South East Coast Ambulance Service NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is part of the National Health Service (NHS). The trust came into being on 1 July 2006, with the merger of the former Kent Ambulance Service, Surrey Ambulance Service and Sussex Ambulance Service. On 1 March 2011 SECAmb became a Foundation Trust. The trust employs over 3,660 staff working across 110 sites in Kent, Surrey and Sussex. This area covers 3,600 square miles which includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country. It has a population of over 4.5 million people. There are 12 acute trusts within this area and 22 Care Commissioning Groups (CCGs).

The trust responds to 999 calls from the public and urgent calls from healthcare professional across Brighton and Hove, East Sussex, West Sussex, Kent and Medway, Surrey, and parts of North East Hampshire.It also provides NHS 111 services across the region and in Surrey provides non-emergency patient transport services (pre-booked patient journeys to and from healthcare facilities).

The emergency operations centre (EOC) receives and triages 999 calls from members of the public and other emergency services. It provides advice and dispatches ambulances as appropriate.The EOC also provides assessment and treatment advice to callers who do not need an ambulance response, a service known as “hear and treat”. Callers receive advice on how to care for themselves, or staff direct them to other services that could be of assistance.The EOC also manages requests from health care professionals to convey people either between hospitals or from community services into hospital.

The emergency operations centre received 929,822 emergency calls in 2014-15. The call volume had increased by 7.24% compared with the previous year.The trust had three emergency operations centres: Coxheath, Banstead and Lewes. The trust plans to move services from Banstead and Lewes EOCs to a new, purpose-built facility in Crawley in February 2017.

Patient Transport Services (PTS) for SECAmb provides a service for people who meet the eligibility criteria within Surrey and a small part of North East Hampshire. PTS headquarters is based in Dorking, Surrey and there are six bases across the area, located at or near the major hospitals. Figures provided show that PTS handles between 1800 and 1950 journeys per week and currently employs 126 staff.

We inspected this location as part of our planned comprehensive inspection programme. Our inspection took place on 3 to 6 May 2016. We looked at three core services: emergency operations centres, patient transport services and emergency and urgent care, including resilience and the hazardous area response team. The 111 service provided by the trust was inspected separately. During the inspection, we visited both ambulance premises and hospital locations in order to speak to patients and staff about the ambulance service.

Overall, we rated this service as inadequate. We rated emergency and urgent care as inadequate and the emergency operations centre and patient transport services as requires improvement.

Overall we rated the service as good for caring, requiresimprovement for effective and responsiveand inadequate for safe and well led.

Our key findings were as follows:

Are services safe?

- The incident reporting culture, the processes for reporting and investigating incidents and the lack of learning from incidents did not support the safe provision of service.
- Safeguarding arrangements within the trust were exceptionally weak. A lack of accountability, understanding and appropriate investigation was prevalent throughout the trust.
- There was low attendance at infection control training leading to inconsistent hand hygiene practices.
- The trust CAD system had not been appropriately updated.
- The trust medicines management process had allowed staff to develop practice outside national guidance and best practice.

Summary of findings

- Low staffing levels were having an impact on both performance and fatigue of staff. The trust did not have access to information to review the mix of staff or safe staffing levels.

Are services effective?

- The trust was not meeting national performance targets for response times.
- The trust was benchmarked as the worst performing trust nationally for answering 999 calls within 5 seconds. Trust performance was as low as 95% within 80 seconds during March 2016.
- Policies and procedures had not been updated in a timely manner or in line with national guidelines.
- There was no tracking system for appraisals leading to inconsistencies in approach.
- There was no competency framework in place against which to assess staff.
- There was a lack of Mental Capacity Act training leading to a variable understanding within the trust.
- There were protocols and guidance for pain relief and patients reported that pain relief had been offered and managed effectively.
- The trust had well developed links with the police, fire brigade and GPs.

Are services caring?

- Our observation of staff interacting with patients demonstrated patient empathy and focus.
- We saw kindness and understanding from staff even when faced by volatile patients and members of the public.
- We saw examples of staff providing patients, relatives and colleagues emotional support.
- Call handlers in the 111 service communicated with callers in a non-judgemental way and treated patients as individuals.
- Ambulance crews largely provided clear explanations to patients adopting a sensitive tone and posture during discussions.
- PTS staff sensitively supported patients to find alternative modes of transport when they did not meet the criteria for accessing PTS.
- There were processes to ensure that staff could access support following traumatic or difficult calls or attendances. Staff were observed providing immediate support to colleagues.

Are services responsive?

- The processes for complaint response failed to meet expected targets. Complaints did not fully acknowledge organisational responsibility and there was little evidence of learning from complaints across the whole trust.
- Organisational planning had not facilitated equal distribution of resources across the geographical area served.
- A 'tethering' system resulted in some patients waiting longer than necessary for emergency attendances.
- Handover delays at emergency departments often significantly exceeded the 15 minutes target and led to a major loss of productive ambulance capacity.
- The trust was working closely with commissioners to plan services against the background of significant increases in demand.
- The trust worked with strategic clinical networks, operational delivery networks and the trauma network to plan for complex care.

Are services well-led?

- Roles and accountability within the executive team lacked clarity.
- There was a lack of clarity regarding the respective roles of the three clinical directors within the executive team.
- The board had numerous interim post holders and we saw evidence of inter-executive grievance.
- Although there was a comprehensive clinical strategy, there was no form of measurement to monitor the attainment of the strategy pledges by the board.
- Risk management was not structured in a way that allowed active identification and escalation to the board. Risks managed at board level did not have robust and monitored action plans.
- Staff reported a culture of bullying and harassment.
- The trust had actively sought to engage with the public, notably with the development of community first responders.
- The trust was utilising social media in an attempt to inform and influence the use of trust services.
- The trust had a positive culture of encouraging innovation, notably in the development of the paramedic workforce and the introduction of critical care and advanced paramedics.

We saw several areas of outstanding practice including:

Summary of findings

- The trust encouraged staff to take on additional roles and responsibilities and provided training and support to enhance the paramedic roles. The specialist paramedics' roles such as the critical care paramedic had expanded and developed.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- take action to ensure all staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns receive an appropriate level of safeguarding training.
- take action to ensure all Emergency Operations Centre premises containing confidential data and critical equipment are secure.
- take action to ensure the CAD system is properly maintained.
- take action to provide every operational Hazardous Area Response Team (HART) operative with no less than 37.5 hours protected training time every seven weeks.
- formulate a contingency plan to mitigate the loss of the Patient Transport Services control room in Dorking that will allow the service to continue.
- take action to ensure that governance systems are effective and fit for purpose. This includes systems to assess, monitor and improve the quality and safety of services.
- take action to improve the reporting of low harm and near miss incidents.
- take action to ensure that national performance targets are met.
- take action to improve outcomes for patients who receive care and treatment.
- take action to adequately manage the risk of infection prevention and control. This includes ensuring consistent standards of cleanliness in the ambulance stations, vehicles and staff hand hygiene practices.
- take action to ensure there are always sufficient numbers of staff and managers to meet patient safety and operational standards requirements. This should include ensuring there are adequate resources for staff to usually take their meal breaks, finish on time, undertake administrative and training.
- take action to recruit to the required level of HART paramedics in order to meet its requirements under the National Ambulance Resilience (NARU) specification.
- ensure that ambulance crews qualifications, experience and capabilities are taken into account when allocating crews to ensure that patients are not put at risk from inexperienced and unqualified crews working together.
- take action to protect patients from the risks associated with the unsafe use and management of medicines. This should include: appropriate use of patient group directives; the security and safe storage of both medicines and controlled drugs; the management of medical gas cylinders.
- take action to ensure that patient records are completed appropriately, kept confidential and stored securely.

In addition the trust should:

- take action to review all out-of-date policies and standard operating procedures.
- develop procedures to ensure HART rapid response vehicles (RRVs) are relieved to attend HART incidents within the timescales set out in standards 08-11 of appendix three of the NHS service specification 2015-16: Hazardous area response teams.
- take action to audit 999 calls at a frequency that meets evidence-based guidelines.
- take action to put in place an effective and consistent process for feedback to be given to those who report incidents and develop a robust system for sharing lessons learned from incidents.
- take action to ensure all staff receive an annual appraisal in a timely fashion in order that they can be supported with training, professional development and supervision.
- take action to address discrepancies in the number of funded ambulance hours with activity across the trust.
- ensure all first aid bags have a consistent list of contents, stored securely within the bags.
- devise a system that will accurately track the whereabouts of the PTS defibrillators.

Summary of findings

- include a question regarding the patient's DNACPR status at the point of each transport booking.
- provide Mental Capacity Act and Deprivation of Liberty Safeguards training to all operational staff.
- take action to engage staff in the organisations strategy, vision and core values.This includes increasing the visibility and day to day involvement of the trust executive team and board across all departments.
- develop a detailed and sustained action plan to address the findings of the staff survey including addressing the perceived culture of bullying and harassment.
- continue to take action to address the handover delays at the acute hospitals.
- ensure there are adequate resources available to undertake regular audits and robust monitoring of the services it provided.
- ensure that there is adequate access to computers at ambulance stations to facilitate e-learning, incident reporting and learning from incidents.
- ensure there is a robust system in place to manage, investigate and respond and learn from complaints.This includes ensuring that all staff understand the Duty of Candour and their responsibilities under it.
- ensure that there is appropriate trust wide guidance and training provided regarding attending patients with mental health problems. This should include reviewing the current arrangements for assessing capacity and consent.
- ensure that there are structured plans in place for all frequent callers as per national guidance. The information regarding this should be collected and monitored as per national guidelines.
- ensure that there are systems and resources available to monitor and assess the competency of staff. This includes ensuring they always involve patients in the care and treatment and treat them with dignity and respect.
- ensure there are robust systems in place to ensure all medical equipment is adequately serviced and maintained.
- ensure that vehicles and ambulance stations are kept secure.
- ensure that there is sufficient time for vehicle crews to undertake their daily vehicle checks within their allocated shift pattern.

Professor Sir Mike Richards

Summary of findings

Chief Inspector of Hospitals

Summary of findings

Background to South East Coast Ambulance Service NHS Foundation Trust

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Our inspection team

Our inspection team was led by:

Chair: Sarah Faulkner, Director of Quality/Executive Nurse, The North West Ambulance Service NHS Trust

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

The team of 40 included CQC inspectors and inspection managers, a pharmacy inspector, an analyst and an inspection planner and a variety of specialists. The team of specialists included a nurse consultant and staff nurse working in

emergency departments, a medical director, ambulance operations managers, paramedic staff including a critical care paramedic and a clinical team leader, an emergency care technician and a senior emergency care practitioner, a safeguarding lead, a head of governance, staff from patient transport services, a HART manager, a call centre manager, an emergency operations centre dispatcher and a community first responder.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The inspection took place from 3-6 May 2016.

The inspection team inspected the following:

• Emergency Operations Centres

• Emergency and Urgent Care including the Hazardous Area Response Team (HART).

• Patient Transport Services

The 111 service was inspected separately.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the South East Coast Ambulance Service. These included local clinical commissioning groups (CCGs); local quality surveillance groups; the health regulator, Monitor; NHS England; Health Education England (HEE); College of Emergency Medicine; General Dental Council; General Medical Council; Health & Safety Executive; Health and Care Professions Council; Nursing and Midwifery Council; National Peer Review Programme; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Public Health England; the medical royal colleges; local authorities, local NHS Complaints Advocacy Service; local Healthwatch groups; and local health overview and scrutiny committees. The inspection team also spoke to 105 staff trust-wide at focus groups the week before the inspection.

We visited all three EOC sites. We spoke to 39 staff during our visits. We spoke to staff from the following staff groups: call handlers, dispatchers, clinicians, managers, paramedics, development coaches, infection prevention and control, and safeguarding. We spoke with the relatives and carers of two patients. We also reviewed patient feedback from the compliments boards at Coxheath and Lewes EOCs, four patient complaints and the 2014 national ""hear and treat "survey. The hear and treat survey measured the experiences of patients who received medical advice over the telephone to manage their conditions. We also examined information sent to us by the public and other stakeholders such as Healthwatch.

During the inspection, we visited 23 ambulance stations, two hazardous area response teams (HART) and four community first responder posts across Kent, Surrey and Sussex. We also inspected the emergency and urgent care support services such as the make ready centres, fleet management and maintenance centres as well as the commissioning and decommissioning centre. We inspected ambulances and reviewed patient records. We also attended 17 hospitals, where we observed the interaction between ambulance crews and hospital staff. We spoke with over 30 emergency department staff to get feedback on the service provided by the ambulance trust.

Summary of findings

We spoke with over 150 emergency and urgent care staff in various roles including paramedics, emergency medical technicians, paramedic students, team leaders, duty station officers, senior managers and community first responders. We reviewed 25 sets of patient care records. We spoke with 31 emergency department patients and their relatives who had used the service. We also observed over 30 patient handovers at emergency departments. We rode, and observed staff-patient interactions and care, on emergency ambulances.

During our inspection we spoke with PTS staff including the PTS co-ordinators, booking staff and senior managers. We observed the work of staff at all the major hospitals. We looked at vehicle maintenance, cleanliness, the planning of vehicle servicing and MOT testing. We also spoke with patients who used the service as well as assessing outcomes from patient satisfaction surveys.

We would like to thank all staff, patients and other stakeholders for sharing their balanced views and experiences of the quality of care provided by the South East Coast Ambulance Service NHS Foundation Trust.

Facts and data about this trust

1. Context

- The emergency and urgent care service and the NHS111 service cover Kent, Surrey and Sussex.
- Patient Transport Services operate in Surrey.
- The area covers 3,600 square miles with a population of more than 4.5 million.
- There are 12 acute trusts and 22 Clinical Commissioning Groups.
- The service has over 110 sites. These include 45 Ambulance Stations, six Make Ready Centres, 59 Ambulance Community Response Posts, two Hazardous Area Response (HART) Centres and two stand-alone Vehicle Maintenance Centres.
- There are two regional offices at Lewes and Coxheath and the Trust HQ at Banstead. Each of these sites also houses an Emergency Operations Centre (EOC) where 999 calls are received, clinical advice provided and emergency vehicles dispatched if needed.
- There are two Contact Centres at Dorking and Ashford where 111 calls are received and responded to.
- Staff: Over 3,600 staff across Kent, Surrey and Sussex, including over one thousand registered clinical staff and over 900 clinical support staff.
- Trust revenue for April 2015 – March 2016 was £249 million with a surplus of £2.2 million.

2. Activity in 2014/15

- 929,822 emergency calls.
- 380,799 non-emergency patient journeys.

3. Safe

- National Reporting and Learning System (NRLS reporting): between February 2015 and March 2016 the trust reported 505 incidents. The majority of these (62%) were classed as no harm. Twenty one incidents were classed as 'severe' and 17 of these were grouped under 'treatment/procedure'. There were no never events.
- Staff survey: the trust scored worse than the national average on questions relating to the percentage of staff witnessing potentially harmful errors, near misses or incidents in last month , the fairness and effectiveness of procedures for reporting errors, near misses and incidents , and on staff confidence and security in reporting unsafe clinical practice . They scored the same as the national average on the percentage of staff reporting errors, near misses or incidents witnessed in the last month.

4. Effective

Emergency response times

- Between April 2015 and March 2016, 71.6% of 999 Red 1 calls received an emergency response within eight minutes after the EOC received the call. This was worse than the national target of 75%.
- Between April 2015 and March 2016, 67.3% of 999 Red 2 calls received an emergency response within eight

Summary of findings

minutes. This was worse than the 75% national target. SECAmb was the fifth worst performing out of 11 ambulance trusts in England for Red 2 response times during this period.

- The trust did not meet the AQI A19 target for Red 1 and Red 2 (combined) in 2015-16. This standard required that a vehicle able to transport a patient to hospital following a Red 1 or Red 2 response arrived within 19 minutes. Between April 2015 and March 2016, the trust met this standard for 93.8% of these calls. This was worse than the national target of 95%.

Ambulance clinical performance indicators (comparison between trusts) (January 2016 data)

- The data indicated that the outcomes for SECAmb patients who had a cardiac arrest was worse than the national average. There was deterioration in the statistics since last year. However, stroke patients were more likely to arrive at a specialist stroke unit quicker than the national average.
- The percentage of patients (66.7%) who received the appropriate care bundle for STEMI was worse than the England average of 80%.
- The percentage of of patients (87.6%) who received primary angioplasty within 150 minutes was the same as the England average.
- The percentage of patients (23%) who had return of spontaneous circulation on arrival at hospital was worse than the England average of 26%.
- The percentage of patients (3%) who were discharged from hospital alive having had resuscitation commenced or continued by ambulance crew following a cardiac arrest was worse that the England average of 6%. This was the smallest proportion across all the ambulance trusts and was significantly worse than the data for the previous year and below the average for 2014-15 of 8.5%.
- In the Utstein comparator group, 20% of patients were discharged from hospital alive which was the same as the England average in January 2016.
- The percentage of Face Arm Speech Test positive patients (61%) who arrived at a hyper-acute stroke unit within 60 minutes was better than the England average of 52%.

Treatment

- Between April 2015 and March 2016, the trust reported a “hear and treat” rate (emergency calls resolved by telephone advice) of 10.2%.This was the same as the England average for the same period. However, for the last three months of this period, the trust’s hear and treat rates were consistently worse than the England averages.
- The proportion of patients who re-contacted following treatment and discharge at the scene, within 24 hours is worse than the England average.
- The percentage of patients discharged, after treatment at the scene or onward referral to an alternative care pathway, and those with a patient journey to a destination other than type one or two A&E (‘see and treat’) is higher than the England average.

5. Caring

- The trust scored similar to other trusts for most questions on call handling, clinical advice and outcome, but worse than the national average on ‘did they listen to what you had to say’.

6. Responsive

Call answering

- The average time to answer a 999 call was consistently in line with the maximum of all trusts (3 seconds) , and in August 2015 some calls were taking as long as 140 seconds to be answered.
- The proportion of calls abandoned before being answered is lower than the England average for 12 out of 18 months (July 2014 – December 2015).
- The proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours is higher than the England average by an average of 1% per month.

Summary of findings

Patient Transport Services

- Patient transport contract key performance indicator times were not met overall.

7. Well Led

- NHS staff survey 2015: overall the trust scored worse than average for 16 questions, including the percentage of staff experiencing discrimination at work in last 12 months , the percentage of staff working extra hours , the quality of non-mandatory training, learning or development and the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months .

8. CQC inspection history

- 4 inspections since 2010.
- Compliant at last inspection December 2013.

Summary of findings

Our judgements about each of our five key questions

Rating

Are services at this trust safe?

Inadequate

We rated the trust as inadequate for safety. This was because:-

- Emergency and Urgent Care and 111 services were both rated as inadequate. Emergency Operations Centre and Patient Transport Services were both rated as requires improvement.
- The incident reporting culture, processes for reporting and investigating incidents and lack of learning from incidents did not support the safe provision of service.
- Safeguarding arrangements within the trust were exceptionally weak. A lack of accountability, understanding and appropriate investigation was prevalent throughout the trust.
- The trust had low attendance at infection control training leading to inconsistent hand hygiene practice.
- The trust CAD system had not been appropriately updated.
- Low staffing levels were having an impact on both performance and fatigue of staff. The trust did not have access to information to review the mix of staff or safe staffing levels.

Incidents

- The trust operated an incident reporting process that was supported by an Incident Reporting and Investigation Manual. At the time of inspection this manual was beyond its scheduled review date.
- During the time period May 2015 to April 2016 the trust reported 57 serious incidents. 42% of these were reported as causing delay to treatment.
- During the inspection staff interviewed indicated that they were aware of the incident reporting process. However, a culture of under reporting incidents existed within the trust driven by work pressure constraints. Low risk or near miss incidents appeared unlikely to be reported.
- It is likely that the low reporting culture is further exacerbated by the lack of feedback mechanisms to staff following the reporting of an incident. A number of staff indicated a view that nothing changes as a result of incident reporting.

Summary of findings

- Staff bulletins included, on some occasions, examples of learning from incidents. However, we did not see strong evidence of either thematic review or cross organisational learning from incidents. Serious incidents within the 111 service were not shared across the trust.
- The trust lacks a systematic approach to the management of incidents. As a result both patient transport services and the emergency operations centre had developed significant backlogs. Staff informed us that the trust had 3,300 open incidents awaiting investigation and were unable to advise the inspection team as to whether these incidents had been closed.
- The trust acknowledges the impact of workload pressures on staff on the reporting of incidents and are seeking to introduce tablet based systems to allow more rapid access for staff to incident reporting.
- Duty of candour was not well understood within the trust. This extended to senior staff holding prominent positions in operational, risk and safeguarding management who were unable to articulate the principles of duty of candour.

Mandatory Training

- The trust basic mandatory training portfolio was of appropriate content and access was largely on line training with some face to face. However, we have noted in our report the lack of access to mental health and dementia awareness training.
- Staff attendance rates for mandatory training were largely good with most exceeding the trust target of 95%.
- However we have indicated in our report that an area of concern is the lack of protected training time provided for the Hazardous Area Response Team (HART).
- Staff were provided protected time to complete mandatory training requirements.
- Driver training was managed in accordance with regulations and staff received, where appropriate, emergency response driving training. The trust has a robust plan to meet the five year reassessment of drivers.

Safeguarding and complaints

- The trust has a comprehensive safeguarding policy that is supported by safeguarding referrals guidance.
- The trust has a dedicated safeguarding team which reports into the trust clinical governance system. This included a designated non-executive director.

Summary of findings

- However, evidence provided by the trust did not include an annual safeguarding report to the board. Review of board agendas from May 2015 to the date of inspection supported the view that no report had been received at trust board.
- Formalised links with county safeguarding boards had not been used to maximum effect and there was no evidence of learning from serious case reviews.
- The board had identified the risk of not sharing information with local authorities in March 2014 but this risk remained, largely unmitigated, on the register in March 2016.
- Senior and middle managers, when interviewed, were unclear about their role in safeguarding. This included when allegations were made against staff.
- The trust policy for managing abuse allegations was dated June 2015 and provided no indication of board approval.
- During the inspection we reviewed two complaints where allegations of abusive behaviour by staff had been made. No subsequent safeguarding investigation had been made and the overall investigation lacked formality and purpose with a lack of external evidence sought.
- The trust did not have a system for robustly tracking safeguarding referrals and operational staff received no feedback following referral.
- Safeguarding training was provided to trust staff and we saw evidence of content of safeguarding training updates. However, the training provided to clinical staff (including paramedics)was at level 2 rather than the required level 3. An exception to this was the 111 service where clinical staff were all trained to level 3.
- Further to the level of training received only 70% of staff had attended level 2 training. There was a lack of clarity regarding accountability for training levels within the trust.
- Ambulance crews when interviewed failed to recognise the vulnerabilities of looked after children. In addition operational staff were not clear on the process for contacting the safeguarding lead.
- When reviewing incident records we identified an incident in which a vulnerable patient was left unattended for a considerable period of time. The crew attending did not consider this a safeguarding issue and no further referral was made.
- PREVENT (anti-radicalisation training) had been initiated. Safeguarding workbooks were available to staff.

Summary of findings

Cleanliness, infection control and hygiene

- The trust had an Infection Prevention and Control manual and had a dedicated infection control team.
- It was unclear from our interviews with managers and staff who was accountable for monitoring and maintaining infection control standards.
- In ambulance stations in particular there was a lack of frequency and completion of audits. As a result we saw examples of poor waste management processes.
- 74% of staff had attended infection prevention and control training in the year prior to inspection, which was below the trust standard of 95%.
- The trust was progressing a strategy of 'make ready centres'. Our observations during the inspection and feedback from staff indicated that this was proving successful in maintaining cleanliness and hygiene standards.
- However we observed poor standards from non make ready prepared vehicles including a lack of hand hygiene gel dispensers.
- Although hand gel dispensers were largely available our observations indicated that staff frequently failed to carry personal dispensers and observe hand hygiene best practice. Some staff had adopted the use of detergent wipes rather than recognised hand cleansing.

Environment and equipment

- Vehicles were serviced in accordance with Ministry of Transport requirement and a servicing recall system was in place. Staff reported that repairs services operated well.
- Staff largely had access to required equipment to deliver service. However, on PTS vehicles there was not always access to defibrillators and comprehensive first aid kits.
- On emergency vehicles there were processes to check kit inventory, however staff reported a lack of pressure cuffs .
- Processes for the general management of equipment were however weak with the trust not operating a central asset register and equipment not identified by an asset label.
- The standard of buildings used across the trust was variable. Whilst some constituted modern accommodation some ambulance stations were in poor repair.

Summary of findings

- EOC accommodation did not provide access for disabled staff and in one EOC we identified an electrical fire hazard. PTS office accommodation was not optimal both inhibiting communication by mobile telephone and providing cramped and unsuitable conditions of work.
- During the inspection we identified a major security breach at an ambulance station. We found the station unlocked and unattended with potential access to vehicles, uniforms, medicines and records.
- One of the EOC was also identified as a security risk due to uncontrolled access following poor maintenance.
- The storage of medical gases on a number of locations did not meet safety standards.

Medicines

- The trust has a Drugs and Therapeutics Committee which reports to the Risk Management and Clinical Governance Committee.
- Policies, procedures and guidelines are in place to ensure the safe and effective use of medicines. However, poor distribution and replacement processes resulted in old policies being in use.
- The trust uses patient group directions (PGD) to allow the supply and administration of urgent medicines by paramedic and nurses. Whilst having appropriate authorisation, PGDs, with the exception of one ambulance station, were out of date.
- Non registered staff (community first responders, associate practitioners and ambulance technicians) were authorised to administer prescription only medicines and registered staff (paramedics and nurses) authorised to administer an off license medicine. Whilst this practice is consistent with some other ambulance trusts it is different to practice in acute hospitals and we are currently seeking clarification of compliance with medicines legislation.
- The use of a biometric medicines storage cabinet to hold medicines has been introduced and proved successful in enhancing monitoring, security and stock control.
- However, where this was not implemented we observed examples where medicines, including controlled drugs, were not stored securely and monitored appropriately. We also saw examples of the inappropriate disposal of part used controlled drugs.

Summary of findings

Records and IT systems

- In the emergency care environment the trust had a paper based system using patient record forms. This system allowed electronic scanning when records were returned to the central records store.
- The trust audited the quality of records held, however these results were not shared with managers and subsequently staff for performance improvement purposes.
- Our audit of patient records during inspection indicated that patient assessments were often incomplete including low frequency of observations.
- The trust also used an intelligence based information system IBIS. This allowed for the holding of additional information including care pathways and DNA CPR on patients identified as complex and high risk by community health services. Staff had confidence in this system.
- The trust considered the instability of the CAD (Computer Assisted Dispatch) to be a significant risk and had as such placed it on the risk register. Staff described a recent upgrade as detrimental to functionality and performance.
- The CAD Gazeteer had not been updated for eighteen months. NHS England currently recommend six weekly updates. The trust was not appreciative of this risk, having not addressed and responded to a safety alert, and its potential impact upon reaching patients in a timely manner.

Assessing and responding to patient risk

- In the emergency care setting patient risk assessment was appropriately undertaken using early warning scores and clinical pathways.
- Processes for the recognition and management of deteriorating patients were in place.
- Staff from emergency departments at acute hospitals advised us that handover was comprehensive. However, our observations during inspection identified both gaps in handover detail and on one occasion inappropriate handover by a support worker.
- EOC services used recognised triage and prioritisation pathways.
- Clinical support to waiting patients was provided via telephone welfare checks. We saw evidence of triage upgrade following welfare calls.

- PTS staff were aware of action required in the event of a patient deteriorating.

Staffing and capacity risk

- Maintaining safe staffing levels was problematic for all operational areas of the trust. The trust had a 44% staff turnover rate. The sickness rate was 3% and agency usage was low.
- Staff were rostered using an electronic system. Staff expressed dissatisfaction with the system citing inconsiderate gaps between shifts.
- The roster system did not afford management the information to assess safe staffing and skill mix.
- We observed and heard from staff that crews with an inappropriate skill mix were despatched to emergencies. The trust had no means of assessing the frequency of such events and few were reported as incidents.
- Staff reported intense fatigue with shifts extending beyond scheduled hours and meal breaks often interrupted. In addition, staff shortages were largely covered by overtime.
- The trust employed a REAP (Resource Escalatory Action Plan), however the trust had been operating at a high REAP level for a sustained period.
- The impact of this was to impede managerial function as resource was diverted to operational activity. A further consequence was an acceptance of this level as the norm and a lack of urgency in escalation.
- The HART was below full establishment resulting in an operational service for only 70% of the required time.
- In the EOC there was a shortfall of over 18 whole time equivalent paramedics from an establishment of 27. Continued clinical support was provided by telephone cross cover from other EOC's but placed intense pressure on staff.
- The established call handler workforce was 171 wte. At the time of inspection there was only 133 in post. This had a subsequent impact on the services ability to promptly answer 999 calls.
- At times of high activity the EOC had planned overspill areas to extend capacity.
- Vacancies also occurred within PTS, however the operational impact was less severe.
- 111 services also experienced significant shortfalls in staffing leading to performance issues. This regularly occurred in early morning, evening and weekend shifts.

Summary of findings

Major incident awareness

- The trust had a documented major incident policy and engaged in EMERGO training exercises.
- The service was widely commended by the public and other services for its response to the Shoreham air disaster.

Are services at this trust effective?

Requires improvement

We have rated the trust as requires improvement for effectiveness. This is because:-

- The emergency and urgent care service, the 111 service and EOC were all rated as requires improvement and PTS services were rated as good.
- The trust was not meeting performance targets for response times.
- Policies and procedures had not been updated in a timely manner or in line with national guidance.
- There was no tracking system for appraisals leading to inconsistency in approach.
- There was not a competency framework in place against which to assess staff.
- There was a lack of MCA training provided to staff leading to a variable level of understanding within the trust.

Evidence-based care and treatment

- The trust had developed care pathway, policies and protocols in line with NICE (National Institute of Health and Care Excellence) guidelines. Staff largely found these accessible and demonstrated an awareness of them.
- However, we found a number of policies in both the emergency and urgent care and the EOC that were beyond review date. In the EOC 50% of policies had not been reviewed since 2012 despite two Joint Royal Colleges Ambulance Liaison Committee (JRCALC) updates during that time period.
- There was little evidence of a programme of continuous clinical audit. Concern had been expressed by commissioners regarding the standard and frequency of audit. The clinical audit team lacked senior clinical oversight.
- The trust was not auditing call handler responses in line with their NHS Pathways licence. Of the required three audits per month 28% of staff had only received one audit.

Summary of findings

Assessment and planning of care

- Triage arrangements for calls received by the EOC were categorised in line with national guidance. This included a body map screen to enhance clinical assessment.
- An appropriate up to date multi-agency policy was in place for conveyance of patients under the Mental Health Act.
- The trust had a register of community first responders (CFR). However, issues relating to the CAD contributed to CFR impact not being maximised. The board recognised the need to enhance the impact of CFR but had not planned an improved form of delivery.
- Processes to ensure that PTS were advised of any special requirements for patients being discharged from hospital were in place.
- There were protocols and guidance for pain relief available to staff and patients reported that pain relief had been offered and managed effectively.The trust did not audit patient satisfaction of pain relief.

Response times

- The trust was not meeting national performance targets for response times.
- RED1 calls (those of life threatening nature) were not always attended to within the eight minute target. Between April 2015 and March 2016 only 71% met the target against the expected performance level of 75%.
- RED2 calls (less urgent but including stroke and fits) were not always attended to within the eight minutes plus I minute additional telephone time target. Between April 2015 and March 2016 only 67.3% met the target against the expected performance level of 75%.
- The trust was just below (93.8%) the 95% target for combined RED1 and RED2 response for 19 minute transfer to hospital.
- Performance was significantly varied between ambulances despatched by different EOC's. For one EOC daily performance was as low as 33.3% (RED1) and 55.8% (RED2).
- The trust was benchmarked as the worst performing trust nationally for answering 999 calls within five seconds. Trust performance was as low as 95% within 80 seconds during March 2016.

- This delay may be exacerbated by the practice of a two minute wrap up time between calls, which was considered by the inspection team as excessive.
- Call abandonment rates for EOC were better than the national average, however for the 111 service abandonment levels were high and in excess of 17% for March 2016.
- Daily 111 service performance for answering calls within 60 seconds was highly variable ranging from 20.4% to 98.5% during April 2016.

Patient outcomes

- Year to date data reported in January 2016 indicated that the trust was performing worse (66.7%) against the national average (80%) for patients receiving the full care bundle for STEMI (Heart attack). However, the percentage of patients receiving primary angioplasty within 150 minutes (87.6%) was the same as the national average.
- 23% of patients had attained return of spontaneous circulation (ROSC) on arrival at hospital which was below the national average (26%). Using the Utstein comparator group data to measure the management of cardiac arrest the trust attained 31.3% ROSC which was worse than the England average of 44.3%.
- The proportion of patients discharged alive following cardiac arrest was 3%, worse than the England average and a deterioration from the 2014-15 position. The proportion of patients discharged alive using the Utstein comparator group was 20% which was the same as the England average.
- 61% of stroke patients arrived at a hospital within 60 minutes which was better than the national average(52%).
- However, 96.4% of suspected stroke patients received the appropriate care bundle, which was worse than the England average 97.8%.
- The 'hear and treat' rates for the trust had deteriorated to below the national average between January and March 2016.

Competent staff

- There were comprehensive induction programmes for call handlers and PTS staff. Feedback from emergency and urgent care staff suggested that their induction programme did not fully prepare them for the role.

Summary of findings

- In addition, we heard from a new member of staff being placed with relatively inexperienced colleagues.
- All paramedics were registered with the Health and Care Professions Council (HCPC) and process of revalidation was in place.
- The trust did not have a controlled process for tracking appraisals. This led to an inconsistent approach to re-appraisal with some staff having multiple appraisals during a time periods whilst others received none.
- Appraisal rates were good across a number of ambulance stations, however some performed less well bringing the trust wide average down to 72%, below the trust target of 100%.
- Appraisal rates in EOC's were lower at 60% and PTS staff reported high compliance with appraisals.
- The trust had built excellent links with universities to develop paramedic education both generally and as specialist critical care and advanced paramedics.
- Paramedics received clinical supervision on a regular basis.
- However, there was no recognised competency framework in use for assessing staff within the emergency and urgent care service.
- The trust had introduced performance coaches into the EOC to support staff development. Coaches were particularly directed towards supporting staff following call audit.
- CRF volunteers received key skills training from the trust.

Coordination with other providers

- The trust had well developed links with the police, fire brigade and GP's and the efficiency of these links daily.
- Over 18% of calls to 999 were referred from NHS111 services and a number of which had no apparent basis for referral. We were provided no evidence from the trust that this was subject to audit.
- PTS services maintained good relationships with acute hospitals and other service users. The introduction of PTS co-ordinators on trust sites had improved processes for patient discharge to home.

Summary of findings

Multidisciplinary working

- We observed call handlers being provided excellent support from clinicians within EOC. However, the pressurised performance environment led to some strains between emergency crews and the EOC.
- The trust had planned multidisciplinary away days to enhance joint working and communication.
- The trust provided HALO (hospital ambulance liaison officers) to acute trust emergency departments during periods of escalation. The acute trusts were largely complimentary of their ability to working alongside their staff.

Access to information

- Mobile ambulance staff found accessing information difficult and some described a lack of computer terminals at ambulance stations. The trust was in the process of implementing mobile tablets and were experiencing some initial connectivity problems.
- EOC staff had access to community health directories of service in order to signpost appropriate services.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- Staff across the trust reported to us during the inspection that there was an absence of training relating to mental capacity.
- Our observations of ambulance crews demonstrated the appropriate use of consent.
- However, non-conveyance patients were not always provided with a full explanation of the reasons for documentation.

Are services at this trust caring?

Good

We rated the trust as good for caring. This was because:-

- All services inspected received the rating of good.
- Our observations of staff demonstrated patient empathy and focus.
- We saw kindness and understanding from staff even when faced by volatile patients and public.
- We saw during the inspection examples of staff providing patients, relatives and colleagues emotional support.

Summary of findings

Compassionate care

- During our inspection we heard numerous examples of compassionate care displayed by ambulance staff. This was supported by our observations of staff in their interaction with patients and carers.
- Ambulance staff were aware and sensitive to the dignity and respect of patients ensuring that they were transported with appropriate blanket coverage.
- EOC staff remained calm and patient focused when receiving calls. Carers, when interviewed, endorsed our observed findings.
- Staff across all services introduced themselves when interacting with patients. The PTS survey endorsed this with over 98% of patients responding that they had been treated with dignity.
- Call handlers in the 111 service communicated with callers in a non-judgemental way and treated patients as individuals.

Understanding and involvement of patients and those close to them

- Ambulance crews largely provided clear explanations to patients adopting a sensitive tone and posture during discussions. Patient feedback supported our observations.
- We were provided with a number of examples where EOC call handlers had supported childbirth and significant acute illness. Staff listened to callers and provided clear instructions. Although our observations supported these examples, the national hear and treat survey scored lower than the national average for feeling that the caller was listening to.
- PTS staff sensitively supported patients to find alternative modes of transport when they did not meet the criteria for accessing PTS.
- 111 call handlers regularly checked understanding with callers. Staff closed the call by clearing restating what was being asked of the caller.

Emotional support

- Emotional support was part of interactions with patients accessing all parts of the trust services. This was achieved by calm clear communication.

Summary of findings

- Processes were in place to ensure that staff could access support following traumatic or difficult calls or attendances. Staff were observed providing immediate support to colleagues.
- External counselling and chaplaincy was available for staff to access.

Supporting people to manage their own health

- A frequent caller policy was in place to support regular service users affording them a frequent callers plan. However, trust monitoring systems were unable to track these patients and was unable to identify the number of patients with a frequent caller plan.
- Staff regularly enquired as to availability of patients own medications during interactions with patients.

Are services at this trust responsive?

Requires improvement

We have rated the trust as requires improvement for responsiveness. This is because:-

- Both Emergency care and EOC were rated as requires improvement. Both PTS and 111 services were rated as good.
- The processes for complaint response failed to meet expected targets. Complaints seldom acknowledged organisational responsibility and there was little evidence of learning from complaints.
- Organisational planning had not facilitated equal distribution of resource across the geographical area served.
- A 'tethering' system resulted in some patients waiting longer than necessary for emergency attendance.

Service planning and delivery to meet the needs of local people

- The trust was working closely with commissioners to plan services against the background of significant increases in demand.
- The trust included the presence of major areas of risk (airports, channel tunnel and M25) in its planning.

However, the HART team was only available 70% of the time due to staffing shortages. The CAD system also failed to identify HART incidents which could lead to the inappropriate dispatch of crews to such incidents.

- Day to day planning and optimum use of resources was facilitated by an ambulance tracking system.
- The trust worked with strategic clinical networks (SCN) and operational delivery networks (ODN) and also the trauma network to plan for complex care.
- Ambulance hours were not distributed evenly across the areas the trust served. This had led to variation in service and longer waits for some locations.
- Staff considered PTS planning to be unrealistic and not taking full account of urban density and weight of traffic.
- The trust worked collaboratively with its partner organisation for 111 service provision to plan services in line with patient needs.

Meeting people's individual needs

- The trust had suitable equipment and processes to support both the emergency and routine transfer of bariatric patients.
- The IBIS system allowed trust staff to identify and tailor treatment towards long term conditions and morbidities.
- A SMS system was in place allowing callers who have hearing impairments or physical disabilities to access 999 services. PTS services used a type talk system to support patients with hearing impairment.
- Arrangements were also in place to support callers for whom English was not their first language.
- Call handlers received training on engaging callers with dementia or mental health issues during induction. However, general dementia awareness training was not provided by the trust.
- PTS staff had advanced knowledge of care plans for dementia and learning disability patients allowing them to fully support them during transfer.

Access and flow

- The major inhibitor to access and flow was delayed handover at emergency departments. The ambulance service has limited influence on the causative factors. In

many cases handover significantly exceeded the 15 minutes target at all acute trusts and has led to a major loss of productive ambulance capacity. Although the trust had initiated the use of HALO staff within emergency units to support immediate handover, during the inspection we observed ambulances delayed on a number of occasions.

- By utilising paramedic practitioners with the skills to provide robust care support the trust had attained a 23% non-conveyance rate. The trust also had a higher rate of transfer to care provided by places other than acute hospitals.
- The trust did however utilise a tethering system whereby a vehicle is held back to attend potential RED1 or RED2 calls. This results in other calls waiting longer than necessary for attendance and had led to patient complaints.
- The patient reminder service for PTS was only used in 50% of cases. There was also a high number of aborted journeys (patient not available but PTS not informed), many of which were linked to discharge processes within the acute trusts.
- Clinician call back within ten minutes from the 111 service was significantly better than the national average.

Learning from complaints

- At the time of inspection the trust had 364 open complaints of which 200 were beyond the standard 25 day response time. There was no severity or thematic analysis of this backlog.
- When reviewing a sample of 25 complaints we identified poor quality of investigation with little clinical oversight.The trust referred to the majority of complaints as "unjustified". There was subsequently little evidence of learning from complaints

Are services at this trust well-led?

Inadequate

We have rated the trust as inadequate for well-led. This is because:-

- Emergency and urgent care services were rated as inadequate. EOC, PTS and the 111 service were rated as requires improvement .
- The board had numerous interim post holders. We saw evidence of inter-executive grievance.
- Roles and accountabilities within the executive team lacked clarity.

Summary of findings

- Risk management was not structured in a way that allowed active identification and escalation to the board.
- Staff reported a culture of bullying and harassment.

Vision and strategy

- In March 2015 the trust ratified a clinical strategy 2014-2019. The document was comprehensive providing a vision for service, a series of milestones and featured a number of strategic pledges to patients.
- Executive directors were assigned lead roles for each strategic pledge. However, during the inspection senior staff did not identify with this accountability.
- Review of minutes of board meetings from March 2015 to the date of inspection could not identify at which point the clinical strategy had returned to board for review. There was no form of measurement for the attainment of the strategy pledges. Furthermore, many of the concerns in our report can be linked directly to the non-delivery of the strategic pledges.
- The trust values of Pride, Innovation, Integrity, Respect and Responsibility featured on the trust website.
- During the inspection we interviewed many staff who did not recognise either the clinical strategy or the trust values. There was little evidence of transfer of strategic or behavioural intent through the organisation.
- A lack of engagement with staff with respect to the development of the trust values had contributed to a workforce feeling of not being listened to.
- This had led to the EOC developing its own set of values and a four point strategy that lacked explicit linkage to the trust clinical strategy.

Governance, risk management and quality measurement

- Board minutes did not appear to be clearly directed by actions with few requests for subsequent updates or further deep dive reviews.
- The trust had a board assurance framework (BAF) that linked strategic risk to strategic objectives.
- The BAF was due for review at the May 2016 trust board meeting and prior to that was updated in July 2015. The BAF was regularly reviewed at Audit Committee during 2016.

Summary of findings

- At the time of inspection the trust board had seven sub board committee meetings. The clinical quality working group, which reported into the Risk Management and Clinical Governance Working Group (RMCGC) had 13 further sub groups reporting in to it.
- Risk management processes were under developed. Staff told us that there were no set criteria for raising issues onto the risk register with no clear escalation criteria to ensure trust board sight. Risks managed at board level did not have robust and monitored action plans.
- Following the project to implement changes in the triage of RED2 and GREEN calls the commissioners initiated risk summit status and subsequently a full investigation in the governance of the project. The findings of the project were highly critical of governance processes at the trust.
- Governance processes did not identify, assess and manage issues relating to incidents and complaints until immediately prior to the inspection.

Leadership

- Following a recent external investigation into the management of change of processes for RED1 response the Chairman had resigned and the CEO was on extended leave.
- At the time of inspection the trust was led by an experienced interim chair.
- In a short period of time the chair has completed a diagnostic and has clear sight on required actions and key risks.
- The chair was supported by seven non executive directors of varying years of experience. During interviews they described the increasing need to become involved in operational functions over the last six months as a consequence of executive delivery failures. Voting non-executive directors outnumbered executive directors.
- The director of commissioning and deputy CEO had been appointed as interim CEO following the extended leave afforded the substantive CEO. The interim CEO described future processes for improving accountability, governance and engagement issues and we heard from some staff that communication had improved. However, some staff were critical of the credibility of this appointment as they considered the post holder associated with previous executive failings.

Summary of findings

- The COO was about to leave the trust to take up an appointment that enables further professional development. The trust has appointed a replacement.
- There is a lack of clarity regarding the respective roles of the three clinical directors within the executive team. This was notable with respect to involvement in and understanding of risk and serious incident management. The director of nursing lacked a clear portfolio.
- The paramedic director has successfully developed the paramedic workforce with a strong education and training strategy. Whilst this focus has clearly developed a cutting edge workforce, the implementation of clinical strategy and attainment of key performance indicators were not well articulated during our interview.
- The director of human resource is also a recently appointed interim (covering sickness absence) and the finance director is new to role. A company secretary had also been appointed within the last month.
- The trust has recently reviewed its process for Fit and Proper Persons Regulation. It now has clear processes for newly appointed directors and addressed appropriately any historic gaps. There was a process for annual declaration.
- The board was in a period of significant transition. The ability to operate as an effective unitary board was constrained by the degree of operational input that has had to be undertaken by non-executive directors, the number of interim positions and the lack of definition of the roles and accountabilities of executives, notably those with clinical responsibilities.
- During the inspection we saw evidence that there remains a number of inter-executive grievances outstanding. The presence of such issues amongst the trust leadership does not augur well for the formation of a successful team.
- Many staff indicated during our interviews that there was a lack of visibility of senior executives within the organisation.
- Local managers in many cases felt they did not have enough time, as a result of operational pressures, to complete managerial and governance functions.
- During the inspection we interviewed trust governors. They expressed serious concerns about the lack of communication with the trust board since recent board appointments.
- The governors interviewed felt there had been a lack of action relating to the concerns expressed to the executive.

Summary of findings

- The processes by which governors hold Non Executive Directors to account had not been developed. There was concern expressed about the use of informal communication routes with executives and non-executives.
- We did not identify any programme of board development during the inspection.

Culture and diversity within the service

- This was a complex and geographically spread organisation and as such varied culturally between counties.
- During our interviews with staff they demonstrated that they were exceptionally proud of the work they do and the positive impact they have on patient lives. The trust was above the national average for respondents to the 2015 national staff survey agreeing that there role makes a difference.
- However, many staff reported a culture of bullying and harassment. Much of these reports stemmed from style of contact and lack of support during sickness.
- Staff also attributed the bullying and harassment culture to the organisation drive towards attaining performance targets. In particular the pressure placed on middle and junior managers, many of whom have not had developmental support to deliver their role.
- The inability to ensure that managers apply HR policies in a consistent manner has led to a collective dispute relating to the transformation (workforce change) agenda.
- The 2015 NHS staff survey data indicated that the trust was worse than the national average for both staff feeling bullied and discriminated against.
- The trust had developed a culture of operating in a crisis by fire fighting, but a lack of step down process and medium and long term planning led to a lack of sustainable change.
- The trust has applied a 4% sickness trigger that may lead to exclusion from promotion. This trigger is reviewed on an individual case basis.
- The trust does not have an active health and wellbeing strategy.
- We heard concerns from a high number of staff during and after the inspection regarding the management of

sickness. We were provided examples where return to work had not been managed in a sympathetic way and due consideration to working practice adjustments had not been made.
- The trust completed the Workforce Race Equality Scheme (WRES)report for 2015. The document has been seen by the board along with a robust action plan. Plans have been shared with staff and trade unions.
- The trust has set equality objectives and makes an explicit link with patient outcomes and experience.
- The action plan was developed by the Inclusion Committee which reports to the board on matters of equality.The trust also had an active BME Staff Network.
- BME staff constitute 2.6% of the workforce which is below the 6.1% within the local population. The trust was aware of recruitment issues and was working with universities to enhance the recruitment of BME staff onto pre registration degree courses.
- BME staff were represented at all levels of the organisation with the exception of the trust board.
- The staff survey indicates that BME staff were less likely to be appointed from shortlisting than white staff and were more likely to enter into a formal disciplinary process.
- The experience of discrimination at work by a manager, and the view of not having opportunities for progression was high for both BME and white staff.
- However, the BME staff sample size for completion of the staff survey is small and casts a question of reliability on the WRES data.

Public and staff engagement

- The trust had actively sought to engage with the public notably with the development of community first responders.
- The trust held an annual survivors event for public, patients and staff to attend.
- The trust was utilising social media in an attempt to inform and influence the use of trust services.
- The trust held annual staff awards to acknowledge long service and individual and team excellence .
- The trust engagement score in the national staff survey had improved between 2014 and 2015 but still remained below the national average.
- Meeting structures and communication across the trust was not standardised and staff reported the receipt of 'mixed messages' from managers.

Summary of findings

Innovation, improvement and sustainability

- The trust had a positive culture of encouraging innovation. This was most notable in the development of the paramedic workforce and the introduction of critical care and advanced paramedics. The inspection team were highly impressed with this aspect of service and workforce development.
- Other areas of service had also introduced innovative practice including mental health triage and the implementation of the make ready stations.
- The trust had embarked upon a transformation programme to re-design the workforce to support both the new operational structure and the delivery of the clinical strategy. However, consultation had lacked clarity and implementation had been delayed. The impact of this was additional stress and uncertainty on the workforce.

Overview of ratings

Our ratings for South East Coast Ambulance Service NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Patient transport services (PTS)	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre (EOC)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
NHS 111 service	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Our ratings for South East Coast Ambulance Service NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Notes

Outstanding practice and areas for improvement

Outstanding practice

- The trust encouraged staff to take on additional roles and responsibilities and provided training and support to enhance the paramedic roles. The specialist paramedics' roles such as the critical care paramedic had expanded and developed.

Areas for improvement

Action the trust MUST take to improve

Action the location MUST take to improve

- Take action to ensure all staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns receive an appropriate level of safeguarding training.
- Take action to ensure all Emergency Operations Centre premises containing confidential data and critical equipment are secure.
- Take action to ensure the CAD system is properly maintained.
- Take action to provide every operational Hazardous Area Response Team (HART) operative with no less than 37.5 hours protected training time every seven weeks.
- Formulate a contingency plan to mitigate the loss of the Patient Transport Services control room in Dorking that will allow the service to continue.
- Take action to ensure that governance systems are effective and fit for purpose. This includes systems to assess, monitor and improve the quality and safety of services.
- Take action to improve the reporting of low harm and near miss incidents.
- Take action to ensure that national performance targets are met.
- Take action to improve outcomes for patients who receive care and treatment
- Take action to adequately manage the risk of infection prevention and control. This includes ensuring consistent standards of cleanliness in the ambulance stations, vehicles and staff hand hygiene practices.
- Take action to ensure there are always sufficient numbers of staff and managers to meet patient safety and operational standards requirements. This should include ensuring there are adequate resources for staff to usually take their meal breaks, finish on time, undertake administrative and training.
- Take action to recruit to the required level of HART paramedics in order to meet its requirements under the National Ambulance Resilience (NARU) specification.
- Ensure that ambulance crews qualifications, experience and capabilities are taken into account when allocating crews to ensure that patients are not put at risk from inexperienced and unqualified crews working together
- Take action to protect patients from the risks associated with the unsafe use and management of medicines. This should include: appropriate use of patient group directives; the security and safe storage of both medicines and controlled drugs; the management of medical gas cylinders.
- Take action to ensure that patient records are completed appropriately, kept confidential and stored securely.

Action the location SHOULD take to improve

- Take action to review all out-of-date policies and standard operating procedures.

Outstanding practice and areas for improvement

- Develop procedures to ensure HART rapid response vehicles (RRVs) are relieved to attend HART incidents within the timescales set out in standards 08-11 of appendix three of the NHS service specification 2015-16: Hazardous area response teams.
- Take action to audit 999 calls at a frequency that meets evidence-based guidelines.
- Take action to put in place an effective and consistent process for feedback to be given to those who report incidents and develop a robust system for sharing lessons learned from incidents
- Take action to ensure all staff receive an annual appraisal in a timely fashion in order that they can be supported with training, professional development and supervision.
- Take action to address discrepancies in the number of funded ambulance hours with activity across the trust.
- Ensure all first aid bags have a consistent list of contents, stored securely within the bags.
- Devise a system that will accurately track the whereabouts of the PTS defibrillators.
- Include a question regarding the patient's DNACPR status at the point of each transport booking.
- Provide Mental Capacity Act and Deprivation of Liberty Safeguards training to all operational staff.
- Take action to engage staff in the organisations strategy, vision and core values. This includes increasing the visibility and day to day involvement ofthe trust executive team and board across all departments.
- Develop a detailed and sustained action plan to address the findings of the staff survey including addressing the perceived culture of bullying and harassment.
- Continue to take action to address the handover delays at the acute hospitals.
- Ensure there are adequate resources available to undertake regular audits and robust monitoring of the services it provided.
- Ensure that there is adequate access to computers at ambulance stations to facilitate e-learning, incident reporting and learning from incidents.
- Ensure there is a robust system in place to manage, investigate and respond and learn from complaints. This includes ensuring that all staff understand the Duty of Candour and their responsibilities under it.
- Ensure that there is appropriate trust wide guidance and training provided regarding attending patients with mental health problems. This should include reviewing the current arrangements for assessing capacity and consent.
- Ensure that there are structured plans in place for all frequent callers as per national guidance. The information regarding this should be collected and monitored as per national guidelines.
- Ensure that there are systems and resources available to monitor and assess the competency of staff. This includes ensuring they always involve patients in the care and treatment and treat them with dignity and respect.
- Ensure there are robust systems in place to ensure all medical equipment is adequately serviced and maintained.
- Ensure that vehicles and ambulance stations are kept secure.
- Ensure that there is sufficient time for vehicle crews to undertake their daily vehicle checks within their allocated shift pattern.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective governance arrangements in place. There were no effective assurance systems for auditing, monitoring or driving improvement in order to protect patients and staff from the health, safety and welfare risks from using the service.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not operate and implement, robust procedures and processes that make sure that people are protected from abuse. There were insufficient resources allocated, scrutiny or oversight of safeguarding within the trust.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

The provider had not have systems in place to ensure that the management and administration of medication met legislative and best practice guidance. In particular patients and staff were at risk because the use of patient group directives, security and storage of medicines were not safe.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have robust systems in place to ensure that that the equipment used was appropriately serviced, maintained and stored securely.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not always provide sufficient numbers of suitably qualified, competent, skilled and experienced persons to ensure that patients received a safe, appropriate and prompt response when calling for emergency services.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...