Yorkshire Ambulance Service NHS Trust

Emergency operations centre (EOC)

Inspection report

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Ratings

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

Our findings

Emergency operations centre (EOC)

Inspected but not rated

A summary of CQC findings on urgent and emergency care services in West Yorkshire.

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:

West Yorkshire.

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.

Our findings

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.

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.

Due to the nature of the inspection we did not rate the service.

- The service did not consistently have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service monitored, but did not always meet, agreed response times so that they could facilitate good outcomes for patients.
- People could not always access the service when they needed it which was not always in line with national standards.
- The service generally controlled infection risk well. Staff used equipment and control measures to protect themselves and others from infection. They kept equipment and the premises visibly clean. The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Our findings

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene

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

Following COVID-19 infection prevention and control (IPC) guidelines the headquarters building had sanitiser gel and masks available at reception. Throughout the building there were wall mounted sanitiser gel pumps at strategic locations such as doorways and within the emergency operations centre (EOC) areas.

All EOC staff wore uniforms which were visibly clean and well maintained. Staff wore masks when moving around the building but not at their desks.
Each desk was separated from the next by a clear plastic screen.

EOC staff were supplied with COVID-19 rapid lateral flow test kits with which they were expected to test themselves twice weekly ,however, as this was no longer mandated at a national level, managers did not record compliance nor was there any process for ensuring compliance.

EOC staff did not have access to polymerase chain reaction (PCR) COVID-19 tests. Staff were expected to self isolate appropriately if unwell.
Staff we spoke with told us they felt protected from COVID-19 within the workplace.

We were told the trust continued to promote and encourage staff to participate in the vaccination programme for Covid-19 and Seasonal Flu. Plans were being made to record and promote seasonal flu vaccination with an anticipated target of 70-90% compliance. Current levels of compliance were 70% for covid 19 and 63% for seasonal flu.

Environment and equipment

Our findings

The design, maintenance and use of facilities, premises and equipment kept people safe.

The provider held comprehensive records detailing all equipment and completed service records.

Staff were able to articulate existing plans for addressing failure of either the computer or telephony systems. The contingency plans were robust and involved mutual aid arrangements in which other ambulance trusts would be able to assist in call taking or dispatch to ensure that patients continued to receive safe care.

We saw multiple large video screens in the various EOC rooms which displayed information in real time such ambulance attendance wait times and number of calls waiting to be answered.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify risk and deteriorating patients and escalated them appropriately. Calls received into the EOC were categorised with a priority level through the medical priority dispatch system (MPDS). MPDS was used by call handlers to make decisions and dispatch appropriate aid to medical emergencies. The system provided standard questions relating to a patient's condition and provided pre-arrival and care instructions to the patient. The system listed calls in order and colour coded them to show their priority level. Calls could be re-prioritised if felt necessary by staff depending on clinical symptoms.
We observed calls which had been triaged by a call handler and sent to the dispatch team for assigning to an ambulance. These calls were held in the dispatch area due to lack of available vehicles, as they were already assigned calls or delayed at hospital ED's.

The EOC staff carried out 'welfare check' calls. They were carried out, usually by specific members of the team, to callers who may require additional support or to check if circumstances had changed with the patient if the ambulance was delayed.

Clinical staff were available within the EOC in an area known as the clinical hub. The responsibilities of clinicians were to 'hear and treat' patients and provide clinical oversight of all calls awaiting an ambulance response. The clinicians were also available to offer clinical support to call handlers who may have medical queries whilst triaging a patient.

We observed that the EOC also had mental health qualified staff to provide specialist mental health support if required.

Our findings

Ambulance response times were available to the call handlers and they were able to provide patients with a realistic response time to manage their expectations and reduce follow-up calls coming back into the system

Staffing

The service did not consistently have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The rising demand for call handling meant staff resources were being continuously stretched. The delay in sending ambulances meant people were calling to the service a number of times to ask for updates or to provide new information if the patient's condition changed.

The trust told us that the difficult and stressful nature of the role, and competition from other employers had also presented a challenge to recruitment.
Some staff we spoke with acknowledged the mental and physical stress caused by the current pressures.

Risk registers for the emergency operations centre included staffing, we also saw additional risk entries for staffing issues such as a shortage of mental health trained nurses.

We saw and were told about extensive recruitment and training programmes currently ongoing to recruit more staff.

Is the service effective?

Inspected but not rated

Response times

The service monitored, but did not always meet, agreed response times so that they could facilitate good outcomes for patients.

Since July 2021, as at other times during the COVID-19 pandemic, YAS had been at Resource Escalation Action Plan (REAP) level 4, which meant the service was under 'extreme pressure'.

In March 2022 there were 116,884 patient contacts at the EOC, 80,901 of those calls were 999.

Calls to YAS via the 999 system were prioritised into one of four categories:

• Category one: for life-threatening injuries and illnesses, specifically cardiac arrest.

Our findings

• Category two: for emergency calls, such as stroke patients.

• Category three: for urgent calls such as abdominal pains, and which will include patients to be treated in their own home.

• Category four: less urgent calls such as diarrhoea and vomiting and back pain.

The trust answered 95 out of 100 of all calls within 165 seconds. This was the fifth slowest of 11 providers and was six seconds faster than the England average. This means that 5% of calls took longer than 165 seconds to be answered.

The trust had failed to meet the national average in all reporting indicators regarding response times for the last six months.

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements.

The trust carried out regular audits to monitor how staff were performing. In relation to the EOC audits included: call handling quality assurance; auditing a sample of triaged calls each month, and a clinician audit to check a sample for the quality of each clinicians calls each month. A new audit assurance tool had been introduced but this was not yet fully embedded.

We saw a further comprehensive audit programme that had been developed and which was due to be introduced to further drive quality improvement.

Hear and Treat clinicians dealt with 25617 calls passed to the clinical hub over the previous three months. Following input and advice from clinicians, demand on ambulances was reduced with 4692 patients receiving a different outcome than an ambulance. 12706 of those calls had received self care over the telephone which also reduced demand on other services in the region such as attending the local hospitals.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff told us they worked with other providers in the wider health and social care setting, such as: social services, hospitals, primary care services and other emergency services. When required, there was good communication between EOC staff and external health and social care services.

The trust complied with the National Ambulance Resilience Unit (NARU) memorandum of understanding on the deployment of 'mutual aid'. The process of requesting or providing mutual aid was an aspect of this memorandum. The trust had good working relationships with other ambulance trusts and often sent and received 'out of area' calls from patients which required transfer to another ambulance service.

We observed all of the various specialists within the EOC working together to deliver the best and safest patient care they could deliver. Call handlers liaised with dispatch staff and raised safeguarding referrals when required. They also passed calls through to the clinicians in the CHUB for further advice and possibly a hear and treat service.

Our findings

Is the service caring?

Inspected but not rated

Compassionate care

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

Staff were professional and demonstrated empathy and reassurance whilst speaking to members of the public during 999 calls.

The MPDS system had standardised advice staff were able to give callers on actions they should take whilst waiting for an ambulance. We observed this advice being given clearly and timely enough for the caller to understand.

A call handler diffused a difficult situation involving a member of the public, who was distressed at the wait time experienced for an ambulance. We heard their sensitive and caring approach while dealing with this.

Staff showed understanding of the impact of their advice, highlighting their interest in further development. They told us of their particular interest in receiving further training to support members of the public experiencing mental health episodes. They demonstrated a keen interest to support the personal and cultural needs of the public.

Staff talked to patients in a way they could understand and made sure patients and those close to them understood their care and treatment.

Healthcare professionals demonstrated the ability to triage patients using effective communication whilst involving patients, relatives and carers in their interactions.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Dispatchers were assigned a dedicated geographical area which was split into different sectors throughout Yorkshire. This gave staff an understanding of the local areas such as; roads, hospitals, traffic information and liaison points.

We were told about new more specialist roles within the EOC which would support staff in ensuring that patients get the right care, at the right time and in the right place.

We were given examples of when the service had worked across county lines with other ambulance services to ensure the most appropriate resource was allocated. The service had developed formal relationships with other providers so that they could work collaboratively and effectively in delivering patient care.

Our findings

Access and flow

People could not always access the service when they needed it which was not always in line with national standards.

Ambulance Response programme (ARP) categories and current performance:

Category 1 target: 7 minutes; actual 25/04/22: 8 mins 18 secs

Category 2 target: 18 minutes; actual 25/04/22: 33 minutes

Category 3 target: 40 minutes; actual 25/04/22: 1 hour 28 minutes

Pressure from excessive demand meant many patients were now waiting too long for their call to be answered or to get a timely response after assessment. Calls into the EOC were monitored at all times. Staff could see performance metrics displayed on large television screens positioned throughout the EOC. Given the level of calls the EOC frequently struggled to match resources to call volume.

The service was aware of the category and status of calls received from patients, members of the public and healthcare professionals to make sure the right response was arranged. The managerial teams and coordinators in the EOC made operational decisions about how to respond to excess demand.

We heard dispatchers make decisions about where to send or redirect resources related to patient risk. This was a dynamic risk assessment - balancing resources and the clinical needs of patients who had been waiting a long time.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service was under intense pressure. Senior management told us they were meeting regularly to assess the pressure on the system and find ways to ease it.

YAS senior management had engaged with hospital trusts and other care providers to attempt to smooth the flow of patients transported to hospital, and lower handover delays. Less busy hospital ED's had been identified and patients from certain postcodes could be diverted to these to help them get treatment as soon as possible and ease the pressure on the busiest hospital ED's.

Call handling staff told us their team leaders and management in the EOC were supportive and encouraging. Senior managers were also a visible presence within the EOC

Our findings

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The Trust had put in place a strategic and tactical response for winter, which was focussed on three key areas: to manage demand, increase capacity, and work with system partners to reduce delays at hospital handover. The service had been at REAP level 4 (extreme pressure) since July 2021.

With the exceptional pressure on the system, the risk to a safe and effective performance of the ambulance emergency operations centres was high. The risk register acknowledged the issues associated with this and there was clear mitigation recorded with dates for review. The service was set up to cope with unexpected events but staff at all levels were becoming more concerned about the ability to manage performance with the increasing demand on urgent and emergency care capacity.

Foreseeable risk such as changes in demand generally (known as surge), adverse weather conditions and loss of service were well embedded and planned for. All events were escalated through clear structures and processes which had always been part of the emergency response.

Our findings

Areas for improvement

- The service should consider how it can improve routine vaccination uptake for all staff.
- The service should consider how it can improve response times and overall performance.
- The service should ensure the newly introduced quality audit assurance tool becomes fully embedded.

Our inspection team

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

For our emergency operations centre inspection, we talked with call handlers, dispatchers, and clinicians. We also interviewed senior operational managers. After the inspection we requested further information and documents from the trust.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation

Regulated activity	Regulation