# Yorkshire Ambulance Service NHS Trust HQ

## Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

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

# Overall summary

We carried out a focused inspection announced at short notice at Yorkshire Ambulance Service (YAS) NHS Trust 111 services on 26 & 27 April 2022. We undertook this inspection as part of a system-wide inspection looking at a range of urgent and emergency care providers in West Yorkshire. This was an unrated inspection.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for West Yorkshire below:

Provision of urgent and emergency care in West Yorkshire was supported by multiple provider services, stakeholders, commissioners and local authorities.

We spoke with staff in services across primary care, integrated urgent care, community, acute, mental health, ambulance services and adult social care. Staff continued to work under sustained pressure across health and social care and system leaders were working together to support their workforce and to identify opportunities to improve. System partners worked together to find new ways of working, linking with community services to meet the needs of their communities; however, people continued to experience delays in accessing care and treatment.

During our inspections, some staff and patients reported difficulties with providing and accessing telephone appointments in GP practices. Some of these issues were caused by telephony systems which were being resolved locally. We found inconsistencies with triage processes in primary care which could result in people being inappropriately signposted to urgent and emergency care services. However, a number of staff working in social care services reported good engagement with local GPs.

We visited some community services in West Yorkshire and found these were generally well run. Service leaders were working collaboratively to identify opportunities to improve patient pathways across urgent and emergency care. These improvements focused on meeting the needs of local communities and alleviating pressure on other services. There were strong partnerships with social care and community teams, so patients had the right support in place on discharge.

However, we inspected one intermediate care service and found it could only take referrals from an acute trust, which meant there were no step-up facilities for patients in the community. The service struggled for ward space to deliver therapeutic activities and there were no communal spaces for patients to meet together or engage in group therapy. Plans were in place to provide additional facilities and to reconfigure the existing layout to provide communal spaces.

The NHS111 service was experiencing significant staffing challenges and were in the process of recruiting a high number of new staff. Staff working in this service had experienced an increase in demand, particularly from people trying to access dental treatment although a system was in place to manage the need for dental advice and assessment. Due to demand and capacity issues, performance was poor in some key areas, such as providing a call back to patients from a clinician.

The ambulance service had an improvement programme in place focused on performance and staffing.

Whilst we saw some improvement in ambulance response times and handover delays, performance remained below target. We identified impact on other services due to the availability of 999 responses; for example, a maternity service had to close temporarily to keep women safe, due to system escalation and because ambulance responses couldn't be guaranteed in an emergency. Staff working in social care services also experienced lengthy delays in ambulance response times which further impacted on their ability to provide care to their residents.

# Overall summary

We inspected some mental health services in Wakefield which were delivering person-centred care and responded to urgent needs in a timely way. Staff worked in multi-disciplinary teams and collaborated with system partners.

People's experiences of Emergency Departments were varied depending on which service they accessed. Some Emergency Departments had long delays, whilst others performed relatively well. In services struggling to meet demand, patient flow was a key factor. Poor patient flow was primarily caused by delays in discharge with a high number of people fit for discharge unable to access community or social care services.

Staff working in some social care services reported significant challenges in relation to unsafe discharge processes, this included a lack of information to support their transfer of care and we were told of examples when this resulted in people having to return to hospital. Local stakeholders had a good understanding of this problem and were looking to improve pathways and discharge planning.

Staffing and capacity issues in both care homes and domiciliary social care services have at times impacted on timely and safe discharge from hospital.

We found services were under continued pressure and people experienced difficulties accessing urgent and emergency care services in West Yorkshire. System and service leaders across West Yorkshire were working together to seek opportunities for improvement by providing services and pathways to meet people's needs in the community; however, progress was needed to demonstrate significant improvement in people's experience of accessing urgent and emergency care.

**Following our previous inspection in October 2016 we rated the provider as good for all key questions, and good overall.**

The full reports for previous inspections can be found by selecting the 'all reports' link for Yorkshire Ambulance Services (YAS) NHS Trust on our website at www.cqc.org.uk

At this inspection we found:

- The provider was open and transparent in relation to the operational challenges within the sector and within YAS111 specifically, which the COVID-19 pandemic had highlighted and exacerbated.
- There were systems in place to identify and manage risk within the service.
- Care pathways were updated regularly, and staff received training to ensure that interactions with patients reflected up to date evidence-based guidance. Staff had access to regularly updated Directory of Services (DoS) information to optimise the signposting options for patients.
- Regular call audits reviewed and monitored the quality of patient interaction and advice given.
- We saw examples of patient feedback which was generally positive in relation to the service provided by YAS111.
- Staff demonstrated a caring and compassionate approach when dealing with calls, we saw that patients' dignity was respected.
- Feedback from staff was mixed. Some staff told us they did not feel supported by management, and that senior staff were not visible or approachable. Not all staff felt valued when carrying out their role.
- High call demand meant that staff development and learning was delayed or deferred in some cases.

The areas where the provider **should** make improvements are:

# Overall summary

- Improve the support available to staff to provide consistent, equitable access to pastoral and professional support and feedback.
- Improve arrangements to ensure staff have protected time to keep up to date with essential internal communications, and complete required learning within timescales.
- Continue to recruit to additional staff vacancies to reduce operational pressures on the service.

**Dr Rosie Benneyworth** BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

## Our inspection team

Our inspection team was comprised of a CQC lead inspector and a GP specialist adviser. A second team comprising a CQC lead inspector, second inspector and a paramedic specialist adviser carried out a review of 999 services as part of the same inspection.

## Background to Yorkshire Ambulance Service NHS Trust HQ

Yorkshire Ambulance Services NHS Trust (YAS) was formed in July 2006 following the merger of the county's previous three ambulance services. The Trust serves a population of over five million people. It covers approximately 6,000 square miles of varied terrain, from isolated moorlands and dales to urban areas, coastal areas and inner city boroughs. The Trust as a whole employs over 5,000 staff and provides 24 hour emergency and urgent care services to a population in excess of five million people, and serves 13 clinical commissioning groups (CCGs).

The NHS 111 service provided by YAS works in partnership with Local Care Direct Which provides out of hours GP care in the West Yorkshire area. YAS NHS111 employs 336 whole time equivalent staff. YAS111 call centres are based in:

**Wakefield site:**

Springhill 2

Brindley Way

Wakefield 41 Business Park

Wakefield WF2 0XQ

**Rotherham site:**

Callflex Business Park

Doncaster Road

Wath-Upon-Dearne

Rotherham S63 7EF

The Trust is registered with the Care Quality Commission to provide the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Transport services, triage and medical advice provided remotely

During our visit, which focused on services for the West Yorkshire area only, we visited the Wakefield site.

Inspected but not rated

# Are services safe?

**Safety systems and processes**

There were systems in place to keep people safe.

- Staff had access to policies relating to safeguarding children and adults. Feedback we received from staff demonstrated that they were aware of how to report safeguarding concerns.
- Not all staff had completed up to date safeguarding training updates. We were informed that online training which was scheduled had to be deferred in the event of a surge in call demand.
- Staff completed an induction programme upon being appointed to the service. This included familiarisation with the NHS Pathways software, and navigation of the system with reference to the Directory of Services (DoS). The DoS is a central directory, aligned with NHS Pathways, and provides details of local health and other support services available to patients when urgent or emergency care is not needed.
- Bi-monthly update training was undertaken by staff to familiarise themselves with any updates or changes to the NHS Pathways. Staff told us this was required as a priority in order to maintain their licence to operate the system.
- There were appropriate infection prevention and control measures in operation within the call centre. We saw that plastic screens had been erected between staff workstations, and that desks had been spaced, making use of a greater area within the building to accommodate this. Staff had access to antiseptic wipes, hand gel and masks. Masks were worn by staff when moving around the building. All workstation areas were required to be wiped at the beginning and end of each shift.

**Risks to patients**

Systems were in place to assess risk and monitor safety

- Staff rotas were planned and managed centrally to provide staffing cover over a 24 hour period, 365 days a year. The provider told us they had difficulties recruiting and retaining staff, which meant that pressures on staff on duty were increased during peak times. Staff were able to work overtime hours if required. The provider shared their staffing budget for the financial year 2022/3 which showed that an additional 97.5 whole time equivalent healthcare advisors, plus 54.57 whole time equivalent clinical advisors, amongst other staff, were awaiting budgetary approval to go out to recruitment to alleviate staffing pressures.

- Calls into the service were received by health advisors, who assessed patient need following an algorithm which matched their presenting symptoms and enabled them to reach a ‘disposition’ for recommended ongoing care or treatment. At any time they had the facility to transfer to emergency services for immediate help. Following their assessment, if the algorithm indicated that clinical advice was needed, they had the option to ‘warm transfer’ a call directly to a clinician to carry out further assessment. If no clinician was available at that time, they discussed with a team leader before placing on a call back queue for a clinician to call back within a specified timescale, depending on the urgency of the situation. Clinician call-back queues were also used for all other patients where clinical assessment was indicated.

- A display board was located on the call centre floor, giving details of the current situation at all times, for example, in relation to number of staff available to take calls, number of abandoned calls and number of patients in the queue. Clinical team leaders monitored the clinical call back queue and were able to prioritise more urgent patients for an early clinical call back. Staff made use of a range of codes throughout their shift, which provided team leaders with an overview of staff activity at all times.

**Information to deliver safe care and treatment**

Inspected but not rated

# Are services safe?

Staff had access to the information they needed to deliver safe care and treatment.

- Staff had access to patient information through their electronic system. Once a patients' GP had been identified, clinical staff were able to confirm a number of details relating to, for example, allergies, medicines taken or key diagnoses. 'Special notes' were visible when patients' GP had inputted additional information, relating to, for example, patients approaching the end of life, or those accessing substance misuse support.

- Patients' own GPs were provided with a summary of any intervention carried out by staff at YAS111, via automatic information sharing arrangements.

**Lessons learned and improvements made**

The service learned and made improvements when things went wrong.

- The provider collated data relating to the 'Four Cs' (complaints, concerns, compliments and service-to-service feedback) which was Trust-wide data. These were reviewed and analysed at corporate level and actions taken to implement change when indicated.

- A standard operating procedure was in place to identify and appropriately manage 'repeat callers' into the service. This was in recognition of the fact that such callers are likely to be experiencing symptoms, or a range of symptoms which could give rise to concern. When a patient called three or more times over a four day period, the process was that any disposition reached was overridden, with a recommendation that the patient be seen within one hour by their own GP, or alternative arrangements during non-working hours.

- We reviewed a number of significant events and saw that appropriate analysis and feedback was given to relevant staff. Systems for wider dissemination of anonymised lessons learned were not fully established. Staff bulletins and generic emails provided some information to staff, however staff told us they did not usually have time during their shift to read information to keep up to date with events occurring elsewhere in the service. The provider told us that a Trust learning group had recently been established, with the intention of more proactively managing and learning from incidents, near misses and complaints.

- The service carried out 'end to end reviews' where a serious untoward incident had occurred. We viewed one such review in detail, and saw that a comprehensive review and analysis of events had been carried out, and appropriate feedback provided to services and staff involved.

Inspected but not rated

# Are services effective?

**Monitoring care and treatment**

Staff assessed needs and signposted patients in line with current legislation, standards and guidance supported by clear patient pathways and standard operating procedures.

- NHS Pathways were regularly updated in line with guidance from the National Institute for Health and Care Excellence (NICE) and other relevant bodies. The provider had systems in place to ensure staff received training to familiarise themselves with any changes to pathways in line with these. Understanding was checked using a knowledge test at the end of refresher training.
- Call audits were undertaken on all staff every month, and staff were scored on their adherence to the pathways and the appropriate navigation through the system, with information given to patients which was up to date and accurate, and reflected in full on the written record.
- Patient need was assessed through staff navigating through a carefully defined algorithm, based on the presenting symptoms of the caller or caller's representative. Those patients with additional needs, for example palliative care patients or young children were assessed using appropriate pathways.
- We saw figures which showed that the number of callers presenting with dental problems had increased from 3,826 in February 2019, to 6,656 in February 2022.
- Another local out of hours provider was commissioned to share assessment processes for patients presenting with dental problems. Children under five years old were assessed within YAS111, using bespoke pathways. Older children and adults were directed to call the relevant provider. Staff told us if patients omitted to do this, assessment of their presenting problem was carried out using the relevant care pathway, and signposting and advice given accordingly.
- Data from the Provider' Integrated Performance Report of December 2021 showed the service received 166,168 calls in that month. Of these, 85.4% were answered, with 22.2% being dealt with by a clinician against a target of 30%. The provider showed us their business plan and recruitment projections; which showed that 54 more clinical advisors were in their planning budget to be recruited to add to the existing 61 clinical advisors already employed.
- A standard operating procedure was in place to safely manage repeat callers, recognising that there was a risk that a serious underlying condition could be the motivation for patients calling three times over a four day period. The system automatically alerted staff to this case, and in these cases, any disposition reached following assessment was overridden to direct the patient to contact their GP practice within one hour, and staff had mechanisms to support patients in doing so.

**Coordinating patient care and information sharing**

The service had a systematic programme of quality and performance through the collection of ongoing data, and call audits.

Providers of NHS 111 services are required to submit call data every month to NHS England by way of the Minimum Data Set (MDS). The MDS is used to show the efficiency and effectiveness of NHS 111 providers. We saw the Integrated Urgent Care Report produced by the provider for March 2022 which showed the provider was meeting the following national performance indicators:

- 84.1% of calls were answered within 60 seconds, against a key performance indicator (KPI) of 90%
- 54.3% of callers requiring clinical call-back received one within one hour, against a KPI of 60%
- 47.6% of calls with a disposition to attend accident and emergency were revalidated to ensure appropriateness, against a KPI of 50%
- 97.4% of calls with a disposition of 999 ambulance were revalidated against a KPI of 95%

Inspected but not rated

# Are services effective?

The provider was aware of the areas where the service was outside of the target range for an indicator, and a supporting business plan and operational strategy were in place to bring about improvements.

We saw that a clinical queue audit had been carried out to review data and determine the percentage of patients requiring a clinical review following a triage assessment which was associated with a primary care disposition. The aim was to identify what proportion of the patients in the 111 clinical queue had a primary care need, and to identify common themes associated with those patients, and whether the time of day altered the outcome. The conclusion of the audit was that increased demand, both within primary care and demand on 999 calls was leading to the increased clinical queue in the service. The data was shared internally and externally to inform future workforce and systems-wide contingency planning.

Staff had monthly call audits, carried out by team leaders; and scoring was given against a number of measurable indicators, such as obtaining correct demographic information, following the appropriate pathway and providing complete and accurate information in relation to the disposition reached. Information given to the patient verbally was compared to information documented on the patient record. Staff were given additional support and training when their performance showed room for improvement.

The clinical assessment system (CAS) supported the sharing of relevant information with other key stakeholders, such as GP practices or community services. Staff had access to staff internally with lead roles, to discuss any issues, for example in relation to safeguarding referrals.

Inspected but not rated

# Are services caring?

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Staff showed they understood patients' personal, cultural, social and religious needs. For example, our inspection dates coincided with the Muslim period of Ramadan (a holy month of prayer, reflection and fasting during daylight hours). Staff demonstrated an understanding of the impact this may be having on the health and wellbeing of patients who were observing Ramadan when they contacted the service, for example, in relation to management of long-term conditions, such as diabetes.
- We listened to staff dealing with calls in real time. We found that staff presented a calm, professional approach to calls, and demonstrated warmth, empathy and professionalism whilst navigating the relevant algorithm on the Pathway.
- We saw results from a YAS111 service user experience survey, conducted during October, November and December 2021. This showed that 95% of people who responded fed back that they had been treated with dignity and respect; 97% said they followed some, or all of the advice given; and 94% said they would recommend the service to friends and family.

**Privacy and dignity**

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Staff made use of telephone interpreter services for patients whose first language was not English.
- Patient feedback we viewed confirmed that patients usually felt they were given the time and attention they needed. Comments included "gave us good attention – unhurried, clearly knew what they were talking about. Professional".

Inspected but not rated

# Are services responsive to people's needs?

**Responding to and meeting people's needs**

The provider organised and delivered services to adapt to patient demand. Patients' preferences were listened to and acted upon.

- Staff had access to special notes completed by patients' own GP, to identify patients with additional needs, such as those approaching end of life; or those who were accessing substance misuse or mental health services.
- Summary care record information also provided clinical staff with an outline medical record, detailing regular medicines prescribed and any diagnoses recorded on their medical record.
- The DoS provided an up to date catalogue of local support services such as pharmacies and community care providers. This included opening times and contact telephone numbers. Staff were able to provide patients with the information they needed to access such services, and were able to make contact on behalf of patients if the situation required it. We saw data which showed that YAS111 had met the target level for performance in this regard.

**Timely access to the service**

Patients were not always able to access care and treatment from the service within an appropriate timescale for their needs.

- The service operated 365 days per year, 24 hours a day. Patients were able to access the service by telephone or via completion of an online form.
- We saw that during the current coronavirus pandemic, there were delays to times within which calls were answered, or clinical call-back was completed, and that the KPIs were not met during these periods. For example, in December 2021 44% of calls were answered within 60 seconds, against a target of 90%. Furthermore, in April 2020 80% of patients were called back within an hour by a clinician, whilst in December 2021 the percentage had fallen to 43.7%.
- Health advisors had the option to 'warm transfer' the more urgent cases to a clinician to assess, if an emergency response was not required. Where clinicians were not available to accept the call, the patient was placed on a clinical call-back queue. Clinical team leaders continuously monitored these queues, and prioritised the more urgent cases for priority call-back.

Inspected but not rated

# Are services well-led?

**Leadership capacity and capability**

Leaders strove to deliver high-quality, sustainable care.

- Leaders recognised and acknowledged the challenges presented to the sector and those specific to their service. We saw that a recovery and improvement plan was in place, spelling out aspirations to make improvements against a range of measures such as culture and leadership, health and wellbeing, recruitment and retention and employee voice.
- Staff told us there were issues in relation to the visibility and approachability of senior staff in some cases. Some staff told us their direct line manager was not supportive or approachable; and some staff told us they were not aware of who the senior or executive team were, nor were they clear of the role they played in all cases. The most recent staff survey results (from the Trust as a whole) from August 2021 were mixed:

- 71% of staff said they felt able to approach their line manager to talk openly about flexible working

- 43% of staff said they felt valued by their team

- 30% of staff said they felt a personal attachment to their team

- 18% of staff said they felt involved in decisions affecting their work

- 29% of staff said they felt disagreements in their team were dealt with constructively

- Feedback from staff during the course of the inspection was mixed; some staff told us they felt supported and valued within the organisation, whilst others told us they experienced a 'blame culture and did not feel that they were valued within the organisation.
- We reviewed anonymised comments from staff who had left the service in the last 12 months. Issues cited included unsociable working hours, feelings of isolation in the role and lack of access to meaningful positive feedback and reward.
- Staff absence data showed that between April 2020 and March 2021 absence rates were higher than Trust averages throughout the year, with combined long and short term absence ranging from 11.6% to 17.36%. short term absence rates were around 8%, peaking to 10.46% in December 2021.

**Governance arrangements**

The service had a vision and strategy to improve in order to be the best urgent and emergency care provider delivering the best outcomes for patients.

- There was a business plan in place which spelled out plans to achieve priorities for the upcoming year.
- Staff and stakeholder involvement had been sought in identifying the core values for the service. Areas identified included innovation, resilience, empowerment, integrity and compassion. The recovery and improvement plan laid out steps whereby the values were to be achieved.
- Staff had access to a comprehensive range of standard operating procedures and guidance which was regularly updated to equip them to carry out the role to which they were appointed.

**Managing risks, issues and performance**

Inspected but not rated

# Are services well-led?

The provider had systems in place to monitor risks and manage performance

- A corporate risk register was in place, which identified a range of areas of risk including health and safety and staffing, operational and clinical risks. These were used to help inform the Integrated Urgent Care Workforce (IUC) recovery and improvement plan.

- Staff performance was measured through regular call audits. Where staff were found to be falling below the expected standards, measures were put in place, through additional training or support, or through an improvement plan to help them achieve the standards required

- The YAS111 recovery and improvement plan included consideration of issues in relation to staff experience, staff absence and leaver rates, the management of staff wellbeing, this included improving freedom to speak up processes.