North West Ambulance Service NHS Trust

Emergency and urgent care

Inspection report

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Date of inspection visit: 12 April 2022 to 20 April 2022
Date of publication: N/A (DRAFT)

Ratings

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

Our findings

Emergency and urgent care

Inspected but not rated

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

The trust's vision is to be the best ambulance service in the UK, providing the right care, at the right time, in the right place; every time for patients accessing its emergency and urgent care (999) care service, non-emergency patient transport service and NHS 111 service. North West Ambulance Service NHS Trust (NWAS) provides 24 hours 7 days a week, emergency and urgent care services to those in need of emergency medical treatment and transport.

We carried out this short notice announced focused inspection of North West Ambulance Service emergency and urgent care between 12 and 14 April 2022. We had an additional focus on the emergency and urgent care pathway and carried out several inspections of services across a few weeks. This was to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures.

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

During this inspection we reviewed the emergency and urgent care services which include ambulance crews attending to 999 calls and the emergency operations centre which is the clinical hub which receives the 999 calls and dispatches vehicles. For both services we looked at elements of safety, effectiveness, caring, responsiveness and leadership of staff who were receiving and attending to 999 calls.

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

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

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Liverpool, Knowsley and South Sefton within the Cheshire and Merseyside ICS below: Cheshire and Merseyside (Liverpool, Knowsley and South Sefton)Provision of urgent and emergency care in Cheshire and Merseyside was supported by services, stakeholders, commissioners and the local authority. We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff had continued to work hard under sustained pressure across health and social care services.

Our findings

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

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

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

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

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

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

Our findings

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

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

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

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Lancashire and South Cumbria below: Provision of urgent and emergency care in Lancashire and South Cumbria was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff felt tired and continued to work under sustained pressure across health and social care. We found demand on urgent care services had increased. Whilst feedback on these services was mostly positive, we found patients were accessing these services instead of seeing their GP. Local stakeholders were aware that people were opting to attend urgent care services and were engaging with local communities to explore the reasons for this.

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

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

Our findings

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

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

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

Summary of North West Ambulance Service NHS Trust

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

- The service was under significant and sustained pressure from demand with ambulances waiting on for handovers at emergency departments. The service was staffed sufficiently to meet the needs in most areas for planned levels of demand. However due to an increased number of callers to the 999 service and the increase in delayed handovers at emergency departments the service was unable to attend to all patients who needed an ambulance within the expected times. The service had taken action to manage the increasing the demand on the emergency and urgent care capacity by increasing the number of call handlers employed by the service and seeking aid from volunteer ambulance services and the military.
- There was increased risk for patients who had long waits at emergency departments throughout the region, the system was pressured with hospitals unable to take patients due to the lack of capacity in emergency departments. Due to ambulance crews waiting outside emergency departments for handover this had increased the risk to patients in the community who were waiting on an ambulance which was either not able to be sent or was excessively delayed. Although the trust was performing in line with or better than the national average, the trust had reported incidents of patients who had come to harm due to delayed response times.
- The trust was not meeting nationally set response time targets, this was due to the increased rate of calls many of which were in the highest risk category and the effect of delayed handovers on the service. The service was performing inline or better than the national average compared with other NHS ambulance trusts in all call categories apart from category 4.
- There was evidence that staff were under high levels of stress since the start of the pandemic, this was seen to have had a negative effect on staffs' mental and physical wellbeing. Staff told us they felt exhausted and demoralised however staff told us that they felt supported by their team and management and that they were proud to do their job. This pressure had been recognised by senior leaders for the trust who had made improvements on staff safety and placed increased emphasis on staff wellbeing.

However:

- The service was committed to improving the service which we saw at its digital and innovation station in Cumbria, this station had improvements made to it which would increase efficiency of crews and in turn increased the time

Our findings

ambulance crews were on the road. The service had also developed stations within the region known as 'make ready stations' these stations had external contractors who restocked ambulance vehicles after shifts ended which meant paramedic crews no longer had to work extra hours at the end of their shift getting an ambulance ready for the next crew.

- Despite the immense pressure the service was experiencing we observed staff who were kind caring and compassionate to both patients and their colleagues. Patients we spoke with commented that the staff looked after them well and that they were doing a very difficult job.
- The service was committed to working with trusts within the Integrated Care system (ICS) to reduce the number of patients coming to emergency departments and improving delayed handovers. Treatment pathways had been developed so that patients could be referred to same day emergency care (SDEC) and acute frailty units, this reduced the number of patients who needed to attend emergency departments.

How we carried out the inspection

For our emergency and urgent care inspection, we met with staff from across the whole organisation. We visited six ambulance stations across the North West region. We also visited the services new digital and innovation station, a medicines hub and saw plans for the services new make ready station in the region. We inspected ambulance vehicles (including emergency ambulances, rapid response vehicles and urgent care ambulances) across the service. We visited six acute hospital emergency departments.

We spoke with patients and their relatives during the inspection. We spoke with staff including senior paramedics, emergency medical teams, advanced paramedics, operational managers, sector managers, the strategic head, the head of service, the consultant paramedic, the medical director, director of quality and the director of operations.

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

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene

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

The service had processes in place to reduce the risk to staff and patients from potential infections including COVID-19. The trust ran a yearly Flu vaccination programme and had implemented a programme of COVID-19 vaccination for staff and monitored staff vaccination rates. Staff completed twice weekly lateral flow COVID-19 testing and staff we met followed guidance and knew how to inform the trust if they had been had tested positive for COVID-19. At ambulance stations staff and visitors were asked to take their temperature before entering the station.

Our findings

All areas were clean and had suitable furnishings which were clean and well-maintained. We visited six ambulance stations during our inspection across Cheshire and Merseyside and Lancashire and Cumbria. Stations we observed were visibly clean and well maintained. We saw that at one station the cleaning equipment used to clean ambulances at some of the stations was dirty. However, some staff told us that cleaning equipment at the station was changed regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff wearing the correct PPE when they were with the patient in both the ambulances and at the A&E departments, there was sufficient amounts of PPE in ambulances such as masks, gloves and aprons.

Staff adhered to bare below the elbow policy and we observed staff carrying out the correct hand washing technique when using handwash sinks within emergency departments. Ambulance crews were observed using hand sanitiser following patient contact while caring for patients on ambulances.

The service contracted a company to deep clean each ambulance every six weeks. The company recorded the date of the last service and next due date and displayed these in the windscreen of each ambulance. If an ambulance had become soiled by blood or fluid spillages or if it had transported a patient with a communicable disease, it would be returned to the station where it would be red tagged to inform staff not to use it, this would be reported and a deep clean would be organised within 24 hours.

Sharps bins did not routinely have their assembly dates documented on them and were not always closed fully when not in use, sharps bins were however visibly clean and not overflowing. We raised this with NWAS senior leaders who informed us following the inspection that the service had trialled an improvement focus in the East Cheshire region. The aim was to improve the closure and labelling of sharps boxes since before the pandemic. This improvement focus had resulted in measurable changes for that sector. Plans to scale this improvement programme to the northwest region had been put on hold due to the pandemic however NWAS had introduced a comprehensive Infection Prevention Control (IPC) audit system which allowed for oversight of this issue and were now aware that around 20% of sharps boxes had issues of labels and locking.

The service had an IPC team and lead IPC paramedic who they could contact for guidance and ask questions, however not all staff we spoke with knew who the IPC lead was. The IPC leads visited the stations in the region to carry out quality assurance visits to check IPC standards on ambulances and stations.

The service generally performed well for cleanliness. Staff completed an electronic safety checklist on their ambulance's portable computer device to confirm that the ambulance was visibly clean at the start of their shift. Staff and managers reported that they would return to an ambulance station to clean an ambulance more thoroughly if it had become particularly soiled.

However, staff reported that there was no guidance about how or when more thorough cleaning of ambulances should take place. Staff and managers confirmed that there was no requirement to record when they had cleaned the ambulances and that it would be possible for ambulances to go more than one day without thorough cleaning if they were not visibly soiled.

Staff and managers said they were sure that staff cleaned ambulances thoroughly quite regularly. However, they acknowledged that oversight of this process could be improved.

Our findings

During our inspection we observed staff cleaning the vehicles between patients. This was usually carried out by the member of the team who was not involved in the handover process. We observed staff wiping down the ambulance with cleaning wipes and on occasions were the ambulance floor had become soiled, they carried out mopping.

There had been an external company employed to clean the ambulances at hospital sites, however this was stopped on the 1st of April 2022 . There were plans for auditing the cleanliness of vehicles following the cancellation of the external cleaning company which would show the effectiveness of the six week deep cleans.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

When staff reported a piece of equipment as faulty, they would red tag that piece of equipment and place it in a specified area of the ambulance station which was used to store faulty equipment; this ensured other staff did not use it. If a piece of equipment became faulty during a shift staff would return to the station to red tag the item and replace it with a working item from the station's store room.

Staff carried out daily safety checks of specialist equipment. At the start of every shift, staff completed daily checks on a tablet device through an electronic programme. Once staff had reported a faulty item an electronic incident report was created. This would be automatically sent to the senior paramedic team and the NWAS control centre to make them aware and to organise for the piece of equipment to be fixed.

The service had enough suitable equipment to help them to safely care for patients. We carried out random checks of stock and equipment on ambulances and at stations during our inspection, all equipment we inspected was in working order and all stock which was checked was in date.

Staff disposed of clinical waste safely. We observed paramedics disposing of clinical waste correctly after handover at an emergency department. There were clinical waste bins at all the stations which we visited, these were well maintained and not overflowing. The service had updated one of its stations in the northwest which was called the digital innovation centre. This station had innovations such as sensored clinical waste bins which would send an alert to the external company who managed the waste to arrange collection and disposal.

All emergency vehicles underwent maintenance checks every three months. This was carried out by the trust maintenance department; maintenance checks were documented on a sticker on the front of each vehicle which included when the check had taken place and when the next check was scheduled. Each vehicle we observed during our inspection had its maintenance checks completed in the last three months. Email alerts were sent to the senior paramedic team leaders and operations managers when a vehicle was due a service.

Staff informed us that all emergency vehicles had up to date satellite navigation systems which would enter the destination of a call automatically when a job was alerted.

Staff we spoke with told us that the stations got a six monthly 'quality assurance visit' whereby relevant health and safety (H&S) officers, quality team and a peer manager would visit a station to assess H&S and quality standards. The results from this visit would be fed back to the operations manager for that sector. The sector manager then provided feedback to staff following the visit and report was produced with an action plan if required. Any actions were followed up by the quality team to ensure they have been completed.

Our findings

Portable appliance testing (PAT) was completed by an external company. During our inspection PAT testing had been carried out in the last six months for all of the equipment we looked at.

The service had developed a process of restocking of ambulances with an external company in one of its stations in the northwest region, this station was known as a "make ready" station. The external contactor had staff who would restock the ambulances at the end of a shift so that it was ready for the next day.

NWAS was building a new station in Blackpool which was due for completion in December 2022, this station is planned to have the 'make ready' contract in place. Staff we spoke with about this said that they welcomed it and believed it would have a positive effect on both staff wellbeing and performance. This process meant that staff would not spend extra hours after shifts restocking vehicles and that they would be able to go straight to calls at the start of a shift increasing the time that they had to see patients.

When we visited the digital innovation station, we were shown their smart stock room which was developed following staff recommendations. Paramedics restocking at this station could add missing items to a list on a portable electronic tablet while in the ambulance, on entering the stock room they were guided by voice activation and coloured lights to the stock they needed. Staff commented that this new process had changed the time taken from 10 minutes to around one minute.

We observed on inspection that the maintenance stickers for the ambulances combined defibrillator and ECG machines had been placed on each unit, however it was not always routinely documented when the maintenance check had taken place and when the next check was needed. This was highlighted to NWAS leaders at the time of the inspection who told us they contacted the organisation who provided the maintenance checks to ensure that stickers were clearly marked with service dates in the future.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, the extensive delays experienced by a number of patients being handed over to the emergency departments were adding risks to patient safety and welfare.

Paramedics and emergency medical technicians (EMT) worked as part of a team whose role it was to treat a patient at the scene and/or take them to an emergency department if required. Ambulance staff told us that when they received a call, they would be given background details and what category the patient was through the electronic patient record form (EPRF), so that they could start planning the best course of action whilst on transit to the scene.

When staff arrived on scene, they would complete the electronic patient record. All details of the emergency call would be entered onto EPRF and if a patient was already known their details would be automatically populated onto the system. The ambulance crew would then record key information about the patient's clinical condition and the treatment provided. Information which had been entered into the EPRF could be viewed in real time by the staff at the receiving hospital. Paramedics could take an image of the injury and attach it to EPRF, for example a broken bone or major trauma so that the trauma team at the receiving hospital would be prepared and could develop an action plan.

Crews told us they used guidance from the Joint Royal College Ambulance Liaison Committee (JRCALC) to treat patients in line with the most complete and current clinical guidance. NWAS held a subscription to JRCALC for all clinical staff which they could access through the ambulance electronic tablet or on their personal phones.

Our findings

Staff shared key information to keep patients safe when handing over their care to others.

We observed ambulance crews handing over patients to emergency department staff, they shared key information such as National Early Warning System (NEWS2) scores and patient allergies.

Shift changes and handovers included all necessary key information to keep patients safe.

Staff told us that they sometimes started a shift at an emergency department to take over from crews who were waiting outside or from those who were looking after patients in corridors waiting for handover. Staff told us that handovers would always be completed, and that staff could raise concerns if they felt a handover had not been handled correctly.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff were able to describe how they assessed and responded to deteriorating patients and patients who experienced delays in handovers. Ambulance crews used NEWS2 observations to assess patients, staff told us that if they felt a patient was deteriorating or that a patient was not improving following interventions, they could call the emergency operations centre (EOC) and ask advice from the on call advanced paramedic. The advanced paramedic could advise on the next steps of treatment, this information would also be relayed to the receiving hospital so that staff there were ready to take handover of the patient.

Staff used the Manchester Triage System (MTS) for triage to determine if a patient needed immediate handover, the MTS had three priority bands for triage; P1 was for patients who required immediate lifesaving intervention, P2 was for patients who needed intervention within two to four hours and P3 was for patients who needed medical treatment but who could be safely delayed.

For patients who had experienced delays in handovers, staff followed guidance for clinical observations such as NEWS for the levels/intervals of observations determined by the patients score. Staff would then enter these into the EPRF on the ambulances computer and this would appear on a monitor in the emergency department for triage nurses to review.

Staff informed us that if they felt a patient had deteriorated while waiting on handover that this would be escalated to the hospital ambulance liaison officer (HALO), where they were in place, and/or chief nurse for the emergency department. Ambulance crews told us that emergency department staff responded quickly and appropriately to patients who had deteriorated rapidly during handover waits.

The HALO's role was to have oversight of ambulances which were on route to the emergency department, they would then liaise and coordinate with the nurse in charge so that the department was ready to receive patients. When there were handover delays, the HALO was a point of contact between ambulance crews and emergency department staff, their role was to relay information and coordinate timely handovers for patients who had deteriorated while waiting. We visited six emergency departments in the northwest however not all departments had a HALO in post.

Delayed handovers had meant that many patients had waited in ambulances for a number of hours, well over the 15-minute national target. In March 2022 the trust turnaround time had decreased but continued to be worse than the national standard of 30 minutes, with a turnaround time of 37minutes:13seconds. We saw that 4,655 attendances (10.3%) had a turnaround time of over 1 hour, with 303 of those taking more than three hours. In March 2022, there were 590 cases of delayed admissions reported which was an improvement from 824 and 708 reported in December 2021 and January 2022 respectively.

Our findings

During the week of our inspection NWAS had experienced 267 delayed admissions and the average time per delayed handover was 117 minutes.

NWAS had developed a process of escalating delayed handovers outside emergency departments at several acute trusts in the north west. This was done through the development of an escalation card. For handovers which were longer than 15 minutes, ambulance crews would follow guidance on what steps to take to ensure that the patient was cared for and monitored appropriately. Ambulance crews would then contact the regional operations coordination centre (ROCC), to inform them that they had experienced delayed handovers at that hospital.

The ROCC would then contact an advanced paramedic in the sector to attend the emergency department, the advanced paramedic would then liaise with the nurse in charge and develop a plan to improve handovers or begin the process of cohorting patients. Cohorting patients may involve an ambulance crew taking care of a number of patients who met a set clinical criteria, this in turn released ambulance crews who could then attend to seriously ill or injured patients who were waiting for an ambulance response. NWAS staff told us that the cohorting of patients in emergency departments was not best practice but was needed in times when the system was under immense pressure.

The service had 24-hour access to mental health liaison and specialist mental health support. Mental health practitioners worked within the trust EOC and staff could contact them for advice regarding mental health questions and concerns.

Staff completed psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff told us about patients who had tried to harm themselves or attempt suicide through medical overdose, these patients would have their capacity assessed and would also be risk assessed with guidance from the mental health team at the EOC. Staff could contact the mental health crisis line for patients who were low risk and a referral could be made for a mental health assessment.

Staff told us that the northwest region had two mental health triage cars which consisted of an EMT, a mental health professional and mental health nurse. Staff had commented that these cars had been an important development for the trust as it allowed mental health patients to be cared for by staff with advanced mental health training.

Staffing

The service didn't always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This was due to ambulance handover delays, unplanned absence through sickness or COVID-19 isolation rules, and the pressure from increasing demand meant staff could not always provide the care patients needed.

The service had an action plan in place when it experienced increased demand or a reduction in staff numbers which was known as resource escalation action plan (REAP). The service had four levels of REAP, one and two were when the service experienced a steady to moderate levels of demand. Levels three and four were when the service experienced severe and extreme levels of demand. The service took action when REAP levels increased such as using senior staff to attend calls.

Following the introduction of the ambulance response programme (ARP) in 2017, it was highlighted by the service that there was a gap between the services resource model and its ability to deliver ARP standards. The service received additional funding following an independent review it commissioned, however it was recognised that this additional resource was still not sufficient for the service to meet ARP standards.

Our findings

Staffing rotas were aligned on predicted demand, this was developed following an in-depth analysis of the trust's historic activity, resources and performance. This project was called "building better rotas" which was completed in 2019. The project was commissioned through the trust using the services of an external company this allowed to model a variety of scenarios in order to forecast future demand and identify actions which allowed for maximum improvements.

Staff told us that they believed the service was short staffed. Staff said that not getting breaks on time or not getting breaks at all was an issue. Staff could be reimbursed for missed breaks by the trust however many staff members did not ask for reimbursement. While on inspection we observed NWAS welfare vehicles at several of the emergency departments we visited, this allowed for staff who were waiting outside to get refreshments such as food and hot drinks. Staff commented that this was a positive initiative but said that the welfare vehicles could visit emergency departments more often.

Through staff feedback it was noted that shifts often finished late which was mainly due to hospital delays or outstanding calls, this was known as extended overtime. The trust collected data on extended overtime which related to a number of reasons. For example, emergency calls which were received prior to a shift ending or delayed admissions and handovers at hospitals. From January 2022 to March 2022, staff worked 16276 hours of extended overtime.

Ambulance crews were usually made up of one paramedic working with an emergency medical technician (EMT). An EMT could give certain medicines, could use a defibrillator, and could assist the paramedic they were working with. The majority of EMTs progressed onto the ambulance apprenticeship programme or became a qualified paramedic. When we spoke with senior paramedic team leaders (SPTL) about how they staffed rotas, they agreed that a paramedic and EMT team could not always be achieved and that crews made up of two EMTs had gone on calls in the past.

There was an operational skill set matrix that indicated what staffing skill mix was appropriate. When coordinators completed rotas, they planned them six weeks in advance to consider long term sickness and annual leave. Staffing gaps within the rotas were covered by overtime or staff owing hours.

The SPLT team assured us that double EMT crews would not be sent to jobs that were above the skill or qualification level of that team. When a double EMT team was on the rota to work, the EOC would be informed and would follow a skill matrix to only send the team to calls that were category three or four. The service was currently under established with EMTs and over established with paramedics in this sector.

The service had experienced pressure from staff sickness and COVID-19 related absences. The overall sickness absence rate for the latest reporting month (January 2022) was 13.7% including COVID related sickness of 5.8%. The trust had placed additional focus on managing attendance and wellbeing. The top five reasons for absence were mental health, COVID-19, musculoskeletal (MSK) Injury and back problems. The trust had seen an increase in long term sickness on previous years and had recognised that the pandemic had had an impact on the underlying wellbeing of staff.

The trust had developed a dedicated attendance improvement team to focus on supporting operational teams to improve attendance management and wellbeing.

There had been a request for military aid to the civil authorities (MACA) from January 2022 to March 2022, this meant the military supplied personnel to assist with low-risk ambulance responses. Over the three-month period the military assisted with 12598 ambulance responses.

Our findings

Is the service effective?

Inspected but not rated

Response times

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

Frontline crews were aware that response times had been an issue over the past six months and had worsened during the winter. However, staff told us they did not always know what other outcome data was being measured by the trust and how the trust was performing.

Ambulance services were measured on the time it took from receiving a 999 call to a vehicle arriving at the patient's location. The NHS constitutional standards are set out in the handbook to the NHS Constitution. They are as follows;

All ambulance trusts to:

- respond to Category 1 calls in 7 minutes on average, and respond to 90% of Category 1 calls in 15 minutes
- respond to Category 2 calls in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes
- respond to 90% of Category 3 calls in 120 minutes
- respond to 90% of Category 4 calls in 180 minutes

The categories are determined by a clinical triage system based on national standards with category one being the most seriously ill or injured patients.

From the trusts most recent data, which is from March 2022, for ambulance services in England, North West Ambulance service responded to patients as follows:

In March 2022, NWAS average response time for category 1 calls was nine minutes and four seconds which was worse than the national standard but better than the England average which was nine minutes and 35 seconds.

NWAS average response time for category 2 calls was 57 minutes and 58 seconds which was worse than the national standard but better than the England average which was one hour and one minute.

NWAS average response time for category 3 calls was three hours seven minutes and 30 seconds which was worse than the national standard but better than the England average which was three hours and 28 minutes.

NWAS response times for category 4 calls was six hours 20 minutes and 44 seconds which was worse than the national standard and worse than the England average which was four hours seven minutes and 42 seconds.

The service had identified three primary reasons for not meeting response time standards, these were a rise in acuity, abstractions (staff absences) and handover delays.

Our findings

NWAS had not met any of the national standards for the response times but it performed above average for category 1, 2 and 3 category calls when compared to the performance of other English NHS ambulance trusts. However, it did perform poorly in its response to category four calls, its response times for these calls was the second worst in the country.

NWAS had also seen increased numbers of calls in March 2022. The service received 14,688 category one calls; this was the highest number of category 1 calls received by an NHS ambulance trust in England. The service had also received the second highest number of category 2 and 3 calls in England for the month of March. The service had increased the number of clinicians who were available to provide self-care advice remotely, known as 'hear and treat'. This had improved following the service implementing a new process of call validation of category 3 and 4 calls in its clinical hub which allowed clinicians time to review incidents before an ambulance was allocated to that call. This new process had increased hear and treat from 9% in December 2021 to 12% in February 2022.

Ambulance crews attending to people on scene and not taking them to hospital was known as "see and treat", in March 29.3% of NWAS calls were managed through this process. For patients who needed to be transported to hospital for medical attention this was known as "see and convey" this made up of 60% of NWAS responses in February 2022 which was higher than the England average of 57%.

However, in February 2022 almost 70% of NWAS calls were category one which reduced the opportunity to use 'hear and treat' and 'see and treat', as these patients needed to be transported to a hospital for medical assistance. The trust had requested an external review of acuity changes by the Association of Ambulance Executives (AACE). To date this review had been unable to explain the shift nationwide of the increase in category one and two calls which have been seen. The trust had highlighted that the demand on the 111 service had directly impacted the number of calls that they were receiving, however the 111 service was progressing through the process of implementing self-care advice through a new messaging service. Staff informed us that patients often commented that they had rung 999 after they were unable to make a GP appointment and could not get an answer from 111.

Patient outcomes

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

Between November 2021 and January 2022, the service had reported 38 serious incidents which had resulted in either death or serious harm. Twenty of these incidents had been reported in January 2022 and 10 of these serious incidents were due to delayed response. In February 2022 the service reported seven serious incidents.

NWAS reviewed incidents thoroughly and examined its own processes so that improvements could be implemented. The trust process for investigating incidents was robust and was carried out by advanced paramedics who had training in incident investigation.

The service was performing close to or above the national average for some of the national Ambulance Clinical Quality Indicators (ACQIs). For return to spontaneous circulation (ROSC) following a cardiac arrest the service achieved this for 50% of its patients against a national average of 45%.

In October 2021, 22.4% of patients survived a cardiac arrest and were discharged from hospital against a national average of 22.9% who survived. In August 2021, the average time for a patient suffering a hyper acute stroke to be taken

Our findings

to hospital after an ambulance was called was one hour and 56 minutes which was slightly better than the national average of one hour and 58 minutes. The average time for a patient suffering a heart attack to be taken to hospital for treatment after an ambulance was called was two hours and 57 minutes which was slightly worse than the national average of 2 hours and 42 minutes.

In October 2021, for patients who had a heart attack, 60.7% of patients received a care bundle which included the recording of two pain scores and administration of aspirin and analgesia against a national average of 74.2%. The trust had investigated this result and had identified that the drop in performance may have been partially due to a new electronic patient record being introduced which may have meant that staff had not recorded their actions completely. The service had made this a key focus of its data quality and audits teams to find areas for improvement.

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.

Ambulance crews we spoke with told us that relationships with staff in emergency departments were mainly positive but that demand and pressure meant that interactions were sometimes difficult. Ambulance crews told us that interactions with junior members of staff within the emergency departments could sometimes be difficult but understood these staff were in a new environment that was experiencing high demand.

During our inspection we observed positive and respectful working relationships between ambulance crews and emergency department staff. We observed crews handing patients over to triage nurses at the emergency departments, we saw teams working collaboratively and staff ensured that there was clear communication of clinical information.

Ambulance crews we spoke with told us that they had a strong relationship with the EOC and clinical hub. They told us that if they requested clinical advice from an advanced paramedic at the clinical hub that this was carried out quickly and that the directions and advice which were given were helpful and appropriate.

Ambulance crews we spoke with told us that staff at the EOC were aware of the pressures that frontline staff faced. If an ambulance crew had attended a traumatic event or difficult call the EOC would always check on the crews well-being and ask if the team needed to be taken out of the call stack to have a break.

The emergency departments which had a HALO were well coordinated and communication between staff and crews was good. In some emergency departments we observed advanced paramedics liaising with the senior clinical team; advanced paramedics commented that they felt relationships were good with hospital staff even though the system was under immense pressure.

The service received mutual aid through both volunteer ambulance service and community first responders. Staff we spoke with told us of the importance of this aid as it released crews to attend to a higher number of category one and two calls.

Is the service caring?

Inspected but not rated

Our findings

Compassionate care

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

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 observed staff communicating with patients while waiting on handovers, the conversations observed were both caring and respectful.

Patients said staff treated them well and with kindness. Patients we spoke with described that they had been treated with kindness, compassion and dignity, that they had been kept informed during times of delay and that they felt the ambulance crews were 'excellent'.

Staff had told us that during the pandemic relatives and carers were not able to travel in the ambulance which could be difficult and upsetting for people, however the paramedic crews told us that they would try to keep patients, relatives and carers informed.

Staff we spoke with told us how they treated patients according to their individual needs and how they also took the time to also support relatives and carers through distressing or upsetting situations.

Staff told us that they would always do their best to maintain both privacy and dignity while waiting on handover either on an ambulance or in the emergency department. Staff did tell us however that this was sometimes difficult due to lack of space and facilities in emergency departments. Staff told us they would ensure that patients were suitably covered during transport and handover to maintain dignity.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for patients with mental health needs. Staff we spoke with gave examples of caring for patients who had experienced a mental health crisis, staff told us that they had training in de-escalation and knew how to care for patients who had become aggressive or disturbed during treatment.

Staff were empathetic and understanding of patients who had become acutely mentally unwell, they told us if a patient had become disturbed or agitated while waiting on handover then staff would care for patients on the ambulance or ask if they could care for the patient in a private room within the emergency department as to maintain the patients privacy and dignity.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

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

Our findings

The service managed ambulance deployment to meet demand, this was done using the services of an external company which looked at historic demand in order to forecast future demand and identify where greater resources were needed. Due to the geographical region the trust covered, it had developed a number of resilience plans for events such as adverse weather, catastrophic and major incidents.

The region had specialist support from the helicopter emergency medical service (HEMS) and the hazardous area response team (HART). The service had support from two HART teams and three HEMS teams throughout the region.

The service was dynamic in its planning of deployment in terms of when the service may see increased demand such as bank and summer holidays. The trust plans allowed for flex to accommodate increased demand by increasing the number emergency vehicles on the road and using the services of independent ambulances and voluntary aid services.

For deployment within low population areas the service would send ambulances to these areas to act as a standby however in recent times due to the increase in demand on the service this rarely happened with each ambulance being needed to meet the demand within the region. This meant that patients in remote areas were at risk of experiencing further delays when vehicles were having to travel long distances to get to them.

The service had worked with the wider ICS to develop alternative pathways for patients to be admitted directly to hospital to reduce the need for patients to be taken to the emergency department. Ambulance crews could refer patients to these services through the NHS service finder, services such as same day emergency care (SDEC) and acute frailty units were used regularly by the service.

Within the region the service used hospital avoidance cars which were jointly funded through the local council and Clinical Commissioning Groups. These cars were staffed by an occupational therapist (from frailty/ falls teams) and one paramedic. These cars would attend category three and four calls to try and divert patients to services who could manage the needs of the patient without the need for attendance to an emergency department.

The service had also introduced a respiratory car within the region. This team consisted of a paramedic, advanced nurse practitioner and a consultant doctor. The team dealt with category one and two calls for patients who were experiencing respiratory concerns. A high percentage of category one calls were conveyed to emergency departments however over 50% of category 2 calls were referred by the consultant to an alternate route known as COPD care (chronic obstructive pulmonary disease), this reduced the number of patients who needed to be taken to the emergency department.

Access and flow

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

The trust received 110,736 (999) calls in February 2022 this was a 17% increase from the same period in 2021. The rise in demand for services and the increased number of handover delays had affected the access to services for patients.

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

The trust measured the number of hours lost when patients were held on vehicles outside of emergency departments, known as delayed admissions. They also measured the time it took for crews to hand patients over at emergency

Our findings

departments. In March 2021, the service lost 3,290 hours due to delayed handovers this had increased to 10,335 hours in March 2022. In March 2021 the service had lost 175 hours due to delayed admissions, in March 2022 this had increased to 1,688 hours. For the year of 2021/22 the service had lost over 13,248 hours due to delayed admissions and 85,859 hours due to handover delays.

The service had seen an increase in the acuity of patients presenting to 999. In recent months category one calls had risen from 9% to 16% and a rise from 52% to 55% for category two calls. This meant that 77% of the trusts incidents were in the two highest categories therefore consuming more resources and reducing the opportunities for alternative pathways to the emergency department.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable to their staff and teams.

The service had an executive leadership structure and regions were divided into sectors. Each sector had sector leads who managed station managers and SPLT in their areas. Ambulance crews told us that they felt that managers up to sector lead level were approachable and supportive and that the SPLT listened to their concerns and would take action when concerns or issues were raised.

However, many of the frontline crews told us they felt that there was not enough visibility of the executive team. We discussed this perceived lack of visibility in a post inspection interview with leaders for the service, they told us that visibility had always been a challenge due to the size and spread of the organisation. Leaders told us that the pandemic had made it even more difficult to be physically visible but that the service was working on greater digital visibility through weekly online meetings, staff forums and blogs. We also saw that three members of the executive team had maintained some level of face to face contact throughout the pandemic, in line with COVID-19 guidelines and that this contact had started to increase as COVID restrictions were reducing.

Leaders told us they often visited staff on the frontline to acknowledge the pressures staff were under and to thank staff for the hard work they were doing.

Culture

Not all staff felt respected, supported and valued. There had been considerable progress around culture since our last inspection and much had been achieved. However, the pressures of the last two years had brought additional challenges which the trust were working to manage.

Staff we spoke with told us that they loved their job and felt part of a great team, however nearly all the staff we spoke with said that the last two years had been a difficult time and that many staff felt exhausted.

Staff we spoke with told us of the negative effect serious incidents had on staff morale and wellbeing. Some staff said that it was very difficult attending a call where a member of the public had deteriorated significantly or may have passed away due to an ambulance not attending on time due to delayed response time and pressures.

Our findings

Staff told us that they felt the culture had improved within the service and that they felt respected by colleagues and their managers, many staff told us that despite the pressures they always tried their best for the patients.

The trust had made improvements in recent years for staff health and wellbeing, they had introduced wellbeing staff forums, health and wellbeing was now part of staff appraisals and managers had training in resilience to support staff. The service also carried out trauma risk management (TRiM) assessments, these were a welfare led process to assess the response of a member of staff who had been exposed to a traumatic incident. Staff we spoke with who had completed TRiM assessments told us that the assessments were both an effective and positive experience.

Staff told us that they believed morale was low within the organisation which was due to an ever-increasing workload and the high incidence of delayed emergency department handovers. Staff said they felt that they could not always provide the best care for patients while waiting on long handovers and this was demoralising for staff, they also told us that they felt frustrated as they knew there were high risk patients in the community who needed their support but due to delays they were not able to get to these patients.

Staff said they felt that that there was an open culture and that that if they raised concerns they felt listened to. Senior leaders told us that the reporting culture within the organisation had improved, historically there was a difficulty in learning due to delays in reporting incidents, however due to early incident reporting learning and improvement were able to be implemented much quicker.

Staff could raise concerns about treatment or personal concerns, through the freedom to speak up guardian. When a member of staff raised a concern, this was reviewed by a sector lead from a different region to reduce the fear staff may have to raise with a direct manager.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Due to the services locality, some parts of the region had seen an increase of population during holiday months. There also was a risk of adverse weather and flooding in the Cumbria region. The trust had developed resilience plans for events such as adverse weather, catastrophic and major incidents.

Leaders understood the risks which the service faced, the service had identified that it was under significant pressure and demand and had introduced a number of actions to combat this. The service had a risk register and risks were reviewed by a risk lead. The service graded risks and developed action plans which were reviewed through an assurance framework. Risks and the progress of action plans were discussed at the service's monthly governance and performance meetings.

The trust had also increased the number of voluntary ambulance services it worked with within the region and had worked with the military who had provided an extra 150 personnel to the service. This initiative had allowed the service to increase operational resources and lower response times for lower acuity patients. This mutual aid agreement was started in January 2022 and was phased out by the end of March 2022. The trust had identified that incidences of aggression and abuse towards staff had increased over the past 12 months and had introduced body worn cameras for all ambulance crews. However some staff we spoke with chose not to wear the cameras, we highlighted this to senior

Our findings

managers who told us that the cameras were not mandatory and that the trust had provided information to all staff on the benefits of the camera for the safety of themselves and their colleagues. Staff who we observed wearing the cameras said they welcomed the introduction and felt that leaders had listened to their previous concerns of abuse and aggression directed at staff.

Our findings

Areas for improvement

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

Action the trust Should take to improve:

- The trust should ensure it continues to take appropriate actions to improve ambulance response times in line with nationally agreed targets. (Regulation 12)
- The trust should continue to influence and play a key role in the increasing demand on emergency and urgent care capacity, patient harm, and unmet patient needs throughout emergency and urgent care along with system partners and others. This should include a focus on improving the safety and effectiveness of services for patients and of its frontline and support staff.
- The trust should develop clearer guidance for staff for the cleaning frequency of ambulance vehicles.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 6 other CQC inspectors. The inspection team was overseen by Karen Knapton, Head of Hospital Inspection.