South Western Ambulance Service NHS Foundation Trust

Emergency and urgent care

Inspection report

Trust Headquarters, Abbey Court
Eagle Way, Sowton Industrial Estate
Exeter
EX2 7HY
Tel: 01392261500
www.swast.nhs.uk

Date of inspection visit: 9 March 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

South Western Ambulance Service NHS Foundation Trust works across the whole of the South West of England from Gloucestershire in the north to Cornwall and the Isles of Scilly in the south.

We carried out this short-notice announced inspection in March 2022. We had a focus on the urgent and emergency care pathway for patients across the integrated care system in Cornwall. As the ambulance trust serves the whole of the South West of England, not all information relates to Cornwall, but we have included specific data and evidence where we can. Some of the data also relates to the NHS trust in Plymouth as patients from the east of Cornwall are mostly conveyed to that hospital rather than the emergency department in Truro. Due to ongoing restrictions for safety during the pandemic, we did not accompany crews attending patients in the community, but met with them at Royal Cornwall Hospital, Treliske, Truro.

As this was a focused inspection, and we did not look at every question in our key lines of enquiry, we did not re-rate the service this time. Our reports published in March 2022 with a focus on Gloucestershire, but also the South Western Ambulance Service Emergency Operations Centres, can be found here: https://www.cqc.org.uk/provider/RYF

A summary of CQC findings on urgent and emergency care services in Cornwall

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 Cornwall below:

Cornwall

The health and care system in this area is under extreme pressure and struggling to meet people's needs in a safe and timely way. We have identified a high level of risk to people's health when trying to access urgent and emergency care in Cornwall. Provision of urgent and emergency care in Cornwall is supported by services, stakeholders, commissioners and the local authority and stakeholders were aware of the challenges across Cornwall; however, performance has remained poor, and people are unable to access the right urgent and emergency care, in the right place, at the right time.

We found significant delays to people's treatment across primary care, urgent care, 999 and acute services which put people at risk of harm. Staff reported feeling very tired due to the on-going pressures which were exacerbated by high levels of staff sickness and staff leaving health and social care. All sectors were struggling to recruit to vacant posts. We found a particularly high level of staff absence across social care resulting in long delays for people waiting to leave hospital to receive social care either in their own home or in a care setting.

GP practices reported concerns about the availability of urgent and emergency responses, often resulting in significant delays in 999 responses for patients who were seriously unwell and GPs needing to provide emergency treatment or extended care whilst waiting for an ambulance. GPs also reported a lack of capacity in mental health services which resulted in people's needs not being appropriately met, as well as a shortage of District Nurses in Cornwall.

Our findings

A lack of dental and mental health support also presented significant challenges to the NHS111 service who were actively managing their own performance but needed additional resources available in the community to avoid signposting people to acute services. The NHS111 service in Cornwall worked to deliver timely access to people in this area, whilst performance was below national targets it was better than other areas in England.

Urgent care services were available in the community, including urgent treatment centres and minor illness and injury units and these services were promoted across Cornwall. These services adapted where possible to the change in pressures across Cornwall. When services experienced staffing issues, some units would be closed. When a decision was made to close a minor injury unit (MIU) the trust diverted patients to the nearest alternative MIU and updated the systems directory of services to reflect this. However, this carried a potential risk of increased waiting times in other minor injury units and of more people attending emergency departments to access treatment. This had been highlighted on the trust's risk register.

Due to the increased pressures in health and social care across Cornwall, we found some patients presented or were taken to urgent care services who were acutely unwell or who required dental or mental health care which wasn't available elsewhere. Staff working in these services treated those patients to the best of their ability; however, patients were not always receiving the right care in the right place.

Delays in ambulance response times in Cornwall are extremely concerning and pose a high level of risk to patient safety. Ambulance handover delays at hospitals in the region were some of the highest recorded in England. This resulted in people being treated in the ambulances outside of the hospital, it also meant a significant reduction in the number of ambulances available to respond to 999 calls. These delays impacted on the safe care and treatment people received and posed a high risk to people awaiting a 999 response. At the time of our inspection, the ambulance service in Cornwall escalated safety concerns to NHS England and NHS Improvement.

Staff working in the ambulance service reported significant difficulties in accessing alternative pathways to Emergency Departments (ED). When trying to access acute assessment units, staff reported being bounced back and forth between services and resorting to ED as they were unable to get their patient accepted. Many other alternative pathways were only available in specific geographical areas and within specific times, making it challenging for front line ambulance crews to know what services they could access and when. In addition, ambulance staff were not always empowered to make referrals to alternative services. The complexity of these pathways often resulted in patients being conveyed to the ED.

Hospital wards were frequently being adapted to meet changes in demand and due to the impact of COVID-19. There was a significant number of people who were medically fit for discharge but remaining in the hospital impacting on the care delivered to other patients. The hospital had created additional space to accommodate patients who were fit for discharge but were awaiting care packages in the community; however, staff were stretched to care for these patients.

Delays in discharge from acute medical care impacted on patient flow across urgent and emergency care pathways. This also resulted in delays in handovers from ambulance crews, prolonged waits and overcrowding in the Emergency Department due to the lack of bed capacity. We found that care and treatment was not always provided in the ED in a timely way due to overcrowding, staffing issues and additional pressure on those working in the department. These delays in care and treatment put people at risk of harm.

Our findings

In response to COVID-19, community assessment and treatment units (CATUs) had been established in Cornwall. These wards were designed to support patient flow, avoid admission into acute hospitals and provide timely diagnostic tests and assessments. However, these wards were full and unable to admit patients and experienced delayed discharges due to a lack of onward care provision in the community.

Community nursing teams had been recently established to support admissions avoidance and improved discharge. This work spanned across health and social care; however, at the time of our inspections it was in its infancy so we could not assess the impact.

The reasons for delayed discharge are complex and we found that discharge processes should be improved to prevent delays where possible. However, we recognise that patient flow across the Urgent and Emergency Care pathway in Cornwall is significantly impacted on by a shortage of staffed capacity in social care services. Staff shortages in social care across Cornwall, especially for nursing staff, are some of the highest seen in England. This staffing crisis is resulting in a shortage of domiciliary care packages and care home capacity meaning many people cannot be safely discharged from hospital. A care hotel has been established in Cornwall providing very short-term care for people with very low levels of care needs; this is working well for those who meet the criteria for staying in the hotel, however this is a relatively small number of people.

Without significant improvement in patient flow and better collaborative working between health and social care, it is unlikely that patient safety and performance across urgent and emergency care will improve. Whilst we have seen some pilots and community services adapted to meet changes in demand, additional focus on health promotion and preventative healthcare is needed to support people to manage their own health needs. People trying to access urgent and emergency care in Cornwall experience significant challenges and delays and do not always receive timely, appropriate care to meet their needs and people are at increased risk of harm.

Summary of South Western Ambulance Service NHS Foundation Trust

On this inspection centred on Cornwall, we reviewed emergency and urgent care services. For this core service we looked at elements of the safety, effectiveness, caring, responsiveness and leadership of the staff and teams responding to 999 calls, and those supporting the emergency departments on site.

This inspection was not rated. We continue to monitor all South Western Ambulance services and will inspect further in the course of our programme of inspections.

For emergency and urgent care, we found:

- The service was under immense pressure from a lack of bed-capacity in the acute hospitals and the community with patients waiting in ambulances at emergency departments (which were also full). The service was staffed and resourced safely to meet people's needs in most areas for commissioned and planned levels of demand. Staffing levels had been increased to deal with some of the predicted increase in demand for ambulances, but not to cope with the lack of bed capacity experienced. However, additional recruitment of staff continued across the service.
- Delays in the handover of patients at emergency departments meant the service was unable to reach all patients who needed an ambulance in a timely way, in line with national targets. There was evidence to show the trust had taken internal action to manage the increasing demand on urgent and emergency care capacity. However, incidents of patients waiting long periods of time for an ambulance were increasing and occurred on most days. This was having a significant impact on the morale of staff across the service and on patients waiting.

Our findings

- There were risks for patients as a result of ambulance handover delays in emergency departments. There were known and unknown risks of harm to patients who were held in an ambulance or waiting in the community and an ambulance was not available or excessively delayed. This led to harm for some patients.
- The NHS contractual response times for ambulances to attend patients were not being met and some were exceptionally long and increasing. This was because ambulances were waiting at emergency departments because of capacity pressures in hospitals and other parts of the health and social care system.

However:

- Despite the pressure and challenges, staff were kind, compassionate and supportive to patients, some of whom had complex needs. One patient said of the staff: "they've been wonderful" and another said, "I just can't fault them."
- There had been some excellent multidisciplinary working and mutual aid to and from the service. Volunteers and first responders continued to play a vital role.

How we carried out the inspection

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

For our emergency and urgent care inspection, we met with staff operating in the county of Cornwall. We spoke with trust's county commander and the deputy county commander for Cornwall. We talked with paramedics, emergency care assistants and other members of staff on duty at the emergency department at Royal Cornwall Hospital, Truro. We spoke with 10 paramedics, emergency care assistants and other support personnel, and the hospital ambulance liaison officer (known as a HALO).

We spoke with six patients while on site at the emergency department. Some were still in ambulances and others had arrived by ambulance and been taken into the emergency department. Although we observed care delivered by ambulance staff for a number of patients, some of these were not well enough to talk with us. Due to rules of safety in the COVID-19 pandemic, and in light of the pressures of demand on the ambulance service, we did not ride out with crews or observe them on the scene with patients.

Is the service safe?

Inspected but not rated

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and where possible minimised risks. Staff identified and quickly acted upon patients in their care at risk of deterioration. However, the delays experienced by a number of patients waiting to be handed over to the emergency department added risks to patient safety and welfare. Some staff felt they were asked to care for patients in situations which were high risk at times.

Delays in the handover of patients to staff at emergency departments meant ambulance staff had to continue to monitor patients and assess and respond to their condition for prolonged periods of time. This included if a patient's condition deteriorated. Paramedics and emergency care assistant training does not include the knowledge and skills to deliver this. To help ambulance staff to monitor a patient's condition they used the National Early Warning Score (NEWS) tool. Staff said they had to provide this extended care and treatment to almost all the patients they took to hospital.

Our findings

Deterioration of patients in the community was managed through experience, training and guidance. Once an ambulance was able to attend, any patients assessed as being at very high risk were brought to the emergency department, into a dedicated parking area and, if needed, the resuscitation unit. Crews gave the emergency department advance warning of the arrival of a seriously ill patient so all staff and equipment could be prepared. There was a red hatched ambulance bay outside of the entrance to the resuscitation bay reserved for crews arriving with a patient in cardiac arrest, with breathing difficulties or serious traumatic injuries.

There were additional risks associated with patients waiting in an ambulance or the community for prolonged times to be handed over to the emergency department. These included: possible skin damage; delays in tests, treatment and medicines; lack of nutrition and hydration; and a lack of access to toilet or washing facilities. Staff monitored these areas as much as possible, but recognising there was no system to prompt this, as this was outside of their usual pathway of care. There were pressure relief mattresses for staff to use for patients waiting for a long time on trolleys and we saw staff using these frequently. This was to help with avoiding tissue damage and to make patients more comfortable. However, some had disappeared from the stock and there were times when there were not enough to go around.

Staff said it was particularly challenging for them to monitor patients experiencing a mental health crisis or with cognitive impairment such as dementia or general anxiety. They had been given training to manage this in the short-term, but this was also outside of their usual experience or training.

There were significant delays in the handover of patients to emergency department staff: In Cornwall in January 2022, only 563 (16%) of the 3,427 patients were handed over in 15 minutes. The average handover time had increased to two hours and 31 minutes. In the 12 months leading to January 2022, 8,600 patients waited over two hours. In the 12 months earlier (February 2020 to January 2021), only 625 patients had been delayed for more than two hours and in the preceding year, only 26 patients had to wait more than two hours.

Many staff expressed concern about the risks to patient safety as a result of these delays. There were incidents reported of patients waiting in ambulances in excess of 15 hours to be admitted to the emergency department. The trust leadership teams and executive officers were fully aware of the situation, kept well-briefed through live data, and were part of system and stakeholder working groups looking at solutions. However, they were not able to report any positive steps for the Cornwall system being made at the time.

We were told ambulance staff regularly arrived on shift to take over the care of a patient waiting in an ambulance at an emergency department from another crew at the end of their shift. Although there was no evidence of harm from staff changeover, staff said they were concerned this could lead to risks for the patient from missing subtle changes in the patient's condition.

Ambulance staff said the medical and nursing staff at the emergency department responded quickly if they believed a patient was rapidly or significantly deteriorating. However, they said there was no routine clinical emergency department support to ambulance staff, but it was available on request. Ambulance staff caring for patients waiting for handover at the hospital 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 service 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.

Our findings

Staffing

In normal circumstances, the service had 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. However, the ambulance handover delays, unplanned absence through sickness, and the pressure from increasing demand meant staff could not always provide the care patients needed. Although improved from previous inspections, many staff were again working beyond their hours and few were getting breaks on time or at all due to the capacity crisis facing the service and handover delays at emergency departments.

Senior trust staff recognised the pressure on the workforce currently, and over the previous two years prior to this inspection. Most staff said they felt the demand and pressure particularly in the six months leading up to our inspection (particularly from handover delays, sickness, including COVID-19, and vacancies) meant they were unable to provide a safe service at all times. The senior leadership at the trust recognised this as a significant area of concern and it was covered in all trust board meetings and risk assessments. The trust was working with all systems across the South West in order to play its part in raising the issue of patient safety and bringing about change. However, the trust had seen much of its performance worsen due to handover delays. In response to this and the additional pressure resulting from staff choosing to leave the service, the trust was continuing and expanding a major recruitment drive.

Staff said they worked beyond their shifts most of the time. However, staff said this was not always as long as at times in the past due to recognition by the trust and a drive to resolve this. Staff said this was mostly around an hour or two – but this was on top of often a 10 or 12-hour shift. However, a lot of staff said they had worked as many as six hours over their shift at times when they felt, as they told us, that was their professional duty.

Most staff said they did not always get breaks or these were delayed. Some staff admitted they did not take their breaks when they probably could. However, staff also said the organisation was not stopping them taking their breaks, but due to handover delays it was increasingly difficult to take a break. The trust told us it was looking at practical arrangements to provide staff with improved facilities at hospital sites due to the increasing delays and the impact on all those involved. There were some facilities to be able to provide staff with food and a ‘welfare car’ was provided by local volunteers with hot drinks and biscuits in the daytime.

The service was under additional pressure from staff sickness and COVID-19-related absence. Sick leave for operational staff was higher than the trust target of 4%. In January 2022, 9.3% of operational staff were on sick leave. This was the highest level since at least April 2020. Of these staff, 4.9% were on long-term sick leave. In the year from April 2020 to March 2021 total sickness absence averaged at around 5%.

The impact of this high rate of sickness was lessened to an extent because of the decision taken by the trust to have more frontline clinical operational staff than it were funded for, which it had achieved. Clinician staffing numbers had increased since April 2019 from 1,614 staff (all numbers whole-time equivalent (WTE)) to 1,859 by January 2022. The plan was to increase to 1,877 by March 2022 – about 66 WTE clinicians above planned levels.

The numbers of emergency care assistants (ECAs) had also increased since April 2019 but had not reached the planned levels. There were 995 emergency care assistants in April 2019, and this had risen to around 1,233 by January 2022. The plans were to have had around 60 additional WTE by January 2022 and this was work in progress with continual recruitment being undertaken.

Our findings

Is the service effective?

Inspected but not rated

Response to patients

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

Performance for the trust had deteriorated since late summer 2021 as demand had increased for the service across the South West. However, the trust continued to reduce the number of patients taken to hospitals by giving advice and guidance to patients or carers by phone or by giving treatment at the scene to reduce pressure on the rest of the urgent and emergency care system.

The NHS constitutional standards for all ambulance trusts are set out in the Handbook to the NHS Constitution:

- 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 two hours
- Respond to 90% of Category 4 calls in three hours

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

In February 2022 data for South Western Ambulance Service showed they responded to patients in Cornwall as follows:

- For Category 1 calls, the average response was higher (worse) than the England average and the rest of the South West with an average response time of 17 minutes, 42 seconds and 90% being responded to within 31 minutes, 48 seconds.
- For Category 2 calls, the average response was higher (worse) than the England average and the rest of the South West with an average time of 1 hour 25 minutes and 90% being responded to within 3 hours, 20 minutes.
- For Category 3 calls, the average response was higher (worse) than the England average and the rest of the South West, with an average response time of 5 hours 31 minutes and 90% being responded to within 13 hours, 44 minutes.
- For Category 4 calls, the average response was higher (worse) than the England average and the rest of the South West with an average response time of 5 hours, 12 minutes and 90% being responded to within 14 hours, 9 minutes.

The ambulance triage system and intervention by trained staff recommended some patients were treated with clinical advice given remotely – usually by telephone. This is called 'hear and treat'. In order to reduce pressure in urgent and emergency care and on crews, 'hear and treat' had increased almost three-fold in the last 10 months. In April 2021, 11% of patients were supported through 'hear and treat'. By February 2022, with a drive to increase this type of patient support, this had increased when 26% of patients were assessed and helped through 'hear and treat'. In Cornwall, with the most serious handover delays in the South West, the increase had been from 10% to 34% of patients being supported through 'hear and treat' in the same period.

Our findings

Due to capacity pressures in the urgent and emergency care system, there was a drive to help reduce the number of patients being taken to an emergency department when another option could be found. This included the patient attending an urgent treatment centre, their GP, or other healthcare provider. Crews attending patients at the scene and not taking them to hospital (known as 'see and treat') had slightly fallen over the last 10 months across the South West overall but remained much the same in Cornwall. For the South West overall this inversely corresponded with the rise in 'hear and treat'. In April 2021, around 36% of patients in the South West were treated at the scene and not conveyed to hospital (the same in Cornwall). By February 2022, this had reduced to 32% (36% for Cornwall).

The drive to help the capacity crisis in emergency departments had seen an increase in 'see and treat' and 'hear and treat' options which had led to fewer patients being conveyed to A&E. In Cornwall in April 2021, 49% of patients were taken to an emergency department by ambulance. By February 2022 this had fallen to 34%. This was significantly below the February England average of 52.6% and was replicated in similar reductions in conveyancing across the South West.

An increased number of patients were diverted to the ambulance service through the South West 111 services who were found not to need an emergency ambulance response. For these patients a community response was the right response. This was reflected in the data from the trust which showed how incidents originating from the 111 services across the South West had been handled:

- In April 2021, 6% of 111-diverted patients could be helped by 'hear and treat'. By February 2022, this had risen to 22%.
- In April 2021, 48% of 111-diverted patients needing to be taken to an emergency department. By October 2021, this had fallen to 38%.

Operational staff reported how they recognised the South West 111 services were unable to assess all patients contacting them using clinical advice. Initial triage systems used without clinical advice meant an ambulance could be despatched when the patient might otherwise be given advice to get treatment in the community. However, the trust leaders for Cornwall said they felt the local 111 service had improved and triage here was working well. Staff from 111 had visited one of the two South West 999 call centres where computer-aided despatch access and training had been provided. This was with the objective to provide patients in Cornwall with the most timely and appropriate clinical assessment either though an ambulance service or a 111 clinician.

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 optimal time.

Between 12 October 2021 and 31 December 2021, there were at least 29 serious incidents reported by the trust staff where patients in Cornwall suffered severe harm or dying as a result of ambulance delays on scene. These incidents included people waiting many hours for assistance following falls, patients in extreme pain, patients with suspected sepsis, and patients in cardiac arrest or experiencing a stroke and not being reached in time.

A review by the trust of incidents of serious harm due to delays in ambulances being on scene had been conducted for several months. A report had been produced for clinical commissioners and regulators outlining the cases where patients came to harm due to no ambulance being available to respond. Many staff said these incidents had an adverse effect on staff morale and wellbeing including those in the patient safety team who investigated incidents. The trust was fully aware of all these issues and had sought help with investigations from multi-agency teams. However, this had provided limited or no additional support due to pressures throughout the urgent and emergency care system.

Our findings

While patient outcomes were adversely affected from delays in response times, other outcome measures recorded against national standards showed some positive clinical indicators. The outcomes for patients who suffered cardiac arrest (information currently only available up to June 2021) showed more patients in the South West survived at 30 days than the England average.

Some improvements were needed in key indicators relating to angiogram, stroke and some patients receiving the right care bundle for specific types of heart attack.

Multidisciplinary working

All those responsible for delivering frontline care worked together to benefit patients. Staff recognised the value of supporting each other to provide good care and worked with other agencies. However, there had been insufficient progress as a wider team to resolve the capacity crisis and some pathways were too complicated or inconsistently followed.

Although the pressures on the ambulance service were unrelenting, the staff in the emergency department worked with the ambulance staff to support a shared approach to patient care as much as possible. We observed a good working relationship between the hospital ambulance liaison officer (HALO), the operational officers, and the emergency department team and saw a strong camaraderie.

Local trust leaders in Cornwall had engaged with stakeholders from the wider urgent and emergency care system. However, they felt concerns raised regarding the ongoing issues and challenges in urgent and emergency care were not effectively acted upon. Pathways for urgent and emergency care could be inconsistently followed, inefficient and complex at times. One paramedic described not being able to avoid transferring a patient to the emergency department despite several attempts to access alternative pathways of care and treatment. Another described how they were unable to directly refer some patients without a GP's authority although the clinical need was clear.

Due to the extreme pressure the trust was under, the trust had to request mutual aid support from the local fire and rescue service. This was provided from November 2020 and ambulance staff spoke positively of the support provided.

There had also been mutual aid given and received by other ambulance services across some boundaries (although not to and from Cornwall staff due to its geographical location) and support from a team of volunteers and first responders. The trust had contracts with a small number of independent ambulance providers who were closely monitored under clear contractual terms.

Is the service caring?

Inspected but not rated

Compassionate care

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

There was a high level of compassion and kindness by staff in delivering care and treatment to patients. Patients we met made comments such as: "They've been wonderful", "nothing is too much bother", "they were fantastic" and "calm, helpful, informative. Made me feel at ease".

Our findings

Staff did their best in difficult circumstances to provide privacy and dignity for patients and were able to achieve this most of the time. However, the situation for patients waiting for long periods of time on ambulances was recognised as uncomfortable and raised anxieties for staff. Staff said the ambulances were fully lit at all times, for safety, but the lights were exceptionally bright and could become oppressive for patients and staff. Some patients felt claustrophobic in the closed ambulance but leaving the door open was a problem in the extremes of weather (cold and hot) and with the engine running all the time for ventilation or warmth.

Staff took the time to interact with patients and those close to them. They gave them as much information as they could about the circumstances of any delay and we heard staff apologise and empathise with the patient in their care. The current guidance around COVID-19 safety for staff and patients, made it was harder for staff to support patients, most of whom came to the emergency departments by ambulance without family or carers. Staff said this had required them to be as sensitive as possible to patient's needs and recognise their discomfort or emotional distress.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of the 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, this was not without some complexity in understanding and accessing community service provision and referrals of care to other services. Due to demand on the whole urgent and emergency care pathway, there were unmet needs for patients.

The ambulance service was planned using long-term extensive data and analysis of demand, but also in response to the changing needs of a system or community. For example, adverse weather, major events or incidents had plans drawn up in advance. This enabled the service to adapt quickly to support patient need particularly if these situations were not anticipated or known far in advance.

The increasing demand for the urgent and emergency care service and reduced capacity and resourcing had led to recommendations to the trust board to increase staffing numbers to above the budgeted number. The recommendations looked at different service delivery models, all of which considered planned, approved and potential increases in staffing numbers and resources.

Over the previous few years, the service had adapted and expanded to meet changing patient needs. This was in response to the Ambulance Response Programme review (in 2017) and new ambulance standards, including response times and the type and number of resources. For South Western Ambulance Service, who piloted this new approach in England, this included more ambulances in the fleet and the move to almost all ambulances on the road being crewed by two staff (retiring the fleet of single-crewed cars).

The service otherwise maintained its other specialist teams such as the hazardous area response team (HART) and the helicopter emergency medical service (HEMS).

The service was part of a number of national and local working groups looking at ways of reducing or limiting admissions to hospital and ensuring accurate referrals of patients to other services. The local county commanders for the ambulance service across the South West worked with commissioners and other providers to contribute to this work through collaboration and local knowledge.

Our findings

However, one area of complexity was with the system used by the ambulance service to divert patients to other local healthcare service providers. Not all services in Cornwall appeared on the system used by the ambulance trust and some had limited levels of information. The trust had to often rely upon its own internal clinical-service document to make sure it had the best information available. In terms of local service provision, there was also a lack of consistency in some services which made redirection of patients a more complex task. Some services provided had different operational hours and not all were open seven days a week.

Some services would not accept referrals from ambulance clinical personnel directly and required the trust to contact a GP to make any referral. This delayed care and treatment for some patients and led to additional work for both the GP and the ambulance service staff.

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.

Access to the service for patients was severely affected by a lack of capacity in acute hospitals, which resulted in delays in the handover of patients to hospital emergency departments. This had an impact on the availability of the emergency ambulance crews to respond to 999 calls. This was not an issue exclusive to Cornwall hospitals and many hours were being lost in emergency departments across the South West and also nationally. There were also a growing number of people calling the ambulance service often due to some calling more than once if they were concerned about the whereabouts of the ambulance or it was excessively delayed.

The trust view of some of the increase in the number of patients being treated over the phone ('hear and treat') was evidence of increased use by patients of the ambulance service rather than alternative community-based services. The trust had endeavoured through clinical assessment of patients to help as many people as possible over the phone. However, evidence the trust gathered demonstrated how a growing number of people could have been helped through another community provider rather than the emergency ambulance service. This was a complex picture with many factors including reduced or delayed access to GPs, real or perceived by patients. The trust was also recording growth in the number of patients who were experiencing a mental health crisis and struggling to find urgent help from community services also under exceptional pressure.

With the growing numbers of ambulances held awaiting handover at emergency departments, there was a growing number of occasions when there were no ambulances available to send to patients. This was despite the number of ambulances measured in operational hours having increased from around 34,000 each week in summer 2019 to around 46,000 each week by February 2022.

The 'call stack' is the term used by ambulance services to describe patients who have called 999 and an ambulance is needed, but there is no resource immediately available. For the trust, the call stack had increased in 2021 at two key times. One was the summer months of 2021, due to a large influx of tourists to the area. A second peak was in and around September 2021, which we were told was not expected in terms of past predictors. There were continued fluctuations which aligned to further rises in the time lost to handover delays at the acute hospitals across the South West which had increased to more than 8,000 hours lost each week in February 2022.

In Cornwall, in October 2021, there were over 80 patients waiting in the call stack, and this was at similar levels during February and March 2022. There were around 50 ambulances available in Cornwall and at times there were none to send to patients due to all being held in the emergency departments or on scene with other patients.

Our findings

Data showed an increase in time lost for ambulance crews waiting outside emergency departments. For ambulance patients taken to the Royal Cornwall Hospital, data showed 6,466 hours of ambulance crew time lost in January 2022 which was a significant increase from previous years: 1,160 hours in January 2021; 197 in January 2020; and 104 hours in January 2019.

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.

Each county or sub-divided county (Devon) in the South West had a leadership structure which had been established three years prior to our inspection. The services were led by county commanders working with deputies and a senior team. Of the officers, paramedics and emergency care practitioners we met who were based in Cornwall, most said they felt supported by their leadership. They said the issues they were facing were understood and recognised, even if solutions were very hard for anyone to find. All staff knew who their local leadership were and also staff from the senior executive team.

Culture

Some but not all staff felt respected, supported and valued, and this extended to not feeling valued beyond the trust. There had been progress around culture but there was more to do. Staff were working long hours and sometimes without breaks.

Many staff were working beyond their hours under intense pressure. The extensive handover delays, staff sickness and unplanned absence had made this harder to resolve in the last year, despite this being a major focus of the organisation. Patients and carers were becoming more anxious and staff were being abused at times. Most staff said they had been recently physically assaulted or threatened by patients and the public and some sustained injuries. However, we saw staff remained focused on the needs of patients receiving care. The senior leadership at the trust were aware of this and had provided staff with body-worn cameras and would ask for intervention from the police if any threats were made or harm came to staff.

Most staff said they felt respected in the service, but the intense pressure was making some feel less valued or supported by the NHS system. All those we asked said they did not see the current crisis could be resolved by the trust and felt almost everything that could be done to support them had been tried or implemented. Most paramedics and emergency care practitioners said they still felt proud to work for the organisation and the job they did. Some staff, who despite the pressure on their resilience remained positive, said they were determined to do their best for patients. We met a number of newly qualified paramedics who had unfortunately known nothing under than the pressure the service was currently under. Some felt they had to operate beyond their experience base, sometimes alone, and like their colleagues often spent many hours just waiting to provide a patient handover.

There was a strong emphasis on the safety and wellbeing of staff in trust policies and its ethos. The trust had a ‘Staying Well’ service which had recently been awarded additional NHS charity funds. There was an employee assistance scheme

provided around the clock by an external provider with immediate contact with a trained counsellor offered to staff. Most staff mentioned how the Cornwall-operations social media group had become a valued resource for communication and sharing. Nevertheless, the county and deputy commanders both recognised how communication was difficult to get right with a workforce spread far and wide.

The pressure on staff was taking its toll. Staff said they recognised there was support for them, but many said they did not have time or the energy to use it. Staff knew it was there, but they said they were increasingly 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 recognition at senior level of the situation frontline staff were facing. There was evidence this had recently been improving and more opportunities to speak out were being offered to staff by the executive team. However, a number of staff told us they were expected to do this in their own time, which made this less accessible to those who had already worked a long day and needed a break.

Staff said they felt there was a culture where they could speak up, but not all said they had either the energy or felt they would be listened to in the midst of the significant increase in demand in the whole urgent and emergency care system. Some staff said they felt the situation was unsustainable and they would see growing numbers of their colleagues leaving the service.

Staff told us they felt demoralised by the situation of leaving patients waiting for hours for ambulances to reach them and having to treat patients in queues outside hospitals. They also felt their progression, opportunities for development and education were extremely limited by the current crisis in bed capacity giving them no time for anything else. However, some of the staff we met told us it they felt it was still a privilege to work as paramedics and emergency care assistants providing emergency care and treatment in their communities.

Management of risk, issues and performance

Leaders and teams used systems and data to manage performance. They identified, recognised and escalated relevant risks and issues. However, there was a limited ability to reduce their impact due to the capacity crisis in urgent and emergency care.

The trust had extensive plans to cope with unexpected events, although it was struggling with how to manage the new serious capacity challenges throughout urgent and emergency care. One recognised risk was from a loss of skills, experience and knowledge from both staff exhaustion and the turnover rate. The trust had recruited and trained additional staff and was continuously advertising for new people. However, it was unable to find solutions to the handover delays and capacity crisis in urgent and emergency care which was the cause of concern around these key issues.

The key challenges for the Cornwall leadership team mirrored those of the wider trust. They included ambulance handover delays; safety and welfare of patients and staff; recruitment and retention of staff; and training/skills support and development.

With the exceptional pressure on the system, the risks to a safe and effective performance for the ambulance frontline services was high. The handover delays were rated at the highest level in the trust risk register but mitigating actions accepted as "not effective". This was due to the limited influence the ambulance service had over the bed-capacity crisis in NHS hospitals. The other serious risk in to operational performance was the trust being at the highest level of escalation (known as 'resource escalation actions plan' REAP black) for an extended period of time. Some mitigating actions had been reported as being partially effective. These included:

Our findings

- Call stack data shared with system partners.
- Command team focused on coordinating the response to demand.
- South West Emergency Services Collaborative Group re-established to consider other forms of mutual aid.

The ambulance service was set up to manage unexpected events but staff at all levels were becoming more concerned about the ability to manage performance with the current increased demand on urgent and emergency care capacity. Events such as the G7 conference in Cornwall and two major incidents in the region stretched resources to capacity. The major incidents were unexpected but were planned for strategically as with all emergency services.

The service followed the government COVID-19 guidance on safety for ambulance trusts. Staff said the national guidance was not always 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.

Our findings

Areas for improvement

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

Action the trust Should take to improve:

Emergency and urgent care

- Continue to influence and play a key role in the increasing demand on urgent and emergency care capacity, patient harm, and unmet patient needs throughout urgent and emergency 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.
- Work with commissioners and others to improve both the information for staff to use to redirect patients and also to review the access of clinical staff to direct referrals to services.
- Discuss the provision of sufficient and effective pressure relieving mattresses for patients held on ambulances with the acute trusts.
- Revisit the concern raised by some staff about only being able to seek wellbeing support in their own time and not having the energy to do this.

Our inspection team

The team that inspected the service comprised a CQC inspection manager and a CQC inspector. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.