel dismissive of reality to the frontline staff and limit the feeling that raising or reporting concerns was a good thing to do.

This was borne out in the CQC survey to SCAS staff, for example one person commented, "Concerned about the culture of problems being swept under the rug, in particular within the management team. Managers getting away with playing by their own rules with no repercussions". Another staff member said, "Whilst I haven't personally experienced any bullying or harassment, I am aware of other staff who have had issues which when reported have been swept under the rug".

The trust performed well on the 2021 NHS staff survey. They also had a good response rate of 57%. SCAS scored significantly above average for the areas which included Teamwork; Recognised and rewarded; Voice that counts; Always learning; Staff Engagement; Compassionate and inclusive and was not significantly below average for similar trusts in any areas.

In the same survey the results for morale and compassion were worse than for the previous year. However, the trust had the best score in the ambulance sector for compassion and inclusiveness, and the second-best score for staff morale.

The Commission conducted their own survey which focused on focused on 999 Operations and EOC core service staff as these were the areas inspected. The results from this were at odds with the NHS survey, although there was a much

Our findings

lower response rate of around 11%. The cohort offered the opportunity to complete the survey was much smaller, so a direct comparison of results cannot be assumed. Over half of the staff responding, (53.9%) disagreed with the statement, “The organisation values staff and provides them with effective support to do their jobs to the best of their ability. A similar number of staff who responded (59.2%) disagreed with the statement “Communication between senior management and staff is effective”. About a quarter of respondents (24.4%) said they had experienced bullying, harassment or abuse at work from their managers in the preceding year. Nearly 60% did not report this. However, 80% of staff who responded said they had not experienced discrimination from a team leader, manager or other colleague in the preceding year.

The support staff received was dependent on the team they worked in. Comments from staff completing the CQC report included references to bullying, harassment, poor health and safety, a disconnect between senior managers, a 'tick box' approach to staff welfare and fear of repercussions from speaking out.

Staff told us that the service had introduced an anonymous feedback system. They felt that this was because staff had reported that some staff feared giving feedback, and because of low morale. The trust has since told us that the decision to implement a feedback system was taken as it introduced a new approach to staff engagement. It is an anonymous tool, so that staff can feel free to speak their mind, although they can choose not to remain anonymous.

The trust had provided information that showed themes identified from this feedback had led to end of shift policy change and the celebration of women

We were contacted by a member of staff who had raised serious concerns during the inspection. They agreed for us to reveal their identity so that we could address the concerns. This disclosure to CQC was made in accordance with the trust Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy which recognises the right of individuals to raise concerns directly with the Commission. Whistle blowers are protected in law by the Public Interest Disclosure Act (1998), an Act of the Parliament of the United Kingdom that protects whistle blowers from detrimental treatment by their employer. The person raising concerns had suffered detriment and their reputation was called into question.

It was suggested that the whistle blower had acted maliciously and was not behaving in line with their professional code of conduct. This was untrue and the whistle blower was able to produce documentary evidence that they had repeatedly raised concerns internally, although there was no requirement for them to do so. This aligns with information from others who shared concerns with the Commission but wanted their identities protected because they were afraid there would be retribution.

Review of investigation reports and discussions with leaders and staff showed that organisational learning was not an embedded part of the culture. Incident investigations resulted in apportioning or suggesting where blame lay rather than focusing on the potential learning across the organisation. The actions tended to be around retraining for individuals rather than wider dissemination to mitigate future risks. Some reports blamed the patients for not providing accurate information to crews and many were judgmental about patients in their reporting.

Some staff felt the organisation’s leadership were visible, but others were concerned about the lack of recognition at senior level of the situation frontline staff were facing. Data provided by the trust showed two key executives, the CEO and the Director of Operations had visited sites and spoken with staff throughout the pandemic, but other executives and non-executive staff had not. Visible leadership is vital to support staff and could be achieved in a safe and pragmatic way either virtually or in person with appropriate PPE, meeting outside and other safety measures. Following receipt of the draft report, the trust shared details of additional visits by executives. It is acknowledged that face-to-face visits were reduced in line with national guidance to limit footfall and reduce the risk of viral transmission.

Our findings

The trust had appointed a freedom to speak up guardian. However, several staff told us they could only access this service in their own time, which made this less accessible to those who had already worked a long day and needed a break. After the inspection the trust said that they freedom to speak up guardian worked flexibly to support staff, however this was not the experience of the staff which we spoke with. No impact on ratings.

The organisation employed in excess of 4,500 staff, but only had one Freedom to Speak up Guardian. They reported to the Interim Director of Patient Care and Service transformation; some staff said that they felt uncomfortable raising concerns that would be reported to someone in their own line management structure and worried that they could be identified.

Following the inspection, the provider said that there was a process in place for when the FtSUG felt there was a conflict of interest in the management structure; an alternative route for speaking up was in place. However, the staff we spoke with were not aware of this and said that they did not feel comfortable raising concerns because they felt there was a conflict of interest.

We received information from someone raising concerns about some women's negative experiences at the trust; they said that this applied especially to student paramedics. The whistle blower said that concerns had been raised with senior leaders, the Freedom to Speak up Guardian and the organisational development team, but there was no evidence the concerns were being addressed. This correlates with reports from staff across the organisation who felt that the Freedom to Speak up Guardian was solely about patient safety issues and that other concerns were not recognised by leaders as being within the Freedom to Speak up Guardian's remit, even though the role was created in line with national guidance.

Our CQC survey had several comments made relating to harassment and bullying. One said, "When sexual harassment is reported it seems to be brushed under the carpet and the person is given a second chance. In the eyes of the law sexual harassment and abuse is never given a second chance and as a result people are reprimanded for their actions.

However, in the ambulance service it seems to be accepted by the management team that staff who act and behave inappropriately are given 2nd, 3rd and 4th chances. In a recent case a member of management themselves who committed the above offence has been allowed to continue in the same role with no real action being taken. Because of this, a lot of staff feel unsafe, unsupported and vulnerable when coming to work".

Bullying and Harassment was a key theme in the annual Freedom to Speak Up Guardian report. This was picked up by a non-executive director in the board minutes (dated January 2022) and there is a business case for increased resourcing for the Freedom to Speak Up Guardian, but this had not been approved at the time of our inspection.

There were more positive comments, but these did not outweigh the negative ones. One person said, "Very calm and supportive place to work", for example.

The culture within the organisation was centred on the needs and experience of people who use the services. Our observations showed that most staff were committed to delivering good care their patients. From our staff survey people were mainly positive about the care people received. One said, "We are a far from perfect organisation and there are many areas we could tighten up training, BUT in the main we deliver a good standard of safe care to the majority of our service users".

There were some differences between how senior staff and frontline staff felt about their work and the organisation.

Our findings

Middle and senior leaders were enthusiastic and very proud of their service. More junior staff did not always feel so positive. Capacity issues were impacting on frontline staff welfare. They expressed concerns around their ability to deliver the best care to the patients due to delays at the hospital emergency departments, reducing their ability to support patients in the community. Delays meant that staff frequently finished late and missed meal breaks and crew skill mix were impacting on staff morale. Some of the newly qualified paramedics felt they had to operate beyond their experience level.

There was good work going on to support staff wellbeing which included;

- An extra day added to each person's annual leave (pro-rata) as a thank you and recognition of the trust staff's hard work.
- 'Teapot' mobile wellbeing vehicles for crews to get drinks and snacks or have time out of the ambulance when they were held outside an emergency department for a long time.
- There was a new end of shift policy that aimed to restrict the number and type of jobs staff responded to at the end of their shift. The policy was generally well liked but there were some concerns voiced about patients left waiting and the potential harms. The trust recognised that there is a fine balance between staff welfare and patient safety.

The SCAS executives offered a lot of support to employees, however, some Emergency Operations Centre staff said that they were not always aware of what was available as much of the communication from senior people is made via emails, and electronic notifications which many of the more junior staff did not feel they had the time to read.

The NHS staff survey for 2021 showed that the SCAS EOC staff score for 'We are recognised and rewarded' was 5.3/10 and the score for morale in the EOC was 4.9/10; there were 205 responses. The trust average score for recognised and rewarded was 5.4, this is above the national average of 5.1. The trust average score for morale was 5.2 against a national average of 5.3.The workforce race equality data showed a difference between the experiences of BAME and White staff was significant for two out of nine indicators at the trust including;

- The proportion of shortlisted staff being appointed to positions from a BAME heritage was lower than the proportion of white staff being appointed (14.4% v 22.3%).
- A worse proportion of staff from a BAME heritage believed that the trust provides equal opportunities for career progression or promotion (45.4% v 60.3%).

However, there were seven out of nine indicators where the trust data was more positive. This included data which showed little variance between BAME and white staff experiencing harassment, bullying or abuse from staff in the last 12 months.

The trust policies placed an emphasis on the safety and wellbeing of staff. Staff said they recognised there was support for them, but many said they did not have the time or energy to use it. They said they were getting support from their fellow crew members or the staff they worked closely with, who were in the same situation.

Governance

The governance systems at the trust were not operating in a way that ensured that patients and staff were protected. The systems failed to assess, monitor and drive improvement in the quality and safety. The board was not sighted on accurate evidence and information to use to provide effective strategic leadership. Governance was ineffective and information was not shared with the board or presented in a way that minimised the risks.

Our findings

There was a range of sub committees, with good representation by non-executive directors that fed into the governance system. However, the committees and the board members were not always sighted on key issues such as safeguarding risks and the level of serious incidents that were occurring. There is a risk that the promotion of a seemingly very positive culture results in poor governance and minimising of governance failings.

The trust had a clear governance structure with four committees that reported into the full board. These were the audit committee, the quality and safety committee and the remuneration committee which were all chaired by non-executive directors. The executive management committee was chaired by the CEO. The next tier of governance groups reported to the executive management committee.

There appeared to be a variance between the trust's own assessment of the strength and assurance gained from their governance processes and what we found.

The Board Assurance Framework (BAF) was weak and had gaps in the level of assurance the board should be receiving.

The BAF had listed "Not having sufficiently robust systems of clinical governance, poor implementation of the patient safety framework and/or unable to effect and evidence of change robustly following adverse incidents or learning from within local health systems; affecting patient outcomes, reputation and adverse scrutiny" as the only strategic clinical risk. This was scored as a significant risk.

There was evidence that two of the non-executive directors felt that it needed revising and specifically mentioned that there was no entry about safeguarding. The response was that the, then, Interim Director of Patient Safety would consider these comments and decide whether to make changes. There was no risk around safeguarding included despite the letter of intent being received before the board meeting.

The top key control was. "CQC must and should do action plan". This suggests that the BAF has not identified internal controls that are sufficiently effective to avoid breaches of regulation.

We saw several examples of serious incident trends that should have been identified, investigated and acted upon to reduce future risks. This had not always happened. In one case call centre staff had not recognised serious breathing difficulties when people dialled 999. This was recognised as a trend but there was no proper investigation and sharing of learning, although some education materials had been developed. There were limited assurance mechanisms and no checking that staff had improved their ability to recognise severe breathing problems.

NHS Pathways have recognised that assessing breathing problems over the telephone is complex compared to seeing a patient face to face. The trust told us that the assurance mechanism to evaluate the impact of emergency call taker education was the call audit cycle, but no objective evidence of improvement has been provided. There are more recent incidents recorded where a failure to respond appropriately to reported serious breathing difficulties had resulted in poor outcomes. Internal investigations identified the calls as non-compliant. This suggests the assurance mechanisms were not effective.

Another example is around failing in defibrillators. There was a known situation where there were 11 cases where ambulance crews identified that defibrillators were not consistently working as intended. This could have been identified by linking an incident report submitted in January 2021 with a letter about this risk, sent by a paramedic in another ambulance trust dated 21 December 2021. The incidents were not investigated as a trend until an investigation report was commissioned in April 2022. Eight incidents had occurred between January and April 2022. The report

published after the inspection in June 2022, said that, “The trust does not have sufficient measures in place to assure themselves that their obligations are being met”. Whilst the report considers most people did not suffer harm because of the defibrillator failings, there are two where the investigator was either awaiting the official cause of death or felt ‘on the balance of probability’ no harm was suffered.

The second strategic risk focused on performance and was recorded as, “Lack of capacity to meet demand in all services due to: changing patterns post pandemic and as the NHS returns to ‘business as usual’ with the potential to result in long waits, delays, poor patient experience, safety issues and inability to meet targets and expectations.”

The key controls were system wide quality improvement and executive reviews of performance data. Nationally facilitated and co-ordinated patient awareness campaigns and national pandemic/emergency standard operating procedures in place and tested. SCAS have worked with partners and across the system to reduce the number of ambulance handover delays focussed on reducing occupancy levels and increasing the number of patients who are not taken to accident and emergency departments. Some measures were seen to be very effective such as the increased specialist support for people in mental health crisis in the community.

SCAS was in the top quartile for the lowest emergency department conveyance through the use of Hear & Treat, See & Treat and non-emergency department pathways. The option to divert patients after arrival at the emergency departments did not lie with SCAS because patients already booked into the acute hospitals had to be transferred from hospital consultant to hospital consultant. One consultant said this was a difficult process and very time consuming, so rarely happened. For situations where there were many ambulances ‘on hold’ waiting to hand over patients already booked into the hospital, we were told that SCAS duty directors initiated discussions about diverts, but the responsibility sat with the acute management team.

For patients who needed hospital treatment, it was for the crews to decide where to take them. Sometimes there was little choice because they needed specific services to be available (such as cardiac catheter services for suspected heart attacks), but some services were available at other hospitals. Winchester had a frailty unit, a respiratory ward and an acute medical unit. Crews that we spoke to gave several reasons why they didn’t want to use the less busy hospital, but confirmed it was for the crew at the time to decide. They said they knew from ‘the grapevine’ how busy each hospital was on any given shift.

There were few control measures that the board were reviewing in depth.

There was no mention of what action the trust could take to address some of the problems themselves; there was no proactive consideration of internal measures to reduce waiting at one hospital. The evidence provided to us was about telling the acute trust they were busy and delaying handovers as opposed to considering what they could do to reduce the number of patients brought to one, very busy, hospital.

The SCAS Code of Governance self-assessment (dated June 2021) was RAG rated as green for all monitor provisions. We were not assured that this was an accurate reflection of the quality of the governance. For example, one monitoring provision was that, “The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust’s effectiveness, efficiency and economy as well as the quality of its healthcare delivery.” It appeared from their interview that, despite the risk of enforcement action, the chief executive was still not well informed about the safeguarding issues we identified and the position of the trust at the time of our inspection in

Our findings

November 2021. Whilst it would not be reasonable to expect a chief executive to manage the detailed response to the safeguarding concerns, it was surprising that they took assurance so readily.

The board minutes dated 31 March 2022, showed the chief executive had reported that, “Good progress is being made with the implementation of the action plan, and we have held two briefing sessions to seek to assure the Council of Governors over our improvement actions.

The governing body is well established and publishes minutes. Those dated 5 April 2022, show some oversight and questioning of the trust executive and chair. There is oversight of appointments of non-executives and discussion around the impact of the pandemic on staffing. There is mention of the concerns around safeguarding, but these are minimised by the executive and do not provide an accurate picture of the situation and level of concern identified in the CQC report.

The chief executive’s report to board (dated January 2022) said that the executive were aware at that time that safeguarding provision needed to be reviewed and strengthened, reflecting the fact that the scope and number of services provided by SCAS has continued to increase significantly (and also against the backdrop of the sustained challenges of operating at high levels of escalation). This was not what we found, nor what the concerns were.

The messaging to board was incomplete. As an example, we were supplied with data that related to Safeguarding Level 3 Adult face to face training for Operational staff (Paramedics or registered nurses) as of the 2nd of April 2022. There were 1135 Operational staff who fell into this group, of which 19.5% had attended a one-day face to face Adult Safeguarding Level 3 event.

Concerns raised by a whistle blower about ongoing safeguarding problems and a lack of response when concerns were raised including that team members and the external consultant brought in to address the problems had to ask to see the letter of intent as it was not shared with the team.

Team members told us that did not see the safeguarding inspection report until they downloaded it from the CQC website. They said that they were not involved in drafting the action plan.

However, following receipt of the draft report the trust told us that the acting director responsible for the safeguarding team had one-to-one meetings with each member of the Safeguarding Team, sharing the draft report with them on screen.

The whistle blower told us that there were approximately 1,600 referrals sitting in the system which had failed to send.

This was escalated in January 2022 but then sat with an associate director who line managed the safeguarding team. The associate directors said they would sort it, but at the time we spoke to the whistle blower, they had not been looked at. The level of risk was unknown as they had not been triaged. The referrals came from across the geographical patch that was covered by the trust and were made by SCAS staff.

The unprocessed referrals had been escalated with the understanding that they would be recorded as a serious incident, but this had not happened until after a section 29A warning notice was served.

After the feedback about referrals not being processed, the chief executive investigated the situation and sent us a response dated. 17 May 2022. The letter confirmed there were 1423 records showing in the SCAS system for further

review and processing. A data cleanse revealed 198 of these were duplicate records and, of the 1225 cases left to review, 700 (57%) cases had already been reviewed some time ago by two clinicians working with the safeguarding team. These were said to be fully safe and appropriate and that staff had simply not closed the cases down correctly on the system, leading to them not showing as closed.

The trust reviewed 958 of the 1,225 records on Friday 13 May and over the weekend. This represented 78% of the 1,225 records. We were told that the trust would review the remaining 268 records with the appropriate staff and access to all the required parts of the patient record by Friday 20th May 2022.

The trust said that they were developing a "read receipt" function which was being added to the referral process so that staff are alerted when the referral has reached the external safeguarding team. This was to be installed by the system supplier in the next system update release.

This demonstrated that the safeguarding governance was not currently effective enough to identify where there are failings in the systems and means that there is potential for significant risks to go unreported.

Similarly, we identified that the trust had a much lower reporting rate of serious incidents (SIs) when benchmarked against other ambulance trusts. For example, in the financial year 2021/22 SCAS reported 19 serious incidents using the Serious Incident Framework. For the same period another ambulance trust with a similar number of staff reported 61 serious incidents and a trust with fewer staff reported 75 serious incidents. This was the lowest reported number of serious incidents for all ambulance trusts. Some ambulance trusts were bigger but allowing for that SCAS was still a very low reporter of serious incidents.

The Integrated Performance Record showed that serious incidents had a target set that was rag rated. The narrative talked about the serious incident level being above the planned number or being high. It wasn't high when compared to other trusts but was perceived as being 'too high' when the level reported exceeded the plan. This presented a risk that staff and middle managers would be deterred from reporting serious incidents. The CEO and Chair sent a letter (dated 18 May 2022) explaining the trust position around this. The letter said, "This figure is not intended as a target, but we acknowledge that using a RAG rating for this is perhaps misleading and will not do so in future for this data item."

The board were not sighted on either the true level of incidents occurring or the benchmark. The Integrated Performance Report published in the board papers from the meeting held on 27 January 2022 showed that a rolling three month average of serious incidents was reported as 17 incidents.

The chief executive and Chair's letter (dated 18 May 2022) said that, "We accept that SI's are differing in numbers across ambulance trusts and note also that commissioners (CCGs) in different geographies have asked that certain types of incidents are declared as SIs. CCGs in the SCAS footprint have regular oversight and reviews of our investigations." It also said that SCAS adheres to the SIRI National Framework on thresholds for reporting.

Having spoken to several CCG representatives we are not assured that they had oversight of the scale of serious incidents that were not being reported, nor had they the data to benchmark against other ambulance trusts to allow a comparison to be made and the under reporting to be identified. The letter also raised a concern that the trust was not referencing the current investigation framework. The Framework quoted in the letter used the term SIRI Framework, which refers to the now obsolete National Framework for Reporting & Learning from Serious Incidents Requiring Investigation; the current framework is the revised Serious Incident Framework published in 2015. The trust Adverse Incident Reporting & Investigation Policy published in 2019 referred to SIRIs rather than the now correct term of serious incident.

Our findings

There were many incidents investigated as major incidents, but these were not reported in the board papers. The Adverse Incident Reporting and Investigation Policy (dated January 2019) did not mention a separate reporting and investigation process for major incidents. The policy states (paragraph 4.3) that a major incident is a serious incident, but this was not what we found. In the fifteen month period from January 2021 there were 13 serious incidents reported via the NHS Strategic Executive Information System (STEIS). In the three month period from January 2022 there were 21 Major incidents that were not entered onto STEIS nor were they reported to the board.

The Adverse Incident Reporting and Investigation Policy had not been reviewed in accordance with the review date. Following the inspection, the trust told us that the time for using the adverse incident policy was extended by the Patient Safety Group pending changes in the new national patient safety strategy.

A review of records relating to major incidents showed that these should have been reported and investigated as Serious Incidents, even if they were later downgraded. Examples included; a situation where three clinical staff had not identified as a red flag for identifying non-accidental injury and several failed defibrillators.

Another incident where advanced life support was provided by SCAS crews during which it was noted that one crew were missing an essential piece of equipment which was required as part of their resuscitation efforts. The patient sadly died. This was not reported as a serious incident.

The unprocessed safeguarding incidents were not reported as a serious incident following the inspection in November 2021. At this inspection, the Chair of the Quality and Safety Committee said the board had been aware of unprocessed referrals but that the scale had surprised them.

A non-executive director was able to talk to us about defibrillators being used with the wrong pads and the need to revisit the reminders about this; there was also an issue with batteries not working which was not mentioned. The mitigation was to ask a second crew to attend if there was an issue but given capacity issues and ability to respond in a timely way, this was not necessarily a true mitigation. It also relied on the second defibrillator working.

Following the inspection, we received information from a whistle blower about concerns relating to equipment governance which had led to patient harm and which they said continues to do so.

We were told that until recently, the equipment committee had not met for two years and that no action taken despite concerns being raised. The staff member talked about issues arising with defibrillators that have not been addressed adequately or in a timely manner and this had resulted in patient harm.

One specific brand of defibrillator had several incidents however this was not addressed, and problems continued. The staff member said that more patients in cardiac arrest had failed defibrillation attempts, resulting in worse outcomes. They believed that SCAS had inadequate resources to ensure that every ambulance had an appropriately equipped defibrillator. The manager responsible was said to blame this on the manufacturer for not being able to supply the equipment that was needed but the staff member said that most of this equipment was not ordered until March 2022. The trust said they the manufacturer had confirmed with the trust that there were supply chain challenges.

Following a request for information about all incidents relating to defibrillators that failed to work properly first time, we were supplied with a report dated 28th May 2022. This report had looked at all incidents reported where defibrillators had not worked properly first time. There was a suggestion that there had been no harm from this repeated equipment failing.

Our findings

We were also told that staff were discouraged from reporting such incidents by their managers. This meant that there may be other incidents that were not reported and so the true level of harm cannot be known. It also means that the trust only began to look at this known trend when the Commission specifically requested a report. Data for the trust showed that they are performing below the average for ambulance trusts on the performance indicators for a return to spontaneous circulation.

The chief executive and Chair sent the Commission a letter after the inspection feedback (dated 18 May 2022). The letter explained that the trust periodically commissioned Internal Auditors to review our processes in relation to Serious Incidents. The most review was undertaken in 2021/22 and considered the design and effectiveness of controls in place around the recording and reporting of serious incidents. The Internal Auditors concluded that SCAS had robust controls in place, as well as governance arrangements, to effectively investigate, report and learn from serious incidents.

The letter went on to explain that, "Each SI that is declared has the oversight of a Clinical Director. A summary of the details is then shared (via the Company Secretary) to all Trust Board Members." We do not refute this is the case for incidents recorded and investigated as serious incidents. The concern is that most significant incidents (those which the trust describe as major incidents) were not considered under the Serious Incident Reporting Framework (2015), published by NHS England. This meant that the board was not sighted on incidents that had occurred and could not have assurance about mitigation and learning. Nor was the opportunity taken to proactively seek and address trends.

We could not identify a Mental Capacity Act lead and staff were not aware of one, but the trust told us that there was a lead. There was no mention of work towards the Liberty Protection Standards that will affect ambulance providers, as the approval travels with the patient. Staff spoken to on site visits were unclear about whether to stop a person awaiting treatment leaving the ambulance and in discussion were very confused about the differences between mental health and mental capacity.

The trust had an Allegations Policy (dated July 2021) that had the Director of Patient Care & Service Transformation as the executive lead. It talks about the threshold for prosecution differing from the threshold of 'reasonable doubt' and internal actions. The policy states that, "Outcomes of any trust internal procedures must be reported to the Local Authority Designated Officer and the Chair of the Allegations Against Staff Strategy Meeting. This will be the responsibility of the investigating officer or Named Professional for Safeguarding". The policy said that it applied to volunteers who are not employees of the trust, but the main body of the policy and required action to be taken in the event of allegations being made against volunteers did not fit with the way volunteers were managed.

The trust used many first responder volunteers who were provided with a SCAS uniform and could use one of the 50 vehicles funded by the SCAS charity or use their own. These had training and were assigned to a volunteer scheme leader. Generally, they appeared to be a very positive addition to the service and were well-managed by enthusiastic and committed leaders.

There had been one incident (in 2019) which involved an allegation of inappropriate behaviour made via the police by a patient attended by a first responder. Their scheme leader immediately met with staff member and stood them down. However, the only protection for patients was a request not to log on and not respond to calls; Their log on to see where a response was needed was not deactivated and their ID badge or uniform was not removed. SCAS were assured the volunteer was safe to start taking calls again because the police had determined there was insufficient evidence to prosecute the person. Leaders further up the line management hierarchy thought that people were automatically prevented from using the system if an allegation was made, but this was still not the case and the risk remained. The

incident had occurred in 2019 and at the time of the inspection in 2022 there had still not been changes made to ensure people were protected following any allegations being made. The process was still reliant on individuals who had allegations made against them not logging on. The issue was not that there had been an allegation but that there was no learning or action to mitigate future risk.

The trust policy did not cover this situation and those aspects which were applicable were not followed. This meant that a confused governance, ambiguity about individual responsibilities and lack of clarity about the process failed to protect the vulnerable.

There was good oversight of performance against the key ambulance indicators such as response times.

Board members completed a declaration of interests that was reported in the board minutes.

The board minutes recorded that the board had considered whether were any issues with fit and proper person requirements for directors. Our review of the fit and proper person assessments of individual directors provided enough assurance that there were no concerns.

SCAS contracted with 9 private ambulance service providers, which included third party services for patient transport, urgent and emergency care and critical care. Each independent ambulance provider was contracted through a Service Level Agreement, which was monitored through quarterly reports. They work in partnership with two air ambulances which are provided by separate charities through a service level agreement. There were suitable arrangements in place for the monitoring of these services.

Financial arrangements were reviewed by NHSI/E and found to be good. The financial team was established and had sound oversight of spending.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. Not all risks were identified and escalated to the board. Leaders held differing views on the high level risks. Mitigating action was not always effective.

The Trust had a Risk Management Strategy which was reviewed periodically (generally annually) and updated when required. It was last reviewed in March 2020. In addition to the core Risk Management Strategy, there has been a focus on managing and mitigating risks associated with the trust's response to COVID-19 during 2020/21, and a separate risk register supported this.

The Annual Governance statement 2021/22 reported that a number of tools were used to identify risk. These included;

- the monthly Integrated Performance Report, including Patient Safety Incidents (formerly SIRIs)
- review of adverse incidents and accident reports
- review of Freedom to Speak-Up referrals
- quarterly reviews of claims and complaints
- workforce engagement and leadership walkarounds

Our findings

The tools used were not presenting a clear picture of the risks to the board and sub committees. This included low reporting and poor management of serious incidents, inadequate Freedom to Speak-Up Guardian resources and a line manager reporting structure that was a barrier to contacting the Freedom to Speak Up Guardian. The leadership walkabouts were very limited, and many frontline staff did not know who their executive leaders were. Non-executive visits had stopped to limit transmission of the Coronavirus.

The trust used a RAG (Red, Amber, Green) rated corporate risk register. This corporate risk register had been rebased in November 2021. It listed 26 open risks and no closed risks. However, the information we reviewed did not provide enough assurance the entries reflected the true risk or had appropriate mitigations.

Staff could not confidently tell us the frequency or process used to review risks and there was a lack of clarity about the hierarchy of risks, even amongst the executive leaders. Information from the core service risk registers and local site risk registers did not always feed into the corporate risk register.

One member of the executive team told us that the three highest risks were, “Workforce, workforce, workforce”. This comment was not reflective of the corporate risk register where workforce concerns were scored at 16 but other risks were scored higher, at 25. On further questioning, it was clear they did not have a sound understanding of risk management and the lack of understanding about risk in their sphere of responsibility was such that we felt it necessary to raise the issue with the chief executive following formal feedback.

We asked for the local risk register for one ambulance station where there was a significant risk to staff health identified, but this was not provided. We raised the specific concern during feedback following our core service site visits on 6 and 7 April 2022 and have seen that there was a more robust response to the concern subsequently. No risk register was offered at the time of the feedback and the local leaders were not aware of it being on a risk register. We were told that it was not taken seriously by the trust. Initial assessment using the SCAS risk scoring formula, suggests this should have appeared on the corporate risk register and the board should have been aware of it as a long standing risk. The local and provider mitigating actions were ineffective and left people at risk of serious respiratory disease and other infectious illnesses such as Salmonella. We were told after the inspection that issue was on the Estates Risk Register as of 2020. The CEO had told us that assessments and consultancy work had been undertaken prior to the inspection, but the risk continued to impact on the wellbeing of staff working at the station. Measures to mitigate the risk were ineffective.

The highest scoring risk register entries were around hospital handover delays, ambulances having to wait outside of emergency departments with a patient onboard for several hours before the hospitals had capacity to accept them into the department.

It was recognised that this took ambulances off the road and that people suffered harm when ambulance availability outstripped demand. The local and corporate risk registers predominantly laid the blame with one hospital, but also talked about demand for 999 calls outstripping resources. There was mention of escalation to NHSI/E and Demand Meetings but no mitigating action by the trust.

There was no accessible record of any decisions to consider using the information the trust has about the pressures on the one hospital and to require ambulances to take patients directly to hospitals where they are less busy. The trust stated that was not a common occurrence and after the inspection said that this is not something that they were able to do.

The guidance offered in appendix 2 of the NHSE/I Southeast Region Operational Escalation framework v9 stated that,” Emergency Departments experience peaks and troughs in pressure, often associated with the number of arrivals by

ambulance. This can result in unnecessarily long waits for patients" It goes on to say that, "The public and healthcare personnel are already used to the idea that an ambulance may take patients to a more distant Emergency Department if it has better facilities for serious conditions, such as stroke or major trauma. Intelligent/Dynamic conveyancing takes this one step further by avoiding Emergency Departments that are known to be under "extreme" pressure, with potential benefits for both the NHS and the patients."

On the 6 April 2022 the trust and one of the acute hospitals had declared a critical incident due to demands being greater than their capacity. We were told that SCAS had ambulance crews not being able to handover patients to hospital staff and declared a critical incident because of long waits. When we visited on 7 April the critical incident was still in progress. There were 12 ambulances that arrived in a two hour period and five which took longer than 15 minutes to handover their patients. The maximum wait was 51 minutes.

The critical incident was about response times from patients making the emergency call to the patient arriving at the hospital. We were told this was what the delays related to and were the reason for the critical incident, which was not related to delayed handovers and not related to queuing at the acute hospital.

We spoke to staff at the hospital about why they were not diverting patients to a hospital where the emergency department was very quiet, and the hospital had capacity. They said that once a patient was booked in, it became quite complex and had to be arranged between two consultants. This is an accurate reflection of the guidance from NHSI/E contained within the Regional Operational Escalation Framework. Acute trusts facing extraordinary pressures and needing to divert must request this arrangement through the Clinical Commissioning Group and notify NHSI/E South East regional leaders. It is not the case for ambulance trusts who are encouraged to operate dynamic (or intelligent) conveyancing to less pressured hospitals.

We asked why patients were not taken directly to the quieter hospital by the ambulance crews, particularly if the quieter hospital was nearer or there was little difference in journey times. He didn't know. We asked several ambulance crews who told us it depended on the crew and was their decision.

One crew talked about doing it a few times as they disliked being stuck waiting but wouldn't do it near the end of their shift. Another crew said they didn't like doing it unless the patient asked. Others didn't know why they didn't do it but said they didn't like being sent too far from their base, particularly near the end of their shift.

The trust had a Demand Management Plan that reflected the Operational Pressure Escalation Level (OPEL) ratings as defined by NHS England for acute trusts. It does not refer to intelligent or dynamic conveyancing or the scope for leaders or crews to decide to use an alternative hospital to reduce the waiting times. OPEL four (the highest escalation level) is when an acute provider is unable to deliver safe and timely patient care delivered and patients are being cared for in a crowded and congested department. Pressure in the local Health and Social Care System continues and there is increased potential for patient care and safety to be compromised. The distance between the busiest hospital and the quieter one within the same ICS is 24 miles. There was another hospital closer, at 15 miles from the busy hospital, but this was across the ICS boundary. Nobody within the system could tell us why the ambulances were not taking people to the quieter hospitals when they could meet that patients' needs and where there was very little difference in the journey times, in accordance with the NHSE/I Southeast Region Operational Escalation framework.

There was system wide work taking place to try to manage the risks of a very busy hospital, but it was very focused on reducing the hospital occupancy rates.

Our findings

An acute trust wishing to divert whilst at heightened OPEL level must have exhausted all internal support options before contacting the CCG and neighbouring trust to agree a divert. This NHSE guidance does not refer to ambulance trusts.

The four REAP levels correspond to Opel (Operational Pressures Escalation Levels) used by other NHS organisations. They provide a framework to maintain an effective and safe operational and clinical response for patients. The Demand Management Plan's only mention of REAP levels was that consideration must also be given in regard to appropriate actions within the REAP.

The board were sighted on the problem but there was an acceptance and normalising of the situation. The minutes also suggest this is very much seen as a problem at the acute trust rather than for SCAS. The board minutes dated January 2022 showed that non-executive directors were asking questions; One non-executive director asked about Queen Alexandra Hospital in Portsmouth and whether any improvements were being seen in terms of patient flow and discharges. An executive director responded that the situation was not getting better, and the Chair noted how this area was complex and a key priority for systems.

The Integrated Performance Report (dated February 2022) showed that SCAS had failed to meet any of the national standards for responses all categories of incidents following a 999 call. In April 2022, SCAS was sitting very much in the middle of all trusts around mean response times weighted against number of calls. For category 1 calls they were sixth out of 11 trusts and for category 3 they were fourth out of 11 trusts. There was an accepted national problem with ambulance delays. The narrative, however showed that resourcing levels were insufficient to meet demand. SCAS was at] REAP 4 and still reliant on military support until March 2022. There was no link to inadequate resources and poor response times; there was a view it was about one acute trust not managing their flow. The IPR says, "The main issue continues to be high levels of delay at [the acute trust] who we continue to work closely with to try to mitigate the impact".

Within the IPR there were several other factors mentioned that impacted on the trusts ability to respond including, "Sickness levels are high" and "111 to 999 transfers cause demand in 999". These issues were being addressed, but not in the context of responding within the standard.

Undoubtedly there was significant impact from the pandemic and staff were feeling pressured. There was some data where increased demand from the pandemic was apparent, but this was not the entire picture. Demand and capacity problems began before COVID-19 reached the UK. There was a year-on-year growth in population of an average 0.87% for Hampshire coupled with an increasingly aged demographic. About half of the increased demand between 2018 and 2022 could have been predicted and planned for.

There was frequent reference to huge increases in demand. One CCG said that the demand had been static over the past three or four years and that the problem of ambulances being held outside one NHS emergency department were longstanding, pre-dating the pandemic. They felt that SCAS could be more proactive in managing the risks of ambulances being held at emergency departments and should be leading systems work around this.

The NHS Commissioning Framework for Ambulances says of capacity that, "Commissioners must be assured that providers have staffing capacity and skill mix to meet the agreed level of demand." SCAS did not have enough staff deployed, nor was there board oversight of the risks associated with a reduced skill mix when responding to emergencies.

Our findings

Category 1 ambulance calls are those that are classified as life-threatening and needing immediate intervention and/or resuscitation, e.g. cardiac or respiratory arrest. The national standard sets out that all ambulance trusts must respond to Category 1 calls in 7 minutes on average and respond to 90% of Category 1 calls in 15 minutes.

Throughout the inspection trust representatives told us that all category one response vehicles had a crew that included a paramedic. Data shows this was not the case.

In the six months between November 2021 and April 2022, there were insufficient paramedics to ensure that each category 1 call had a paramedic aboard. There was no paramedic for 9.3% of category 1 calls. The trust told us that, "With a Category 1 call to a cardiac arrest for example, the nearest available resource would be allocated to provide immediate assistance and basic life support. This will be an appropriate accredited responder that includes the utilisation of indirect resources such as community first responders or fire responders. A first responder had five days training, although they were able to commence basic life support and carried an AED so that they can administer early defibrillation. They could also administer Aspirin, Glucogel and oxygen if this is indicated. They cannot provide other more advanced life saving measures.

Not having a paramedic attend limits the treatment options for patients and there were examples where people did not receive care or treatment that met their needs because there were not appropriately qualified staff making the decisions and providing treatment.

After the inspection the trust told us that a quick response time is more significant than the skill set of the first attending responder. They would always dispatch the nearest resource including volunteers to a Category 1 call in order to facilitate a quick response. Volunteers all undergo appropriate training for their role.

There was no reporting of this as a risk to the board nor within the Urgent and Emergency Care risk register.

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. Data or notifications were not consistently submitted to external organisations as required.

The trust invested in its IT infrastructure to future proof the organisation. Leaders understood that using technology brought cost and outcome benefits for the organisation, for staff and for patients.

They had moved towards an increased use of virtual meetings to reduce the risks of virus transmission and were continuing to encourage their use because it was cheaper, more efficient, reduced staff travel time and our carbon footprint.

Crews had access to handheld devices which were password protected and designed to capture data in real time. They were being provided access to software that allowed access to policies and guidance and the trust information systems wherever they were, using their personal devices. Information was kept confidential and stored securely.

Information was collated and generally reliable but there were inconsistencies described elsewhere in this report around incident data presented to the board and completion of IT based safeguarding processes. These meant data was not always submitted as required to other bodies.

Our findings

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There was significant effort and resources being put into engagement and the trust operational leaders were very mindful of the impact of the pandemic on frontline staff. The new strategy looked to increase the focus on stakeholder involvement and widening engagement. This included work with partners in the Integrated Care Systems to address health inequalities.

Non-executive directors were being asked to take the lead for a geographical area, to become key players to influence stakeholders within their patch had a specific interest (such as MPs). This was described as providing opportunities for elevator pitches.

There were evolving networks for staff with protected characteristics, including a disability network, a women's network, and a race equality network and a LGBT network.

An action plan was created following publication of the Workplace Race Equality Standards survey results. This was being monitored and reported to the board.

Messages were sent out regularly to update staff about news, to share key messages and provide clinical updates. This was not entirely popular with staff who felt they were too long and there were too many messages to read.

The trust was using a weekly pulse survey to maintain oversight of staff morale. The response rate had lowered over time, which was felt to be due to 'survey fatigue' so was being reduced to monthly surveys.

The trust was very much an outward facing organisation and had used the pandemic to improve its visibility, influence and focus in both the local system and nationally. We saw high levels of engagement with other key stakeholders and a desire to have a national profile, for example by providing COVID Response Service 1,2 and 3.

SCAS was named as a Veteran Aware Trust in recognition of its commitment to improving NHS care for veterans, reservists, members of the armed forces and their families. This reflects their understanding of the communities they serve, including Portsmouth (which is the home of the Royal Navy) along with Tidworth and Aldershot, large garrison towns, one with a large Gurkha community.

The SCAS communications team were working hard to reach all the SCAS staff as well as those communities who were often underrepresented at engagement events. They had seen COVID-19 had changed ways of working and communicating with far more virtual engagement. This had a positive outcome of enabling people who found accessing 'live' events challenging greater opportunity to be heard. The use of virtual meetings had expanded how well people could engage with patient forums, particularly regular users of patient transport services who were often unable to attend face-to-face meetings.

The communication team also used social media platforms to reach staff who were geographically spread and the wider public. They had used messages put out on social media to try and reduce inappropriate use of ambulances services by showing people alternative sources of help and support.

Our findings

Learning, continuous improvement and innovation

There was a general commitment to continually learning and improving services. Leaders encouraged innovation and participation in research. However, the basic identification and sharing of learning when things went wrong was insufficient. There was no embedded Quality Improvement programme. Staff were committed to learning but felt that demand and under-resourcing prevented any real focus on this.

SCAS considered themselves a forward-thinking organisation and were involved in developing new ways of working locally and through national projects. There was a fledgling research base and examples of good collaboration on developmental work across the Integrated Care System to build new care pathways and ensure people were able to access the right care, in the right place.

Specific examples of innovation and an outlooking focus included;

- Paramedics from SCAS were the first in the country to supply COVID-19 patients with home oxygen monitoring kits if they didn't require immediate admission to hospital but were at higher risk of complications. This work was completed with one of the acute trusts in the Integrated Care System
- SCAS was the first ambulance trust to launch fully electric emergency response vehicles into its vehicle fleet.
- A trial of paramedic-led home blood testing for frail and elderly patients who required an ambulance helped to prevent the need for transfer to hospital in more than half of cases.
- A pioneering initiative developed by SCAS involved dedicated research paramedics arriving rapidly on scene to deliver a new trial treatment for head injuries in older adults, leading to improved outcomes.
- SCAS sent enough medical equipment to maintain a Ukrainian field hospital for up to two weeks – potentially helping to save hundreds of military and civilian lives in the country.
- The urgent care pathways project, which was established in 2019, secured SCAS a place as one of four finalists for the Ambulance Trust of the Year at the Health Business Awards 2021. The urgent care initiative saw ambulance service clinicians take a leading role in assessing and treating patients over the phone or in their homes when handling 111 or 999 calls and determining their next destination for ongoing care.
- SCAS featured among nine finalists in the Health Service Journal's Trust of the Year award 2021 for its wider contribution to regional, national and global healthcare.
- Education and training facilities at SCAS offered a cutting-edge learning environment which included an immersive suite with projections of real-life scenarios, a 3D printer to make bones, life cast and trauma manikins and a special effects make-up team. The equipment, which also included a fleet of simulation vehicles such as a double-crewed ambulance, patient transport vehicle and two large, fully-functioning ambulance simulators known as Simbulance 1 and 2.
- SCAS provided support and consultancy to India through a project which was the first NHS international partnership with India when it was launched in July 2019.It followed a decision by the Indian Government to begin a significant investment programme to address wide gaps in healthcare provision inspired by the 'free at point of contact' NHS ambulance services available in the UK – and resulted in an approach to SCAS for guidance. Over the course of the year, SCAS staff supported the expansion of 108 Emergency Response Services – the equivalent of the UK's 999 service – and the introduction of 104 Mobile Medical Unit Services – the equivalent of the UK's NHS 111 and GP visiting services – in Andhra Pradesh.

Our findings

- Work by the communications team built on the trust learning disability strategy. They had developed resources for people with learning disabilities about appropriate use, in collaboration with the local authority. They were also working with their 111 call handlers to support them in understanding how best to respond to calls from people with learning disabilities.
- SCAS worked with a mental health trust to provide a community based mental health team initiative. A Band 6 paramedic and psychiatric nurse used a marked rapid response vehicle to attend people calling 999 for mental health reasons. The team actively sought to identify and respond to incidents, case managed patients and were very well respected by the wider staff team.

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
Inadequate ↓↓ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Requires Improvement ↓ Aug 2022	Inadequate ↓↓ Aug 2022	Inadequate ↓↓ Aug 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.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Ambulance	Inadequate	Good	Good	Good	Inadequate	Inadequate
Overall trust	Inadequate ↓↓ Aug 2022	Good → ← Aug 2022	Good → ← Aug 2022	Requires Improvement ↓ Aug 2022	Inadequate ↓↓ Aug 2022	Inadequate ↓↓ Aug 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. 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 acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
South Central Ambulance Service NHS 111	Good Sep 2018	Good Sep 2018	Good Sep 2018	Good Sep 2018	Good Sep 2018	Good Sep 2018
Overall trust	Inadequate ↓↓ Aug 2022	Good → ← Aug 2022	Good → ← Aug 2022	Requires Improvement ↓ Aug 2022	Inadequate ↓↓ Aug 2022	Inadequate ↓↓ Aug 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 Central Ambulance Service NHS 111

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Sep 2018	Good Sep 2018	Good Sep 2018	Good Sep 2018	Good Sep 2018	Good Sep 2018

Rating for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency operations centre (EOC)	Requires Improvement ↓ Aug 2022	Good →← Aug 2022	Good →← Aug 2022	Requires Improvement ↓ Aug 2022	Requires Improvement ↓ Aug 2022	Requires Improvement ↓ Aug 2022
Patient transport services	Requires improvement Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Emergency and urgent care	Inadequate ↓↓ Aug 2022	Requires Improvement ↓ Aug 2022	Good →← Aug 2022	Requires Improvement ↓ Aug 2022	Inadequate ↓↓ Aug 2022	Inadequate ↓↓ Aug 2022
Resilience	Good Nov 2018	Good Nov 2018	Not rated	Good Nov 2018	Good Nov 2018	Good Nov 2018
Overall	Inadequate	Good	Good	Good	Inadequate	Inadequate

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 operations centre (EOC)

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 areas for all staff and most staff were able to complete it.

Staff told us much of their training was available online. New emergency call takers (ECTs) had a comprehensive training package which included three weeks classroom training before working with a mentor and coach on live calls prior to taking calls independently.

We asked the trust to provided details of mandatory training EOC staff were required to complete. The list included conflict resolution e learning, dementia core skills e learning, equality and diversity, fire safety, health and safety, infection prevention and control, information governance, manual handling e learning, safeguarding adults, and children. The trust set a target compliance rate of 95%; staff in the EOC had a higher than target achievement rate in each module.

The training on dementia enabled the call takers to explain the complex caller option in the triage system used.

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.

Staff received training specific for their role on how to recognise and report abuse. All new staff received safeguarding training to the level required for their role on induction. The leads for the clinical support desk delivered ongoing safeguarding training for staff in the control room. ECTs and dispatch staff were trained to level two in safeguarding children and adults and the clinical staff were trained to level three. Staff we spoke with were able to explain the process for reporting abuse or concerns raised on calls through the electronic reporting system and could show us the alerts in the system relating to safeguarding, and specific patient management plans.

Staff did not refer directly to the safeguarding team and they did not get to know outcomes. Few staff could tell us who the leaders or managers for safeguarding were.

Details provided by the trust showed that staff completed levels 1 and 2 for safeguarding adults and children and achieved 99% compliance. We did not see evidence that clinical staff had completed level 3 training, but we were assured by staff that this was the case for all clinical staff. A member of clinical staff told us they helped deliver safeguarding training for the non-clinical staff.

Emergency operations centre (EOC)

The governance of safeguarding across the trust was poor and we saw incident reports where clinicians working in the EOC had failed to recognise indicators of serious risk to children.

Environment and equipment

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

The premises at Southern house was secure and all areas accessed via card entry systems. There was a lift to the first floor and ramp access around the site for wheelchair access. The main room which housed the emergency call takers, dispatchers and clinical team was crowded and could be noisy. The space was also shared with the NHS 111 team.

Staff used control measures to protect themselves and others from infection. The premises were visibly clean. All staff wore a uniform and were well presented. Hand sanitising gel dispensers were available to staff and visitors throughout the site. Staff had access to disinfectant wipes to clean their desks before and after their shift, which we observed staff using. Staff completed infection prevention and control training as part of their mandatory training, data provided to us from the trust showed that 100% of EOC staff had completed this.

Measures to mitigate the spread of COVID-19 had been adopted throughout the EOC. Rooms had been adapted to allow for social distancing and maximum room occupancy numbers were adhered to whilst on the inspection. Separation screens were installed between desks and staff were discouraged from standing and communicating with colleagues over the top of the screens.

All staff in EOC were expected to wear masks when not at their desks, unless they had an exemption. We saw managers reminding staff if they were not wearing them. Staff working in the EOC were not expected to test regularly for COVID-19, however if they had symptoms, they would be asked to follow procedure, isolate, and provide a negative test before returning to work.

Staff were able to access a desk with IT equipment; including computer, monitors, headset, and telephone in working order. In the event of equipment and software failure, there were systems and processes to ensure the service could continue to operate. If the computer system failed, emergency call takers would still receive information and use paper forms. The forms contained the necessary information required for each call. Staff received training on the paper format when they first joined.

Staff told us they had the equipment they needed to carry out their roles. Following occupational health assessments, some staff were provided with equipment that had been adapted for their individual needs, such as lumbar supports.

The regulations relating to display screen equipment were displayed on the information notice board as a reminder for staff.

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.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff in the EOC used approved triage systems to prioritise calls based on risk and need, using the NHS Pathways system (NHSP).

Emergency operations centre (EOC)

NHSP is a telephone and digital triage clinical decision support system. The triage system prioritised, and coded calls based on responses to questions asked by the ECTs.

The ECTs followed the call handling procedure in line with the requirements laid out by NHS Pathways (NHSP) user licence and training for the safe use of the system. It detailed the local procedures to be used with regard to specific scenarios within NHSP and CAD (Computer Aided Dispatch) functionality.

We listened to a number of calls during the inspection. Staff followed triage pathways consistently to determine the right response for the patient. This response was not always to send an ambulance but included for example, a clinician talking with a patient and carer, and another asking the caller if they were able to take themselves to the local walk-in centre. Some calls were complex; patients were asked about their condition, and staff entered the answers on to the system covering all aspects of the patient's current condition and any medications. Staff determined the risk and acuity of the patient to ensure the correct response. Calls were categorised as high risk calls requiring attendance within 18 minutes, to lower risk calls for patients who were not able to get to hospital unaided.

The EOC handled four categories of calls; category one included people with life-threatening illnesses or injuries, category two for emergency calls, category three for urgent calls and category four for less urgent calls. The level of urgency identified would then determine how the ECTs clinicians and dispatch team would coordinate a response.

During the inspection, the EOC staff were following the Enhanced Clinical Safety Policy (ECSP), which formed part of the larger surge/demand management plan. Staff explained the service was in surge management triggered by the critical incident status. The ESCP procedure was designed to ensure that category 1 and category 2 patients, who were the highest clinical priorities, received an ambulance response within a timely manner, which meant there were large numbers of category three and four patients waiting within the clinical stack. Increased pressure was put on the clinical support desk and the NHS 111 clinicians to safely manage the category three and four patients.

Subsequent to our site visit, we found incident records that showed harm attributable to incorrect categorisation of calls and delayed responses.

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 and adjusted staffing levels and skill mix.

Data provided by the trust included staffing numbers for both EOCs. In April and May 2021 the service operation centres were over recruited; however from June 2021 until the time of the inspection the operation centres were increasingly understaffed. From August 2021 until the end of March 2022 the vacancy rate for EOC staffing in SCAS ranged between 12% and 18% for all staff groups. This equated to between 36 and 56 staff shortages across all groups between August 2021 and the end of March 2022.

For the ECTs the vacancy rate ranged from 10% in August 2021 to a peak in September and October 2021 of 24% which equated to a shortage of up to 37 call takers. However, the ECT establishment had been increased at this time to address the rise in demand. There had been some successful recruitment by March 2022 which had reduced the vacancy rate for this group of staff to 13% but this meant that there continued to be a shortfall of 20 staff.

Emergency operations centre (EOC)

The clinical support desk was also severely impacted by staff shortages in the 12 months prior to our inspection with an average vacancy rate of 27% which equated to an average shortage of 14 -15 clinical practitioners.

Staff sickness rates between April 2021 and the end of March 2022 also severely impacted the service. The sickness rate for the total staff group in the EOC averaged 9.85%; with clinical staff sickness rate averaging 7.29% and ECTs 11.81%.

Emergency call takers turnover rate further impacted on service provision through the year with an average rate of 60% compared with an average of 38% for the whole staff group in the EOC. This rate was at its highest in the first three months of 2022 which peaked at 76% turnover in March.

Staff told us they felt vulnerable at night sometimes as staffing numbers were often low. On one recent Saturday night in Southern House the ECT numbers were reduced to two with just one clinician. This meant that up to 30 calls were stacking and it was difficult to take a break. The trust told us that the call centre was virtual, so additional staff were in Northern House. Southern House was shared with the NHS111 team so there were other staff in the building.

Some of the recent data was due to the latest recruitment strategy. The trust had negotiated with a local provider to increase capacity by increasing the number of call takers for SCAS and train them to work from another centre. This meant the SCAS could expand the number of call takers on duty in an attempt to better meet demand.

Staff told us that recruitment increased the pressure on them as the coaching and mentoring increased the burden on the team. They understood that this was necessary in the short term to improve the service and reduce the pressure going forward.

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.

Patient records were managed, completed, and stored appropriately and confidentially. Patient records were held electronically, and staff required a password and login details to access them. The EOC used the computer aided dispatch (CAD) system to record patient details, triage calls and deploy ambulance resources.

A new record was created at the start of every 999 call and patient details were recorded on the CAD system. The system then guided emergency call handlers through a series of questions to identify the patient's condition and the category and coding generated the ambulance response required. Emergency call handlers updated information as the patient's situation developed during the call and crews could access this information electronically.

We saw staff used a flagging system to alert callers of any known risks. For example, information received from healthcare professionals, patients and their families, GPs, and local authorities as well as multidisciplinary care plans for frequent callers, agreed resuscitation orders and alerts to indicate potential violence and aggression.

Information governance training compliance rates were reported in the Integrated Performance Report. At the time of the inspection the completion rate was 97%.

Medicines

Staff gave advice on medicines in line with national guidance.

Emergency operations centre (EOC)

The EOC did not store any medication.

Call handlers followed the NHS pathways protocol for advice and obtaining information from the patient or the caller.

Call handlers understood their limitations in offering advice relating to medicines and the importance of giving advice accurately and clearly.

We observed call handlers asking patients whether they were taking any medicines or pain control medication and provided advice accordingly. The information received and advice given was recorded in the patient's call record and shared with the clinical support desk and attending crew. This informed the care the patient received. Call takers were also able to obtain advice relating to medicines from the clinical support desk to ensure accurate information was provided to the caller.

The clinical team used the Joint Royal College Ambulance Liaison Committee (JRCALC) for medicines guidance. These were available electronically to ensure staff had access to the most up to date version.

Incidents

The service did not always manage patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and included wider service and partner organisations. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

SCAS had an adverse incident and reporting policy which described an incident as any unintended or unexpected event which could have, or did, lead to harm. Staff told us they were given an overview of the incident reporting process during their period of mentorship and understood that incidents were to be graded according to the impact on the individual or individuals concerned.

Staff knew what incidents to report and how to report them in the electronic incident reporting application. Staff gave examples of things they would report, such as patient safety incidents where harm had occurred, or a patient record which did not contain up to date information. Staff told us that the system provided a receipt notification when they reported an incident and shift officers provided updates on reported incidents.

Electronically reported incidents went to the clinical governance leads and line managers in the trust. In the six months to the end of March 2022, there were 306 incidents reported by staff in the EOC, 21 of which were reported by the clinical support desk. The most reported incidents related to delays (200), patient treatment or care (21) and IT systems (29).

Education and quality leads for the EOC told us that they attended safety huddles every two weeks where incidents were reviewed. The head of the EOC had oversight of all incidents reported by the EOC team.

Serious incidents such as those causing permanent injury or catastrophic harm led to a full investigation and report. Outcomes, and identified actions to reduce or eliminate the risk of the incident recurring, were monitored by the Patient

Safety Group or Serious Incident Review Group. Staff we spoke with did not know how this process happened beyond their own initial report.

Emergency operations centre (EOC)

There were low numbers of Serious Incidents reported when compared to other ambulance trusts. Some incidents which resulted in poor outcomes for patients, and which should have been investigated and reported as serious incidents were not. This included a child patient presenting with symptoms highly suggestive of non-accidental injury not being identified as being at risk and referred as a safeguarding concern. The low reporting meant that the board had an inaccurate picture of risk and patient safety. Investigation reports tended to blame those involved in the incident, this included a suggestion that clinicians were not professionally curious enough. Professional curiosity means not taking a single source of information and accepting it at face value. It involves testing assumptions and triangulating information from different sources. In this situation the non-specialist professional staff had not been provided with training to enable them to develop the skills and knowledge that underpinned professional curiosity in a safeguarding situation but were responsible for making key decisions about safeguarding risks.

1. Where follow up action had involved a change of practice or there were lessons to be learnt this we understood this was communicated through the trust newsletter, safety bulletins, risk alerts, and staff briefings.
2. Staff were not always aware of learning from incidents; they said any learning would come from checking their emails, directives and reading bulletins. However, staff found this overwhelming on busy shifts and they were not always able to absorb the information. They were aware that they needed to read and acknowledge directives and updates but found it difficult to find the time to read them. Staff told us there were no opportunities for formal team meetings, as they were all cancelled when the system was at REAP4.
3. There was limited evidence of staff acquiring measurable learning from incidents within the EOC.

The adverse incident and reporting policy included the requirement for initiating the duty of candour, and there was a separate policy detailing the process for carrying out this. Duty of candour is a regulatory duty that relates to openness and transparency. It requires the providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Clinical staff understood this requirement, but call handlers had a limited knowledge of this.

Staff we spoke with were aware of the Trauma Risk Management (TriM) peer support system and were able to access the team if they felt upset or traumatised following an incident.

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.

The service used the recognised NHS pathways system to assess calls received by the EOC. Protocols were in place for the assessment and planning of care for paediatric patients, major trauma, obstetrics, cardiac arrest, hyper acute stroke, and minor injuries. Staff provided care and treatment based on national guidance and evidence.

Emergency operations centre (EOC)

All calls were categorised in line with national guidance, for example category one calls were calls assessed as immediately life threatening. Pathways provided emergency call takers (ECTs) with questions based on the patient's urgent medical complaint or condition and offered prompts where required. Emergency call takers chose the most appropriate category for the call based on responses to the questions provided which was colour coded according to priority.

We listened to calls handled by the ECTs, they followed the system through to disposition efficiently and effectively and were calm and polite when callers were clearly anxious, in pain or frustrated by the system.

The trust employed dedicated auditing staff; this team audited random samples of calls every month. When call handlers failed to meet the required standard several actions were utilised to support the call handler to improve. These actions included: a call review plan (CRP) highlighting identified development areas which is discussed with the individual. The individual concerned is expected to complete a reflective document detailing the issues and actions highlighted which is kept on file.

Staff confirmed that audit failures were discussed with their line mangers during regular one-to-one meetings.

Pain relief

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

Emergency call handlers recorded pain described by patients and callers as part of the questions prompted by the electronic Pathways system. They also advised patients who were waiting for emergency responses to gather any regular medication in case they needed to go to hospital. This ensured that patients had a supply of any regular pain medication if they needed it.

Clinical staff talked to patients about their pain and, when appropriate, advised patients to use their usual preferred analgesia to relieve pain.

Response times

The service monitored but did not always meet, agreed response times.

The trust monitored nationally measured NHS Ambulance Quality Indicators (AQI) for a range of indicators including their call answer rates.

Calls to emergency operations centres (EOC) should be answered within a maximum of ten seconds on average. The trust call answer times between September 2021 and March 2022 were consistently slower than the England average. In March 2022, the mean time to answer calls was 106 seconds; this was the second slowest of the providers nationally and was 64 seconds slower than the England average.

The EOC was measured and benchmarked against other trusts for its performance against the 99th centile time to answer calls. This measure shows the time to answer 99% (99 out of 100) of 999 calls. This is defined as the time in

seconds between call connect and call answer. This measure identifies the longest waits to have calls answered; in March 2022, the trust answered 99 out of 100 of all calls within 760 seconds. This was the slowest of 11 providers nationally and was 464 seconds slower than the England average. At the time of our inspection the EOC was working with NHS England on a 'turn around' program to improve call handling times.

Between January and March 2022, the trust abandonment rate for 999 calls and calls from other healthcare professionals was 7.8%. The trust told us that the abandonment rate was high due to call answer performance.

Patient outcome

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

The trust provided data for their hear and treat rates; these were incidents resolved by staff over the telephone and therefore not requiring an ambulance to be dispatched. This was a nationally measured Ambulance Quality Indicator (AQI) standard for which the trust was benchmarked against other NHS ambulance services in England. The national average for November 2021 to February 2022 was 11.65%. SCAS provided figures for the months of October 2021 to March 2022. They performed consistently well against the national average with a rate of 11.95%. This was showing an improving trajectory with the March rate of 12.65%.

There was a programme of audit for EOC activity which was overseen by the Education and Quality Assurance team.

Staff used these audits to identify concerns relating to incidents, complaints, and call times, as well as random monthly samples. The EOC audit data for seven months from August 2021 to March 2022 showed high levels of compliance for clinical staff with an average compliance rate of over 95%. The call audits for the nonclinical ECTs was more mixed; the average compliance rate for these calls was between 88 and 89 percent. These calls include high numbers of new trainees; audit failures were taken seriously by the trust and call takers worked on action plans for improvement.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. At the time of the inspection the EOC team were working with another provider to improve capacity and a number of staff were in their induction period following a three week period in the classroom. We saw they were well supported by mentors and coaches, and staff told us they were provided with online learning programmes.

The trust set a target of 95% for appraisal completion. Appraisal rates for the Southern House EOC showed that 12% (100/113) of non-clinical staff had not had an appraisal. However, the clinical support desk had completed 100% of staff appraisals. Clinical staff felt that the appraisal were well-structured and a useful opportunity to discuss their ambitions and development. The service had been working through a period of high demand and during periods of severe pressure, appraisals had taken second place to answering calls. Most staff told us they were able to fit in one to one time with line managers when they needed it.

Emergency operations centre (EOC)

Feedback from call audits was usually delivered in a one to one setting and call takers were able to attend those meetings. Staff we spoke with told us they had meaningful supervision with mentors as well as one to one meetings. It was helpful to have a number of mentors and coaches available as shift patterns varied, but there was always someone with the right skills to call on for support.

Clinical staff who had been off work for a period of long term absence such as maternity leave, had 'keep in touch days' before they were ready to return to their normal role. They also received lots of email communication with the team to update any changes and developments. When they ready to return to work they were rostered to work with a clinical educator to learn all updates and re-sit all assessments when they returned. Staff we spoke with told us they had meaningful supervision from mentors.

The trust offered lots of opportunities for staff to learn and develop new skills; a number of staff had completed route cause analysis training which ensured the team had the skills to investigate incidents and complaints.

There were a number of 'champions' who had enhanced skills to support teams; these included for example, sepsis, radios, and fall back which was initiated in times of IT failure.

The education team worked with Health Education England (HEE) to provide funding for additional qualifications and training. HEE supported investment in teaching and learning technology and resources.

Other upskilling opportunities offered of the SCAS workforce included for example, first degrees and master's degrees; courses to develop Microsoft Office excel spreadsheets. External webinar training such as difficult conversations, minor injuries, and paediatrics.

The trust provided a wide range of academic training available to staff who applied; 12 staff had completed mentorship training; 19 staff had completed a level 3 award in education and training and 24 had completed a level 3 certificate in assessing vocational achievement. All of which significantly supported the ongoing training of new call takers.

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.

The staff in the EOC did their best to deliver coordinated safe care; we observed the internal multidisciplinary team working between emergency call takers, dispatchers, clinical advisors, and frontline crews to manage and direct care and treatment for callers.

The clinical staff had links with local primary and community care services; they assessed patients and if it was clinically appropriate, referred them to other local services, including GPs and community nursing or social services. A district nurse was available for support during the day on weekdays to support with managing category 3 and 4 callers.

Staff were working on new care pathways with local acute trusts such as same day emergency care (SDEC).

We observed effective team working between the EOC and external bodies. The service worked with other ambulance services to increase call handling capacity throughout the week as well as police and fire services to manage best first response.

Emergency operations centre (EOC)

Support for callers with mental health issues was provided by NHS111.

Call handlers knew how to redirect callers to the 111 service, the NHS non-emergency number. Staff told us they would sometimes receive calls from patients who were told to hang up and dial 999 for an ambulance from 111, instead of 111 passing the call through the computer system to 999, which meant calls received this way would require a new triage which could cause delay to patient care. This had improved during the last year and there was a reduction in reported incidents of this occurring. The director of operations told us that one of her main aims was to develop more coordinated teams. Call handlers did not participate in any form of engagement with the 111 service. There was no evidence of shared learning between 111 and EOC.

The trust worked with several local acute trusts to provide a maternity triage service 24 hours a day, seven days a week. Southern House EOC provided space for two midwives as a base to take calls outside of office hours.

Health Promotion

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

There were several pathways available for staff to refer callers to other services when they were not calling with a medical emergency or there was a more appropriate service in their local area that could meet their needs. The clinical advisors accessed a web-based information system to find relevant services to refer patients to care and support other than an ambulance response when this was appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

There was no separate Mental Capacity Act Policy. The requirements of the Mental Capacity Act (2005) were shared in the Mental Health Act Policy, after a section on detention. There was very limited guidance for staff to enable them to understand the principles or implementation of the Act. This meant staff could perceive the MCA (2005) as being part of the Mental Health Act and only applicable to people presenting with mental health conditions.

EOC staff were not expected to conduct mental capacity assessments over the telephone. If a staff member had concerns about a patient's capacity, they would note it on the electronic system for dispatcher and crews to see and raise this with a clinical manager if appropriate.

All staff in the EOCs were expected to follow the principle of the Mental Capacity Act 2005 in assuming that all patients had capacity unless they found evidence to suggest otherwise.

Clinical staff in the EOC that we spoke with understood and could articulate the relevant consent and decision making requirements of the Mental Capacity Act 2005. (MCA)

Is the service caring?

Good 

Emergency operations centre (EOC)

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 demonstrated compassionate, empathetic care to patients and members of the public in difficult or challenging circumstances. Staff demonstrated their commitment to each caller on each of the calls we listened to. During calls the staff we observed were calm, professional, and considerate of the patient's needs. We heard staff interact with people in a respectful and considerate way while ensuring they asked specific questions to follow the electronic pathways and assess the patient. We listened to calls where staff took time to ensure questions were answered, where possible, by the patient rather than supporting family members or carers to ensure the information was accurate.

We reviewed compliments that the trust provided to us and themes that came through were around the calmness and reassurance that the call handlers provided. "The call handler was brilliant, really kind and reassuring and told me exactly what to do. Made a big difference to our lives" "The call handler was patient, calming, kind and managed to get details of the problem even though I did not make much sense".

Emotional support

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

We observed staff supporting callers and patients who were distressed and anxious. Staff showed understanding of the impact of their advice and used relevant support tools to aid them in their delivery of care. Staff communicated clearly and sensitively and reassured callers when help was on the way. Staff showed reassurance to callers before ending the call. For example, they said to callers "you're doing really well" and "stay nice and calm" while reassuring patients and telling them that crews were "coming as fast as they can".

Dispatchers provided continuous emotional support to the most unwell patients and callers while an emergency ambulance response was on its way. Where necessary advisors remained on the line until the ambulance crew arrived at the scene. This provided reassurance to callers they were not alone during a distressing time.

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.

We saw examples of commendations received from members of the public by emergency call handlers praising their response on emergency calls and their clarity to patients and those close to them.

Emergency call handlers and clinicians managed the expectations of callers and their families in line with the trust expectations. When critical lifesaving emergency responses were required, staff were clear with their instructions and stayed on the line until a crew arrived to take over lifesaving actions. We saw examples of this happening during the inspection in critical and emergency situations.

Emergency operations centre (EOC)

Staff demonstrated an understanding of the importance of involving patients, relatives, and carers in their interactions.

During our observations, staff always asked to speak with patients first-hand where this was considered appropriate, or where not possible, would ask the caller to be by the side of the patient before triage began.

Staff communicated with patients and callers appropriately. Staff repeated information and asked callers if they understood the information being provided to them. Staff asked questions of third party callers to aid them in their triage. For example, where a patient was reported to be looking pale or flushed, call handlers asked the patients relative or carer if this was a normal complexion for them or if they looked more pale than normal.

Is the service responsive?

Requires Improvement 

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

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. Since the pandemic there had been an increase in demand which the service had taken action to meet. SCAS was working with another ambulance service to increase capacity. This service was able to take 15% of SCAS calls during the week and 10% of calls at the weekend; this relieved the pressure on ECTs and went some way to reducing call wait times.

SCAS were also working with the Isle of Wight Ambulance Service; they were recruiting call takers to be based at their EOC to increase emergency call taker capacity. SCAS were on track to have an extra 26 ECTs fully trained and operational by early July 2022.

The Clinical Support Desk (CSD) had doubled the number of nurses and paramedics in their team. This enabled clinical navigators to direct callers to more appropriate care and reduce the number of unnecessary ambulance journeys required. 'Hear and Treat' levels were measured, this is the telephone advice that callers who do not have serious or life-threatening conditions receive from an ambulance service after calling 999. Callers may receive advice on how to care for themselves, or be directed to alternative services for example, a pharmacy or urgent treatment centre. Staff told us that they had worked hard in recent times to improve the patient pathways and their 'Hear and Treat' score card had improved from 4% to 13%. However, ECTs told us that they often struggled to enlist support from the CSD particularly at night.

An urgent community response team of experienced clinical matrons supported the EOC clinical team between 10am and 4pm each day, which supported an improved response to some callers without requiring the dispatch of an ambulance.

SCAS were developing new pathways at the time of the inspection; for example, direct access to Same day Emergency Care (SDEC) at the local hospital without the need for the patient to go to the emergency department.

Emergency operations centre (EOC)

The service had systems to help care for patients in need of additional support or specialist intervention. Call takers worked with other emergency services to coordinate a response if support from police or fire and rescue were needed.

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.

Frequent callers were identified and flagged on the system to staff. However, updating of this service was dependant on other healthcare providers updating the trust with information. The trust maintained a frequent caller database with individual patient care plans for callers with complex needs.

Staff had access to an interpreting service for callers and patients whose first language was not English. However, there was mixed response from staff on how to access and use these services. Members of staff we spoke with had not had to use these services.

The service used 'type talk' for callers of patients who were deaf or speech impaired.

Patients received welfare calls if the ambulance response to their calls had exceeded the target time. Patients were called back and asked if any of their symptoms had changed or worsened. A new triage would be completed if answering positively to either of those questions. However, we saw evidence that welfare calls were often made outside of the target time and patients could be waiting several hours before receiving a call.

The service had systems to help care for patients in need of additional support or specialist intervention. Call takers worked with other emergency services to coordinate a response if support from police or fire and rescue were needed.

Mental Health support for ECTs and clinicians was provided by the NHS111 team. SCAS had access to a rapid response vehicle for referrals needing a mental health assessment. This was available between 4pm and midnight, but staff found that this was not consistent.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

The service used a recognised electronic prioritisation and triage system to manage the stack of calls awaiting resource allocation.

Staff we spoke with told us that the system generated a review time for patients who had been waiting for an ambulance response for longer than the recommended time frame and clinicians would contact these patients to complete a welfare check and check the patient's status. If the patient had deteriorated, or their condition had improved, clinicians would reassess the patients and recategorize the call appropriately.

The EOC frequently struggled to match resources to call volume. Trust performance data showed between the months of June 2021 and March 2022 national standards were missed for all categories of patients. During our inspection, we observed calls and dispatches and at one point during the day there were 27 outstanding dispatches.

Emergency operations centre (EOC)

The service had standard operating procedures to manage particular scenarios and conditions. During the inspection, we saw the enhanced clinical safety policy initiated by gold command, following declaration of critical incident status.

The procedure was designed to ensure that category 1 and category 2 patients received an ambulance response within an agreed time. The clinical support desk was responsible for clinical assessment and prioritisation of these calls and during the inspection the desk had 12 cases at any one time.

This impacted on the management of less urgent category 3 and 4 callers who waited hours for care/treatment. In this scenario welfare calls were assigned to one ECT who made welfare calls to check on the patient's condition and directed the patients to other care pathways where possible. We saw that welfare calls were not always made in accordance with the procedure.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients, relatives, and carers knew how to complain or raise concerns. There was information on the trust's website signposting patients and members of the public on how to complain to the service.

SCAS had a 'Patient Experience Policy' which included the management of complaints. The trust aimed to acknowledge complaints within three days and provide a full response within 25 working days. We reviewed responses to three complaints, SCAS responded to two of them in line with the timeline in the policy.

During the previous 12 months the EOC had received 175 formal complaints. By far the greatest number of complaints related to delays (110) with 'no ambulance at all' next (19) and inappropriate care pathways next (14). During the week beginning 28 March 2022 the EOC had received 34 complaints, of which 27 related to delays.

The EOC had appointed a complaints manager in August 2021 to co-ordinate the response to formal complaints, improve efficiency, and take the pressure away from very busy control duty managers.

All complaints responses were dealt with by the trust patient experience team; individuals involved in any complaints received feedback from their managers and call auditors.

We did not see evidence of sharing wider learning across different staff groups. Staff told us they assumed changes in practice came from learning from complaints and concerns, but they were generally not given that level of detail when changes took place.

Is the service well-led?

Requires Improvement 

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

Emergency operations centre (EOC)

Leadership

Leaders in the EOC had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership team in the Southern House emergency operations centre consisted of a head of service, control duty managers (CDMs - 4), shift officers, and senior emergency call takers. The clinical support desk (CSD) had one manager supported by team leaders.

There was dedicated and experienced leadership within the EOCs. Senior staff had often been part of the ambulance service for number of years and had worked in various roles before progressing into senior roles.

During the inspection we saw evidence of clear responsibilities, roles, and systems of accountability within the EOC.

Managers and team leaders were easily accessible, and staff were clear on who they were accountable to.

We observed positive examples of leadership from EOC leaders; we observed team leaders supporting ECTs during difficult or concerning calls if requested. Staff we spoke with said that EOC leaders allowed them to take a welfare break following distressing calls when requested. The 2021 national staff survey showed that more than 70% of the EOC staff said their immediate line manager listened to their concerns; just under 70% demonstrated a caring approach, and a similar number took immediate action to help solve a problem.

Leaders described the work they were doing to manage increasing call demand, which involved the whole team in mentoring and coaching new staff.

The SCAS leader course and the Essential Skills for People Managers was open to all leaders and aspiring leaders.

The head of the EOC told us he made it a priority to look after the team and made a point of seeing all new staff following initial training and all staff who asked for support. All staff spoke highly of the head of the EOC.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The SCAS vision statement was 'towards Excellence – saving lives and enabling you to get the care you need.' With a set of core values which included

- Teamwork – delivering high performance through an inclusive, and collaborative approach which values diversity.
- Innovation – continuous improvement through empowerment of our people.
- Professionalism – setting high standards and delivering what we promise.
- Caring – for our patients and each other.

Emergency operations centre (EOC)

At the time of the inspection we observed staff demonstrating these values when dealing with callers. Staff worked well together in the EOC to do their best to ensure patients received the correct care. The clinical and non-clinical staff demonstrated a patient and empathetic attitude to callers.

Senior staff had put a particular focus on recruitment of call takers to increase capacity to manage the growth in demand. We saw a detailed model of how a large onboard of new call takers would be accommodated at a location managed by another trust and the support required to implement this. Staff from all areas of the EOC were involved with supporting the trainees often as mentors and coaches.

Staff understood the need to develop alternative care pathways to alleviate pressures on the wider health and care system and we saw ECTs and clinicians worked together to achieve this goal. However, ECTs told us that access to the clinical support desk was often difficult as they were so busy.

Culture

Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. Staff did not always feel respected, supported, and valued by trust executives.

During the inspection, staff we spoke with told us that there was a generally positive culture in the EOC; we observed a positive working culture between staff groups.

Senior call takers, dispatchers, and other team leaders we spoke with had all worked their way up from ECTs and felt that they had been offered opportunities and supported to gain promotion.

Staff were encouraged to submit favourable event reports in recognition of their support for one another. We saw some of these, for example, 'L communicated to the patient with such warmth and empathy, it was easily one of the best calls I have listened too…. I feel that L really went above and beyond on this call and I hope she understands how much of an exceptional call taker she is and how much she is appreciated by both her colleagues and patients.'

'Throughout the entirety of the call, the ECT remained calm and professional. He acted quickly and efficiently using his active listening skills and his initiative, acting on what could be heard and what was stated. he provided excellent reassurance, comfort, and direction to all those on scene, in order to quickly and safely help the patient appropriately, using all tools provided on ICAD & Pathways to help him…… He should feel extremely proud of himself, as am I.'

We saw examples of the 'Wallboard' which staff accessed electronically and featured staff successes, such as, congratulations to ECTs when they were signed off as competent; 'well done to all call takers with details of the number of calls taken in the month (March 2022 Southern House 51,508)

The trust had initiated a number of support mechanisms for staff during the last two years. There were a number of mobile apps offered to staff to help manage stress, for example mindfulness and meditation.

We saw minutes from a health and wellbeing forum which was held every three or four months and attended by representatives from across the organisations including the EOC. Issues under discussion included, the flexible working policy, and the Long COVID Rehabilitation Programme. The 'Time to talk' day held in February 2022 was well attended with 50 staff logged into the session. We were told the duty managers were also wellbeing champions.

Emergency operations centre (EOC)

The trust issues a monthly 'pulse' questionnaire to staff, 'how was your month'; individuals told us that they had responded when they felt particularly pressured and the leadership had helped them with helpful suggestions.

A commemorative coin has been produced to thank all staff employed at SCAS prior to March 2021 for their hard work during the COVID-19.

The SCAS executives offered a lot of support to employees, however, when talking to some staff they were not always aware of what's available as much of the communication from senior people is made via emails, and electronic notifications which many of the more junior staff did not feel they had the time to read. The NHS staff survey for 2021 showed that the SCAS EOC staff score for 'We are recognised and rewarded' was 5.3/10 and the score for morale in the EOC was 4.9/10; there we 205 responses.

Governance

Leaders did not always operate effective governance processes in the emergency contact centre. Staff at all levels were not always clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.

The trust had an emergency operation centre clinical governance group which fed into the trust clinical review group and the patient safety group.

The EOC clinical governance group met every couple of months and we received minutes from the three most recent meetings following our inspection. The meetings were attended by senior leads in the EOC along with trust governance leads.

We did not see evidence that themes from complaints and incidents were identified and discussed nor evidence that learning was shared with all staff in the EOC.

It was noted in the minutes for EOC governance meeting of August 2021 that there was a lack of engagement in clinical governance due to the operational pressures on the service and the importance of clinical governance to the quality of service and patient safety. However, we did not see evidence that this had improved in the minutes of meetings we received for the months of October and January 2022.

Senior leaders told us that they were planning to instigate a daily safety huddle with EOC staff, but this had not been implemented at the time of the inspection.

The trust provided a risk register for the EOC, we noted from governance meeting minutes that it had not been discussed or updated since August 2021, however the register was updated on 27 April following our visit.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The emergency call centre maintained a risk register for the area which included risks relating to potential patient harm due to waits for 999 resource, demand exceeding resource available, and issues with telephony systems.

Other risks related to potential unsafe practice due to numbers of staff off sick or on maternity leave reducing the available expertise and support for training and coaching. We were told that recruitment and retention was the biggest concern for the EOC, this was reflected on the risk register, and recruitment was ongoing to address this. The trust had been under pressure with increasing demand throughout the previous year and the plan to increase capacity and improve efficiency was ongoing with trained ECTs expected to be functioning from July 2022.

The trust used a calls audit procedure to monitor the quality of calls. However, we did not see evidence to show these were used to improve performance metrics following investigations of complaints and incidents.

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. Data or notifications were consistently submitted to external organisations as required.

We observed 'real-time' electronic dashboards that monitored performance in the centre and staff reviewed these throughout the day. This information included the number of calls waiting to be answered, waiting time to dispatch, and the surge level. The team leads, and senior team used this information to manage capacity, demand, and staff responsiveness to calls.

However some data retrieval methods were inefficient; for example, the system uses a call category in the stack, the clinical support desk navigator uses a spreadsheet to filter the stack by call category but there was no live breakdown of count of activity, staff had to manually count when they were required to feed into the critical incident updates throughout the day. Another example we saw was while the clinicians can identify the nature of the call and the time of a call in the stack, breaches of these calls against standards was not indicated in the system.

There were no reporting mechanisms to evaluate the welfare calling policy compliance, efficacy, volume/activity, or profile.

Staff were able to access policies, protocols, and other work-related information through the trusts internal intranet, however staff told us they did not often have the opportunity to check e mails to see what updates may be available, and directives could sometimes be overwhelming.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The EOC displayed useful information for staff to read. This included the Staff survey 2020/21 – results and engagement plan, and the 'EOC pledges to staff 2020/21'. These included Recognition at work – do you feel supported? Health and well-being – what more can we do? And, Errors and feedback- reporting and receiving. The board also included wellbeing information for staff on stress, and sources of stress and information about risks to health relating to the physical set up of desks, chairs, and screens. The display board was in the corridor outside the control room and easily accessible for staff.

Emergency operations centre (EOC)

Staff told us the trust engaged well with them during their training programme and they had opportunity to meet senior managers during this period. The trust did their best to offer family friendly rotas and senior staff were supportive in finding shift patterns which fitted around home life and met work demands.

The trust were working with a national lesbian, gay, bisexual, and transgender rights charity (LGBTQ+) to deliver a series of workshops taking to help individuals create more inclusive cultures. There were a variety of sessions focussing on for example, engaging senior leaders on LGBTQ+ inclusion, and understanding more about LGBTQ+ people's experiences of mental health and wellbeing.

Following feedback from staff the trust have initiated a number of changes to improve the environment, such as provision of coffee machines and cold refreshments.

The trust uses 'Hot News' bulletins to try and keep staff informed of operational issues; we saw some examples which included information about leave carry over, new staff operational staff appointments and the appointment of a new director.

The service engaged with local system partners in a variety of ways, about specific patients or process, care planning, to share information. The clinical team worked with social services, community, and district nurses to improve care pathways for frequent callers and callers with dementia for example.

Senior management did not always engage staff well when communicating change. Staff in the EOC gave an example of a recent change made to the daily shifts worked by the ambulance crews. From December 2021 crews about to end their shifts were not dispatched to any calls that met category 3 or 4. This had a big impact on emergency call takers, increasing the call stacking and the wait times for patients who incurring extra call backs. This was not discussed with the senior team in the EOC, and had a detrimental impact on their wellbeing.

The trust website promoted an annual patient survey and the NHS friends and family test to enlist feedback from the public.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. However, many staff in the EOC felt they did not have the time or support from managers to access learning and improvement.

The Trust had enlisted the support of an NHS ambulance in the Midlands to manage a proportion of the calls to the 999 service during the week and at weekends. This helped reduce call takers' response times.

Emergency and urgent care

Inadequate ↓↓

Is the service safe?

Inadequate ↓↓

Our rating of safe went down. We rated it as inadequate.

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 all staff.

Staff confirmed they had not undertaken any face-to-face training. Although there were courses available online, crews said there was no time to do any, as they were always carrying out clinical work. Electronic devices had been given to staff to do training and read emails when queuing at hospitals.

All new emergency ambulance staff received initial mandatory training which had to be successfully completed before deployment. For example, equality and diversity, dementia core skills, health and safety, information governance and infection control and protection. The trust told us eLearning was available. The completion rates varied depending on the role but did not always reach the trust targets. For example, the completion rates of level 2 infection prevention and control were 80% for team leaders, 85% for ambulance technicians and 86% for newly qualified paramedics.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Staff could tell us how they would respond to patients with mental health needs, learning disabilities, autism and dementia. The trust provided training and 78% of operational staff had completed training in the Mental Capacity Act (2005).

Staff said that considering COVID-19 and an increase of patients with mental ill health the mandatory training was not enough to help them with the patients care they had been seeing over the past 24 months.

Safeguarding

Not all staff understood how to protect patients from abuse or how the service worked with other agencies to do so. Clinical staff had not had the appropriate level of training on how to recognise and report abuse in line with the national guidance, "Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) and "Adult Safeguarding: Roles and Competencies for Health Care Staff (2018).

The service had a safeguarding policy which staff could access.

Staff had not received training specific for their role on how to recognise and report abuse. National guidance detailed in the intercollegiate guidance documents states paramedics should have level 3 safeguarding training. Paramedics had completed level 2 training however, as of 2 April 2022, only 20% of paramedic staff had attended level 3 safeguarding training.

Not all staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff were not clear about their responsibilities in making safeguarding referrals when there was a concern for welfare, for example, when there was suspected child abuse. Staff we spoke with were unsure who the safeguarding lead was.

The service could not demonstrate they had considered the roles of different groups of staff and determined which level of training was required for both children's and adults safeguarding training. This meant adults and children were at risk of not having their safety and wellbeing recognised and not receiving appropriate support. The trust had a statutory and mandatory training policy that contained a matrix to show which groups of staff should complete which training. However, the line for child safeguarding level 1 and 2 did not suggest any groups who should complete this. There was no line for level 3 safeguarding children training. There was a line for levels 1 and 2 adult safeguarding but no line for level 3 adult safeguarding, which is the national recommendation for paramedic staff.

Allegations against staff and volunteers by other staff or members of the public were not always acted upon in a way that protected people. Allegations were sometimes dealt with or dismissed at a local level. The policy did not cover allegations against volunteers.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They mostly kept equipment, vehicles and the premises clean but we observed staff who were not following infection prevention and control processes.

Most ambulance stations areas were clean and had suitable furnishings which were clean and maintained. We found them to include adequate kitchen facilities and rest areas. The consumable stock rooms were tidy and labelled.

However, at North Harbour, there was a significant pigeon problem. Pigeons were nesting in the high areas of the garage. Their droppings were on vehicles, equipment, on the floor and bins. Cardboard boxes containing personal protective equipment, also had pigeon droppings on them. We were told that the packages were wiped down before use. However, this posed an infection control risk as equipment was contaminated with pigeon droppings. Staff in the make ready area were wearing respirators as they were at an increased risk of serious lung disease.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). The trust had revised their infection control policy to in response to COVID-19 and new ways of working. Staff told us they had received training in using PPE. Staff mostly adhered to infection control principles such as gloves and masks which were worn during all patient transfers. Our observations confirmed this. However, staff did not always follow national guidance. For example, using hand sanitisers or washing their hands after removing their gloves.

When the ambulance crews were at the station, they followed social distancing and infection prevention guidelines.

There was hand sanitiser at the entrances to the stations. There were clinical wipes, and hand sanitiser in communal areas.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The trust contracted an external company to make ambulance vehicles ready for use. Most vehicles were cleaned overnight, and a notice placed on the widescreen when the vehicle was ready.

Most of the vehicles we looked at including floors, the cab, the equipment and the cupboards were visibly clean.

However, the vehicles at one station were dirty. The team leader told us that this service was contracted to an external provider and they had not been washing the ambulances due to their capacity and agreed they were dirty.

Staff said the stations in the New Forest did not have a 'make ready team' and the crews were responsible for preparing the vehicles, which could be a challenge in ensuring the vehicles were ready on time. The trust told us after the inspection visit that the station was serviced by mobile 'make ready teams', which differed from the staff perspective.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment. The 'make ready' team prepared and replenished stock in the ambulance vehicles, including equipment such as the defibrillator. The 'make ready team' told us they saw their role as the pre-checks for the crew and to assist crews to get back on the road as soon as possible. One station did not have a 'make ready team' and the crews were responsible for sourcing equipment and preparing the vehicles, which could be a challenge in ensuring the vehicles were ready on time.

Equipment was usually available to meet patient's needs, for example: child restraints and baby harnesses. The emergency vehicle trolleys could carry patients with a high body mass index comfortably because they had expanding 'wings' to enlarge the width of them. Replacement equipment was stored at ambulance stations and staff had access to the equipment store.

However, there were several occasions when staff were unable to operate defibrillator machines when needed. The ambulance staff used workarounds, such as waiting for a second ambulance to respond to these situations. The staff we spoke to said they knew that patients had suffered harm, but the trust was not able to identify this as not all incidents were reported.

There was also an incident recorded where a patient had been rescued from water, when an essential piece of resuscitation equipment was not available.

The main 'make ready' stores were clean, equipment was stored and rotated on shelves off the floor. Nitrous oxide (pain relief gas) cylinders were full and stored in suitable cupboards and stored securely within the garage. Oxygen cylinders were stored in an external secure cage area and were chained securely to prevent accident injuries. Clean linen cupboards were available for crews to restock at the entrance to the stations. There were clear directions about how to report and manage equipment and vehicle faults on the staff noticeboard.

Staff disposed of clinical waste safely. Clinical waste stored at the stations were collected twice a week. There were no concerns about the tagging of bags or storage on the vehicles or at the stations. Waste bins were available for segregated waste.

Emergency and urgent care

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. However, delays experienced at the emergency departments were adding risks to patient safety and welfare in the community.

When people called 999, they were assigned an urgency category based on their condition, which determined the type and time of the response from the service. 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. From July 2021, 12% patients experienced a delay for an ambulance to attend.

For category 1 and 2 calls, ambulance crews treated patients on the scene and if required took them to an emergency department for ongoing care. The risk to the patient would then be handed over to the emergency department teams on arrival. The NHS contract states all handovers between an ambulance service and an emergency department must take place within 15 minutes with none waiting more than 30 minutes. The responsibility for the patient is that of the emergency department when the ambulance arrives.

Category 3 patients waiting for an ambulance or assessment by a paramedic were at risk of deterioration whilst waiting for a response. Other support was offered through call backs, 'hear and treat' and by rapid response staff 'seeing and treating', this helped to reduce risk and waiting for an ambulance.

Staff used a nationally recognised tool to identify deteriorating patients and usually escalated them appropriately.

Ambulance crews used the National Early Warning Score (NEWS2) tool to monitor and manage deteriorating patients.

The NEWS2 score was recorded on the electronic patient care report based on the assessment of patient's clinical observations and vital signs. NEWS2 is a simple scoring system. It used scores based on physiological measurements to help identify patients who are deteriorating and indicate the priority for medical intervention.

Ambulance staff said generally staff at the emergency departments responded quickly if they believed a patient was rapidly or significantly deteriorating. Ambulance staff caring for patients waiting for handover at the hospitals were supported by the hospital ambulance liaison officer (known as the HALO) who coordinated and managed their work.

They were an employee of the ambulance trust and an experienced paramedic. They maintained a constantly updated view of all patients remaining with the ambulance staff. They liaised with the hospital staff to prioritise and identify the risk of patients on the ambulances. The work they did was spoken of as highly valued by the ambulance service and the emergency department staff. At one hospital emergency department the emergency nurse practitioner oversaw the care of patients in the ambulances and triaged them – arranging medical intervention and testing such as ECG's. Where there were concerns a consultant reviewed them.

There was a process for additional support and transferring patients to the appropriate department. For example: suspected stroke – there was a definitive pathway which was in line with guidance. Stroke patients were transferred direct to hyper-acute stroke units or admitted to the emergency department where they were met by a specialist stroke nurse.

There were reported incidents and incidents had not been reported (but which we were told about by SCAS staff, GPs and emergency department staff) where patients had suffered significant harm as a result of delays or where ambulance staff had made poor decisions about the care of patients. Staff knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient, using a recognised tool, and reviewed this regularly, including after any incident. The assessment supported staff to meet patients' needs.

The trust had worked with other care providers to identify primary community pathways. These included pathways for patients with frailty, dementia, mental health, end of life care, chest infections, urinary tract infections, catheters and falls.

The electronic patient care record (ePCR) contained protocols and flow charts for specific conditions such as head injuries. Staff were able to make an onward referral using the ePCR, for example to a patient's GP if they had identified a patient at risk of falls.

Conversations took place to ensure the patients received the appropriate care and treatment. The dedicated GP line or frailty service enabled a 'sense check' of staff's decision making, and to agree the best plan for patients where the decision to transport was unclear. Staff had been supported and encouraged to learn how best to give a non-conveyance message to relatives and patients. This was done by clinical educators, role modelling and coaching staff.

Staff shared key information to keep patients safe when handing over their care to others. We observed good handovers from ambulance staff to hospital staff using the SBAR method (Situation, Background, Assessment, Recommendation).

The handover information detailed the current situation for example what actions/treatments the ambulance staff had given. The history leading to the current situation. The ambulance staff assessment of patient's treatment needs, and any recommendations they may have.

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.

Senior trust staff recognised the pressure on the workforce currently, and over the preceding two years. Most staff said they felt the demand and pressure particularly in the six months leading up to our inspection, from handover delays, sickness, including COVID-19 and staff vacancies.

The number of staff did not always match the planned numbers. The service had increasing attrition rates that were not matched by the same level of recruitment. Managers told us that staff were leaving to work in GP practices and private ambulance services where terms and conditions and development opportunities were reported to be more attractive.

Data provided by the trust confirmed this. Managers told us they spoke with staff planning to leave and encouraged staff retention. The overall trust staff monthly turnover rate was 9.74% in March 2022 compared to 5.16% in April 2021. There was an action plan in place to improve staff retention.

Local managers told us that the expectation was ambulance crews would always include a qualified paramedic, however due to the available staff crews this was not the case. For example, between 01 November 2021 and 01 April 22 18841 emergency calls were received, of those 1753 vehicles who responded, did not have a qualified paramedic as part

of the crew. The trust confirmed that 9.8% of ambulances did not have a paramedic as part of the crew when attending category 1 calls. This meant patients may not have received the most appropriate assessment and treatment. There were examples where patient needs had not been met because the lack of qualified paramedics; this included not being able to have opiate analgesia and not being able to offer aspects of advanced life support, when needed.

After the inspection site visits the trust told us that SCAS operates two tiers of ambulance crews, one with a paramedic and another where there is not a paramedic but a technician and emergency care assistant. During the pandemic the trust also operated ambulances crewed solely by emergency care assistants. They said that each type of vehicle is deployed through emergency operations centre to clinically appropriate incidents, although staff told us, and we saw that the crews were not always appropriate to the category of incident. The trust said that the crews knew they had the ability to call for paramedic back up if required to deliver advanced care and felt that this deployment allowed SCAS to target the appropriate skills of their crews to the appropriate patients.

The trust said that student paramedics on placement from university were always supernumerary, therefore on a double crewed ambulance they were a third person, and, on a response, vehicle were a second person. The trust said that they were always be supervised by a registrant with more than one year's experience. Staff told us that student paramedics were sometimes working as part of the crew and were not supernumerary that they should have been 'extra' to observe, but this wasn't always possible. Whilst observing in an emergency department we met a crew which had responded to a category 2 call where there was no qualified paramedic, but an ambulance technician and a student paramedic.

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.

Patient notes were comprehensive, and all staff could access them easily. Staff used an electronic tablet for recording the electronic patient report forms (EPRF), they were clear and up to date, including key information. All electronic patient records we looked at were clear and complete with records management processes following the Joint Royal Colleges

Ambulance Liaison (JRCALC) guidance. All the records seen were dated, timed, signed and had an identifiable number. These had been audited monthly pre-pandemic by clinical educators and any issues addressed but this had stopped as demand was outstripping resource and capacity issues.

The electronic device was secured through a screen password and a lock screen feature to meet Information Governance and Data Protection requirements. Records were shared electronically with the receiving hospital. The receiving member of nursing staff signed the electronic tablet to confirm handover. In case of IT failure or the receiving provider not having the ability to accept an electronic form, paper copies of the electronic patient report form were completed.

When patients transferred to a new team, there were no delays in staff accessing their records. We observed nine handovers of patients from ambulance staff to the hospital and records shared with relevant staff of other agencies.

Handovers were robust and reflected information on the trust's electronic system.

When patients were left at home (see and treat), a paper copy was left with the patient, along with information regarding specific advice for common injuries and illnesses.

Records were stored securely. Confidential waste was locked away and secured on the ambulance until it could be disposed of at a station.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored safely.

Staff followed systems and processes to prescribe and administer medicines safely. There were processes and policies which detailed how medicines should be managed. The trust had up to date Patient Group Directions (PGD's) which are written instructions for the administration of authorised medicines to a specific group of patients. This meant that medicines were administered to patients by staff with the legal authority to do so.

Staff did not always store and manage all medicines safely. We found that medicine security and access did not always follow trust policy. For example, two stations visited did not always ensure that access to medicines was restricted to authorised staff. At one station the key for access to medicines storage was not secure or held by authorised staff.

At a second station medicine storage was in a metal filing cabinet within a locked room. The metal cabinet was not locked, and there was a potential risk that medicines could be accessed by unauthorised staff. This was fed back to the trust who responded.

The trust had undertaken a full review of all medicines storage facilities in line with the Safe and Secure Handling of Medicines Policy. There is an action plan in place to address issues following a planned program of works. This includes addressing storage and storage rooms, Hythe was listed on a three year improvement plan. The project was on track with a minimum of five stations planned for the year 2022/23.

There was a lack of sufficient storage for medicines at the main store, however the pharmacy team were managing the situation as best they could. It was recognised by the trust that a new main central store location for medicines was required.

There was a clear process for the distribution of medicine bags to stations to ensure medicines were available to administer. Medicine bags were tagged and sealed to ensure medicines were available when needed and fit for use.

However, some of the medicine bags were too small to contain all the required medicines without something falling out unnoticed by staff. This had led to an increase in reports of missing medicines from bags. This issue, although part of the improvement plan for medicine distribution, was taking time to deliver the required change. The paramedics checked their medicines bags as part of their overall checks at the start of their shifts.

Staff were asked how they accessed pain relief such as morphine, which was locked in a safe on the vehicle, when the paramedic was with a patient, (a paramedic is the only member of staff who can access controlled medicines). They said they would hand their key card to a colleague if not a paramedic. The trust policy states only the member of staff with the key can access the medicines in the safe. On informing the trust of these concerns they replied; 'Handing a key card to a non-registered member of staff is not part of the policy. This issue has been picked up and addressed with the local team. We will continue to monitor to ensure there is policy compliance and understanding of the responsibilities of registered staff'.

Medicine rooms and refrigerator temperatures were electronically monitored to ensure medicines were stored within the recommended ranges. An electronic central logging system alerted staff to any temperature variations so that action could be taken.

Medical gases were stored safely and securely.

There were processes to audit medicine safety and security, however these audits were not always being undertaken due to staff capacity. This meant it was not always possible for the service to identify where issues were, identify any trends and see what needed to be done in order to mitigate the risks. The lack of medicine safety and risk audits was included on the risk register, with improvement plans in place.

The Misuse of Drugs Act 1971 places controls on some medicines called Controlled drugs (CD) and under the Misuse of Drugs Regulations 2001 there are certain controls for storage. On one ambulance the CD cupboard was out of use as the lock was broken. This had been reported to the trust on 29 March 2022 and no action had been taken. This meant that the crew could not carry any CDs such as morphine which in turn impacted patients. For example, staff told us of one incident where a patient's pain was not effectively managed. Staff followed the trust process and requested some morphine from one of their support crew, who themselves did not have any morphine, this meant the patient's pain was not treated whilst they were being transported to emergency department. After the inspection the trust sent a plan of the action they would take to ensure medicines were safely stored and managed.

Staff learned from safety alerts and incidents to improve practice. Staff understood how to report a medicine incident or safety concerns following the trust incident reporting policy. Staff told us they received updates about errors or incidents.

Incidents

The service did not always manage patient safety incidents. Not all staff recognised and reported incidents and near misses.

Managers did not always encourage reporting and not all investigated reported incidents. The trust did not always share lessons learned with the whole team and the wider service. When things went wrong, staff did not always apologise and nor were patients or family members given comprehensive and unambiguous information and suitable support, as required by the regulation relating to the Duty of Candour. Where apologies were offered in writing, they tended to be for the distress felt by the patient or relatives and not for the care shortcomings.

Managers ensured that actions from patient safety alerts were implemented and monitored.

Not all staff knew what incidents to report or when to report them. There was a policy for staff to refer to giving guidance on the reporting of incidents. There were 273 reported incidents between October 2021 and April 2022. For example, delays at hospital handovers, which led to delays in response to other calls, patient treatment and care and IT. Some staff told us they used the urgent and emergency care electronic system to report incidents and there was varying level of feedback and support provided. Staff told us a member of staff had given a patient too much glucose.

Following an investigation, the trust had changed the bottles so staff could see the different strengths more easily.

Many staff said they were discouraged from reporting incidence by their local managers as it created too much work.

Emergency and urgent care

The level of reporting and types of incidents being reported was not in line with the averages for other ambulance trusts.

Staff did not always report serious incidents in line with trust policy. This meant the trust under reported incidents as they did not have the information from staff. Staff told us sometimes they used the trust's electronic system to report incidents. Others said they did not use the electronic patient record as they could 'get lost', so waited until they returned to the station. Four staff we spoke with who were on 'hold' at a hospital said they knew how to report incidents but didn't usually bother unless it was a big clinical mistake as 'nothing happened and there simply wasn't time'.

One said, "Things happened, and you just had to accept this to cope with everyday life". None of these staff knew about any serious incidents but did get to hear about 'bad calls' on the grapevine.

Staff gave examples of what they would make a report on such as; missing medicines, clinical errors and issues with the triage system. Some staff said there was a 'no-blame' culture and they wanted to learn from incidents.

Feedback from CQC's staff survey suggested that there was a blame culture. 'SCAS think they encourage reporting of incidents and near misses, however there is still a culture of blame and finger pointing. Rather than striving to find the cause and learn from mistakes, instead just blame the individual and move on'.

Staff gave an example of a recent serious incident. A clinician attended a call for a cardiac arrest and assessed resuscitation would not reverse the patient's outcome. A second crew assessed it was a potentially reversible condition. Following an investigation further risk were mitigated by ensuring the member of staff worked with senior supervision. Support was given to the member of staff and the family were informed.

Incidents that should have been reported as serious incidents by ambulance crews were not. This included where patients had died or suffered significant harm. Senior leaders at the trust supported a stance of non-compliance with the national reporting framework. Specific examples were seen but are not reported to avoid the potential to cause distress to bereaved relatives.

Staff did not fully understand the duty of candour. Most could talk about being open and transparent and gave patients and families a full explanation if and when things went wrong, but this was not always followed through in practice.

Some staff we spoke with were unfamiliar with the term 'duty of candour'. However, all staff were aware of it and in discussions they could all explain the meaning. Some of the staff we spoke with told us the phrase meant, 'saying sorry if you've done something wrong'. Staff could not recall an incident when this had happened.

Analysis of the responses from the trust to patients or their families showed that the duty of candour was not always completed in line with the requirements of the regulations. Apologies were about feeling distressed rather than for service delivery failings. The letters were not sent out in a timely way as required.

Managers debriefed and supported staff after any serious incident. Support could include a return to base, cup of tea, a physical check and time to talk. A quiet room was available, and staff were supported with essential paperwork.

In the case of a major incidents there was always a staff debrief. Staff gave us an example of where a very experienced crew had managed the case of a patient drowning. The situation had involved air ambulance, trust staff and an incident commander. A debrief was held immediately afterwards and support was given at the time and afterwards as needed.

Emergency and urgent care

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it 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 had access to policies to support the delivery of high-quality care according to best practice and national guidance.

The electronic handheld devices held current care plans, flow charts and policies for patient care and treatment. Policies reviewed after inspection were comprehensive, in date and version controlled. For example, end of life care pathway 78% of staff operational staff had completed end of life care training between 01 April 2021 and 31 March 2022.

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 mobile devices. Where guidelines were available from JRCALC the service did not have a separate policy as the JRCALC guidelines were regularly updated and best practice. For example, the service does not have a separate sepsis policy but refers to the JRCALC guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the 2015 Code of Practice. The service outsourced the transportation of patients held under the Mental Health Act. The trust had contracted out secure mental health specialist services with independent providers and the service was arranged through the police.

Where ambulances had transferred patients to hospital who were a significant risk to themselves or had self-harmed, the hospital prioritised these patients and tried to find somewhere appropriate for them that was calmer and allowed them greater privacy within the hospital.

Pain relief

Staff assessed and monitored patients to see if they were in pain, however patients did not always receive pain relief.

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.

Ambulance staff used the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance to assess acute and chronic pain. The guidelines were written as an essential resource for NHS paramedics, the principles are also applicable to the work of all pre-hospital clinicians. The JRCALC guidelines are also an important part of clinical risk management and ensure uniformity in the delivery of high-quality patient care.

Other pain assessments were used for adults, children and those with a memory loss or who had a learning disability.

These included number scores between one and ten, a set of faces to determine how severe pain was for children over the age of three years and a pain score for those who either could not communicate or those who found it difficult.

However, not all patients received pain relief when it was identified they needed it, or they requested it. Training records showed in the year April 2021 to March 2022 all emergency care operational staff had initial training in pain management. This included emergency care assistants, associate ambulance practitioners and paramedics. However, concerns regarding staffing and the lack of paramedics meant the trust could not be assured that all patients received adequate pain relief. Ambulance crews who were not qualified paramedics could administer some forms of analgesia, but not controlled drugs for the most severe pain.

Records seen and most patients told us they had received pain relief when needed. However, one patient said “No, I didn’t get pain relief, but I expect they just wanted to get here quickly, and I needed something stronger than a couple of paracetamol tablets”. Another relative said their parent had not been given analgesia as they couldn’t swallow paracetamol. The paramedic had explained to them that anything stronger may prevent the doctors being able to make an accurate diagnosis.

There were also delays in providing analgesia or an inability to offer pain relief where the ambulance crew did not include a qualified paramedic. This added to delays in providing the most effective pain relief caused by delays in ambulances responding to emergency calls. Some patients remained in significant pain whilst they waited several hours before an ambulance to arrive, including people with fractured ribs and hips.

Response to patients

The service monitored response times so that they could facilitate good outcomes for patients. Data showed a deteriorating response over the previous 18 months, which was a similar picture across NHS ambulance services nationally.

Factors contributing to these delays were long delays at accident and emergency departments to discharge patient staff vacancy rates and staff sickness.

During the time period of October 2020 - March 2022, time to attendance for 90% of incidents compared to the standard of 15 minutes and other providers. The provider met the standard in 12 of the 18 months. Response times were quicker than the England average in 14 months and slower in 4 months.

Staff told us there were issues with scheduling and they felt that ‘control lacked empathy.’ They said it was very hectic with elderly patients waiting long periods following a fall. Staff told us about the day before our inspection when a patient had been on the floor for up to 14 hours following a fall before the crew arrived. One incident report showed that the medical examiner at the hospital had identified that a long delay where an elderly person had been trapped under their bed had contributed to their death.

There were concerns about triaging for example, where patients were left to wait for longer periods to their detriment.

For example, a patient who had suffered a catastrophic brain haemorrhage was transferred to the neurology unit in a poor condition; they had experienced delays in the emergency ambulance arriving at their home.

The response to patients was monitored through complaints and call backs for same condition. The service managers felt those taken to the emergency department were appropriate. This was confirmed by direct observation and feedback from medical staff at the local emergency department.

Patient outcomes

The service monitored the effectiveness of care and treatment, but staffing shortages, performance and delays sometimes resulted in poor outcomes.

The service participated in relevant national clinical audits. The service participates in the national Ambulance Clinical Quality Indicator (ACQI) programme.

The Association of Ambulance Chief Executives (AACE) published a report in November 2021 following a structured clinical review of handover delays at hospital emergency departments across England. It identified the extent of potential harm that was being caused to patients when they had to wait in the back of ambulances or in corridors before they were accepted into the care of the hospital. Over eight in ten of those whose 'handover' (from ambulance clinician to hospital clinician) was delayed beyond 60 minutes were assessed as having potentially experienced some level of harm; 53% low harm, 23% moderate harm and 9% (one patient in ten) could have been said to have experienced severe harm.

In response to this report, the trust carried out an audit themselves of 859 electronic patient records for the month November 2021. The audit indicated for 72 patients that had experienced a hospital handover delay over one-hour, further investigation was needed. A 'Patient Outcome' was requested from the receiving hospital and in each of the 72 cases the actual harm of the patient was reported to be lower than first identified. The trust acknowledged that all incidents where patients were waiting to be handed over to the hospital their experience was poor.

The trust used the information from their audits to improve care and treatment. They launched an initiative to help patients receive the right treatment more quickly and avoid unnecessary transfers to emergency departments.

Ambulance staff were supported to assess patients at home and take a lead role in working with GPs and consultants in hospitals to determine a patient's next steps.

Information received from the trust stated more than 37,000 patients (numbers till the end of November 2021), who would previously have been conveyed to busy emergency departments for further assessment/treatment, were referred to other services more appropriate to the patient's needs, in liaison with the patient's GP.

During the COVID-19 pandemic trust staff focused on moderately unwell patients with medical conditions, older patients who were frail with chronic conditions who are at risk of falls, those with respiratory conditions such as COPD and asthma, people in mental health crises or children who require a specialist paediatric assessment.

The trust carried out a Care Bundle 50 Audit of 50 case records each month for specific performance indicators which formed part of the National Clinical Audit Programme (NCPI) which was suspended as part of the review of clinical indicators included in the Ambulance Response Programme (ARP). Lower limb fracture was least compliant indicator scoring 40.2 % in the year ending March 2022. Elderly falls scored 64.2 % and febrile convulsions 77.8%.

Competent staff

Emergency and urgent care

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.

Managers did not ensure staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers 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 these were not always applied. Professional updates and clinical skills updates were not consistently completed which affected mandatory compliance.

At the time of our inspection less than 80% of staff had completed the mandatory professional updates against a target of 95%.

Staff who had been with the trust for a few years, told us their induction had been good and was in line with their job. All staff grades should have been supported on their shift and had able to complete assessments at two, four and six months.

Following the inspection, the trust told us that the newly qualified paramedic consolidation of learning programme did not change at any time during the COVID-19 Pandemic. They confirmed these staff were required to complete 8 operational shifts with another band 6 paramedic. In the first year they did not work with Leaners or students and could not solo respond. They had access to a validation line for support in decision making, which was mandatory for some categories of patients. However, staff told us that due to operational pressures this was not consistently applied. Staff agreed it was trust policy for newly qualified starters to be supported for the first six months, but those we spoke with said this was not always the case in practice

Managers did not support staff to develop through yearly, constructive appraisals of their work. None of the staff we spoke to had received appraisals in the past two years. The Integrated Performance Report dated 13 January 2022 showed that appraisal rates continued to decline. In December 2021, the trust reported that across SCAS 59.9% of staff had an appraisal, but this fell to 43% for operational staff and 34% for south based operational staff.

Managers informed us the COVID-19 pandemic and operational pressures had impacted the appraisal programme and there was an action plan to restart appraisals. Managers shared concerns that the capacity of the managers and ability to release staff to complete the programme of appraisals was not realistic. Staff were offered a Health and Wellbeing meeting with the team leader and clinical educator via a video call. However, there were no documents to confirm this. The board papers for January 2022 showed that there was consideration of whether it was possible to record when Health and Wellbeing calls took place, but the electronic staff record system did not allow for this. The trust could not be assured the calls were taking place and we did not see any evidence of other mitigation that allowed oversight of professional practice.

Managers made sure staff could access meeting notes when they could not attend. Staff meetings were virtual and occurred once every 13 weeks for three and half hours. Information from the meetings was available at the ambulance stations and was sent out in emails.

Where managers identified any training needs for their staff, there was not always the time or opportunity for staff to develop their skills and knowledge. Clinical educators were paramedics with allocated time to support learning and development within the team. They worked on the rota as a paramedic unless off rota for dedicated management or

supervision shifts. They were meant to work on shift with each member of staff twice a year, but it was unclear how often this was happening due to demand for emergency services. Staff told us management time had gone down 24% due to the demand for emergency services, and team leaders carrying out clinical work, however we did not receive the data to confirm this.

REAP is the national Resource Escalation Action Plan a framework designed to maintain an effective and safe operational and clinical response for patients. The trust had been operating at REAP 4 for some time. This is when they are at the highest operational alert level due to extreme pressure.

SCAS reaction to REAP 4 was to increase the level of clinical resource to prioritise patient care. The trust had reduced some of the team management time of team leaders during REAP 4 episodes to increase their response capacity. As the trust had been at REAP 4 for some time, this impacted significantly on team management.

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.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was good collaborative work between hospital staff and the Ambulance Liaison Officer (HALO) at the emergency departments of the four hospitals we visited. An emergency nurse practitioner carried out initial triage and was responsible for streaming patients following assessments to prevent delays in care.

At one NHS hospital there was ongoing work to tarmac the ambulance bay. The hospital had put in a workaround to manage the flow of patients to the emergency department. A nurse was allocated to triage patients which were parked a few hundred yards away from the four bays. Staff told us there was one bay which was kept free for emergency/ trauma patients. At another NHS hospital senior hospital staff told us there was good communications with the trust.

Crews told us that they did not always see the work that is going on behind the scenes and so could become frustrated feeling nothing was being done. The trust's clinical operations manager had three or four calls a day with the deputy chief operations officer for one NHS hospital. Relationships were good with both parties understanding that they were trying their best in impossible circumstances.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff accessed the trust's mental health practitioner or the 111 service, if they had concerns about a patient's mental health.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff usually supported patients to make informed decisions about their care and treatment. They usually followed national guidance to gain patients' consent. However, there was confusion amongst staff on how to support patients experiencing mental ill health to make their own decisions.

There was no separate Mental Capacity Act Policy. The requirements of the Mental Capacity Act (2005) were shared in the Mental Health Act Policy, after a section on detention. There was very limited guidance for staff to enable them to understand the principles or implementation of the Act. This means staff could perceive the MCA (2005) as being part of the Mental Health Act and only applicable to people presenting with mental health conditions.

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 prior to any care or treatment.

Staff demonstrated the care plans and flow charts available on the handheld devices allowed staff to give patients accurate information on which to base their consent. Staff were not able to complete a record unless this assessment had been completed.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff explained when a patient could not give consent, for example they were unconscious, they would make a best interests decision based on all the information they had available including information from families and carers.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. The care plans and flow charts available on the handheld devices allowed staff to give patients accurate information on which to base their consent. We observed staff gaining verbal consent from patient prior to taking observations and reiterating that consent every time observations were completed.

Not all staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Mental health training was provided on induction to the trust and was refreshed in the mandatory training and professional update programme. However, we observed a situation where person with mental ill health decided to leave the ambulance crews care and the NHS hospital site. The crew were uncertain as to whether they should stop them.

They did not know whether the patient had capacity and were unclear about what having capacity meant. The advice they had was confusing about whether leaving against advice automatically meant the patient lacked capacity and they should be restrained. They didn't get the help and advice they needed to ensure the patient was kept safe.

Is the service caring?

Good 

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

Compassionate care

Staff did not always treat patients with compassion and kindness. Staff 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 and those close to them in a respectful and considerate way.

We visited four NHS hospital emergency departments. We saw good care provided to patients by the ambulance crews.

Staff communicated with patients when moving them between different areas of the hospital and kept them informed of what was happening.

Staff protected patient's privacy and dignity by drawing curtains, closing vehicle doors when care was provided. Staff were seen to fetch hot drinks and extra blankets for patients in ambulances. Patients in ambulances were not left alone. If one of the crew went to have a drink or comfort break, the other remained with the patient. Patients being moved were always well covered.

We observed some staff being abrupt with patients. But patients said staff treated them well and with kindness. 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 the staff had been friendly and approachable, and all their needs had been catered for despite any delays they were experiencing.

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

We received positive feedback from a GP. A patient had attended the GP practice in state of collapse, following dental surgery. Anaphylaxis (a severe, potentially life-threatening allergic reaction) was diagnosed and the GP's began resuscitation. The GP knew the patient had a very complex home life. The patient refused to go to hospital as they were worried about a young family member. The ambulance crew made contact with the relative and explained the situation. The patient went willingly in the ambulance as the crew had arranged a divert to pick up the child on the way to the hospital.

Emotional support

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

Patients were treated with care and staff interacted with patients in a compassionate manner frequently checking to ensure the patients were comfortable. Most patients told us that the staff were very good and had provided assurance when they arrived.

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 observed staff talking to patients and providing reassurance. Staff sometimes went beyond their role of assessments, treatment and conveyance. For example, a patient told us, "I wanted to come to this hospital, we were halfway between the two, so they agreed to bring me here. They were very kind, very helpful and remembered to pick up my bag with my purse and keys in it and fetched my coat. They made sure there was water and food for my cat before we left too".

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 we saw the care pathways and information available for both the patients and staff was on the handheld electronic device.

Emergency and urgent care

Staff talked to patients in a way they could understand, using communication aids where necessary. We observed staff talking and interacting with patients. Staff did not use technical jargon and ensured patients understood their care and treatment. Staff told us that translation services were available, and they had the tools such as a visual pain scale, available on the electronic devices to aid pain communication.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Is the service responsive?

Requires Improvement 

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

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. There were 27 bases across the trust area, from which emergency services could be deployed. The trust had worked with primary healthcare to plan how the wider system could meet the needs of local people and communities in their area. To aid patient flow there were five specialist practitioners (paramedics) who used their knowledge and skills to independently provide healthcare, focused on patients with minor illness or injury, long term conditions, and other urgent care needs. They worked in the frailty team, on GP projects and as an urgent responder. In primary care, they helped to assess acute same day appointments and undertook home visits on behalf of GP surgery and the 111 team.

Facilities and premises were appropriate for the services being delivered. Although the stations varied in size they were designed with the space and facilities required to deliver and develop the service.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff had the support of a single point of contact to raise concerns or to leave messages for the patient's GP.

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.

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 learning difficulties and those living with dementia. Staff explained, when appropriate or necessary, the patient's primary carer could accompany the patient.

The mandatory training programme included training in equality, diversity and human rights.

The clinical notice boards in the stations had information and guidance for staff, for example, information on how to treat patients with Downs syndrome.

Staff had had training in crisis management, and they could access support from local police forces when attending to patients with known histories of violence.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. Staff had access to a translation service on the handheld devices.

The staff were informed of any known issues or communication problems by the Emergency Operations Centre or Clinical Coordination Centre. Staff told us that on the next update of the handheld devices they would be able to access a patient's previous call out history, which would also give insight and information on any specific needs or considerations.

Access and flow

People could not always access the service when they needed it, in line with national standards, and could not always receive the right care in a timely way.

Staff supported patients when they were transferred between services. The hospital ambulance liaison officer (HALO) post provided a link between ambulance crews and emergency department staff at hospitals. The role assisted the handover of patients and kept staff and patients informed of any delays. Crews consistently told us that the HALO roles were helpful in handing patients over smoothly at hospital.

Handover start time is defined as the time of arrival of the ambulance at the emergency department, with the end time defined as the time of handover of the patient to the care of emergency department staff. National guidelines/ best practice is 15 minutes.

A national report from the Nuffield Trust on 14 February 2022 stated the Southeast, (which includes this trust), had performed best so far this winter, with 88% of ambulances arriving at hospital with either no handover delay or experiencing a delay of less than 30 minutes. In the Southwest the figure was only 70%, and 18% of ambulances arriving at that region's hospitals experienced a handover delay of more than 60 minutes, which was more than double the English average. At seven hospital emergency departments in the trust's area in the week beginning 29 November 2021, 730 ambulances had to wait between 30 and 60 minutes to handover patients and 76 over 60 minutes.

In the week ending 3 April 2022 for the same hospital emergency departments 74 ambulances had to wait between 30 and 60 minutes to handover patients and 52 over 60 minutes.

Due to the pressures on the emergency pathway some patients were delayed accessing the hospital from the ambulance. These patients were cared for by the ambulance crew in the ambulance. We observed ambulances waiting to offload their patients at three of the hospital locations we visited during our inspection. Patients were triaged by hospital staff in the ambulance and in some cases, we observed the accident and emergency clinicians administering care in the ambulance. We also observed ambulance crews taking a patient from the ambulance for diagnostic imaging and then returning them to the ambulance to continue to wait for admission.

There were recorded incidents where patients suffered harm because of or exacerbated by long delays in ambulances arriving. Ambulances waiting at hospitals were not available to reach people in urgent need of care or treatment. There

was limited evidence that the service was considering what measures they could take that were about action related to their own resources to minimise the delays at one hospital. There were several hospitals reachable in under forty-five minutes of the busiest hospital, but patients were not taken to these even though they were very quiet when we inspected. There were patients taken to the busiest hospital despite a much quieter emergency department, without any ambulance handover delays, when the difference in journey time was ten minutes. Occasionally crews made the decision to take patients to a different hospital but this was not embedded in practice and not usually related to how busy a hospital was. The guidance provided by NHSI/E encourages dynamic conveyancing to reduce waiting times for handovers, but the trust was not utilising this and did not recognise it as an option.

As an example, in October 2021 an elderly patient fell, fractured their hip and was unable to move. They waited over 15 hours for an ambulance to arrive. They died five days later with the medical examiner for the hospital citing the delay as a contributory factor. The incident record supplied by the trust said that there were 16 ambulances 'on hold' waiting to handover patients at one hospital, so unable to respond to further calls and no opportunity to send assistance earlier. Information from a neighbouring hospital within the same ICS shows that on the same morning their longest handover time from ambulance to hospital staff was 12 minutes. The trust could have used intelligent conveyancing to allow a faster turnaround of ambulances and have more resources available to people needing assistance.

The trust had worked with one hospital to introduce the use of home blood oxygen monitors to enable people to remain at home and monitor their condition and seek further support in the event of a deterioration. This had reduced the number of COVID-19 positive patients being taken to hospital.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients, relatives and carers knew how to complain or raise concerns. There was information on the trust's website signposting patients and members of the public on how to complain to the service.

Staff understood the policy on complaints and knew how to handle them. The trust had a 'Patient Experience Policy' which included the management of complaints. The trust aimed to acknowledge complaints within three days and provide a full response within 25 working days.

Managers investigated complaints and identified themes. The senior team said they believed that most complaints were about staff attitudes and these were dealt with locally. In the six months between October 2021 and April 2022 a total of

175 complaints had been made: 134 were related to delays, situations when ambulances had not attended or patients were not taken to hospital; 18 concerning staff attitude/communication; 17 regarding care records, safeguarding and the call category; 7 'other'. The action taken regarding these complaints to prevent reoccurrence was not clear.

All complaints responses were dealt with by the trust patient experience team; individuals involved in any complaints received feedback from their managers and call auditors.

Managers shared feedback from complaints with staff and learning was used to improve the service. We did not see evidence of sharing wider learning across different staff groups. Staff told us they assumed changes in practice came from learning from complaints and concerns.

Emergency and urgent care

Is the service well-led?

Inadequate ↓↓

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

Leadership

Leaders did not always have the skills and abilities to run the service. They did not all show an understanding of the priorities and issues the service faced. Not all staff said they were visible and approachable. They did not offer support to staff to develop their skills and take on more senior roles.

The operational services were led by heads of operation, clinical operation managers and team leaders. Most of the staff we met said they felt supported by their local leaders however, they described a disconnect between the local teams and the wider trust. They described working in silos.

All staff knew who their local leaders were but not all staff knew the senior executive team. They were unable to tell us who their leads were for: safeguarding, learning disability, dementia, risks or complaints.

Local leaders were often deployed operationally, which meant they did not have time to lead. Many management tasks were 'put on hold', leaving staff with less support and oversight. The trust had been operating at REAP 4 for some time and this had resulted in managers being required to work operationally to increase the resources available.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy, developed with all relevant stakeholders.

This was impacted at this time by the COVID-19 pandemic.

The trust had a vision and a set of values, they stated should underpin everything staff did. The vision had four goals:

- Be an exceptional place to work, volunteer and learn
- Provide outstanding quality of care and performance
- Be excellent collaborators and innovators as system partners
- Be an environmentally and financially sustainable organisation

We observed most staff applied these goals and values in the care and treatment of patients. However, in feedback from staff to the CQC staff survey, staff did not feel the vision and goals were applied throughout the trust. For example:

- emergency fleet vehicles were in a state of disrepair. The satnav software was outdated, leading to increased driver
- fatigue and inadequate route selection (delaying arrival). Poor support for newly qualified paramedics, leading to low
- morale. The lack of support had led to poor clinical decision making and medicine management.
- Some staff felt there was a lack of respect and transparency with barriers in management leading to distrust and an

- inability to communicate effectively.

The trust had drafted a strategy for 2022 – 2027 which was presented and approved by the board at the meeting in March 2022.

Culture

Not all staff felt respected, supported and valued, and this extended to not feeling valued beyond their local teams. Staff were working long hours and sometimes without breaks. The service did not always have an open culture where patients, their families and staff could raise concerns without fear.

Not all staff felt supported, respected and valued. The support staff received was dependent on the team they worked in. CQC invited staff to complete a survey. There was a small response rate but there were comments from staff which included references to bullying, harassment, poor health and safety, a disconnect between senior managers, a 'tick box' approach to staff welfare and fear of repercussions from speaking out. Staff said the service had introduced an anonymous feedback system, because staff feared giving feedback, and because of low morale is. Staff we spoke to who had not responded to the survey (either because they did not have time or because they did not believe it was anonymous) said the local culture was about who the local manager was. Many reported feeling isolated and demotivated. Some acknowledged this was, in part, due to the pressures of the pandemic but others felt they were not valued by the organisation. Middle managers were more positive than lower grade operational staff.

The 2021 NHS staff survey results were more positive, with a higher response rate (Median 57%) and scores that places the trust above average when benchmarked against other ambulance trusts. Scores for most questions sat above average. The exceptions were around staff morale and feeling safe and healthy at work. The trust scored particularly well for the questions about inclusion and diversity.

The culture within the organisation was centred on the needs and experience of people who use the services. Our observations of patient staff interactions demonstrated that most staff were committed to delivering the best care possible to their patients.

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 the hospital emergency departments, reducing their ability to support patients in the community. Delays meant that staff frequently finished late and missed meal breaks and crew skill mix were impacting on staff morale. Some of the newly qualified paramedics felt they had to operate beyond their experience level.

The trust policies placed an emphasis on the safety and wellbeing of staff. Staff said they recognised there was support for them, but many said they did not have the time or energy to use it. They said they were getting support from their fellow crew members or the staff they worked closely with, who were in the same situation.

Some staff felt the organisation’s leadership were visible enough, but others were concerned about the lack of recognition at senior level of the situation frontline staff were facing.

Emergency and urgent care

The trust has appointed a freedom to speak up guardian. Leaders of the trust said that the Freedom to Speak Up Guardian was always available to staff and that they could decide to speak to the FTSUG at any time. However, several staff told us they could only access this service in their own time, which made this less accessible to those who had already worked a long day and needed a break or had commitments that meant they could not stay late to speak to someone.

Local leaders told us that the stations did not always reflect the diversity of the area. There was a lack of flexibility to work and progress as team leaders. Feedback in the survey supported the lack of development opportunities, and poor equality

Governance

There was a governance process, but it was not effective. Staff at all levels were clear about their roles and accountabilities, however there were no opportunities to meet, discuss and learn from the performance of the service.

There were structures and systems of accountability in place to support the delivery of the service. The governance structure included senior staff meetings, strategic meetings, operational meeting and meeting with external organisations. However, the information being presented upwards did not always reflect what was happening and the scale of risks. Concerns were dismissed and not addressed, leaving risk that had no mitigation.

We asked staff about governance processes for example, audits. They gave examples of the audits; medicines, vehicles checks, patient records, hand hygiene, and monthly station audits. However, there were no audits taking place. Local leaders suggested this was due to the work pressures.

Staff were clear about their roles and understood what they are accountable for. Team leaders understood how their teams were performing and risks to the service. However, some staff expressed concern that lesser qualified crews could be dispatched to higher category calls, and they were not fully supported when working outside their scope of practice.

Following the inspection, the trust told us that SCAS operates a 2-tier service matching the appropriate crew skill mix to the most clinically appropriate patients. This enabled them to get a response to every patient and the crews know they can call for enhanced skills for support from a paramedic, if necessary.

We have an active, continuous recruitment campaign to fill as many clinical vacancies as we can. However, due to the shortage of paramedics graduating, compounded by diversification role opportunities for registered paramedics, we are unable to fill every vacancy in order to roster a paramedic on every ambulance.

Engagement with staff. Staff told us they were asked to fill out many surveys, at present they had no time to do this unless they did so in their own time; not many staff completed them. Senior management corresponded by email. This included a newsletter. These were often lengthy, and staff did not feel they had the time in work hours. They had fed back to team leaders they could be shorter, and bullets points as with so many emails difficult to know what was important. There had been meetings for staff however, operational staff said they were no longer able to attend meetings.

Management of risk, issues and performance

Emergency and urgent care

Leaders and teams did not use the systems and data to manage performance. They did not always identify and escalate risks and issues.

There were low numbers of Serious Incidents reported when compared to other ambulance trusts. Some incidents which resulted in poor outcomes for patients, and which should have been investigated and reported as Serious Incidents were not. This included several cases where defibrillators had failed when used.

The low reporting meant that the board did not have an accurate picture of risk and patient safety.

Investigation reports tended to blame those involved in the incident. This included a suggestion, a patient hadn't given clear information.

The service had local risk registers for the station specific risks and a wider service risk register. Each department had their own risk register and the top three risks for operations were: handover delay at one hospital, failure to respond in a timely fashion and patient outcomes.

Senior staff said the service had limited influence over the bed-capacity crisis in NHS hospitals.

Operations staff told us of other risks. One of the highest risks was about safety of staff. For example: the number of incidents of violence against 999 staff reported between 1 April 2021 and 31 March 2022, was 223. Incidents of violence against ambulance staff increased by 23% nationally in 2020.

At one station there was limited parking and staff had to park away from the stations. Staff said they had been sexually harassed and accosted by other car park users. Staff did not feel safe. Although this had been reported, they were not aware of any actions that the trust had taken to mitigate these risks.

The trust had introduced a pilot for body worn cameras for operational staff. A few staff were using them at North Harbour, but more did not want to use them for various reasons including a feeling that they were about being checked up on or inconvenience.

The service followed the government COVID-19 on safety for ambulance trusts. Staff said the national guidance had not always been clear in the early days of the pandemic, but the trust updated them when it changed and those staff, we spoke with said they thought it was now well understood and implemented. The staff we asked said they would speak up if they felt infection prevention and control protocols or practices were not being followed by colleagues.

The ambulance service was set up to manage unexpected events and the trust had plans for major incidents. These were reviewed with partner organisations to ensure they would be able to manage any incidents.

Potential risks were considered when planning services such as seasonal or other expected or unexpected fluctuations in demand. For example, in response to increased visitor numbers in the summer. There were standard operating procedures in place, for the use of non-registered crews to respond to clinically appropriate patient in times of high demand such as at REAP4.

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. Data or notifications were consistently submitted to external organisations as required.

Staff had access to the internal intranet site called 'The Hub', accessed via their personal login details, they could enter the site from any device anywhere.

In the ambulance stations there were notice boards with information for staff such as: health and safety and 'Hot news', driving standards.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had a staff feedback system where staff were sent a weekly email and asked how they were feeling, why, and what can be better. These were collated and analysed monthly. Frequent responses were about 'stacking' at one local

NHS hospital, a lack of meal breaks, late finishing and rota changes (when working partnerships and teams were split for operational reasons).

Staff could be sent to a different station to work and this was unpopular. Senior staff said moving staff to different teams had the unintended benefit of reducing the risk of a closed culture developing where poor practice and behaviours were tolerated.

Staff at all the stations told us there were no team meetings and no senior staff visibility, although most felt supported by local team leaders. The trust told us that this was to allow more staff to be focussed on patient safety.

The trust was working with a national lesbian, gay, bisexual and transgender rights charity (LGBTQ+) to deliver a series of workshops taking to help individuals create more inclusive cultures. There were a variety of sessions focussing on, for example, engaging senior leaders on LGBTQ+ inclusion, and understanding more about LGBTQ+ people's experiences of mental health and wellbeing.

The trust used 'Hot News' bulletins to try and keep staff informed of operational issues; examples included information about leave carry over, new staff operational staff appointments and the appointment of a new director.