Yorkshire Ambulance Service NHS 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	Good
Are services at this trust safe?	Good
Are services at this trust effective?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Yorkshire Ambulance Service NHS Trust (YAS) was formed on1 July 2006 when the county's three former services merged. The trust covers North Yorkshire, South Yorkshire, West Yorkshire, Hull and East Yorkshire covering almost 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline and inner cities. The trust employsover 4,670 staff and provides 24-hour emergency and healthcare services to a population of more than five million.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, an NHS 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and emergency operation centres (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a resilience and hazardous area response team (HART).

We carried out a follow up inspection of the trust from 13-16 September 2016, in response to a previous inspection as part of our comprehensive inspection programme of Yorkshire Ambulance Service NHS Trust in January 2015. In addition, an announced comprehensive inspection of the NHS 111 service was carried out on 10-12 October 2016.

Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. We therefore did not inspect all of the five domains: safe, effective, caring, responsive and well led for each of the core services we inspected.

We inspected five core services:

- Emergency operations centres
- Urgent and emergency care
- Patient transport services
- Resilience services including the hazardous area response team
- NHS 111 services.

Overall, we rated all of the five key domains as good which meant the overall rating for the trust was also good.

Our key findings were as follows:

- The trust had undertaken a number of initiatives to improve staff engagement; the staff forum had become embedded since our previous inspection and was viewed positively by staff.
- Relationships between the trust and trade unions had improved since the previous inspection but there still more work for the trust to do.
- Staffing levels throughout the trust were planned and monitored. The trust had challenges due to national shortages however; it was addressing this through a range of initiatives.
- From April 2016 the trust was participating in the national trial of the ambulance response programme (ARP) which helped the service to dispatch appropriate ambulance resources. There were no performance targets for the ARP pilot. The trust monitored its performance on response times.
- At the previous inspection there had been concerns in relation to equipment checks, maintenance of equipment and consumable stock. At this inspection we found the trust had put in place a system to ensure equipment and stock was suitable to use.
- In most of the core services we found infection control procedures were followed and the ambulance stations and vehicles we observed were generally clean. However there were still inconsistencies in the way staff maintained vehicle cleanliness across the PTS service.
- There were systems in place to share learning from incidents and adverse events. Most staff we spoke with confirmed they received feedback by email after reporting an incident. A safety bulletin was produced and shared across the trust to share lessons learnt.
- There were high levels of compliance with safeguarding training at levels one and two, and all staff who were determined by the trust to require level three training, had received this.
- From April 2016 the trust had commenced a local review of mortality and morbidity, supported by local audits linked to the trust's commissioning for quality and innovation (CQUIN) targets to explore all deaths in the care of the trust, where Recognition of Life Extinct (ROLE) had been invoked by YAS paramedics.

Summary of findings

- Within the NHS 111 service, call abandonment rate was 2%, compared to the national average of 3%. We saw that 89% of calls were answered within 60 seconds, compared to the national average of 87%.
- Within the PTS service there was a clear lack of management oversight and lack of ownership of roles and responsibilities, and governance systems were not fully embedded throughout the service.

We saw several areas of outstanding practice including:

- The rapid arrest team provided clinical leadership in the response to cardiac arrest patients, which had improved the success rate in the return of spontaneous circulation (ROSC).
- The 'restart a heart' team was commended for its CPR work with school children. More than 31,000 children were trained in hands-only CPR in conjunction with the British Heart Foundation.
- Community first responders were trained volunteers who were available to attend emergency calls and to provide initial care before the arrival of an ambulance. More than 300 community first responder schemes worked closely with the ambulance service.
- The service supported 670 public access defibrillators across the Yorkshire region which was available for use by members of the public. The scheme particularly helped people to access defibrillators in remote villages.
- A member of the air ambulance crew had completed training in Crew Resource Management (CRM). The qualification enabled the member of staff to undertake critique and feedback of incidents whilst taking account of human factors.
- HART staff presented evidence on the benefits of early antibiotic administration in open fractures. This treatment now has become standard practice within YAS.
- The trust was part of the urgent and emergency care vanguard programme, to support the development of new approaches to the provision of urgent and emergency care. The West Yorkshire urgent and emergency care network aimed to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services.
- The trust had contributed to the development of a Pharmacy Urgent Repeat Medication Scheme (PURM) across the locality which enabled patients to access essential medicines from participating pharmacists out of hours. This scheme had won a 'Pharmacy Innovation' award.
- The NHS 111 service had implemented access to palliative care nurses on weekends and bank holidays, who were able to provide support to patients approaching the end of life.
- The trust had made use of a comprehensive workforce management tool to forecast anticipated call levels and deploy staff accordingly. The development of this tool and the transformation of planning within the organisation were recognised by a National Planning Award from the Professional Planning Forum.

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

Importantly, the trust must:

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff.
- Within patient transport services (PTS) the trust must ensure that all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure secure seating for children is routinely available in ambulance vehicles.

In addition the trust should:

- The trust should review the training requirements for operational staff in the PTS service for vulnerable groups such as patients living with dementia and patients experiencing mental health concerns.
- The trust should review the arrangements for operational staff to check their vehicle and equipment at the start of the shift to ensure they have sufficient time to complete the checks.
- The trust should review the audit procedures for reviewing the recording of controlled medicines.
- The trust should continue to ensure that equipment and medical supplies are checked and are fit for purpose.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Yorkshire Ambulance Service NHS Trust

Yorkshire Ambulance Service NHS Trust (YAS) was formed on1 July 2006 when the county's three former services merged. The trust covers North Yorkshire, South Yorkshire, West Yorkshire, Hull and East Yorkshire covering almost 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline and inner cities. The trust employsover 4,670 staff and provides 24-hour emergency and healthcare services to a population of more than five million. YAS is the only NHS trust that covers the whole of Yorkshire and Humber.

The trust provided an accident and emergency (A&E) service to respond to 999 calls, patient transport services (PTS) and emergency operation centres (EOC) where 999 calls were received; clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART). The trust also provided an NHS 111 core service for when medical help is needed fast but it is not a 999 emergency. This core service was inspected in October 2016 and is included in this report.

In 2015-16 the trust received 2.6 million calls and responded to 854,966 urgent and emergency calls. The NHS 111 service received 1,511,038 calls for the year which averaged at 4,139 calls per day. Within PTS in 2015-16 the service made around1,036,052 journeys transporting patients across Yorkshire and neighbouring counties each year.

The trust covers a population of approximately five million people and ethnic diversity ranged from 1.9% to 18.2% of the population. Within West Yorkshire, South Yorkshire and the Kingston upon Hull area, the life expectancy for both men and women was lower than the England average. Whereas in North Yorkshire the life expectancy was higher than the England average for both men and women.

Our inspection team

Our inspection team was led by:

Chair: Darren Mochrie

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team of 24 people included CQC inspectors, inspection managers, national professional advisor, pharmacy inspectors, inspection planners and a variety of specialists. The team of specialists comprised of

paramedics, emergency medical technicians, operational managers, patient transport service managers, emergency operation centre managers and operations directors.

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 team inspected the following:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services

Summary of findings

- Resilience Team including the Hazardous Area Response Team
- NHS 111 service

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the ambulance service. These included the clinical commissioning groups (CCGs), NHS Improvement, NHS England, and the local Healthwatch organisations. We talked with patients and staff from the trust and from a range of acute services who used the service provided by the ambulance trust. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out the announced inspection visit from 13-16 September 2016, the NHS 111 service between 10-12 October 2016, and we undertook an unannounced inspection on 6 October 2016.

What people who use the trust's services say

The CQC Ambulance Survey looked at the experiences of over 2,900 people who called an ambulance service in December 2013 or January 2014. Responses were received from 262 patients at Yorkshire Ambulance Service NHS Trust. The trust scored better than other trusts in two of the outcome measures and about the same as other trusts in the other two outcome measures.

We reviewed the most recently available Friends and Family Test (FFT) and patient satisfaction survey results for the NHS 111 service and found that between January and March 2016:

- 93% of respondents said that they were likely or extremely likely to recommend the service to friends and family
- 93% of patients were happy with the responsiveness of the service in answering their call
- 92% of patients said the call handler listened to them effectively
- 90% of patients said the call handler was reassuring
- 96% of patients said they understood what the call handler said to them
- 96% of patients said they had been treated with dignity and respect
- 96% of patients said they understood the information and advice they were given
- 89% of patients said the information and advice they received was helpful

Facts and data about this trust

The population the trust serves includes:

- South Yorkshire
- North Yorkshire
- Hull & East Yorkshire
- West Yorkshire

Yorkshire Ambulance Service NHS Trust also provides an NHS 111 service to:

- Bassetlaw
- North Lincolnshire.

Activity

- In 2015-16 the trust's A&E service responded to 854,966 urgent and emergency calls.
- The total number of calls for 999 and NHS 111 handled by the trust was 2.6 million calls per year.
- Within PTS in 2015-16 the service made around1,036,052 journeys transporting patients across Yorkshire and neighbouring counties each year.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **We rated safe as Good because:** • The trust was aware of its obligations in relation to the duty of candour requirements. The trust's policies detailed the requirements to ensure the duty of candour regulation was met. • Staffing levels throughout the trust were planned and monitored. The trust had challenges due to national shortages however; it was addressing this through a range of initiatives. • At the previous inspection there had been concerns in relation to equipment checks, maintenance of equipment and consumable stock. At this inspection we found the trust had put in place a system to ensure equipment and stock was suitable to use. • In most of the core services we found infection control procedures were followed and the ambulance stations and vehicles we observed were generally clean. • There were systems in place to share learning from incidents and adverse events. Most staff we spoke with confirmed they received feedback by email after reporting an incident. A safety bulletin was produced and shared across the trust to share lessons learnt. However: • There were still inconsistencies in the way staff maintained vehicle cleanliness across the PTS service. • Staff in PTS reported they did not always receive the bulletin and there was no consistent system to share the learning from incidents with frontline staff across the service. **Duty of Candour** • The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.	Good

Summary of findings

- The trust had a 'Being Open Policy' which detailed the process undertaken by the organisation to ensure duty of candour was adhered to. Upon notification of a notifiable safety incident these were reviewed by the Quality & Safety Team to determine the accurate level of harm.
- If the level of harm had been confirmed to be moderate or above, the duty of candour process would be implemented. This involved initial contact with the patient and/or relative as soon as was practically possible.
- The trust would then invite the patient and/or relative to take part in the investigation and feedback was offered via a variety of options including face to face, telephone consultation or in writing, depending on the preference of the individual.
- The trust had implemented a system to ensure all notifiable safety incidents were captured. Any moderate and above incidents were also reviewed fortnightly by the Incident Review Group (IRG). Monthly, quarterly, bi-annual and annual audits were conducted of the process and reported against key performance indicators (KPIs) within the quality, governance & performance assurance directorate dashboard.
- Throughout the trust most staff we spoke with understood the duty of candour requirements and being, open and honest.

Safeguarding

- The executive director of quality governance and performance assurance was the executive lead on the board for safeguarding. They were supported by the deputy director of quality and nursing who was the trust lead for safeguarding children's and adults.
- At the time of inspection the trust were in the process of recruiting to the head of safeguarding role which had been vacant for a couple of months.
- The trust had a safeguarding policy which included arrangements for children, young people and adults at risk. Procedures were in place for all staff to make a safeguarding referral where concerns were observed.
- There was a dedicated health desk in the emergency operations centre responsible for reporting safeguarding concerns. The health desk was open 24 hours a day, 365 days a year.
- When safeguarding risks to children and families were encountered, an internal data flag was triggered to make ambulance staff aware of heightened risks when attending an identified address.
- Staff had undertaken their safeguarding training for children and adults as part of statutory and mandatory training and in

addition to induction training. There were high levels of compliance with safeguarding training at levels one and two, and all staff who were determined by the trust to require level three training, had received this.

- Staff undertook safeguarding children's level one and two and safeguarding adults training every two years. Staff who required level 3 safeguarding training in relation to their specific role had received this.
- The intercollegiate document for safeguarding children and young people: roles and competences for health care staff (2014) states that; 'All clinical 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 should have level three safeguarding training. This included paramedics.

Incidents

- The trust had a web based incident management system. Staff told us they could also report incidents via a 24 hour dedicated telephone line. Staff described this as a useful service as it saved time and meant it allowed incidents to be reported in situations where it otherwise may not have been possible to report them, for example due to where they were working and lack of access to a computer.
- The service had two main policies for incident reporting, an incident and serious incident management policy and an investigations and learning policy. Incidents were graded according to severity which had been further refined during 2016 to support the appropriate investigation of incidents.
- Where a serious incident was identified, a root cause analysis (RCA) was carried out to establish the causes of the incident and to allow staff to identify risks and make appropriate changes to prevent similar incidents from occurring.
- Most staff we spoke with confirmed they received feedback by email after reporting an incident. Learning from the investigation of incidents was also shared. A significant events and lessons learned report was presented in alternate months to the trust quality committee and six-monthly a significant events and lessons learned report was prepared for the trust board in public.

Summary of findings

- A safety bulletin was produced and shared across the core services however staff in PTS reported they did not always receive the bulletin and there was no consistent system to share the learning from incidents with frontline staff across the service.
- Between 29 May 2015 and 30 June 2016 within EOC, there were 309 reported patient safety incidents. The main causes were delayed response, delayed dispatch and delayed back up. Of these, nine incidents were reported as “catastrophic.” For example, a patient death had resulted. Five had been reported as major; examples included an inadequate clinical response, which resulted in harm to a patient. Fourteen incidents were reported as moderate harm; examples included delayed response or dispatch, which may have contributed to harm to patients.
- Twenty-five incidents reported were minor, such as a delayed response which may have contributed to harm or death. Eighty-seven incidents were reported as a near miss, where there may have been potential harm to the patient. One hundred and sixty nine reported incidents resulted in no harm caused whilst in YAS’s care.
- For emergency and urgent care services 2369 incidents were reported between 1 January 2016 and 19 May 2016. The type of incidents included vehicle damage to ambulances or other vehicles, assaults on ambulance crews, injury to patients, equipment faults and drug errors.
- We found that 1149 (48.5%) of incidents were reported as “no harm”, 15% were reported as “near miss” and in 863 incidents (36.4%) harm had been caused. Of the incidents where harm was caused, 64 of these affected patient care, which represented 2.7% of the total incidents. Five “catastrophic” incidents had occurred, where patients had died whilst in the care of the service. The reasons for this included missed diagnosis, failure to follow procedures, delayed dispatch and delayed response.
- We also found that from May 2016 to August 2016 there had been a further 263 incidents reported through the national reporting and learning system (NRLS), of which 90 (34.2%) had been reported as “no harm”. Ten incidents were reported by the service as “severe” and included two incidents of excessive response times which had resulted in patient deaths.
- Five of these incidents were reported as “internal comprehensive”. These were serious incidents which required investigation; of these, three related to patient deaths due to

either excessive response times or the way the call was classified in the call centre. One of the internal comprehensive incidents referred to a delayed response to a road traffic collision which was beyond the control of the service.

- Within the PTS service there were 622 incidents reported from 1 January 2016 to 14 July 2016. The incidents included patient slips, trips and falls, vehicle damage, faulty equipment and aggression shown towards staff by the public.
- Of the incidents reported, 55% were reported as 'no harm'. These included incidents such as equipment faults, patients not at the address to be picked up or patient falls while in the care of the service but who did not sustain an injury.
- In the same time period, 43% of incidents were reported as 'minor'. These included vehicle damage after collision, minor injury to patients while in the care of the service or injury to staff while handling patients. A total of 2% of incidents had been reported as 'moderate', which included more significant injuries to patients such as a fractured hip sustained while in the care of the service or other significant injuries to staff.
- Of the 280 incidents which resulted in harm, 54% were recorded as damage to vehicles or equipment, 27% were recorded as harm to staff and 19% were recorded as harm to patients.
- There had been 60 incidents for the resilience service from 2 January 2016 to 25 June 2016. In 31 incidents, (52%) no harm was reported to have been caused. These incidents included damage to vehicles and broken ampoules of medication. 21 incidents (35%) were classed as minor harm; examples included minor damage to vehicles and minor injuries to staff from slips, trips and falls. Two incidents (3.3%) were classed as moderate, these both related to staff injury from falls.
- Six (10%) incidents were not classified, they included reports of HART staff dealing with multiple major traumas within a week including suicides, shooting incidents, and house fires, all with fatalities.
- Within the NHS 111 service an incident had occurred where a patient with testicular pain was directed to a next day GP appointment. The patient was subsequently found to have testicular torsion which required immediate medical attention. Following this incident, the provider notified NHS Pathways of an omission in the assessment algorithm. As a result the pathway was changed to include a question to identify whether pain was increasing within the last four hours, in order to better identify such cases. Testicular torsion occurs when the spermatic cord (the cord that supplies the testicles with blood) becomes severely twisted.

Cleanliness and Infection Control

Summary of findings

- At the previous inspection in January 2015 we found there were variable standards of cleanliness, infection control and hygiene across the areas visited. This was particularly relevant for ambulances in the HART/ resilience team and the urgent and emergency care services.
- Vehicle cleaning had been rated as a high risk on the corporate risk register control measures had been put in place and this had reduced the risk to moderate.
- At this inspection we found infection control procedures were followed and the ambulance stations and vehicles we observed were generally clean.
- Within the resilience service at the previous inspection a number of concerns had been identified and raised in relation to cleanliness and infection prevention and control these had been immediately addressed at the time of the inspection. On this inspection we found that these changes had been embedded and sustained.
- A vehicle ”make ready” system to prepare vehicles for use had been introduced as a pilot and was due to be implemented across the service. At some ambulance stations, cleaning staff also cleaned the vehicle exteriors and the cab of the vehicle and vehicle cleaning was recorded daily.
- Vehicles were scheduled to receive regular deep cleaning at intervals of 35 days. A sticker in the vehicle gave the date of the last deep clean and when the next one was due. We found this plan was being followed for most vehicles. For example we inspected 24 ambulance vehicles within the urgent and emergency care service for the cleanliness of the vehicle. Of these, 20 were visibly clean, including the cab area. Re-usable equipment such as splints, blood pressure cuffs and slide sheets were visibly clean in 21 of the vehicles we inspected.
- Clinical audits for hand hygiene, vehicle cleanliness and ambulance stations were undertaken monthly. The results of audit were reported to the trust board in the integrated performance report. The trust reported that compliance with audit had improved over the previous 12 months, and most areas were achieving 95% compliance.
- Staff training in infection prevention and control was provided at induction and refresher training took place every second year. For 2015-16, 94% of staff had completed this training.
- Staff was seen to be compliant with IPC procedures in relation to bare below the elbows and using hand cleansing gel between patient contacts.

- However in the PTS service we found variations in the cleanliness of the vehicles we checked. Some were very clean inside and out. However, some were found to have visible dirt on the inside particularly in the driver's area. General vehicle housekeeping standards were poor across all localities.
- There were inconsistencies in the way staff maintained vehicle cleanliness across the PTS service. We found cleanliness recording sheets present on some vehicles we checked but not present on others. Some staff we spoke with was not aware of a formal procedure for cleaning the PTS vehicles but other staff were able to explain this.
- The trust provided information which indicated that staff could clean the vehicles at the end of their shift if there was time if not this would be undertaken in the morning. However staff told us there was often insufficient time at the start or end of a shift to clean properly. Day to day cleaning of the exterior of the vehicles varied depending on the facilities at the station and the weather conditions. Staff also said time constraints meant cleaning the outside of the vehicle was not seen as a priority.

Environment and equipment

- At our previous inspection we found in the urgent and emergency care service the supply of consumable items and the maintenance of equipment was variable.
- At this inspection we found equipment and consumable supplies were readily available and in date. Regular logistics checks of equipment were being undertaken and disposal bins for out of date consumable items were provided in ambulance stations.
- Faulty equipment was clearly labelled as such and reported to the clinical supervisor. We reviewed a selection of consumable stocks at the ambulance stations we visited and found these were appropriately stored and on the whole in date. Any out of date items were identified to staff at the time of the inspection.
- A number of issues had been identified at the previous inspection within the resilience service in relation to equipment checks. Following this, equipment checks, and recording the findings had been implemented. During this inspection we found that daily checks were done of equipment on HART vehicles and each month vehicles would be completely emptied and a full check of all equipment on board was done. Tags with identity numbers provided ongoing assurance that the necessary equipment was available and any consumable items within date.
- We observed daily checks taking place during our inspection and each of the vehicles had a completed checklist on board.

Summary of findings

We spoke with staff about the daily and monthly checks and they said it had just become routine and part of their role. Staff said as they had taken on board the findings of the last report as a team; everyone had taken responsibility for the findings and been involved in addressing them. It was felt this was how the changes had been sustained. We were also told the checklists had been adapted following feedback from staff.

- We reviewed additional monthly checks of four HART vehicles from January, March and April 2016 and found these to be fully completed. Any issues were noted to be promptly addressed. For example, one vehicle had been moved and was not on a charging point and had a flat battery. It was documented that the vehicle had been plugged in and reported.
- We found the security at some of the ambulance stations to be poor. At Harrogate station, there was no gate at the entrance to the station. There was a hole in the fence, which backed onto a private garden. We also observed staff working alone in the garage area with the doors open. This was a risk to staff safety and vehicle security.
- At Scarborough ambulance station we saw there was no fire escape from the first floor. The trust provided information that showed the station had had a fire risk assessment in June 2016. The initial risk level in the Scarborough assessment was indicated as 'High', partly owing to the fire safety practice issues a number of actions had been completed and had reduced the risk to medium. There were six further actions to be completed and this would reduce the risk to low.

Staffing

- Before the inspection the trust provided information which indicated that the planned establishment for paramedics was 1208 whole time equivalent (wte). This included staff in management roles and within the urgent and emergency care and resilience core services. The actual number of staff in post was 1092 wte which meant there was a vacancy of 116 wte.
- The trust was able to provide information on the planned and actual numbers of staff employed in each part of the Yorkshire area. Paramedic staff were 5% below planned levels in North and East Yorkshire, but almost 5% over establishment in South Yorkshire. Similar variations were reflected in other areas and staff groups.
- A strategic workforce planning group was established during 2015. Workforce numbers were based on a recognised modelling approach supported by an external organisation.

The workforce plan developed during 2016-17 reflected demand profiles for each area. The trust had undertaken recruitment events which included some which were aimed at recruiting people from black and minority ethnic backgrounds.

- The service had also introduced two emergency ambulance technician grades to increase the flexibility of the service.
- Planned workforce numbers and recruitment were monitored weekly and reported through the monthly service transformation programme board and to the trust executive group. We found the workforce plan had been communicated and understood by staff which had helped to support retention.
- Staff rotas were arranged up to six weeks in advance for an 11 week period. Staff start times were staggered to 7:00, 8:00 and 9:00 to provide cover for meal breaks and lessen the impact of shift changes. Staff told us they felt the meal break policy worked well in areas where shifts could be staggered.
- At the time of our visit staff were being consulted about significant changes to the rota. The executive directors within the trust reported they felt this was the right approach to engage with staff to ensure the implementation of new rotas would go as smoothly as possible.
- Information supplied to us from the trust indicated the PTS service had a budget for 726.7 whole time equivalent staff (wte) staff and the actual number in post was 692 wte. Other information showed there were vacancies equating to 20.9 wte staff or a rate of 16.4% in administration and clerical positions of all grades in the PTS communications and control team.
- The planned and actual staffing levels in most teams for the band 2 and band 3 ambulance care assistants matched. There were three wte band 2 vacancies in the North locality (23.4%) and 1.5 wte band 2 vacancies in the South locality (5.28%). There were also vacancies for band 4 staff with two wte vacancies (28.6%) in the South locality.
- The overall staff turnover in PTS service from April 2015 to July 2016 was 5.2%. This was similar to other services nationally.
- There were seven HART teams, each comprising of two supervisors and four operatives, with six staff on duty at any one time. This was in excess of the minimum requirement of five, in accordance with NHS Service Specification 2015/16 and NARU interoperability standards 1 – 7 and 12 national requirements for HART.
- Within EOC there were two centres at Wakefield and York which were open 24 hours a day, seven days a week.
- Information provided by the trust prior to inspection showed vacancies across the EOC service to be:

Summary of findings

- 2.63 WTE (out of a budget of 13.5 WTE; -19.48%) staff on the health desk,
- 16.82 WTE (a budget of 127 WTE; -13.24%) EMD staff,
- 6.77WTE (a budget of 127.25WTE; -5.32%) dispatchers,
- 2.69WTD (a budget of 26.5WTE; -10.15%) team leaders,
- 0.56WTE (against a budget of 8.56WTE: -6.54%) senior managers and
- 1 WTE (out of a budget of 5 WTE; - 20%) control centre staff.

- Within the NHS 111 service the trust acknowledged difficulties with access to clinical advisors for call handlers. The trust was carrying out active recruitment drives for clinicians, and had developed a home working protocol which was being used to attract suitably experienced clinicians to undertake these roles. A senior clinical advisor grade had been introduced to provide clinicians with career development options.
- The NHS 111 service had a comprehensive and rigorous recruitment and selection and induction programme for all staff. Induction included training on information governance, safeguarding, infection prevention and control, equality and diversity and confidentiality.
- We saw that staff attrition rate in the NHS 111 service was approximately 40% per year. The trust told us this was partly explained by the rigorous training and testing process, meaning not all staff were able to progress to satisfactory completion. In addition they told us that some staff were able to access career development opportunities to train in other roles such as paramedics and nurses, whilst other staff left as they found the call centre environment and shift patterns difficult to manage. They told us they had introduced a feedback tool for staff to use following completion of their training programme to identify any trends or issues identified.

Are services at this trust effective?
We rated effective as Good because:

Good

- Care and treatment was delivered based on National Institute of Health and Care (NICE) Guidance, Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and the Resuscitation Council UK (RCUK) guidelines.
- Outcomes for patients had improved for the return of spontaneous circulation (ROSC). At our previous inspection we reported that the trust was one of the worse performing ambulance trusts at 23% for patients who had had a cardiac arrest returning to spontaneous circulation (ROSC) at the time of arrival at hospital. For this inspection, the service's cardiac

arrest survival rates were ranked first in England for June 2016. Survival to discharge from hospital after an out of hospital cardiac arrest (Utstein) was 61.5% in June 2016, which also ranked first nationally.

- Following a heart attack the 74% to 92% of patients received the correct treatment in line with ambulance guidelines. Between August 2015 and July 2016 the trust performed above the national average for ten out of the 12 months.
- From April 2016 the trust was participating in the national trial of the ambulance response programme (ARP) which helped the service to dispatch appropriate ambulance resources. There were no performance targets for the ARP pilot. The trust monitored its performance on response times.
- Staff in the dialysis units and renal patients reported that overall the service was better than it was 12 months ago but the most significant improvements had only occurred in the last few weeks.
- From April 2016 the trust had commenced a local review of mortality and morbidity, supported by local audits linked to the trust's commissioning for quality and innovation (CQUIN) targets to explore all deaths in the care of the trust, where Recognition of Life Extinct (ROLE) had been invoked by YAS paramedics.
- Within the NHS 111 service call abandonment rate was 2%, compared to the national average of 3%. We saw that 89% of calls were answered within 60 seconds, compared to the national average of 87%.

However:

- Between August 2015 and July 2016 the proportion of patients receiving primary angioplasty (unblocking of a coronary artery) within 150 minutes was below the national average for all of the twelve months.

Evidence based care and treatment

- Throughout frontline services staff followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC guidelines) which provided evidence based clinical advice to ambulance services. The service also followed a number of national recommendations from NARU and The National Institute for Health and Care Excellence (NICE guidelines).
- Staff had access to policies and procedures and other evidence-based guidance via the trust's document management online system.
- The trust used the Department of Health's assessment criteria to determine whether a patient was eligible for patient

transport. The PTS communication and control staff and hospital-based staff used specific questions to determine the patient's condition, mobility and disability as well as determining access to their home.

- There was an eligibility flow chart and checklist available to staff who made bookings for PTS. However, some PTS staff in the East Locality reported hospital staff not always understanding the type of transport the patient required when they made a booking. This sometimes resulted in the wrong type of vehicle or crew being dispatched to the patient.
- The resilience service had fulfilled all requirements in relation to International Organisation for Standardisation (ISO) 22313 for the last three years. YAS was the first ambulance trust to achieve this. ISO 22313 is a business continuity management system which enables organisations to plan, respond and recover from disruptive incidents as they occur.
- All operatives we spoke with from the HART and air ambulance team told us they used evidence based practice to underpin their care and treatment of patients. We reviewed a number of policies on the trust intranet, including amputation guidelines and thoracotomies in blunt trauma cardiac arrest. They were easy to access, in date with an author and version control evident.
- Operatives told us if they needed to practice outside of a standard operating procedure as they felt it was in the best interests of the patient they would always seek advice from the medical response team before proceeding.
- One of the operatives had developed an 'app' to allow easy access to all clinical procedures whilst at an incident. It included a quick reference guide for all extended skills staff may use.
- Within the NHS 111 service the NHS Pathways licensing agreement required all call handlers and clinical advisors to have at least three of their recorded calls audited each month to check their competency using the NHS Pathways triage system correctly. All staff completed a self-audit each month with two further calls audited by their team leader or a member of the practice development team. Recently appointed staff received five call audits per month.
- Where staff had 'failed' call audits they received five call audits in the following month, where they were expected to pass at least four of these. Although we saw evidence to indicate that call audits were being carried out, staff told us that face to face feedback from call audits was not provided for all staff. Staff were able to access details of their call audits via 'SharePoint'

but not all staff were aware of this. The trust provided us an action plan which sought to address the call audit feedback process, raise awareness of the 'SharePoint' facility and increase the number of face to face 1:1s being held.

Patient outcomes

- The trust routinely collected and monitored information about patient care and treatment. Ambulance clinical quality indicators measured the overall quality of care and end-results for patients following care and treatment.
- Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) which included signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure, was a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate effective treatment at the scene. The ROSC is calculated in two patient groups. The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests. The rate for the 'Ustein comparator group' provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival.
- Outcomes for patients had improved for the return of spontaneous circulation (ROSC). At our previous inspection we reported that the trust was one of the worse performing ambulance trusts at 23% for patients who had had a cardiac arrest returning to spontaneous circulation (ROSC) at the time of arrival at hospital. For this inspection, the service's cardiac arrest survival rates were ranked first in England for June 2016. Return of spontaneous circulation after an out of hospital cardiac arrest (Utstein) was 85.7% in June 2016, which ranked first nationally. Survival to discharge from hospital after an out of hospital cardiac arrest (Utstein) was 61.5% in June 2016, which also ranked first nationally.
- Following a heart attack the 74% to 92% of patients received the correct treatment in line with ambulance guidelines. This includes certain drugs being given and observations being taken and recorded. Between August 2015 and July 2016 the trust performed above the national average for ten out of the 12 months.
- Heart attack or ST segment elevation myocardial infarction (STEMI) is caused by a prolonged period of blocked blood supply within the coronary arteries. Reductions in STEMI mortality and morbidity is influenced by those patients who received the appropriate care bundle, those who have timely

delivery to the cardiac catheter laboratory for intervention, and those who have timely thrombolysis (clot busting medicines). Between August 2015 and July 2016 the proportion of patients receiving primary angioplasty (unblocking of a coronary artery) within 150 minutes was below the national average for all of the twelve months.

- The urgent and emergency care service was involved with the development of sepsis pathways nationally and supported the development of a regional network for sepsis to improve outcomes of patients with sepsis.
- From April 2016 the trust had commenced a local review of mortality and morbidity, supported by local audit linked to the trust's commissioning for quality and innovation (CQUIN) targets. Over the last 12 months the trust had undertaken a pilot piece of work to explore all deaths in the care of the service, where Recognition of Life Extinct (ROLE) had been invoked by YAS paramedics. The procedure provided a mechanism to audit and screen all deaths whilst in the care of the trust and identify any patients where there were concerns about the management that may have contributed to their death. Common themes identified had been sepsis and recent contact with a health care provider.
- Although there was no national guidance in relation to the provision of PTS, the trust had adopted a similar service model to other ambulance services in England. Patient travel was linked to their appointment time and patients were given a set time band for when they might be collected. This was 120 minutes in this service.
- YAS NHS 111 service monitored their performance against the National Minimum Data Set (MDS) and KPIs, some of which were locally agreed. Performance was monitored by the clinical governance and quality assurance group. The average monthly performance for the YAS NHS 111 Minimum Data Set August 2015 to July 2016 showed:
  - 89% of calls were answered within 60 seconds compared to the England average of 87%.
  - 2% of calls were abandoned after at least 30 seconds compared to the England average of 3%.
  - 86% of calls were triaged compared to the England average of 87%.
  - 19% of calls were transferred to a clinical advisor compared to the England average of 22%.
  - 16% of calls were placed on a 'call back' queue compared to the England average of 13%.
  - The average episode length of calls was 22 minutes compared to the England average of 16 minutes.

- The provider showed us evidence which indicated they were in the upper quartile nationally for ambulance dispositions of 8% and referral to emergency departments at 6%.

Response times

- For the year April 2016 to March 2016 YAS response times were measured and reported nationally following the agreed national response standards for Red 1, Red 2, and Category A19 calls. The national target for immediately life threatening Red 1 calls was that 75% of calls (the most time critical, where patients were not breathing, do not had a pulse or peri- arrest) were to be responded to within 8 minutes.
- Data showed that between April 2015 to March 2016 out of the eleven national ambulance trusts YAS was the ninth best performing ambulance service in NHS with responses at 70.8% against the target of 75%.
- Red 2 national performance standard was that 75% of Red 2 calls (still serious, but less immediately time critical, like strokes or fits) were to be responded to within 8 minutes. Data showed from April 2015 to March 2016 the trust was fourth of the eleven ambulance services in the NHS with responses at 71.4%.
- A19 calls national standard was that 95% of Category A calls should be responded to within 19 minutes with appropriate transport to convey the person to hospital. Data showed from April 2015 to March 2016 the trust was second of the eleven ambulance services in the NHS with responses at 95%.
- From April 2016 the trust was participating in the national trial of the ambulance response programme (ARP) which helped the service to dispatch appropriate ambulance resources to patients who were very unwell, for example those that had suffered a cardiac arrest. Yorkshire ambulance service was one of three ambulances services nationally to participate in the clinical coding trial, with evidence of performance monitored by NHS England and the national NHS England ARP Group to assess the impact on patients of both quality and performance. The aim of the trial was to enable the most appropriate clinical response to each 999 call. The trial aimed to test a new evidence-based set of clinical codes that better describe the patient's problem and what response/resource was required.
- Incoming emergency calls were allocated to a category which determined the response, which was nationally agreed. For the ARP, Red calls, requiring a response within eight minutes, were for time critical responses to patients experiencing a life-threatening episode and requiring immediate intervention or resuscitation. Amber calls, requiring a response within 19 minutes, were for responses to patients with potentially serious

conditions that may require rapid assessment, urgent on-scene intervention or urgent transport. Green calls requiring a response within 60 minutes, were for urgent responses to patients situations which were not immediately life-threatening that needed transport within a clinically appropriate timeframe or a further face-to-face or telephone assessment and management.

- A second stage trial was due to be undertaken by the trust between October and December 2016 to further refine the clinical code set.
- There were no performance targets for the ARP trial. The trust and NHS England's ARP team monitored its performance on response times and this was reported to the board in the integrated performance report. This showed the number of calls each month divided into different categories and the time from allocation to the team being mobile.
- We saw in the August 2016 integrated performance report the trust reported its performance as:
  - Red performance (8 minute response) year to date (YTD) was 69.3%
  - Amber R (19 minute response) YTD was76.1%
  - Amber T (19 minute response) YTD was 67%
  - Amber F (19 minute response) YTD was 72.4%
  - Green F (60 minute response) YTD was 94.9%
  - Green T (60 minute response) YTD was79%
  - Green H (60 minute response) YTD was 98.7%
- Within the resilience service data from April 2016 to September 2016 with the exception of three calls was achieved in less than 15 minutes. This demonstrated compliance with the NHS HART Interoperability Standard 8 in Appendix 3 of the NHS Service Specification 2015/16.
- Interoperability standard 11 requires that HART staff can be on scene within 45 minutes at strategic sites of interest. The location of the HART and resilience bases meant they had quick access to major road networks in the region. This allowed the required vehicles to reach a variety of locations in a timely way.
- The target for call handling in the PTS communication and control centres was for 80% of calls to be answered within three minutes. Information supplied showed this target was not achieved with 78.5% of calls answered within three minutes in April 2016, 58.9% in June and in September 2016, it was 71.3%. Staff based within a control centre told us they had been short staffed and it was a challenge to achieve this target.
- PTS performance was monitored through key performance indicators and these were reported to the board in the

integrated performance report. In the August 2016 report this showed for arrival prior to appointment performance was above the target at 82.9%. Performance against the KPI for departure after appointment was 1.4% below a target of 91.7%.

- Combined localities performance data shows between September 2015 and August 2016, the percentage of inward patient journeys ensuring patients arrived between zero and 120 minutes prior to their appointment exceeded the target of 82.9% at 86.8%.
- There were variations in performance across the localities with the West locality only just achieving the target for patients arriving for their appointment on time and East and North localities exceeding this target by more than 4%.
- The target set by commissioners for PTS had decreased since our last inspection from 93.2% to 82.9%. Overall, performance had improved at 3.1% over target performance at this inspection compared to 0.9% over target performance at our last inspection although the percentage of patients arriving on time for their appointments had decreased from 91.8%.
- This performance data for September 2015 to August 2016 also showed the number of patients collected with 90 minutes after their appointment was 91.8% against a target of 91.7%. This is an improvement on the performance data supplied at our last inspection when 89.1% of patients were collected within 90 minutes of being ready against a target of 91.3%.
- The performance data supplied for August 2016 showed there had been deterioration in the performance in patients being collected since April 2016. This was particularly the case in the West locality. Senior managers were aware of this and attributed it to the introduction of the change programme and the auto planning system. Overall the performance data showed an improving trend.
- The PTS operated to a different set of quality standards when transporting renal dialysis patients. This was similar to other ambulance PTS services, which recognised the needs of this group of patients. The service was required to drop off patients no more than 30 minutes prior to their scheduled time and collect them again no more than 30 minutes after their treatment was complete. This adhered to NICE guidance which stated 'Adults using transport services to attend for dialysis are collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis'. However, there were still some patients who waited for more than 30 minutes for transport to arrive to take them home after their treatment was completed.

- We spoke with 11 renal dialysis patients. Overall, they reported the service was better than it was 12 months ago but the most significant improvements had only occurred in the last few weeks. Staff in the dialysis units we visited also felt the service had improved over the last 12 months. However, there were still delays in return journeys back home with some patients being advised of delays of two hours or more.
- Within the NHS 111 service call abandonment rate was 2%, compared to the national average of 3%. We saw that 89% of calls were answered within 60 seconds, compared to the national average of 87%.

Multidisciplinary working

- Staff worked closely with hospital providers of emergency and other providers of services to coordinate appropriate pathways of care for patients.
- We observed the handover of patients between ambulance crews and staff in hospital emergency departments. The handovers we observed were well structured and comprehensive.
- Ambulance service managers met at least six weekly with their hospital emergency department counterparts where the response to ambulance vehicle delays and the local escalation plan were discussed. In response to excessive ambulance vehicle waiting times, the ambulance service sent a clinical supervisor to coordinate the situation and provide support for ambulance staff.
- We found the ambulance service worked closely with acute hospitals regarding long handover times in order to reduce heightened risks associated with the deteriorating patient.
- At one hospital, there was a joint task and finish group of hospital and ambulance staff and including social care and commissioners. The group met monthly to identify and reduce avoidable causes of delay. Actions were agreed and followed up, which included exploring diversional pathways. This initiative had already resulted in improved ambulance turnaround performance.
- The trust worked with residential and nursing homes to identify where patients who were unwell required transport to hospital and where care and treatment could be provided by an alternative healthcare practitioner, so that unnecessary hospital admissions were reduced.
- Referral pathways were in place with community services in some areas, for example the community nursing service, to reduce the transport of patients to hospital.

- Within the resilience service we reviewed training exercises plans which had been undertaken detailing the outcomes and learning. They tested operational and multi-agency command in line with JESIP principles and involved other services such as the fire service as well as emergency operations centre (EOC) within YAS.
- We looked at the findings from one such training exercise, a building collapse. This stated due to the structure of the exercise and the use of mutual aid team's staff had to work with members from other NHS trusts. This enabled the standardisation of urban search and rescue (USAR) to be tested.
- The EOC were involved in the training exercises as the initial calls about the incident came to them, be this from a 999 call or being contacted by another emergency service.
- Patient transport services (PTS) formed part of the trust's overall emergency planning response. For example following a mass casualty incident patient transport services could be used to evacuate patients with minor injuries away from the scene.
- There was evidence of multidisciplinary working between PTS staff and other care providers such as care homes, hospitals and GPs. During our inspection, we saw cooperation between hospital staff, the communication and control centre and staff in the patient reception centres (PRC's).
- Some ambulance care assistants and staff in PRCs told us the staff in the communication and control centre lacked the local knowledge of road conditions, geography and specific locations, which resulted in inefficient route planning. This was in relation to auto plan in West Yorkshire. Overall, we observed good relationships between ambulance care assistants and staff in the communication and control centre. This was important in order to promote good team working and effective care for patients.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Mental health awareness and mental capacity was part of the trust's mandatory training schedule.
- The trust had specific policies relating to mental capacity and consent to examination or treatment and staff were aware of how to access these.
- Staff understood how consent and capacity issues affected the care of patients and patients' consent to care and treatment was documented in their records. We observed ambulance staff in their interaction with patients and saw that verbal and written consent was requested as appropriate.

Summary of findings

- Reference prompt cards were used by staff to confirm NHS England guidance about the Mental Capacity Act. The reference cards provided guidance, prompts, flow charts and contact numbers as to capacity assessments, making best interest decisions, and deprivation of liberty safeguards. The clinical hub service desk was also available to provide advice for staff.
- Within the resilience service, HART operatives demonstrated a good level of understanding. Staff described how they would always take on individuals' choices and views. We were told they acted in accordance with people's best interest during emergency situations. This meant that decisions about care were often made by the paramedics in accordance with their training.
- Staff in the NHS 111 service understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing telephone triage to children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Are services at this trust responsive?

Good

We rated responsive as Good because:

- A transformation programme had commenced which brought together actions taken following CQC's inspection with other work programmes including those mandated by NHS England. In conjunction with other organisations, the service was undertaking an assessment of the likely future needs of the region for emergency ambulance services.
- The trust was part of the urgent and emergency care vanguard programme, to support the development of new approaches to the provision of urgent and emergency care. The West Yorkshire urgent and emergency care network aimed to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services.
- Within the NHS 111 service the trust understood the needs of the population it served and engaged with the lead commissioner and 23 associate commissioners to provide a service which was responsive to these needs.
- The NHS 111 service had implemented access to palliative care nurses on weekends and bank holidays, who were able to provide support to patients approaching the end of life.
- Systems were in place across the trust to electronically record additional information for vulnerable patients via the 'special notes' system.

However:

- Staff expressed concern as to the limited availability of staff training to use bariatric equipment and in some types of vehicles there was limited room for manoeuvring equipment for bariatric patients.
- In the PTS service there had been an increase in complaints with a specific focus on renal services in West Yorkshire following the introduction of Auto plan. The trust had been taking actions to address the service issues and had been engaging with users of the service and voluntary agencies in the improvement process.

Service planning and delivery to meet the needs of local people

- Since the 2015 inspection, a transformation programme had commenced which brought together actions taken following CQC's inspection with other work programmes including those mandated by NHS England. In conjunction with other organisations, the service was undertaking an assessment of the likely future needs of the region for emergency ambulance services. This included elements of capacity and demand analysis, resource management and information management for performance improvement. The project used internal sources of information which included patient feedback, complaints and lessons from the investigation of incidents. It also took account of the impact of growth in demand, seasonal variations, financial constraints on the service, and challenges in recruiting qualified staff. The objective of the programme was to ensure emergency services were sustainable in the future.
- The needs of the local population influenced the planning and delivery of emergency ambulance services across the Yorkshire region. The service worked closely with commissioners to ensure that ambulance services were delivered as required by commissioners. Regular meetings were held with lead commissioners to discuss activity and service requirements.
- The trust was part of the urgent and emergency care vanguard programme, to support the development of new approaches to the provision of urgent and emergency care. The West Yorkshire urgent and emergency care network aimed to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services. The project expected to commence in February 2017 with a three to four year implementation. The objective was improved coordination of services and reduced pressure on emergency departments and in turn on ambulance services.

Summary of findings

- The trust had plans in place to replace its oldest ambulance stations with 18 hubs forming a hub and spoke arrangement of locations over a period of several years, with four of these planned to be operational in the next five years. We visited the Manor Mill site which was the first of these hubs to be operational. The ambulance stations at Bentley and Doncaster were due to be replaced by a second hub.
- The PTS primarily operated a Monday to Friday 8.00am to 5.30pm service and had 415 vehicles within its fleet. However, the service also operated outside of these times to provide specific support to patients attending for renal dialysis when needed. There was also a dedicated discharge service which operated into the evenings in some localities; this was included within the main core contract.
- The PTS supported acute hospital discharges across the region. Operating times varied across the area, due to the commissioning arrangements. For example, in the East it operated between the hours of midnight to 11.00p.m and in the North it was 10.00a.m - 8.00p.m.
- The service had recently commenced a pilot in May 2016 using Auto Plan. This was an automated software planning system to schedule patient journeys. The PTS transported patients based on the time of their appointment and auto plan scheduled journeys to ensure patients were collected and delivered within an agreed window of time. The pilot, which was originally trialled in Leeds, was then rolled out to West Yorkshire. A senior manager told us there had been 'teething problems' such as patients travelling in the vehicles for long periods of time. As a result of this, the ambulance service was currently reviewing the software.
- Within the NHS 111 service the trust understood the needs of the population it served and engaged with the lead commissioner and 23 associate commissioners to provide a service which was responsive to these needs.
- NHS 111 staff were able to directly book appointments with the out of hours service for patients who lived in Wakefield, Sheffield and Huddersfield. Patients could also be directed to accident and emergency, local pharmacies or minor injuries units in accordance with the most appropriate disposition (outcome) identified for the caller.

Meeting people's individual needs

Summary of findings

- Translation services were available for patients whose first language was not English. A qualified interpreter was available on-line, usually within 90 seconds. Ambulance service managers met the providers of the translation service monthly to monitor and review the responsiveness of the service.
- Equality and diversity training was available to all staff to enable them to meet the spiritual needs of individuals. The training included providing an understanding of the spiritual needs of different faiths and how these might be addressed by staff
- The trust was the first ambulance trust to receive "working to become dementia friendly" recognition by the Dementia Action Alliance in 2014. The service procured ambulances vehicles with a dementia-friendly specification and these were identified with a dementia-friendly sticker in the vehicle.
- The trust had developed a learning resource to support staff called "Dementia learning resource for Ambulance staff". The document contained information on dementia/ delirium, agitated behaviour, pain and distress and communication. There was also online awareness training available to staff.
- The needs of patients with dementia could be identified for staff using a data flagging system. Staff could also be nominated as "Dementia Friends."
- The trust had produced 'life story' books which were aids to staff when supporting a patient with dementia however we found these were not always available on vehicles or in all ambulance stations.
- The special needs of patients with learning disabilities and physical disabilities could also be identified for staff using the data flagging system. Patients with physical disabilities were assessed using a complex manual handling risk assessment form and high risk patients had their addresses flagged to support a specialist response.
- The service employed a "YAS expert patient" who had worked with patients with physical disabilities including wheelchair users.
- We observed a vehicle used for the transfer of bariatric equipment and ambulance vehicles fitted with bariatric stretchers. We found the issue of equipment for these patients was the subject of consultation with staff. For some types of vehicles, staff expressed concern as to the limited room for manoeuvring equipment for bariatric patients.
- Staff also expressed concern as to the limited availability of staff trained to use bariatric equipment. The service was in the

process of addressing these concerns by extending access to bariatric equipment and the provision of replacement vehicles carrying stretchers and tail lifts for moving and handling bariatric patients.

- For bariatric patients known to the service, their needs were assessed and a care plan was prepared which reflected moving and handling risks. We found specialised equipment to support bariatric patients needed to be made more widely available and accessible to emergency ambulance crews.
- There was a policy in place for the transportation of bariatric patients and a pathway for the control centre to follow, to ensure the service met the needs of these patients. PTS had four dedicated bariatric vehicles and had a full inventory of equipment such as hoists and large wheelchairs. We spoke with a senior manager who told us it was unlikely all vehicles would be requested at the same time due to the careful booking and planning of these vehicles. Hospital staff we spoke with knew 48 hours' notice was required if a bariatric patient required transportation.
- We spoke with a locality manager who told us a risk assessment was completed by a team leader when a booking for a bariatric patient had been requested. Team leaders we spoke with confirmed this.
- Within the NHS 111 service the trust had implemented access to palliative care nurses on weekends and bank holidays, who were able to provide support to patients approaching the end of life. They were able to liaise with local pharmacies via the pharmacy urgent medications scheme (PURM) to obtain medicines during the weekends, and were able to arrange transfer to local hospices rather than accident and emergency departments, when appropriate.
- Systems were in place in the NHS 111 service to electronically record additional information for vulnerable patients via the 'special notes' system. The information was available to call handlers and clinical advisors at the time the patient or their carer contacted the YAS NHS 111 service. This assisted the staff member to safely manage the needs of these patients.
- Call handlers had received training to help them identify and support confused or vulnerable callers. Advice could be sought from a senior clinical floor walker, or transferred to a clinical advisor for further assessment.

Access and flow

- The trust had a Demand Management Plan (DMP) to support the trust to respond to situations where the available resource capacity did not match the demand across the Yorkshire &

Humber region. This in turn was supported by Local Escalation Action Plan (LEAP) and Resource Escalatory Action Plan (REAP). The DMP was designed to be utilised in situations of excessive call volume or reduction in staff numbers, which resulted in the supply of ambulance service resources being insufficient to meet the clinical demand of patients.

- Alternative pathways of care were used including 'see and treat and hear and treat' leaving patients at home if appropriate following assessment, alleviating inappropriate admissions at hospitals.
- The ambulance service reported and monitored handover delays at hospital emergency departments across the Yorkshire region. The main causes of delays were attributed to a lack of assessment cubicles (in 20- 30% of instances); a lack of hospital beds for admission (in 40 50% of instances) and clinical staff availability (in 30- 40% of instances).
- Unnecessary journeys to hospital were reduced through the service's participation in the the ambulance response programme (ARP) which helped the service to dispatch appropriate ambulance resources. Incoming emergency calls were allocated to a category which determined the response. Ambulance crews we spoke with said the ARP helped in the response to very unwell patients categorised as Red. Patients categorised as Amber waited up to one hour, and this also included responses to seriously unwell patients. Crews were aware of the need to monitor closely the appropriateness of response for these patients. Benchmarking information between the two triage systems and between the three participating trusts was shared on a daily, weekly and monthly basis with the trial sites.
- Each call to the emergency services was assessed using a dedicated prioritisation system as part of the ARP. Red calls, requiring a response within eight minutes, were for time critical responses to patients experiencing a life-threatening episode and requiring immediate intervention or resuscitation. Amber calls, requiring a response within 19 minutes, were for responses to patients with potentially serious conditions that may require rapid assessment, urgent on-scene intervention or urgent transport.
- The PTS service had changed their procedures in May 2016, which meant renal patients had travelled with non –renal patients. This had commenced in the Leeds area initially and then was rolled out to the whole of West Yorkshire in June 2016. This resulted in large numbers of complaints by patients regarding the time they were waiting to be transported home. Patients had written to NHS England and their local MPs to

advise of the difficulties they were experiencing and the impact it was having on their lives. Senior managers acknowledged the timeliness of transport particularly around the collection of patients. Measures were put in place to improve this and there had been written communication with renal patients directly from senior managers in the trust. Discussions were also on-going with the local hospitals in relation to patients being declared 'ready' in a timely manner to avoid delays. Yorkshire ambulance service had specifically appointed a new member of staff to improve this who commenced in August 2016.

- There were examples when patients care and treatment had been compromised because of problems with PTS. An example included patients who were taken off their dialysis treatment early as the transport had arrived and was unable to collect them later.
- Within the NHS111 service patient demand was increasing and staff recruitment, particularly of clinicians, was challenging. The trust was using innovative approaches to attract and retain staff. A senior clinical grade had been developed, to provide career development options for clinical staff. In addition, a homeworking pilot scheme for clinicians had been evaluated, and was being implemented. At the time of our inspection these posts were being advertised.
- The trust had experienced challenges in meeting their two hour KPI target for clinical call backs to patients in the NHS 111 service. In order to mitigate risk to patients, the clinical advice call back queue was closely monitored by clinical team leaders, utilising a standard operating procedure to ensure that urgent calls were prioritised, and clinicians were directed to deal with these.
- The NHS 111 service prioritised people with the most urgent need at times of high demand. Capacity and demand was estimated using a comprehensive workforce management tool, and was monitored closely at all times. A daily conference call was held across all three sites to assess staffing capacity and patient demand, with staff being offered shift slides or overtime to accommodate anticipated surges in demand. In addition the service held weekly and monthly organisational planning meetings to co-ordinate staff cover to best meet anticipated patient demand.

Learning from complaints and concerns

Summary of findings

- There was a policy for managing compliments, comments, concerns and complaints within the trust. Key performance indicators for compliments, comments, concerns and complaints were included in the monthly Board Integrated Performance Report.
- In the August 2016 integrated board report it showed that the trust had received 1,394 complaints YTD figures across all services. The proportion of complaints to demand was 0.08%.
- Themes highlighted in the Integrated Performance Report indicated that delayed response was the largest area of concern for YAS complainants for emergency operations and patient transport. Operations & Clinical/Patient were the largest number for the NHS 111 service, whilst attitude of staff is the most frequently reported issue for the urgent and emergency care service.
- Themes highlighted in the report indicated that delayed response and staff attitude were the two most common areas of concern for YAS from complainants for A&E operations. Delayed response was the largest area of concern for people using patient transport. Operations & clinical/patient were the most common concern for people using the NHS 111 service.
- The trust monitored its performance on a monthly basis against response times to complaints. Responses to complaints were being made in time in 88% of cases in August 2016 (date agreed with the complainant) with an average response time of 24 days. YTD compliance was 92% and average response time was 23 days.
- The trust used escalation rates to measure complainant satisfaction with the investigation of complaints. The trust reported that the percentage of concerns and complaints reopened due to dissatisfaction with the initial response was 1.8% (YTD figures).
- The incident review group met fortnightly and reviewed complaints graded red or amber. The quality committee reviewed the handling of complaints and compliments every second month to identify themes and trends and received an annual report of complaints.
- The clinical quality development forum received a quarterly lessons learned report highlighting trends and themes and identified actions. The trust board received an annual quality, risk and safety report which included complaints management. The quality accounts described changes made as a result of complaints.
- The trust told us they recognised the importance of sharing learning across the organisation when things have gone wrong, including learning from complaints. In 2015 the Safety Update

was introduced which is a monthly bulletin, pulling together learning from across different inputs to share across YAS. This was then triangulated within the Quality & Safety Team alongside other inputs such as Clinical Case Reviews (CCRs) to identify trust wide learning.

- In the PTS service there had been an increase in complaints between June 2016 and August 2016 with a specific focus on renal services in West Yorkshire following the introduction of Auto plan. The trust had been taking actions to address the service issues and had been engaging with users of the service and voluntary agencies in the improvement process.
- Seven of the renal patients in the West Yorkshire area we spoke with advised us they had received a written apology from the service in relation to these delays. This letter also advised the service would ensure they arrived no more than 30 minutes before their appointment, and be picked up no later than 45 minutes afterwards. In all other localities, most renal patients were satisfied with their service and felt delays traveling home were acceptable as they felt the service was doing its best.
- Within the NHS 111 service information about how to complain was available and easy to understand and evidence showed the provider responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services at this trust well-led?

Good

We rated well-led as Good because

- The trust had an overall integrated business plan for 2014-15 to 2018-19. The plan outlined the trust's ambitions, aspirations and plans for the next five years which were 'to provide an ambulance service for Yorkshire and the Humber which is continually improving patient care, setting high standards of performance, always learning and spending public money wisely.
- There were a number of initiatives which were central to the strategic priorities. These included an expansion in the number of urgent care clinicians, expanding the existing NHS 111 service and developing care pathways for specialist groups such as frequent callers, mental health patients and palliative care.
- The trust had a governance framework that supported delivery of safe and high quality care from 'the frontline services to board'. There were a number of assurance groups including the audit committee, quality committee and finance and investment committee.

Summary of findings

- Relationships between the trust and trade unions had improved since the previous inspection but there still more work for the trust to do.
- The trust had undertaken a number of initiatives to improve staff engagement the staff forum had become embedded since our previous inspection and was viewed positively by staff.

However:

- The PTS service had developed an operational plan which set out its strategic objectives but staff we spoke with felt they had not been involved in this plan and were unclear about the future direction of the service.
- Within the PTS service there was a clear lack of management oversight and lack of ownership of roles and responsibilities and governance systems were not fully embedded throughout the service.
- There were inconsistencies in the monitoring and oversight of staff performance and adherence to policies and procedures. This meant there were differences across the PTS service in how information was shared following incidents, cleanliness of vehicles, equipment stored on vehicles and learning from complaints.

Vision and strategy

- The trust had an overall integrated business plan for 2014-15 to 2018-19. The plan outlined the trust's ambitions, aspirations and plans for the next five years which were 'to provide an ambulance service for Yorkshire and the Humber which is continually improving patient care, setting high standards of performance, always learning and spending public money wisely.'
- The trust's mission was 'Your Ambulance Service, Saving lives, caring for you' and the vision was 'Providing world class care for the local communities we serve.'
- The trusts operating plan for 2016/17 identified the key priorities, risks and milestones for the trust over the next year to help achieve the vision. The vision and mission were to be delivered through strategic objectives which included:
  - Deliver world class health outcomes in urgent and emergency care
  - Ensure continuous service improvement and innovation
  - Develop and retain a highly skilled, engaged and motivated workforce
  - Work with partners to provide system leadership and resilience

Summary of findings

  - Provide a safe and caring service which demonstrates an efficient use of resources.
- There were a number of initiatives which were central to the strategic priorities. These included an expansion in the number of urgent care clinicians, expanding the existing NHS 111 service and developing care pathways for specialist groups such as frequent callers, mental health patients and palliative care.
- The trust had developed a set of values and behaviours based on an acronym We Care which stood for Working together for patients, Everyone counts, Commitment to quality of care, Always compassionate, Respect and dignity and Enhancing and improving lives.
- The YAS vision and values were displayed on staff notice boards and staff had access to communications bulletins via emails.
- The trust resilience planning was firmly based on the Civil Contingencies Act, National Ambulance Resilience Unit (NARU) and Joint Emergency Services Interoperability Programme (JESIP) guidelines. Emergency preparedness, resilience and response (EPRR) frameworks and Hazardous Area Response Teams (HART) interoperability standards fed into this. Senior trust staff were heavily engaged in the development and implementation of national policies and operational procedures. These had all been encompassed into one document of 21 standards to provide a specific resilience vision and strategy aligned with the overall trust and national guidance.
- The PTS service had developed an operational plan which set out its strategic objectives but staff we spoke with felt they had not been involved in this plan and were unclear about the future direction of the service.

Governance, risk management and quality measurement

- The trust had a governance framework that supported delivery of safe and high quality care from 'the frontline services to board'. There were a number of assurance groups including the audit committee, quality committee and finance and investment committee. The assurance committees were attended by non-executive directors who provided challenge and scrutiny.
- The risk management strategy aligned key corporate risks with strategic objectives and was reviewed annually by the executive. The risk and assurance group provided oversight of potential risks to the trust identified in the risk register.

Summary of findings

- A Board Assurance Framework and Corporate Risk Register identified strategic and operational risks. We reviewed the corporate risk register, which documented actual risk, control measures and residual risk ratings. The Board Assurance Framework was presented regularly to the trust board.
- Risks on the corporate risk register included an inability to deliver performance targets and clinical quality standards, acute hospital reconfigurations and failure to learn from patients and staff experience and adverse events within the trust or externally.
- The trust had a business continuity policy; this described the roles, responsibilities, and processes to ensure continuity of services, protection of patients and staff and the reputation of the organisation.
- As part of the inspection we observed a quality committee meeting and we reviewed a sample of reports that formed part of the board papers, there were no concerns raised from this.
- Following our previous inspection the service had undertaken a review of the "well-led" committee structure during 2015 and a review of executive and senior management portfolios in 2015-16.
- A clinical governance group with executive representation met monthly and clinical governance risks were discussed and actions taken were recorded and monitored.
- An integrated performance report was prepared monthly which included key facts and figures for the trust and all core services, workforce scorecards, and demand and performance statistics, including a graphical presentation of daily performance for emergency and urgent care. Progress against the strategic objectives was assessed on an exception basis using red-amber-green ratings. Quality indicator results were compared with national benchmarks.
- Over the last 12 months the trust had undertaken a pilot piece of work to explore all deaths in the care of the service, where Recognition of Life Extinct (ROLE) had been invoked by YAS paramedics. The procedure provided a mechanism to audit and screen all deaths whilst in the care of the trust and identify any patients where there were concerns about the management that may have contributed to their death. Common themes identified had been sepsis and recent contact with a health care provider.
- Within urgent and emergency care the locality manager's meeting was held monthly; meetings were recorded and

actions reviewed and closed when completed. Actions included escalation of key risks and monitoring of local performance. Locality managers also met weekly to monitor performance and actions were reviewed at a monthly operational meeting.

- The PTS risk register contained six risks, four were moderate risk and two were low risk. The moderate risks related to patient slip, trips and falls and had been on the register since 2013 but had been reviewed regularly. The other moderate risks included the service for renal patients in the two West Yorkshire localities, unplanned accident and emergency operations affecting PTS and the lack of PTS bid resource.
- PTS completed operational risk reports, which were completed by the locality managers. They outlined specific risks to the service. Risks included the loss of technology to communicate to the staff, how transport should be dispatched in the event of a breakdown in the system, financial risk due to tendering and on-going risks of slips, trips and falls.
- There were inconsistencies in the monitoring and oversight of staff performance and adherence to policies and procedures. This meant there were differences across the PTS service in how information was shared following incidents, cleanliness of vehicles, equipment stored on vehicles and learning from complaints.
- Significant concerns had been identified in the resilience service at the previous inspection in terms of assurance processes, this related to equipment and cleanliness. This had been resolved at the time of inspection and robust audit and assurance systems had since been embedded and maintained.
- There was a clear governance structure for the resilience function within YAS. Team meetings fed into monthly managerial meetings. We reviewed a number of meeting minutes across the resilience service and saw how information was shared and communicated with external stakeholders such as the Local Resilience Forums. One example of this was the national pandemic influenza exercise.
- Within the NHS 111 service, the trust had introduced both internal and external 'end to end review' processes where, with patient knowledge and consent, selected calls were reviewed by a panel, and the patient journey through the healthcare system, including the incoming YAS NHS 111 call, was tracked. We saw evidence that learning gained from these processes was disseminated and was improving standards.
- There were arrangements for identifying, recording and managing risks and issues and implementing mitigating action plans. There was also a programme of continuous internal audit.

- The trust supplied monthly performance reports for the NHS 111 service to the CCGs via the Contract and Performance Management Meeting, which summarised the ongoing work across the region and included statistical data relating to call activities, audits and trends as well as quality and patient safety updates. This gave an overview and assurance of the service for Commissioners. A risks and issues log was created, update action logs monitored progress towards completion of identified actions.

Leadership of the trust

- Since the previous inspection the chief executive had been appointed substantively into their post in May 2015. The executive director of operations had also been substantively appointed into their role in 2015.
- There had been two further interim appointments at executive director level into the roles of executive director of finance and executive director of workforce and organisational development. At the time of inspection the trust were actively recruiting to a substantive director of finance position.
- There had been a new chair of the trust appointed in July 2016 and a new non- executive director also appointed in 2015.
- Following the well-led review the trust had undertaken a director portfolio review and a new planned and urgent care directorate had been created.
- Changes to the executive leadership were recognised as positive by staff. The chief executive was seen as approachable by most staff however, some staff in some of the core services reported they had not seen the executive team during their work.
- The management structure for emergency and urgent care had been revised since our previous inspection. An executive director of operations and an associate director of locality operations had been appointed. Three locality directors (Band 8c) representing west, north and east and south localities reported to the associate director of operations. There were seven locality managers (Band 7) in each of three localities, who reported with a head of operations to the locality directors. Clinical supervisors (Band 7) reported to locality managers and paramedic and non-qualified ambulance staff reported to clinical supervisors.
- We found strong leadership throughout the resilience service, staff at all levels told us they felt supported and understood their role. Command support at a strategic level via the Health

Gold Cell was a strength of the resilience service. As well as the knowledge and specialist roles of managers within the service. Resilience staff were experienced in their roles with many having been in post for a number of years.

- Within the PTS service there was a clear lack of management oversight and lack of ownership of roles and responsibilities and governance systems were not fully embedded throughout the service.
- Some staff within PTS services told us they rarely saw the locality managers for their area and it was sometimes very difficult to get in touch with a team leader.
- Within the NHS 111 service we saw that team leaders, shift co-ordinators and clinical team leaders were visible in all three call centres. Not all staff we spoke with had regular face to face contact with their team leader, however staff were aware of whom their team leader was, and described how they were able to access support if needed from a team leader or clinical team leader.

Culture within the trust

- The trust had commissioned an external company to undertake a cultural audit and the report had been finalised in December 2015. The audit had received 1,378 responses from trust employees.
- The report highlighted eight cultural dimensions which included shared vision, blame, quality and learning and facilitating change. The report made recommendations which included:
  - Promoting a vision for YAS that engages all staff in developing and delivering the vision
  - Development of a behaviours framework that can be used to help assess guide and reward positive behaviour and reduce/ eradicate negative behaviours.
  - Development and implementation of a programme of training for all leaders and managers.
- As a result we saw the trust had developed an action plan to address the points raised from the cultural audit and included actions on development of a behavioural framework for YAS leaders and staff and a greater focus on staff engagement.
- In the 2015 NHS staff survey the trust had a response rate of 40.6% against a national average of 35.5%. The trust had scored in three indicators better than the national average and in seven indicators worse than the national average.

Summary of findings

- The trust scored better than the national average in indicators for percentage of staff reporting errors, near misses or incidents in the last month, the percentage of staff appraised in the last 12 months and quality of non-mandatory training, learning or development.
- The trust scored worse than the national average in indicators for percentage of staff reporting good communication between senior management and staff, percentage of staff able to contribute to improvements at work, support from immediate managers and the percentage of staff reporting recent experience of harassment, bullying or abuse.
- The trust hada 'Freedom to Speak Up campaign, and several staff in different services had becomes guardians. The initiative had been launched by the trust in July 2016.
- The relationship between the trust and union representatives had improved since our previous inspection and the trust had recognised a number of unions who represented staff. The trust provided information which indicated union representation was included in a number of meetings. For example the safer responding group, health and safety committee and trust procurement group.
- There was also a staff side representation group which was attended by union representatives and senior service managers and operational staff. However union staff reported that there was still inconsistent attendance and involvement from executive directors.
- Within the EOC the service had several initiatives in place, which included, Favourable Event Reporting (FERF). This initiative encouraged learning from positive practice, by recognising and reinforcing successful events and behaviours. Staff had received positive feedback from their managers and they had acknowledged their behaviours and practice. This had been particularly evident at the staff away days.
- We found within some ambulance stations there were examples of inappropriate communication with staff from team leaders and line managers. We raised this with the trust who addressed this at the time of inspection.
- We saw in the NHS 111 service the trust had responded to a number of bullying and harassment issues within the call centre environment. An independent arbitrator had been appointed to assess the issues and made recommendations for actions to be carried out. The service had accepted the findings and adopted the recommendations, which included the appointment of mental health 'first aiders' within the call

centre; development of the staff champion role and access to staff counselling for affected staff. The 'bullying and harassment' policy was being changed to a 'dignity and respect' policy, to widen the scope of the policy.

- The Workforce race equality standard (WRES) aims to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. In line with this standard the trust had developed a WRES action plan. The workforce within this trust has 4.3% BME representation, and has increased from 3.94% in 2015.

Fit and Proper Persons

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- We reviewed files of executive and non-executive directors and found they were compliant with the requirements.

Public and staff engagement

- The staff forum had become embedded since our previous inspection and was viewed positively by staff. The service used social media to engage with staff and provided feedback from adverse events and safety roadshows.
- YAS TV had been introduced across a number of stations across the trust. The purpose was to share learning through the use of videos and information which was cascaded to staff via the TV in stations.
- The trust had an expert patient role which had been developed in 2008 but had since expanded the scope so it now included attendance at core meetings, follow-up engagement meetings and review samples letters to patients from the patient relations team.
- Whilst on inspection the new HART vehicles were delivered, these were to replace some vehicles which had reached the end of their operational life. From speaking with staff they had been consulted and had been involved in the planning, the design and layout of the new vehicles. Staff felt they would further improve the service due to the improved layout, size and manoeuvrability of the vehicles.

- The trust had established a Nurse Leadership Forum. The forum had been instrumental in developing a professional framework for nurses, acquiring online tools to help with nurse revalidation requirements and exploring means of improving recruitment and retention of nurses within the NHS 111 service.
- The trust had held a number of summer 2016 roadshows across the Yorkshire and Humber region. The events offered members of the public a chance to come along and learn more about the ambulance service; participate in first aid training or have a look into careers or volunteering opportunities at the trust.
- The events took place at a number of community venues across the region, at the roadshow in Bradford over 1,000 members of the public attended.
- The trust had a YAS forum which was chaired by the trust chair. The YAS Forum was structured with a total of 22 members: 13 publically elected (with one vacancy in East Yorkshire), four staff who had been elected and five appointed forum members who represented a wide range of external stakeholders with whom the trust worked in partnership to deliver services.
- The trust was in the process of re-introducing the YAS critical friend's network. Recruitment was in process to the network. People who want to be involved would need to have had some contact with the ambulance service in the last three years. The purpose of the network was to contribute ideas and thoughts to the trust regarding service developments.
- The trust website included a patient feedback link which enabled the public to make a complaint, report a concern, provide a compliment or make a comment (the four Cs).

Innovation, improvement and sustainability

- The YAS loggist role had been refreshed alongside the YAS command support assistants. This would provide a wider skill-set and capability and ensure a more robust command function at both tactical and strategic levels.
- The service had started the role of consultant paramedics for urgent and emergency care and introduced two posts to provide focussed clinical leadership for the emergency service.
- The rapid arrest team provided clinical leadership in the response to cardiac arrest patients, with the objective of improving the success rate in the return of spontaneous circulation (ROSC). A clinical supervisor attended the scene of a cardiac arrest. Staff commented that the service needed to be extended to more rural areas.

Summary of findings

- The ‘restart a heart’ team was commended for its CPR work with school children. More than 31,000 children were trained in hands-only CPR in conjunction with the British Heart Foundation.
- The service received national recognition for its clinical leadership in the development of the West Yorkshire urgent care vanguard. The West Yorkshire urgent and emergency care network planned to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services. The project expected to commence in February 2017 with a three to four year implementation. The objective was improved coordination of services and reduced pressure on emergency departments and in turn on ambulance services.
- Members of ambulance staff had won national and regional awards in the last two years, for example the Queens Ambulance medal and the Yorkshire Evening Post awards. The YAS resilience team was highly commended in the category for “Emergency Response Worker of the Year”.
- A member of staff was part of a project supported by the mental health charity MIND. The Blue Light programme was a project run across all emergency services, including the ambulance service. The aim of the project was to improve the mental health of staff working in emergency service by having ‘Blue Light Champions’ in each area of the service to act as support to staff.
- There was a proposal for a nursing internship provided by the trust. This gave the trust an opportunity to explore an innovative way to enhance the current workforce against the back drop of high attrition rates and recruitment challenges. The proposal offered nurses the option of working in the ambulance service and as such provided an exciting and new opportunity for nurses.

Overview of ratings

Our ratings for Yorkshire Ambulance Service Trust HQ

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	N/A	Good	Good	Good
Patient transport services (PTS)	Requires improvement	Good	N/A	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre (EOC)	Good	N/A	N/A	N/A	Good	Good
Resilience	Good	Outstanding	N/A	N/A	Good	Good
Overall	Good	Good	N/A	Good	Good	Good

Our ratings for Yorkshire Ambulance Service NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	N/A	Good	Good	Good

Notes

Nb. Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. We therefore did not inspect all of the five domains: safe, effective, caring, responsive and well led for each of the core services we inspected.

Outstanding practice and areas for improvement

Outstanding practice

- The rapid arrest team provided clinical leadership in the response to cardiac arrest patients, which had improved the success rate in the return of spontaneous circulation (ROSC).
- The 'restart a heart' team was commended for its CPR work with school children. More than 31,000 children were trained in hands-only CPR in conjunction with the British Heart Foundation.
- Community first responders were trained volunteers who were available to attend emergency calls and to provide initial care before the arrival of an ambulance. There were more than 300 community first responder schemes which worked closely with the ambulance service.
- The service supported 670 public access defibrillators across the Yorkshire region which were available for use by members of the public. The scheme particularly helped people to access defibrillators in remote villages.
- A member of the air ambulance crew had completed training in Crew Resource Management (CRM). The qualification enabled the member of staff to undertake critique and feedback of incidents whilst taking account of human factors.
- HART staff presented evidence on the benefits of early antibiotic administration in open fractures. This treatment now has become standard practice within YAS.
- The trust was part of the urgent and emergency care vanguard programme, to support the development of new approaches to the provision of urgent and emergency care. The West Yorkshire Urgent and Emergency Care Network aimed to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services.
- The trust had contributed to the development of a Pharmacy Urgent Repeat Medication Scheme (PURM) across the locality which enabled patients to access essential medicines from participating pharmacists out of hours. This scheme had won a 'Pharmacy Innovation' award.
- The NHS 111 service had implemented access to palliative care nurses on weekends and bank holidays, who were able to provide support to patients approaching the end of life.
- The trust had made use of a comprehensive workforce management tool to forecast anticipated call levels and deploy staff accordingly. The development of this tool and the transformation of planning within the organisation was recognised by a National Planning Award from the Professional Planning Forum.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff.
- Within patient transport services (PTS) the trust must ensure that all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure secure seating for children is routinely available in ambulance vehicles.

Action the trust SHOULD take to improve

- The trust should review the training requirements for operational staff in the PTS service for vulnerable groups such as patients living with dementia and patients experiencing mental health concerns.
- The trust should review the arrangements for operational staff to check their vehicle and equipment at the start of the shift to ensure they have sufficient time to complete the checks.
- The trust should review the audit procedures for reviewing the recording of controlled medicines.

Outstanding practice and areas for improvement

- The trust should continue to ensure that equipment and medical supplies are checked and are fit for purpose.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) Care and treatment must be provided in a safe way for service users How the regulation was not being met: It was not always possible for ambulance crews to access secure vehicle seating for children. Specialised equipment to support bariatric patients needed to be made available and accessible to all emergency ambulance crews. Vehicles in the PTS service were visibly clean but the service did not have a robust system to monitor the daily cleanliness of vehicles and staff did not have sufficient time to clean the vehicles thoroughly. There were items of equipment stored in some vehicles in a way which posed a risk to patients and staff, such as oxygen cylinders which were not securely fastened. In nine vehicles in urgent and emergency care services we saw sharps boxes were either full, or open, or not dated and signed. Clinical waste was found in the cab or saloon of the vehicle in some instances. There were still examples across services where equipment was not available for staff to use or consumables or medication were pass their expiry dates.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) Systems and processes must be established and operated effectively to:

This section is primarily information for the provider

Requirement notices

(2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services.

How the regulation was not being met:

The allocated time of six minutes for crews to check their vehicle and equipment at the start of their shift was insufficient for all essential equipment to be checked.

There were occasions where paper records were not always stored securely.

The recording of medicines administration contained some discrepancies which were not always identified through audit procedures.

Learning from incidents, complaints and audit was not always consistently shared across staff groups particularly in the PTS service.

Within the PTS Service there were identified risks missing from the risk register, so it was unclear what actions had been taken to mitigate these risks.

There were vehicles which were found to have faulty equipment and fittings in place, which were still in operation and had not been properly reported particularly in the PTS service.

There was no standardisation regarding the type of equipment to be carried on PTS vehicles. There was no consistency in the amount of equipment and supplies stored on board vehicles and where on the vehicles these should be stored.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty. How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The planned establishment for paramedics was 1208 wte. The actual number of staff in post was 1092 wte which meant there was a vacancy of 116 wte.

There were vacancies equating to 20.9 wte staff or a rate of 16.4% in administration and clerical positions of all grades in the PTS communications and control team.

Staff attrition rate in the NHS 111 service was approximately 40% per year.

Reg. 18 (2) (a) Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform.

How the regulation was not being met:

Within the EOC not all of the nursing staff was up to date with safeguarding training.

Within PTS services there were no formal arrangements for one to one meetings or supervision sessions between the team leaders and ambulance care assistants, neither was there a formal record of individual staff performance.

There was a lack of role specific training for staff within PTS services to enable them to carry out their role effectively.

Staff in PTS services was undertaking excessive manual handling activities due to insufficient training in the use of a particular carry chair and the limitations of the carry chair.