CareQuality Commission

Yorkshire Ambulance Service NHS Trust

Yorkshire Ambulance Service NHS Trust HQ

Quality Report

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

Ratings

Overall rating for this ambulance location	Requires improvement ●
Emergency and urgent care	**Requires improvement** ●
Patient transport services (PTS)	**Requires improvement** ●
Emergency operations centre (EOC)	**Requires improvement** ●
Resilience	**Requires improvement** ●

Summary of findings

Letter from the Chief Inspector of Hospitals

Yorkshire Ambulance Service NHS Trust (YAS) was formed on 1 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 employs over 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, a 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).

Our inspection of the ambulance service took place between 12 to 15 January 2015 with unannounced inspections on 19 January 2015 and 9 February 2015. We carried out this comprehensive inspection as part of the CQC's comprehensive inspection programme.

We inspected four core services:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience Services including the Hazardous Area Response Team:

Overall, the trust was rated as Requires Improvement. Safety, effectiveness, responsive and well-led were rated as requires improvement. Caring was rated as good.

Our key findings were as follows:

- At the time of inspection four out of the six executives were in substantive positions however there had been a recent loss of the Chief Executive and a history of change at executive level within the trust.
- There was below national average performance over Red 1 and 2 targets and an increased number of complaints which did not meet the trusts 25-day response times. The trust reported during this period an increase in activity across all services.
- The trust were in the process of changing the culture in the organisation from performance target driven to one of professional/clinical culture.
- There was a history of poor staff engagement and relationships between senior management and workforce. There was a recent introduction of new rotas and meal breaks which had had a further negative impact on relationships.
- We had significant concerns within the HART service about the checking of equipment -a large number had passed their expiry dates and assurance processes had not detected this. There were also inconsistencies with checking of breathing apparatus and the processes observed did not follow best practice guidance. We re-visited the HART base two days after the announced inspection and one month later to check that changes had been implemented in response to our concerns.
- Development work had been undertaken to strengthen the assurance and risk management process and these showed improvement, but lacked maturity. Issues were found on inspection for example there were security issues at one station, cleanliness of ambulances across the region, but particularly at the HART unit, which demonstrate a lack of robustness with misleading results giving rise to false assurance.
- The trust had major difficulties in recruiting staff, national shortages of paramedics contributed to the trusts difficulty in recruiting paramedics which impacted on the ability to be responsive and also enable staff to attend training and other activities.

Summary of findings

- The trust was working hard to be more outward facing, working in partnership with commissioners and improving consultation with patients and public.

We saw several areas of outstanding practice including:

For the trust:

- The trust's 'Restart a Heart' campaign trained 12,000 pupils in 50 schools across Yorkshire.
- The trust supported 1,055 volunteers within the Community First Responder and Volunteer Care service Scheme.
- Green initiatives to reduce carbon in the atmosphere by 1,300 tonnes per year.
- The emergency operations call centre was an accredited Advanced Medical Priority Dispatch System (AMPDS) centre of excellence.
- Mental Health nurses working in the emergency operations centre to give effective support to patients requiring crisis and mental health support. This included standardised protocols and 24 hour access to mental health pathways and crisis team.

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

Importantly, the trust must:

- The trust must ensure all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure that equipment and medical supplies are checked and are fit for purpose.
- The trust must ensure all staff are up to date with their mandatory training.

In addition the trust should:

- The trust should ensure all staff receive an appraisal and are supported with their professional development. This should include support to maintain the skills and knowledge required for their job role.
- The trust should ensure risk management and incident reporting processes are effectively embedded across all regions and the quality of identifying, reporting and learning from risks is consistent. The trust should also ensure staff are supported and encouraged to report incidents and providing feedback to staff on the outcomes of investigations.
- The trust should ensure all ambulance stations are secure at all times.
- The trust should review the provision and availability of equipment for use with bariatric patients and ensure staff are trained to use the equipment.
- The trust should review the safe management of medication to ensure that there is clear system for the storage and disposal of out of date medication. The trust should also ensure oxygen cylinders are securely stored at all times.
- The trust should ensure records are securely stored at all times.
- The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.
- The trust should ensure performance targets in relation to patient journey times and access to booking systems continue to be monitored and improve.
- The trust should ensure there are appropriate interpreting and translation services available for staff to use to meet the needs of people who use services

In addition, the trust should consider other actions these are listed at the end of the report.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care	Requires improvement 🟠	Overall urgent and emergency care was rated as required improvement in safe, effective, responsive and well-led and was rated as good for caring. There was an established system for reporting of incidents but we found some staff were reluctant to report incidents and some reported that there were actively discouraged from reporting incidents. We found there was no formal feedback system and little evidence of changes that had occurred as a result of an incident being reported. Infection control practices were not always followed by staff. A large number of ambulances were dirty on the outside and there were some poor practices relating to the disposal of clinical waste and the general cleanliness of the inside of ambulances. Appropriate equipment was generally available but this had not been standardised across the trust and on occasions staff had to wait for support from others with the correct equipment. The service followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. The ambulance service was not meeting national target emergency response times for responding to life threatening conditions. However, for category A calls resulting in the arrival of an ambulance at the scene of the incident within 19 minutes, the trust performed well. Patients were treated with compassion, dignity and respect by ambulance staff. Staff explained treatment and care options in a way that patients could understand; they explained and involved patients in decisions. The trust was dealing with a steady number of national emergency calls. The trust had an increasing number of calls where the patients were not conveyed to hospital. There was an established process for the handling of complaints but there was limited evidence of learning from complaints and staff received little feedback in relation to complaints.

Summary of findings

While the trust had a vision and strategy' front line staff were not clear about what this was and were not engaged with the trusts vision and strategy for the service. Staff did not feel valued or listened. Staff were positive about the direct local leadership but felt that there was a lack of consultation and consideration of how things worked on the frontline, at a higher level. There were systems in place for monitoring performance against national targets and indicators and internal expectation such as mandatory and statutory training.

Patient transport services (PTS)

Requires improvement ●

Overall YAS patient transport required improvement in safe, effective, responsive and well-led and was rated as good for caring.

Procedures to ensure the safety of services needed to improve, specifically around incident reporting and equipment checks. Systems for the maintenance and replenishment of vehicles were not always timely which meant vehicles were regularly off the road impacting on journey times. Arrangements were in place to respond to emergencies and the service took account of seasonal fluctuations in demand, the impact of adverse weather or disruption to staffing.

The trust was not meeting all its performance targets particularly for renal dialysis patients and this was having an impact on patients' care and treatment. There were staffing vacancies and staff felt stretched, particularly in the communication and control centre where this had an impact on the planning and scheduling of transport.

PTS staff was caring, compassionate and dedicated to improving the service. Complaints procedures and systems to give feedback when things went wrong were not fully understood by patients or staff. The trust had a strategy for the development of PTS to support safe non-emergency travel between people's homes and healthcare settings, but most staff was unaware of this strategy. There were systems in place to monitor risks, quality and performance. However, risk management processes were not fully embedded across all regions and the quality of identifying, reporting and learning from risks was variable.

Summary of findings

Emergency operations centre (EOC)

Requires improvement ●

Overall the Emergency Operations Centre was rated as requires improvement for safe and well-led and was rated as good for being effective, caring and responsive. Most of the staff we spoke with did not feel supported or encouraged to report incidents; instead of reporting incidents directly, they escalated them to their line managers to report. As a result they did not always receive feedback and learning was not shared.

Emergency Operations Centre (EOC) services were delivered by caring and compassionate staff. We observed staff talking to people in a compassionate manner and treating them with dignity and respect. There was support for people who had difficulty accessing the 999 emergency call service because they could not speak English or they had hearing difficulties or speech impairment. Most staff we spoke to were unaware of the trust's specific vision or strategy for the service but recognised the trust's values. There was a disconnect between the risks and issues described by staff and those reported and understood by the leaders of the service.

Resilience

Requires improvement ●

Overall the resilience service was rated as inadequate for safe, responsive was rated as good and well-led required improvement. Effective and caring were inspected but not rated.

We had significant concerns within the service about the checking of equipment, a large number had passed their expiry dates and assurance processes had not detected this. There were also inconsistencies with checking of breathing apparatus and the processes observed did not follow best practice guidance. We re-visited the HART base two days after the announced inspection and one month later to check that changes had been implemented in response to our concerns. We found immediate actions had been undertaken and all equipment had been audited and replaced with new equipment where necessary.

Resilience, including HART, applied evidence-based practice during care and treatment and had gained ISO 22301 for Business Continuity Management Systems. Significant progress had been made in terms of staff education including the assessment of

Summary of findings

core competencies and performance outcomes. There were good examples of multi-disciplinary team working and coordination with other agencies. In relation to caring, there was no concerning information in terms of staff conduct and there were positive examples of how staff had supported patients and provided emotional support.

There were positive examples of Resilience planning and suitable on-going assessments of service demand and pro-active planning. In relation to the concerns highlighted with equipment and some vehicles, there was concern that the responsiveness of the Resilience function, including HART, had been compromised. This, potentially, could have had a negative impact on being able to provide a swift response to Resilience / HART related call-outs.

CareQuality Commission

Requires improvement 🟠

Yorkshire Ambulance Service NHS Trust HQ

Detailed findings

Services we looked at

Emergency and urgent care; Patient transport services (PTS); Emergency operations centre (EOC); Resilience

Detailed findings

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Detailed findings from this inspection

Background to Yorkshire Ambulance Service NHS Trust HQ

Yorkshire Ambulance Service NHS Trust (YAS) was formed on 1 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 employs over 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 provides 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 not inspected as part of this inspection.

In 2013-14 the trust's A&E service responded to 795,750 urgent and emergency calls and received through the EOC 2.2 million 999 and NHS 111 calls per year which averages at 2,180 calls per day. Within PTS in 2013-14 the service made around 886,312 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: Elaine Jeffers

Head of Hospital Inspections: Julie Walton, Care Quality Commission

A team of 51 people included CQC inspectors, inspection managers, national professional advisor, pharmacy inspectors, inspection planners and a variety of

Detailed findings

specialists. The team of specialists comprised of paramedics, urgent care practitioners, operational managers, call handlers and experts by experience that had experience of using services.

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

• Resilience Team including the Hazardous Area Response Team

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 (CCG's), the Trust Development Authority, NHS England and the local Healthwatch's.

We held focus groups and drop-in sessions with a range of staff in the service and spoke with staff individually as requested. We talked with patients and staff 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 13–15 January 2015 and undertook unannounced inspections on 19 January 2015 and 9 February 2015.

Facts and data about Yorkshire Ambulance Service NHS Trust HQ

The population the trust serves includes:

• South Yorkshire
• North Yorkshire
• Hull & East Yorkshire
• West Yorkshire

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

• Bassetlaw
• North Lincolnshire.

Activity

• In 2013-14 the trust's A&E service responded to 795,750 urgent and emergency calls.
• The total number of calls for 999 and NHS 111 handled by the trust was 2.2 million calls per year which averaged at 2,180 calls per day.
• Within PTS in 2013-14 the service made around 886,312 journeys transporting patients across Yorkshire and neighbouring counties each year.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Patient transport services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre (EOC)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Resilience	Inadequate	Not rated	Not rated	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Emergency and urgent care

Safe	**Requires improvement**	🟠
Effective	**Requires improvement**	🟠
Caring	**Good**	🟢
Responsive	**Requires improvement**	🟠
Well-led	**Requires improvement**	🟠
Overall	**Requires improvement**	🟠

Information about the service

The trust emergency and urgent care service referred to by the trust as the A & E service, consisted of nearly 1,900 paramedics, emergency medical technicians (EMTs) and emergency care practitioners (ECPs) working in front line services. The service had a fleet of over 500 specially-equipped emergency vehicles (rapid response vehicles and ambulances) operating from 62 ambulance stations and a network of stand-by points, where vehicles waited until needed. For alternative responses to incidents the trust also had Emergency Care Practitioners (ECP) who were paramedics or nurses with advanced training who responded to the full range of patient conditions but have specific additional skills around treating and discharging patients. There were also cycle response units staffed by paramedics or EMTs who used specially-adapted motorcycles or bicycles to navigate congested city centres to reach patients and provide emergency care. The bikes carried life-saving equipment such as defibrillators for use in cases of cardiac arrest.

Doctors would provide support to ambulance crews at serious road accidents and other trauma incidents. Community First Responders were volunteers from the community who provided basic levels of clinical intervention and pastoral care which included emergency first response to patients including those with cardiac arrest prior to the arrival of an ambulance crew.

During the inspection we visited 14 ambulance stations in York, Harrogate, Pocklington, Pately Bridge, Middlewood, Bentley, Doncaster, Leeds Central, Huddersfield, Keighley, West Hull, Beverley, Sutton Fields and East Hull. We spoke with approximately 165 members of staff including emergency care practitioners, paramedics, emergency medical technicians and emergency care assistants, urgent care assistants, clinical supervisors, locality managers, community first responders, pharmacy technicians and domestic staff. We spoke with 35 patients and relatives who had used the service. We also observed patient handovers at Emergency Departments (ED) at a number of hospitals. We inspected in the region of 65 vehicles and reviewed 80 patient records. We visited 9 hospitals where we observed interactions in the emergency department and spoke with staff in both the emergency department and other areas of the hospital where they had had interaction with the emergency services and in total we spoke with approximately 34 members of hospital staff.

Emergency and urgent care

Summary of findings

Overall urgent and emergency care was rated as requires improvement in safe, effective, responsive and well-led and was rated as good for caring.

There was an established system for reporting of incidents but we found some staff were reluctant to report incidents and some reported that there were actively discouraged from reporting incidents. We found there was no formal feedback system and little evidence of changes that had occurred as a result of an incident being reported. Infection control practices were not always followed by staff. A large number of ambulances were dirty on the outside and there were some poor practices relating to the disposal of clinical waste and the general cleanliness of the inside of ambulances. Appropriate equipment was generally available but this had not been standardised across the trust and on occasions staff had to wait for support from others with the correct equipment.

The service followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. The ambulance service was not meeting national target emergency response times for responding to life threatening conditions. However, for category A calls resulting in the arrival of an ambulance at the scene of the incident within 19 minutes the trust performed well.

Patients were treated with compassion, dignity and respect by ambulance staff. Staff explained treatment and care options in a way that patients could understand; they explained and involved patients in decisions. The trust was dealing with a steady number of national emergency calls. The trust had an increasing number of calls where the patients were not conveyed to hospital. There was an established process for the handling of complaints but there was limited evidence of learning and feedback from complaints being cascaded to all staff.

While the trust had a vision and strategy, front line staff were not clear about what this was and were not engaged with the trust's vision and strategy for the service. Staff did not feel valued or listened to. Staff were positive about the direct local leadership but felt that there was a lack of consultation and consideration of how things worked on the frontline at a higher level. There were systems in place for monitoring performance against national targets and indicators and to some extent internal expectation such as mandatory and statutory training.

Emergency and urgent care

Are emergency and urgent care services safe?

Requires improvement ●

There was an established system for reporting of incidents but we found some staff were reluctant to report incidents and some reported that there were actively discouraged from reporting incidents. We found there was no formal feedback system and little evidence of changes that had occurred as a result of an incident being reported.

Infection control practices were not always followed by staff. A large number of ambulances were dirty on the outside and there were some poor practices relating to the disposal of clinical waste and the general cleanliness of the inside of ambulances. Appropriate equipment was generally available but this had not been standardised across the trust and on occasions staff had to wait for support from others with the correct equipment.

We found new equipment had been introduced without all staff receiving the required training, for example, the track chairs and a harness for the safe transportation of children. Medicines were mostly appropriately stored and managed. However, in some locations, the security standards and processes for controlled drugs needed to improve. Staff were knowledgeable about safeguarding and there was a clear procedure for the reporting of concerns. Patient records were maintained to a high standard though they were not always securely stored. Staff were clear about their responsibilities in relation to 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders though there was no formal system for alerting staff that these were in place.

Patients were appropriately identified and escalated for treatment if their condition deteriorated. Mandatory training figures were below target. Staff were clear about the skill mix required on an ambulance and worked flexibly to ensure this occurred. Shift changes to manage resources and been introduced, but staff were working extra hours and some were experiencing stress and fatigue as a result.

Incidents

- We found there had been 77 harmful incidents reported to the National Reporting Learning System (NRLS) by the trust between December 2013 and November 2014. Fifty four were within the emergency and urgent care service.
- The trust had a Risk Manager who was responsible for providing the trust's quality committee with an update on significant events highlighted through the trust's reporting systems and by external regulatory bodies. The aim of the report was to provide an assurance on actions taken to effectively learn from adverse events. A review of the report titled 'Significant Events & Lessons Learned for September 2014' demonstrated that the number of open serious incidents was monitored; analysis of trends was undertaken and considered.
- There was a trust-wide electronic incident reporting system. Staff were able to report an incident directly, when they had access to the computer system or via a telephone direct to the central hub in the emergency operations centre. We found the majority of staff were clear about the reporting system and how to access it.
- However staff we spoke with had a mixed view of the effectiveness of reporting incidents. They received an automated response that the report had been received but most staff told us that they did not receive any further feedback. We found there was some apathy amongst staff about reporting incidents, some staff told us that they were actively discouraged from reporting incidents and we were told of three incidents that had placed staff and patients at risk that had not been reported. Two related to damage to an ambulance door and one related to a lost phone.
- Staff were unable to provide us with any examples of changes that had occurred as a result of incidents being reported.
- Locality Managers and Clinical Supervisors had a role in reviewing incidents and these were supposed to be completed within three weeks. We looked at the reports for one Clinical Supervisor and one Locality Manager and found that these time frames were generally adhered to. They confirmed that in general there was only feedback from an incident if this was given verbally or it was escalated to a serious incident.
- There was a system in pace for the cascade of safety alerts which were sent to staff by email and were displayed on the notice boards in ambulance stations.

Emergency and urgent care

Although staff reported that at times it was difficult to find the time to access their emails. We were unable to establish the exact system for ensuring that where necessary, action was taken in response to safety alerts.

Duty of Candour

- We found staff on the front line were not informed of the duty of candour and the associated requirements relating to this.

Safety thermometer

- The NHS Safety Thermometer tool was developed by the Health and Social Care Information Centre (HSCIC) to support patient safety, measure harm and reduce harm. The success of the NHS Safety Thermometer sits in enabling frontline teams to measure how safe their services are and to deliver improvement locally.
- The NHS Safety Thermometer is not relevant in some areas, such as ambulance trusts, but we asked about the processes for harm measurement and reporting. We found the trust produced a monthly safety thermometer briefing and included the number of harm-free days and incidents relating to the patient transport service (PTS) and Accident and Emergency (A&E) service.

Mandatory training

- The trusts statutory and mandatory training policy (version nine, dated April 2014) included a training needs analysis for emergency and urgent care clinical staff. For example the list included bullying and harassment training three yearly; conflict resolution three yearly; fire safety and prevention awareness annually; infection control and prevention three yearly; investigations of incidents, complaints and claims three yearly, resuscitation three yearly.
- The trust provided mandatory training figures which showed that dementia awareness training had completion rates from 25 to 100%; health and safety - three yearly with completion rates of 28 to 100%; mental health awareness & capacity - three yearly with completion rates 28 to 100%.
- We found the information was broken down by division and grade of staff. For example band five Paramedics in South Yorkshire had the least percentage score for all training at 28% followed by band 5 paramedics in North Yorkshire at 35%

- Staff were aware of the need to complete statutory and mandatory training. They told us that this training was provided through e- learning and if they did not complete the training on line they were provided with a work book to complete.
- Some staff told us that they had not completed any practical manual handling of loads training for four or five years and one person told us this was ten years.
- The trust told us mandatory training was rostered into staff's off-duty however the majority of staff told us they undertook training in their own time as there was no protected time for training.
- Clinical supervisors reported they received feedback on staff who had underscored/performed and they followed up with these members of staff any learning areas that needed addressing.
- Staff told us they had competed driver training in order to drive under blue light conditions when they first undertook this role although they had not had any further update trainings since that time.
- Information provided by the trust showed that between May 2014 and December 2014, 140 drivers had completed D1 training which introduced the driver to the practical systematic driving framework, road traffic law, the Highway Code, and the Ambulance Driving Manual. Ninety seven had completed D 2 driver training which covered advanced driving techniques in non-emergency and emergency situations.

Safeguarding

- Staff had a good understanding of what safeguarding concerns might be and all were clear about the process for reporting concerns. Safeguarding referrals were reported by telephoning a central 'hub' number. This number operated 24 hours a day. Most staff reported this worked well.
- Staff said they prioritised safeguarding concerns and most of the time were given the time to complete the reports.
- We found there was variability as to whether staff received any feedback following a referral. For example in South Yorkshire staff told us that they got feedback regarding safeguarding concerns. This was received by email. However, staff we spoke with in West Yorkshire reported the feedback from safeguarding alerts was

Emergency and urgent care

variable across the teams. The trust senior managers told us that their ability to provide feedback was dependent on them receiving feedback from external agencies.

- We found staff were expected to undertake safeguarding children's level one and two and safeguarding adults training every three years. However we found from training figures the trust provided completion rates for all the training ranged from 28 to 100% completion.

Cleanliness, infection control and hygiene

- We found there were variable standards of cleanliness, infection control and hygiene across the areas we visited.

- Staff who delivered direct patient care were observed to be wearing wrist watches. Staff told us that this was acceptable practice within the trust. The trusts infection prevention and control policy dated 12 February 2014 stated that any watch worn had to be waterproof and washable which was in line with what staff reported. However the trust policy did not contain guidance on how often wrist watches should be decontaminated or cleaned.

- This was not in line with current best practice which considers that bare below the elbows means that all staff in contact with patients could effectively decontaminate their hands and wrists between each episode of patient care or contact which is not possible to do properly when wearing cuffs, watches and/or jewellery.

- Staff across the trust told us it was difficult to ensure the vehicles were cleaned regularly as they did not have protected time from emergency calls to do this.

- In North Yorkshire we looked at 21 ambulances vehicles and found the inside of the vehicles to be clean.

- In West Yorkshire we saw ambulances and other vehicle interiors were generally clean and tidy. We observed staff cleaning the interior of the vehicle, equipment and changing of linen following the handover of patients to the emergency department. However at the unannounced inspection we visited Keighley ambulance station and found three vehicles which had dirty flooring and dirty exteriors. We asked staff who told us there was no formal routine for when vehicles were cleaned this was done as and when staff had time in their shift.

- In South Yorkshire we saw seven ambulances or response cars of which three vehicles were not clean. For example, in one ambulance the patient area had dirty flooring with engrained dirt along central floor runners and other disposable items, such as ECG pad protectors, were left on floor. The two clinical waste bins near the front bulkhead were full. The cab passenger side dashboard had multiple muddy foot prints and used dirty gloves had been left on dashboard on the driver's side.

- Two out of four ambulances at Doncaster Royal Infirmary /Bentley ambulance stations were not clean. For example, one ambulance which staff confirmed was ready for use, had a malodour; items pre-prepared by staff to use for cannula insertion were stored in a clean vomit bowl inside the rubbish bin which contained rubbish including used gloves; there was engrained dirt on the floor, dust and debris in the cab area, and; a red slide sheet that was visibly dirty with black grease and dirt. Staff at Bentley ambulance station stated they had no protective equipment to wear to clean and no time to clean the ambulances.

- In both York and Leeds we noted that the exterior of the vehicles were particularly dirty. High pressure washers were available at the ambulance stations though staff said they did not have the time to clean down the outsides.

- In the Hull area the standard of cleanliness varied. Of the 14 vehicles we reviewed 11 of them were not clean. We found used gloves, particularly in the cab areas as well as clinical waste and dried blood on the vehicle walls. One of the deep cleaning team in this area told us "crews used to clean vehicle before they went off duty but this no longer seems to happen." The paramedic job description reviewed included the responsibility to ensure the vehicle was properly cleaned. One crew were very proud of their vehicle and "kept it spotless" throughout their shift. They worked as a team sharing the responsibilities for ensuring the vehicle was kept clean. This included cleaning equipment and the vehicle and disposing of clinical waste safely.

- There was a deep cleaning schedule on each ambulance. In South Yorkshire we found that deep cleaning had been undertaken at least every 2 months. Information displayed inside vehicles in North Yorkshire indicated that deep cleaning had taken place in the last five weeks. In the Hull area there was a weekly schedule and exceptions report for deep clean team which

identified the vehicles by fleet number with date cleaning due. However, information in one vehicle indicated that it had not been deep cleaned since October 2014 and the weekly schedule and exception list indicated that the cleaners had been unable to locate or access one vehicle that had been due to be cleaned at the end of December 2014. Leeds station used an electronic tracking system for locating vehicles on a five weekly cleaning cycle.

- Managers told us that if a vehicle became excessively contaminated during use, staff would escalate this to their line manager and arrangements would be made to provide a replacement vehicle, whilst the vehicle was deep cleaned.

- Ambulance stations and ambulances were equipped with clinical waste bags and sharps disposal bins. On three of the ambulances we inspected, sharps bins were not clearly labelled with a start date of when the bin was brought into use and these bins were not signed by the member of staff. We also saw one sharps box overfilled on another ambulance. In South Yorkshire there was a lack of suitable sharps bins which fitted the space in the ambulances or fitted into the response bag. Staff confirmed that due to lack of suitable sharps bins, on occasion, they had decanted from the smaller sharps bin to the larger ones.

- Personal protective equipment (PPE) such as gloves was available for staff to use. We saw most staff used PPE appropriately only wearing gloves during patient contact. We saw other staff put on gloves before leaving the vehicle and use them to record information on. However, staff did not wear sleeve protectors when wearing high visibility jackets. In North Yorkshire ambulance crew were not even sure that they had sleeve protectors. Full body protection suites were available.

- Hand cleansing gel was available on the ambulance and staff had access to hand wash sinks at emergency departments and other hospital facilities. While we observed some ambulance staff washing their hands after handling of patients this was not consistent.

- In North Yorkshire a third party was contracted to clean the ambulance station. They had a clear daily check list of tasks to complete which was monitored by supervisors from their company. Mops and buckets were colour coded and mops were stored with the head down and out of water and the buckets were empty.

- In the Hull area the cleaners responsible for the ambulance stations were employed by the trust. They also had a weekly task sheet which when reviewed was completed and up to date as was the shower cleaning log. Supervisor visited once per month and had a responsibility for monitoring the service provided.

- In West Yorkshire the ambulance stations we visited were visibly free from clutter but the standard of cleanliness varied. One of the ambulance stations we visited (Huddersfield) mops colour coded for cleaning ambulance interiors were being stored in buckets within the ambulance station and within the sluice room area. There were no schedules in place to indicate when mops and buckets were last used. We found there were no controls in place to identify dirty and clean flows within the sluice room. We also saw clean linen was stored next to dirty linen within the sluice room and cleaning products stored on the sluice room floor.

Environment and equipment

- Staff said they were allocated 20 minutes at the start of their shift to check their vehicles but "nine times out of ten" were called out before they were able to make the checks. This meant that at times the ambulance crew could not be assured that they had all the required equipment. There were no records on vehicles to indicate which checks had been completed, when and by whom.

- Ambulance stations had dedicated areas for the storage of replacement stock and ambulance staff were responsible for restocking their vehicles.

- The management of consumables including stock rotation was not consistent. There were out of date consumables identified at Middlewood ambulance station, for example suction catheters, and dust on other items such as dressings. In addition to this, a flexible suction catheter (expired 2012) and oropharyngeal airway were found to be out of date on a vehicle. We also found packaging was damaged on oxygen masks, nasopharyngeal airways and a flexible suction catheter.

- Staff reported a lack of equipment. One staff member said there was no lifting device available on their last shift and had to find one at a hospital. They were unable to get one for a couple of hours.

Emergency and urgent care

- Staff reported a lack of splints, particularly box splints, available at Bentley and Doncaster stations. Staff gave examples of two recent occasions where they had to call a rapid response vehicle to bring the correct splint to an incident.
- In South Yorkshire we saw that an ambulance had a ECG/ defibrillator machine which was not adequately secured on a wall mounted bracket. The pack's feet were missing which meant it was only partially held in place with the upper bracket. This piece of equipment was placed over the lower limb area of patients on stretchers which placed them at risk. The crew explained there had been previous incidents reported about this matter but no action taken.
- Not all of the ambulances were equipped with child safety harnesses and therefore it was not clear how children could be transported safely. In North Yorkshire we found one of these on a new ambulance but five out of six staff were not aware of how to use this piece of equipment and it was not available on the other three ambulances in the station. Staff told us that on occasion they would use the families own car seat or parents may hold children on their laps.
- A new track chair and been provided for the safe transit of patients particularly down stairs, removing the need for ambulance staff to lift the chair and patient. However, these were not available on all ambulances and most staff told us that they had not been trained to use the chair and that it was not always possible to use the tracks on the chair, as they would not go round corners on stairs. Therefore we found staff were lifting patients on the chair placing themselves at risk of harm.
- Staff told us that they reported faulty equipment to the clinical supervisors. Vehicles did not run without some equipment, such as radios on ambulances, although cars did. Staff reported turnaround times for radio repairs was about two weeks.
- We found Bentley station was in a state of disrepair. There was a bucket placed underneath leaking pipes in the ceiling of the old locker room, which was now identified as a training room. We saw on our visit this was half full of liquid. The sluice room had a wooden drainer that had been covered with water resistant material. The original wooden drainer was visible and had dirt between the edges. The sluice room was unlocked and substances that should be securely stored under the control of substances hazardous to health regulations were kept in this area. The lockers had

recently been moved from the garage area to an adjacent area. This area had an uneven concrete floor, with holes and trip hazards. We saw a metal post with sharp corners had been wrapped in a softer material to avoid injury; this had been secured with cling film. The store room was off the changing area. Part of the wall between the changing area and the store room was missing and the timber frame was exposed. The hole was large enough for a person to step through.
- We asked the trust for the risk assessment for this station. The trust provided us with information about an assessment undertaken because of the asbestos in the building however we found this did not cover all of the issues identified.
- In West Yorkshire both of the ambulance stations visited were older premises and the buildings were showing signs of deterioration. At one of the stations one of the vehicle access doors had been damaged and was not in use. Therefore vehicles accessed and exited the station via the one remaining door, which had the potential of causing delays of vehicles exiting the station in an emergency. Senior managers told us that estates team had assessed the damage and had ordered the parts to carry out repairs. Managers assured us that repairs to station doors were categorised as high priority. However, there was no detail provided on how long the repairs may take and therefore it was unknown on how long the door would be out of action. There was also a vehicle wash bay that had a sign advising operatives to wear a hard hat whilst working in the bay. The station manager told us that this was due to a deteriorating problem with the concrete roof above. They told us that the roof had been examined by the estates staff and a risk assessment of this area had been completed. The wearing of a hard hat was a precautionary measure.
- Generally ambulance stations visited were secure. Security arrangements were also in place throughout the interior of ambulance stations. Staff used swipe cards or entered numbered codes to access internally secured areas within stations. In Sutton Fields the station was found to be unsecure and the inspection team were able to gain open access to the station and to the ambulances in the parking bay.
- Staff told us that reporting repairs to fleet services for maintaining their vehicles generally worked well. Fleet operated a mobile service along with services provided

at a number of ambulance stations. Staff provided mixed views on the efficiency of this service with some crews informing us that they had been off the road for up to four hours waiting for a replacement light bulb.

- We observed that one ambulance had a broken door stay on the rear door, this meant the door had to be held open or it swung shut. Staff told us that when they reported the issues they had been told by workshop staff and the clinical supervisor to 'use with caution.' However, there was a potential for harm to be caused to both staff and patients.

Medicines

- Generally we found there was a well-established system in place for the safe management of controlled drugs (CD's) on the ambulances and in the ambulance stations. This included secure storage, a secure transport system and an audit trail. Although we did see there were inconsistencies in the signing in and out of CD's within the controlled drugs register on one vehicle. On one ambulance in the Hull area we found the code to the lock written on the side of the cupboard and therefore was not secure.
- In Leeds we found out of date CD's were retained in an old sharps box within the medication cupboard in the emergency department. We found this was virtually full and we were unable to establish whether clear protocols had been agreed and who took responsibility for the safe management of these medicines.
- Ambulance staff were able to restock their medicines from dedicated stock cupboards in hospital emergency departments. However, we found that there was not a consistent system across all areas and medication was not always safely stored; out of date medication was stored alongside in date medication. We observed that the medicines store for the ambulances service at Northern General Hospital was well-stocked and was audited monthly by the hospital pharmacy team. At York Hospital the store was checked by a pharmacy technician employed by the ambulance trust. At the time of the inspection a full stock check was performed and observed. It was found that five vials of naloxone, one box of ibuprofen, two vials of ondansatron (anti-sickness medication) and a diabetic hypoglycaemia kit were not accounted for. At Leeds

General Infirmary there was no evidence of medicines stock audits and we found out of date medicines were stored in the same cupboard alongside in date medicines.

- There was a monitoring system for medicines held on the ambulances and there was a log book to record these checks and when medication was used. The checks were scheduled to take place monthly. In general we found that these were undertaken and recorded however in West Yorkshire we found there had been no audit on the prescription only medicines (POM) on one ambulance since July 2014.
- Records were maintained of the administration of any medication the patient report form (PRF) was used to record the administration of medicines. Details of any medicines administered were also verbally provided to the emergency department healthcare practitioner when handover took place.
- At the Huddersfield ambulance station the oxygen was stored on open racks within the main station and not securely stored. On one ambulance in North Yorkshire the oxygen cylinder was not securely stored and there were four loose cylinders on the back seat of a rapid response vehicle presenting a risk to anyone in the front of the vehicle if there was any sudden braking.

Records

- We reviewed 80 records and found them to be satisfactorily completed. The majority were clear and legible and followed the medical model.
- Staff at the receiving hospitals said the level of information at handover was appropriate. A copy of the patient report form (PRF) was provided to the receiving hospital and a carbon copy retained by the ambulance crew.
- In general the completed PRF records were managed safely and securely in the ambulances and were then transferred to safe storage at the ambulance stations. However in South Yorkshire we found that records were not always stored securely. On two ambulances we found confidential patient information and in one station, the box for confidential information was full and documents could be accessed.
- The standard of record keeping was also audited by the trust five records per month at each station were audited.

Assessing and responding to patient risk

Emergency and urgent care

- There were clear pathways for assessing and responding to patients involved in trauma and for patients suffering from chest pain and suspected stroke, which we found were being followed.
- Pre-hospital vital signs such as respiration, pulse rate, blood pressure, heart rate monitoring and the patient's condition were recorded on the PRF. Any changes or deterioration in a patient's vital signs and condition was used to inform the clinical decision making process and urgency of the situation.
- In the event of a patient's condition changing or deteriorating, systems and processes were in place for staff to seek specialist clinical support and advice from the clinical hub, whilst at the scene or in transit. The clinical support hub was staffed 24 hours a day seven days a week and had access to the crisis team and the medical incident commander.
- Ambulance staff told us if there were concerns over their own or other people's safety they would escalate the issues through to the control centre and seek support to stand back until assistance arrived.
- There was a system for staff to alert others to the need for assistance by pressing an emergency button on their hand held radios. Although one member of staff expressed concern that when they had been threatened by patient, they had pressed the emergency button to alert all crews that police were needed it took one hour for assistance to arrive. Another member of staff in a different area told us about an instance when they had requested back up from the police and this was not provided.
- The trust was rolling out a new system to ensure that a clinical supervisor attended a cardiac arrest incident, to ensure that there was as senior person present to act as the coordinator.
- Urgent care assistants were undertaking their role of transporting patients under low acuity calls and used a pre hospital early warning score to ensure that it was safe for them to transport the patient.
- We observed the handover of approximately 20 patients into the care of the emergency department healthcare practitioners. Handovers included brief details of the patient's medical history, medication regime, allergies, present condition and details of pre hospital treatments and observations. Staff reported there were really good relations with the police and that ambulances may transport patients under section 136 of the mental health act.

Staffing

- The trust had made some changes to the way staff were deployed and ways of working. We found this had not been well received by most of the staff we spoke with. However, we found it had been acknowledged by the trust that not all the initiatives had been successful, for example increasing the number of rapid response vehicles, and a further review had been undertaken and amendments were scheduled to occur in April 2015.
- Senior managers told us that core staffing rotas and skill mix for dual crew ambulances (DCA) was fixed, to include a paramedic or band five technician on every ambulance, working with a band three emergency care assistant. Rapid response vehicles were staffed by paramedics or paramedic practitioners. This was reflective of the rosters and staffing level that we observed.
- We found staffing rotas were planned six weeks in advance. Each clinical business unit had its own dedicated mailbox for staff to communicate work availability and raise rota queries with the resource team. Staff had a rolling shift pattern over a 12 week period. We observed in Harrogate that staff did not always go direct to the resource team as they were able to go to their clinical supervisor to address issues with their shifts. This put additional pressure on the clinical supervisors who were already under pressure from their other workload.
- Where gaps appeared in the rotas due to vacancies, leave or unplanned absence, the resource team were able to use staff on relief shifts or offer overtime in order to maintain the staffing numbers and skill mix. We also observed a clinical supervisor proactively working to ensure that a remote station was appropriately staffed while a paramedic was off sick. We were told the hours worked by staff were monitored through the electronic rostering system.
- During the course of our inspection we looked at staff resource and how the trust managed staffing resource across the areas. We did not observe any concerns about staffing numbers or skill mix.
- Staff expressed concerns about not having time to check their vehicle before receiving a call to attend; difficulty in getting their meal breaks, and; the need to work over at the end of their shift. We were told of occasions where staff had to travel for two hours to get back to their station for their meal break. This was

because they were unable to carry food on the ambulances and their meal was back at the station from which they started their shift. Staff also told us about times when they had had to work up to two hours past the end of their shift.

- From discussion with staff it was clear that there was a system for staff to either take the time back or be paid when they worked over their allocated shift time. There was also a compensation system for missed meal breaks which included payment and time back. Although we did speak to one member of staff who had not had a meal break the day before and had then missed their meal break that day as well.

- The trust had recently introduced a service called the urgent care team, whose role it was to respond to requests for transfers by General Practitioners and other health care practitioner. The plan was for these ambulances to be staffed by two band three urgent care assistants and while recruitment was on-going this could also be a band three emergency care assistant. The aim was that by providing this service, ambulance staff with a higher level of skill mix would be more available to attend emergencies.

- Staff were clear that two band three emergency care assistance should not routinely be allocated to an ambulance allocated for emergency calls, as they would not have the correct skill mix to attend an emergency. When this did happen they would be allocated to lower acuity calls where transport had been requested for example by a GP. If they were required to attend a higher acuity call it would be to provide transport where a paramedic was already on scene.

- There were in the region of 900 community first responders -volunteers that were trained to attend emergency calls and provide care until the ambulance arrives. The trust had around 200 community defibrillators available to be used by members of the public.

- It was our understanding that each area had at least one clinical supervisor on duty for each shift. In some areas they were covering an extended area as they were not enough of them due to colleagues being on secondment or off sick. They acted as the first point of contact for staff for daily management and clinical issues. They would also act as the bronze commander for incidents. Locality managers were trained to act as a silver level commander and worked an on call roster to provide 24 hour cover.

- A significant number of staff expressed concerns about the lack of understanding and knowledge of the skill levels of other grades of ambulance staff, for example emergency care practitioners, technicians and emergency care assistants.

Anticipated resource and capacity risks

- It was not clear that staff throughout the trust understood their role if a major incident occurred. In South Yorkshire one out of three staff were clear they understood their role and responsibilities. In West Yorkshire Staff we spoke with were aware of the trusts major incident procedures and how such incidents were escalated through to the trusts silver and gold incident command. In the Hull area and North Yorkshire we found front line staff had a limited knowledge of the trust's major incident plan and equipment.

- The trust had recently made pocket guides available for staff about their role in a major incident, however not all staff had received the books and some staff that did have them did not have them with them.

- The clinical supervisors we spoke with had received the relevant training to take on the role of a bronze commander in an emergency. Locality managers had been trained to take on the role of silver commander. They had also completed training specifically in relation to the Joint Emergency Services Interoperability Programme (JESIP). One hundred and eleven staff had completed JESIP Operational Commander Course; 39 JESIP Tactical Commander Course; 70 JESIP Control Room Manager and Supervisor Course; 221 JESIP E-Learning Package and 12 the JESIP Validation Exercises . It was not clear from the information provided how these numbers related to the number of staff identified as needing to complete these training sessions.

Professionally requested inter-hospital transport

- We spoke with staff at Doncaster Royal Infirmary and Northern General Hospital in areas that had requested or received inter-hospital transfers. A flowchart was in place to support the process. Staff were positive about the process and experience of inter-hospital transfers. This was reflective of the feedback we received at York Hospital, where we were told that the ambulance would arrive in an acceptable time frame and there were no concerns.

Emergency and urgent care

- The staff on the critical care unit at York Hospital told us that there was a standardised trolley for patient transfer and that this fitted on a 'standard ambulance' therefore enabling a safe transfer.
- Staff on the neonatal intensive care unit were also positive about their experiences of working with the ambulance service. They had a central telephone number to a service called 'Embrace'. They confirmed the time-scale for the transfer- urgent of non-urgent patients and had not experienced any significant delays with urgent transfers. The equipment used fitted on to a standard ambulance trolley.
- Medical consultants told us that in the event of a patient presenting at one hospital who needed urgent transfer to another hospital for specialist services there was never a difficulty in acquiring a nil delay transfer.

Professionally requested hospital to home transport

- We spoke with staff at Doncaster Royal Infirmary and Northern General Hospital in areas that had requested hospital to home transport. Staff were mostly positive about the process. A flowchart was in place to support the process.
- None of the staff we spoke within emergency department reported any concerns with requests from hospital to home transport.

> **Are emergency and urgent care services effective?**
> (for example, treatment is effective)
>
> **Requires improvement** ●

The service followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. The ambulance service was not meeting national target emergency response times for responding to life threatening conditions. Although for category A calls resulting in the arrival of an ambulance at the scene of the incident within 19 minutes the trust performed well.

Staff followed medical protocols in assessing patients and made effective use of other available protocols, standard pathways and relevant guidance. Patients experiencing a heart attack were transported quickly to hospital. Patients that had had a stroke had appropriate care but there could

be delays in their transport to hospital. The trust had mixed outcomes overall for the survival of patients who had had a cardiac arrest with low numbers of patients returning to spontaneous circulation (ROSC) at the time of arrival at hospital but good survival rates from arrest to discharge. Staff had a good understanding about consent and the Mental Capacity Act 2005.

Evidence-based care and treatment

- Information provided by the trust in the form of a paper titled NICE Guidance Implementation report to be reviewed by the Quality Committee June 2014 demonstrated that the trust monitored their position, progress and implementation of NICE Guidelines.
- The trust was using recommended documentation to review their compliance against the guidance. This was demonstrated by baseline assessment tool for NICE guideline on Head Injury: triage, assessment, investigation and early management of head injury in children, young people and adults (CG176). There were 26 recommendations identified relevant to the trust and the trust was compliant with 24. Action was being taken to ensure compliance with the last two recommendations.
- Staff had access to Joint Royal Colleges Ambulance Liaison Committee guidance, and where relevant this was included in the patient record form.
- Local audit activity was limited. The clinical supervisors remit included this but they were restricted due to the lack of time and other workload pressures.
- Emergency Care Practitioners (ECP's) did presentations at urgent care forums to share experience and learning with each other. For example one ECP said within the last year they had given a presentation on the use of antibiotics which had involved conducting clinical audit. This had led to a change in practice and reduction in the number of rarely used, stocked antibiotics.
- Some ambulances had resource files that included information on the sepsis screening tool; pre-hospital early warning score; paediatric triage tool; Situation Background Assessment Recommendation (SBAR) for stroke handover, Yorkshire acute stroke pathway; adult cardiac arrest checklist; and the urgent care alternative pathways – quick reference guide, which included a mental health pathway.

Assessment and planning of care

Emergency and urgent care

- Staff were able to access clinical advice by contacting the 'clinical hub' 24 hours a day, seven days a week. Staff in South Yorkshire reported that this worked well. In North Yorkshire while staff were positive about the support there were concerns over how long it sometimes took to get through on the phone. Staff would also contact the on duty clinical supervisor for advice.
- Ambulance staff followed clear protocols for assessing and responding to patients involved in trauma incidents, patients suffering from chest pain and suspected stroke.
- Staff were aware which location was the appropriate one to transport patients too particularly for those on specific pathways such as diabetes, stroke and chest pain. Staff in the emergency departments said they felt the ambulance staff had a good understanding of the pathways and access to other services.
- There were a number of alternative urgent care pathways in line with the recommendations of the Urgent Care Review 2013 by Sir Bruce Keogh. It was recommended that by treating patients at the scene and reducing conveyance rates the ambulance service would contribute to alleviating some of the pressures in emergency departments and offer a better service to patients. These had been developed through partnership working with other providers and included direct referral to specialist teams such a respiratory teams.
- Emergency Care Practitioners (ECP) supported crews to consider alternatives to hospital Emergency Departments (EDs). This included arranging direct medical or surgical admission to a ward, avoiding the Emergency Department. ECPs could assess and treat all age-groups of patients at home, school or work. In the Sheffield area we were told that service was also available to nursing homes and staff had a direct number to contact this part of the service.
- The patient record form (PRF) contained assessment guidance for ambulance staff to follow to identify patients with mental health problems. There was also a section within the PRF for assessing the patient's mental capacity and for obtaining their consent. At York hospital the mental health liaison nurse and consultant psychiatrist told us that liaison with the ambulance service was good.

Response times

- When a 999 call was made, it was triaged and assigned a category that determined the response. There were nationally agreed categories: Red 1 calls were for patients with cardiac arrest or who had stopped breathing; Red 2 calls were for other life threatening emergencies. Red 1 and Red 2 calls together were referred to as category A calls and the trust was expected to respond to 75% of these within 8 minutes. In addition, there was another national target stating that a vehicle capable of transporting a patient should arrive at the scene within 19 minutes in 95% of cases.
- In 2013-14 the trust had a mixed performance against the England average for Red1 calls but over the year performed better, particularly between July and November. In the first two quarters of 2014-15 the trust had performed worse than the England average rarely getting over 70% of Red 1 calls responded to within 8 minutes.
- The trust performance for Red 1 calls in January 2015 was 70.6% against an England average of 71.5%.
- In 2013-14 the trust performed slightly better than the England average, for response times to Red 2 calls only performing worse in quarter four. In the first two quarters of 2014-15 the trust started worse than England averages, however had started to match the England average at the end of quarter 2 with response rate of 70%.
- The trust's performance for Red 2 calls in January 2015 was 67.2% against an England average of 67.5%.
- For all category A calls resulting in the arrival of an ambulance at the scene of the incident within 19 minutes, the trust performed better than England average and did not breach the 95% target during 2013-14. The trust had also performed better than England average and did not breach the 95% target during the first six months of 2014-15.
- For the proportion of incidents attended that were managed without the need for transport to the emergency department, for 2012-13 the trust had a lower proportion than the England average by between 5-10%. Over 2013-14 the trust continued to have a lower proportion then England average but less than the previous year. For the first six months of 2014-15 the trust continued to have a lower proportion although reduced when compared with the two previous years.

Pain relief

Emergency and urgent care

- Patients were assessed for pain. Pain relief was provided in accordance with guidance and the staff member's competency. Staff gave examples of when they had contacted other staff in order for the patient's pain relief needs to be met.
- Pain relief is included as part of the overall assessment of the patient's conditions and pain relief management was recorded on the patients PRF records handed over to the ED healthcare practitioner.

Patient outcomes

- The Department of Health had a number of ambulance quality indicators for patients who may have a cardiac arrest or stroke emergency. The trust was better than expected for the number of stroke positive patients who received the appropriate care bundle. A stroke positive patient was identified as showing FAST symptoms. In August 2014 57.3% of patients arrived at a stoke unit within 60 minutes below the England rate of 60.4%.
- For ST segment elevation myocardial infarction (STEMI), which is a type of heart attack, the trust was the best performing trust for patients receiving an appropriate care bundle at 85%.
- 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. That is, reviving a patient when their heart had stopped. The highest performing trust was 40%. The trust was the second highest performing trust for the overall cardiac survival rate for patients who have a cardiac arrest survival to discharge. The trust performed similar to expected for the proportion of patients who received treatment in hospital within 150 minutes. Treatment was either primary percutaneous coronary intervention [PPCI], which is a surgical treatment for heart attack patients that unblocks coronary arteries carrying blood to the heart, or primary angioplasty, which is a surgical procedure used to widen blocked or narrowed coronary arteries.
- The rates of patients re-contacting the trust following discharge on the scene was consistently higher than the England average for 2012-13 by 2-3%. This improved in 2013-14 with the rates of patients re-contacting the trust following discharge on the scene falling below the England average of 5.6% to 4.6%. The rates continued to fall during the first six months of 2014-15 remaining below the England average of 5.2% at 3.8%.

- For the proportion of incidents attended that were managed without the need for transport to A&E over 2012-13 the trust had a lower proportion than the England average by between 5-10%. This information included patients discharged, after treatment at the scene or onward referral to an alternative care pathway, and those with a patient journey to a destination other than to A&E. Over 2013-14 and the first six months of 2014-15 the trust continued to have a lower proportion than the England average.

Competent staff

- Information provided by the trust showed that staff appraisal rates varied across the trust ranging from 9% to 100% for the time period December 2013 to November 2014. There was a mixed view from staff on the effectiveness of appraisals. In response to this the trust had introduced a new process whereby staff were allocated protected time for their appraisals and were then observed for the rest of their shift. All staff had been issued with a clinical framework portfolio file to be used as part of this process. This had only recently been introduced and although we received positive feedback about the new process it was not yet fully embedded in practice.
- In South Yorkshire where staff had had an appraisal they also had a development plan in place. Staff said this was useful and the clinical supervisor had spent time with them as part of this process which was considered to be valuable.
- However, we found that information displayed within Middlewood ambulance station showed that most of the personal development reviews were overdue. The information was last updated on 2 October 2014, of 192 staff, 51 had an up to date development review. The remaining ones were either out of date or unknown. We saw that 25 had not been reviewed since 2013; this included emergency care practitioners. A clinical supervisor confirmed that dates were planned but many reviews were out of date.
- In West Yorkshire over 76% of staff across had received an appraisal. In North Yorkshire one member of staff told us they had not had an appraisal for six years.
- We received mixed opinions from staff regarding the provision of clinical support and preceptorship for newly qualified paramedic staff. Some staff told us that there was no preceptorship programme for newly qualified

paramedics or for newly recruited trained paramedics. Others told us that staff completing their paramedic diploma struggled to achieve the required 700 hours of directed practice with a qualified paramedic.

- A number of staff also told us that access to clinical supervisors (CS) was hindered by them being too busy and not enough time was spent with team members. Some staff reported seeing their clinical supervisor for one shift in every 12 to 18 months. Others reported a lack of direct clinical supervision.

- There were also mixed views on the opportunities for further development in the trust. New emergency care assistants were being supported to complete a diploma based course. The emergency technician role was being phased out, some of these members of staff were being supported to undertake paramedic training as were the assistant practitioners, however there was competition to gain a place on courses and there were a limited number of places. Although we were also told by senior managers that not all the places were filled.

- Continuing professional development days (CPD) were advertised via email, on bulletin boards and through weekly operational updates. We received mixed opinions from staff with regards to CPD training and support. Some staff reported they were supported to attend whilst others reported having to attend in their own time. Some of the adverts for opportunities clearly stated that the participant would have to attend in their own time.

- The trust policy 'Support for Learning and Development (December 2014) clearly explained that there was a process in place to apply for support with CPD and that certain criteria had to be met for support to be considered. These included a completed performance development review (PDR) or appraisal with the learning opportunities clearly captured in a personal development plan (PDP). Therefore it was unclear how this could be applied proportionately when a large number of staff did not have a current PDR and PDP.

- All staff could access the "YAS 24-7" e-learning resource where additional volunteering training packages could be accessed other than the mandatory ones; however, staff reported that they rarely had time to access them whilst they were on shift.

- There was mixed views on the clinical update days provided by the trust. It was unclear if these were to be one or two a year. Staff reported that they were

frequently cancelled at short notice or if you were on a relief day you would get called in to work. Some staff told us that they had not attended one of these days for three to six years.

- Clinical supervisors were supported through a three day clinical supervisor course and a five day bronze commander role training, delivered by resilience team.

- New staff were positive about the support they had received including an induction, time to complete mandatory training and driver training relevant to their role. A new urgent care worker who joined the organisation in November 2014 said "I'm thoroughly enjoying it." An emergency care assistant, who had been with the organisation for two and half months felt that the support from their immediate colleagues was 'excellent.'

- The community first responders were expected to attend four group meetings and to have training every six months to maintain their knowledge and skills.

- We heard mixed views from staff on how supportive the organisation was. There were positive stories about staff being supported through difficult situations and return to work after periods of absences. For example there was a husband and wife on different rosters to ensure they were able to provide child care.

- However, there was also a number of staff feeling unsupported or pressured for example unable to take compassionate leave twice when both parents passed away in the same year.

Coordination with other providers

- Yorkshire ambulance service was a member of the critical care network and attended monthly meetings.

- The emergency departments and other wards at departments within the acute hospitals were positive about the coordination of care. The emergency department (ED) consultants we spoke with were all positive about the service provided by the trust and reported that the co-operation between front line ambulances and ED departments was good.

- The trust had locality managers who regularly met with the acute trust to work to ensure safe and effective patient care. The acute trusts were satisfied with the interaction and on the good outcomes achieved. In some areas such as Hull, the ambulance trust had placed a senior member of staff known as the Hospital

Emergency and urgent care

Ambulance Liaison Officer (HALO), in the hospital to work within the emergency department to help manage turnaround times. In other areas officers would attend as indicated by demand.

- Staff in emergency departments said that ambulance staff were good at pre-alerting them about high risk patients and patients who needed input from specialist services, for example when a patient had had a stroke. This helped the emergency department prepare for their arrival and alert other professionals when necessary impacting on the outcome for patients in a positive way. At York hospital we saw that this worked well for a patient who had had a stroke, with the stroke team already in the emergency department when the patient arrived.
- We were told by the trust that they did not use private providers to support the emergency service however, in the Hull area we were told that a private provider was being used for low acuity calls termed Green 4. It was unclear how the trust was assured that this was a safe and effective service.
- The trust had clear pathways and information was available to staff on where to transport patients to this included but was not limited to trauma cases, patients who had had a stroke, for those with chest pain or who had had a cardiac arrest and for mothers in labour.
- The midwifery pathway had been agreed in consultation with all trusts across the region. Staff at the acute trusts were positive about the relationship with the ambulance service.
- The trust was part of the Yorkshire & Humber Multi-Agency Section 136 Pathway Group. The aim of the group is to provide the best support to vulnerable people within communities through partnership working to improve sharing of relevant information across service, development of effective service models and support to enable appropriate cost-effective commissioning of the Section 136 pathway.
- Staff in the hospital coronary care departments were positive about the relationship with the ambulance service. There were clear pathways in place and staff felt that these were well implemented.
- Telephone conferences referred to as 'silver level conferences' took place daily. Representatives from the hospitals and the clinical commissioning groups took part in these calls. The aim of the call was for there to be a general update of activities and pressures across the local health economy. This enabled trusts to be

informed of any possible on effects on services. If there was a potential problem that would impact on the ambulance service the locality manger would escalate this to the head of operations so that plans to manage the situation could be put in place.

Multidisciplinary working

- We spoke with staff with the emergency departments and other departments of the acute trusts, such as maternity services who received patients from the emergency ambulance service. Staff spoke very positively about the handover from the ambulance staff. One senior member of staff commented how this had improved over the past year.
- The ED staff we spoke with commented positively about the caring and professional delivery of care to patients by ambulance staff. They reported close working relationships and effective communication between both groups of staff. We observed handover of patients to the emergency department staff. We saw these were clear and comprehensive.
- Staff gave us examples of how they had liaised with patients' GPs when they were not transferred to hospital to ensure they accessed the right services.
- Emergency department consultants reported that the ambulance service provided an excellent service and there was good engagement between the services to ensure the cardiac programme, stroke pathway and major trauma systems operated with minimal problems.

Access to information

- There was a special notes resource incorporated into the Computer Aided Despatch (CAD) system used by the trust. This enables 'flags' to be recorded that can be used to safeguard both staff and patients and improve the quality of the service. Flags were categorised into violence, medical, safeguarding, access or locations requiring police attendance.
- The trust did not routinely flag patients with 'Do not attempt cardio pulmonary resuscitation' (DNACPR) orders on the dispatch system. This was because of the risk of delaying an ambulance response to other patients at the address or causing confusion. Children with specific End of Life Care plans were flagged on the system and on a case by case basis an adult may be flagged if clinically indicated.

Emergency and urgent care

- Staff we spoke with about DNACPR decision orders were clear about the procedures to follow in respect of managing these orders. We observed staff handing communicating patients' DNACPR wishes during hand over at the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff gave examples of how they implemented the mental capacity act and supported patient's decisions. Staff we spoke with said they obtained consent, as appropriate, prior to providing care. Staff demonstrated a good understanding of 'best interest' decisions.
- The PRF included a section for recording consent to treatment had been obtained from the patient and or their relatives acting on their behalf. There was also a section for an assessment of a patient's mental capacity and consent on a separate form if they refused treatment or transportation. We saw that staff completed this section and ensured the patient had capacity to make decisions before it was agreed that they would not be taken to the ED.
- Some ambulance staff expressed concern regarding the lack of up to date training on Mental Capacity. Although an e learning training package was available.

Are emergency and urgent care services caring?

Good 🟢

Patients were treated with compassion, dignity and respect by ambulance staff. Staff explained treatment and care options in a way that patients could understand; they explained and involved patients in decisions. Patients were supported to manage their own health by using non-emergency services when it was appropriate to do so. Patients, their relatives and others received emotional support when experiencing distressing events, including when someone had died.

Compassionate care

- The trust had a dignity code which stated that to treat someone with dignity is to treat everyone as being of worth, in a way that is respectful of them as valued individuals.

- Patients were treated with compassion, dignity and respect by ambulance staff throughout our inspection. For example we observed staff transporting a patient from the ambulance to handover in the emergency department. They were compassionate and caring towards the patient and their family and had an excellent rapport with staff. Ambulance crew maintained dignity of the patient when transferring from stretcher to a cubicle bed. They spoke to patients in a caring and respectful manner. There was clear mutual respect between ambulance crews and nursing staff. They worked together as a team and communicated well with waiting relatives.
- All the patients and relatives we spoke with were very positive about the compassionate care they had received.
- Patients were kept covered to help maintain their dignity. Some patients described how they had been transferred to the ambulance by chair in a dignified manner.
- A patient told us "ambulance crew brilliant, fast, caring and made me feel better, I cannot praise them enough."

Understanding and involvement of patients and relatives

- Staff explained treatment and care decisions in a way that patients could understand and included them and or their relatives in decisions about their care and treatment and why they needed to be conveyed to hospital.
- We observed staff attending to one patient. The staff were caring and compassionate. They explained everything to the patient in calm, quiet voices. The patient said "I've never had less than five star treatment by the ambulance service."
- All the patients we spoke with said that staff explained what was happening and offered patients choices, such as being transported to the ambulance using a chair. A young person told us that they had been well treated and felt in control and aware of what was happening.
- In the Yorkshire Ambulance Service - A&E Service User Experience Survey Report for April 2014 to November 2014 for the question 'I understood my care and treatment' the trust has scored 95%. For the same time period 92% would recommend the service to a family member or friend.

Emotional support

Emergency and urgent care

- All the patients we spoke with said that staff constantly reassured them. One patient said "they made me feel better."
- Ambulance staff consistently showed patience and sensitivity to the needs of patients who were particularly anxious and vulnerable. We also observed them reassuring relatives during what for them was a distressing period of time.
- A patient said, "The crew were first class I felt involved which helped me emotionally." A second patient told us "The ambulance staff were wonderful, kind and sympathetic. I hate to be a nuisance but they came quickly."
- We observed a good example of support when a patient died. Staff were observed to be very compassionate and caring, performing their duties while also caring for the neighbour and relatives. We saw staff were particularly caring they put a pillow under the deceased's head and covered them with a quilt to make them look more comfortable for when the relatives saw the patient.

Supporting people to manage their own health

- When it was appropriate to do so, ambulance staff supported patients using the emergency service to manage their health by using non-emergency services. The trust facilitated alternative pathways for patients who, once assessed, did not need hospital treatment. These included ambulance staff referring to the emergency care practitioner who would then refer patients to other professionals or medical centres such as GPs, pharmacists or treatment centres.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

Requires improvement ●

Dedicated equipment was available to be used when a patient was obese, however we were not able to establish where these ambulances were based and staff gave us examples of situation where patients' dignity had to be compromised for their own safety as the equipment had not been readily available. Information on how to communicate with people for whom English was not their first language was not routinely available. The trust was

dealing with a steady number of national emergency calls. The trust had a reducing number of calls where the patients were not conveyed to hospital. There was an established process for the handling of complaints but there was no evidence of learning from complaints and staff received little feedback in relation to complaints.

Service planning and delivery to meet the needs of local people

- The trust had five specific vehicles which had an enhanced range of equipment available for patients considered to be bariatric or obese. This included but was not limited to a patient hoist, a bariatric spinal board, a carry chair and collars and splints. This was in addition to support which was available from the Hazardous Area Response Team (HART), a team comprised of specially recruited and trained personnel. Wwe were unable to establish where these ambulances were based and the utilisation of these vehicles within the trust was not clearly defined.
- These had been introduced as an improvement beyond the basic capability of the existing fleet. However staff told us that these ambulances were not always able to respond in a timely way for emergencies and described incidents where the patient's dignity had had to be balanced with the need for emergency care. One incident related to a patient who had arrested at the top of a flight of stairs and they had to be carried by staff as the equipment was not available in a timely way.
- Over the peak winter period the clinical support hub consisted of specialist Mental Health and Social Care advice directly to assist front line staff to meet the needs of local people.
- A general ambulance would be used to convey patients under section 136 of the mental health act. However, staff were unclear as to how quickly a response should be made to such a call.
- Emergency departments were equipped with an electronic monitor indicating the number of ambulances on route. The system was also used for the ambulance staff to book in on arrival at the department. The information for the system was used to monitor the activity at the site and the time ambulances were staying at the department. This information could be used to monitor targets and any pressure on the system.

Emergency and urgent care

- In some areas we found emergency care practitioners were working with care homes to review patients to establish if they needed to be conveyed to hospitals or cared for by another practitioner in the community

Meeting people's individual needs

- A translation service was available which could be accessed by telephone, but some staff were not aware of this. Other staff said they used the translation service or they were assisted by family members.
- Some staff had translation booklets, with key phrases which they found very useful. We were told these were issued individually and not all staff had access to them.
- We saw booklets regarding people with learning disabilities and easy read/pictorial aids. These were found in an office. Staff confirmed they were not used on the ambulances.
- Many ambulances had logos indicating they were 'Dementia friendly.' We asked staff about this and they told us were unaware of the stickers and had received no training. The Trust told us they had pledged to ensure that all staff would receive Dementia Training by March 2017 and had an action plan in place to support a series of Dementia Friendly services
- The PRF contained assessment guidance for ambulance staff to follow to identify patients with mental health problems. There is also a section within the PRF for assessing the patient's mental capacity and for obtaining their consent. We saw these areas were consistently completed within the patients PRF we looked at.
- Information was available for staff about end of life care and caring for people living with dementia. There was an end of life care learning resource for ambulance staff available in the ambulance stations. This included information on how to manage DNA CPR orders and limitation of treatment orders for children. The resource also included basic information about different religions and spiritual considerations. There was also a resource about dementia.

Access and flow

- We were told by the staff at the acute trusts that there had been excellent work achieved in establishing open communication and improving handovers of patients brought to the hospital especially on the special pathways for myocardial infarction, stroke and major trauma.

- In 2013/14, the trust had 14.6% of all Red 1 calls in England and 9.1% of all Red 2 Calls in England. The trust had been dealing with a steady number of calls since 2012; in April to September 2014, the trust had 15% of Red 1 calls and 9.3% of Red 2 calls in England.
- Calls closed without transport were the number of emergency calls that received a telephone or face-to-face response from the ambulance service. For the trust there had been a reduction in these types of calls. In 2013-13 just over 9% of all national emergency calls that received a telephone or face-to-face response from the ambulance service were received by the trust. For the year 2013-14 the proportion of calls across England received by the trust stayed around 9% but dropped in the last month to 7.5%. For the first two quarters of 2014-15 the proportion of calls across England received by the trust dropped in the last six months from just over 9% to 7.5%.
- We observed that the response time for calls was monitored and call escalated if required. For example a call originally graded as low acuity call Green 4 was for a patient waiting to transferred from home to the hospital was up graded to a Green 2 to ensure transportation took place when the patient had been waiting for over four hours.

Learning from complaints and concerns

- The trust told us that people were able to give their feedback in a variety of ways. This included by telephone, email, in writing, via the trust external public website or by using a paper feedback form. People could also give their feedback to a member of staff or volunteer face to face, who would ensure it was handled in accordance with the person's wishes.
- The key performance indicators for compliments, comments, concerns and complaints were included in the monthly board integrated performance report. The quality committee reviewed the handling of complaints and compliments and any themes within them on a bi-monthly basis. The clinical governance group received a regular report every four months highlighting trends and themes and identifying strategic actions to address. The incident review group reviewed all complaints which were graded red or amber. The group would direct the investigations and request any additional clinical overview, or trust wide learning, as required on each individual case.

Emergency and urgent care

- Complaints were handled by patient relations co-ordinators. The co-ordinators would risk assess and grade each complaint and progress the investigations for all green graded complaints. All Ombudsman or re-opened complaints were allocated to the patient relations manager, as was any complaint which was reported as a serious incident.
- The trust had an internally agreed response standard of 25 working days. The trust had managed to achieve this standard in only approximately 60-70% of cases and as a result, the policy was reviewed. The revised Policy for Managing Compliments, Comments, Concerns and Complaints has taken this into account and the new standard was for an overall average target response time of 25 working days with a range of target response times from 10-25 working days for a concern and up to 65 working days for those complaints which were also serious incidents.
- The trust said that learning from individual complaints was identified and implemented on a case by case basis. We were told that learning was recorded within the individual case records and themes were generated and reported through the clinical governance group and assurance provided to the quality committee and trust board through the 'Lessons learned' reports.
- Minutes of the quality committee June 2014 reflected that there was a monitoring system which noted there had been a decrease in the number of complaints received about the attitude of operational staff.
- The trust said that information about how to give feedback was made widely available via posters in vehicles and patient reception centres and on the trust external public and internal websites. Leaflets including feedback forms will also be made available at all reception points. None of the ambulances we inspected had information for patients regarding how to make a comment or complaint. Staff said they would direct patients to the website.
- We found little evidence of learning and feedback from complaints being cascaded to all staff. Staff said they only received feedback about complaints if it related to them.

Are emergency and urgent care services well-led?

Requires improvement ●

While the trust had a vision and strategy' front line staff were not clear about what this was and were not engaged with the trusts vision and strategy for the service. Staff did not feel valued or listened to. Staff were positive about the direct local leadership but felt that there was a lack of consultation and consideration of how things worked on the frontline at a higher level. There were systems in place for monitoring performance against national targets and indicators and internal expectation such as mandatory and statutory training. Although staff were only aware of their performance against national expectations. Staff spoke positively about the high-quality care and services they provided to patients and relatives but a lot of staff were unhappy, they felt they were not listened to. Feedback from patients was generally positive but the outcomes from staff engagement supported the low morale.

Vision and strategy for this service

- Information about the organisation's values was displayed on noticeboards within the ambulance stations and communicated through operational updates.
- In discussions and observations, it was evident that all staff displayed the values of the organisation. Staff showed in their conversations with both patients, relatives and other healthcare professionals, a drive for quality and safety.
- However, many of the staff we spoke with felt they were not listened to or engaged with within the wider organisation. They were not clear about the vision and strategy for their part of the service. Others said that the executive team had a vision for the service, but did not have an understanding of what it was like to work in the service.
- Formal team meetings were not arranged. However the Locality Director in West Yorkshire told us they undertook a series of monthly informal open surgeries at ambulance station across the area to provide staff with an opportunity to share information and for senior managers to provide feedback on organisational change. Staff attendance at the surgeries was reported to be very variable.

Emergency and urgent care

Governance, risk management and quality measurement

- Performance against national targets were displayed in each ambulance station, so staff were able to see how they were performing, however besides national targets, staff were unclear of how success was measured.
- While we were told there were risk registers staff were unaware of what was included on the risk register and if any of the entries were relevant to them and their work.
- We reviewed the risk register for emergency and urgent care. The information included the level of current risk and the level of risk they were aiming for, along with a judgment on how adequate the control measures were. We noted that some of the risks recorded on the register had a risk rating higher than they were aiming for, yet the controls were judged to be adequate. We told that this was because indicators of whether the existing controls plus the additional mitigating actions to address gaps in control are adequate to deliver the desired residual risk. This means that a risk can be high but controls adequate. For example one relating to operational demand the risk rating was red but the control was judged to be adequate.
- Dashboards were used to monitor performance by clinical business unit. The information included performance; demand; resource; RRV's; operational ambulance quality indicators; clinical ambulance quality indicators; complaints/concerns; compliments; serious incidents; statutory & mandatory training and appraisals or PDR's. Local mangers would be aware of the performance of their area, there was also an oversight of local risk and the management plans

Leadership of service

- Local leadership teams for the service comprised of Head of Emergency operations, Locality Managers and Clinical supervisors. Clinical supervisors were managed by locality managers. One locality manager we spoke with, had 11 direct reports. Clinical supervisors provided local leadership. Clinical supervisors had 16 -18 direct reports.
- The majority of staff felt that local leadership was good. Most staff spoke positively about the clinical supervisors and their accessibility. Some staff told us that access to clinical supervisors (CS) was hindered by them being too busy and not enough time was spent with team members.

- Both clinical supervisors and locality managers identified they had large workloads and were unable to support staff as planned with supervision, training and appraisals. Clinical supervisors described how they were filling in the gaps of the service, such as delivering equipment.
- Staff reported a lack of involvement and consultation with changes to service provision at both local and regional level.
- Staff felt that direction from senior leadership was inconsistent. For example, guidance on meal breaks was issued then withdrawn, then a different version reissued. We heard comments from staff which included; "poor communication; staff do not trust management as no communication; staff could not name key executive members; no point in feeding back to management as they are not interested".
- A student paramedic working with their paramedic mentor said they felt supported at a local level and "enjoyed the job, meeting people; can make people better"; however "Get treated as slave to the regime; regularly miss meal breaks; not much communication from the trust."
- We were told that a clinical leadership program was due to commence shortly.

Culture within the service

- Staff at all levels recognised there was a split in the culture. Some staff were satisfied and most said the enjoyed the work they did. Staff spoke positively about the high-quality care and services they provided to patients and relatives but a lot of staff were unhappy. They felt they were not listened to and some staff within South Yorkshire and the Hull area felt they were 'forgotten' by the senior management team at headquarters.
- Ambulance staff told us they generally enjoyed their job although they felt their work/life balance was compromised by over-running shifts, confusion regarding annual leave and meal breaks.
- Most of the staff we spoke with were frustrated that they could see what was needed to improve but the systems and support were not in place.

Public engagement

- The trust conducted a monthly survey to obtain feedback on the patient experience. Paper surveys are

posted to a random 1% sample of addresses from which 999 calls were made in the survey period. Alongside the postal survey, the web survey (same questions) was constantly accessible online.

- The trust said that in order to promote the survey notices are displayed in all the ambulances informing and encouraging patients to provide feedback about the service. We did not see any of these notices in any of the vehicles we saw.

- Feedback from the November 2014 survey was mainly positive and included the comments such as; "paramedics were wonderful, caring and reassuring, the service was extremely efficient and effective." However one comment highlighted the time it took the ambulance to arrive was unacceptable.

Staff engagement

- Many of the staff we spoke with said they felt disengaged from the trust. There were differences in how visible the senior management team were across the trust.

- The executive team reported that they undertook 'listening watches' and this was confirmed when one member of staff told us that executive team had recently been out on an ambulance in South Yorkshire.

- The staff forum had recently been instigated, correspondence was via emails and we saw examples of these on the notice boards in ambulance stations.

- The trust, through a third party, did undertake staff surveys called pulse surveys however we were told that staff often chose not to complete the survey.

- In September 2014 as part of the staff friends and family test 1600 staff were contacted. A total of 159 staff responded representing at return rate of 12% which was 6% down on the previous quarter covering April to June. For the question 'How likely are you to recommend the Trust to friends and family if they needed care or treatment?' the score was 79%. For the question 'How likely are you to recommend the Trust to friends and family as a place to work?' the score was 43%.The comments relating to feedback on the trust as a 'place work' highlighted a pattern of references to low morale, long working hours and lack of support from managers.

- In the 2013 staff survey the trust was in the bottom rankings when compare to the other ambulance

services for support from immediate managers, which was 3.13 compared to 3.16 (Higher score the better) and Staff job satisfaction, which was 3.22 compared with 3.23 (Higher score the better).

- The trust were in the top ranking results when compared to other Ambulances Services for the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months, which was 22% compared to the average of 28% (lower score the better); percentage of staff believing the trust provided equal opportunities for career progression or promotion, which was 73% compared to the average of 68% (higher score the better); Percentage of staff experiencing discrimination at work in last 12 months, which was 15% compared to the average of 20% (lower score the better); percentage of staff appraised in last 12 months, which was 75% compared with 67% (Higher score the better) and the percentage of staff suffering work-related stress in last 12 months, which was 47% compared with 50% (lower score the better).

- A team brief was issued monthly and a weekly Operational Update bulletin. Staff said they received information mostly by email but did not have time to read it. We saw the team brief was on noticeboards in ambulance stations.

- Staff told us they were aware that unions and staff side were often in conflict with the executive team and directors.

Innovation, improvement and sustainability

- In the Hull area the Head of Emergency Operations sent commendation letters to staff who have achieved Return of Spontaneous Circulation (ROSC) which has resulted in a patient's life being saved.

- We saw that clinical supervisor and research fellow had published some of their work relating to the scope of observational pain scoring tool in the journal of paramedic practice.

- Peers could recognise good practice in others by submitting a document through the YAS 24-7 e-resource.

- The trust was rolling out a new system to ensure that a clinical supervisor attended a cardiac arrest, to ensure that there was as senior person present to act as the co-ordinator.

Patient transport services (PTS)

Safe	**Requires improvement**	🟠
Effective	**Requires improvement**	🟠
Caring	**Good**	🟢
Responsive	**Requires improvement**	🟠
Well-led	**Requires improvement**	🟠
Overall	**Requires improvement**	🟠

Information about the service

Patient transport services (PTS) provide non-emergency transport for patients who are unable to use public or other transport due to their medical condition. This includes those attending hospital, out-patient clinics; being admitted to or discharged from hospital wards and needing life-saving treatment such as chemotherapy or renal dialysis.

Yorkshire Ambulance Service (YAS) PTS road operations team is made up of 467 specialist vehicles and 758 staff. PTS make around 886,312 journeys transporting patients across Yorkshire and neighbouring counties each year.

The PTS communication centre supports the frontline operational staff by dealing with all aspects of booking through to transportation. The service is supported by 19 on site patient reception centres (PRCs) and liaison officers within hospitals across Yorkshire.

We inspected the North, South, East and West Yorkshire PTS service. We spoke with 60 patients or their carers and 90 staff which included PTS crew, volunteers, call centre operation staff, maintenance staff and PTS managers. We spoke with 18 hospital staff whose patients used the service and checked 22 PTS vehicles. We also looked at performance information provided by the trust.

Summary of findings

Overall YAS patient transport required improvement in safe, effective, responsive and well-led and was rated as good for caring.

Procedures to ensure the safety of services needed to improve, specifically around incident reporting and equipment checks. Systems for the maintenance and replenishment of vehicles were not always timely which meant vehicles were regularly off the road impacting on journey times. Arrangements were in place to respond to emergencies and the service took account of seasonal fluctuations in demand, the impact of adverse weather or disruption to staffing.

The trust was not meeting all its performance targets particularly for renal dialysis patients and this was having an impact on patients' care and treatment. There were staffing vacancies and staff felt stretched, particularly in the communication and control centre where this had an impact on the planning and scheduling of transport.

PTS staff was caring, compassionate and dedicated to improving the service. Complaints procedures and systems to give feedback when things went wrong were not fully understood by patients or staff. The trust had a strategy for the development of PTS to support safe non-emergency travel between people's homes and healthcare settings, but most staff was unaware of this strategy. There were systems in place to monitor risks,

Patient transport services (PTS)

quality and performance. However, risk management processes were not fully embedded across all regions and the quality of identifying, reporting and learning from risks was variable.

Are patient transport services safe?

Requires improvement 🟠

There were systems in place for staff to report incidents however this was not fully embedded in all areas and the safety infrastructure was variable in supporting continuous learning. Most staff had received mandatory training. Equipment was not being checked consistently across all regions. Standards of cleanliness and hygiene were maintained and staff were aware of infection prevention and control issues. There were systems and processes to ensure patients were safeguarded from harm and abuse.

Systems for the maintenance and replenishment of vehicles were not always timely which meant vehicles were off the road, impacting on journey times.

There were staffing vacancies in some areas and staff felt stretched, particularly in the communication and control centre where this had an impact on the planning and scheduling of transport. Active recruitment drives were taking place to increase staffing numbers.

Arrangements were in place to respond to emergencies and the service took account of seasonal fluctuations in demand, impact of adverse weather or disruption to staffing.

Incidents

- In the Department of Health NHS Survey 2013, 79% of staff had reported errors, near misses or incidents witnessed in the last month; this was within expectations compared with other trusts.
- Incidents were reported using the trust's web based incident reporting system. Most staff told us they could report incidents using the Personal Digital Assistants (PDAs) or were able to call a dedicated incident line at the emergency operations centre.
- Staff provided examples of reporting incidents which caused actual harm however there was limited understanding of defining and reporting near misses and non-harm related incidents. Some staff in the control centre said they had not received training in incident reporting. However, there was incident training included in the trust's mandatory training workbook issued to staff.

Patient transport services (PTS)

- Most staff said they received an automated email acknowledging receipt of the incident report however not all staff said they received feedback about the actions taken to minimise recurrence of harm. We reviewed a sample of incidents which showed recommendations had been shared in PTS team briefings and one incident was used as a case study during staff training.
- There was one serious incident reported for PTS in August 2014 which related to a patient fall. Records showed a comprehensive investigation using root cause analysis tools was completed and submitted to the commissioners. The recommendations included communication to staff reminding them of their responsibilities for securing patients in vehicles - minimising risks prior to and during the movement of patients and additional training. Team leaders in South Yorkshire confirmed they were aware of the recommendations and had shared this learning with staff.
- Information on the safety thermometer for January 2015 indicated two of the reported falls were being investigated due to the severity of the fall. One of the falls had not been reported and had been brought to the trust's attention via a complaint. There was information on the safety thermometer sheet which reminded staff to report incidents as soon as possible.
- There were 98 incidents reported for PTS. The majority of which related to access, admission, transfer and discharge (Source: NRLS April 2013 – May 2014). We reviewed three incident investigation reports which showed action had been taken to make improvements. These included review of vehicle risk assessments, changes to guidelines and learning outcomes and improved communication with patients and hospital staff.
- The Associate Medical Director told us there had been no safety alerts issued by the Central Alerting System (CAS) that specifically related to PTS.

Mandatory training

- Most staff said they could access mandatory training and the training was of a good quality. However staff in some of the regions had limited access to computers for on-line training. Although most stations had access to

computers PTS staff said these were mainly used by emergency crews. Part time staff also said they found it difficult to complete their mandatory training due to operational pressures.
- In some areas we found staff groups such as mechanics were unable to access regular training to remain up to date with manufacturers' updates. Fleet staff told us when training was organised there were no 'backfill' arrangements to enable them to attend.
- Trust data for September 2014 showed completion of statutory and mandatory workbooks was below the trust target of 95%. However, these figures did not correspond with PTS internal records of completion and submission, which the service attributed to delays in entering completed workbooks onto the system.
- Staff received a three day Approved Driving Instructor ADI course. Records showed PTS had completed the required driver training.

Safeguarding

- There were processes in place to safeguard people from abuse. The safeguarding policies and procedures were understood by staff and procedures were co-ordinated with other agencies so people's protection plans were implemented effectively.
- Staff gave examples of how they had identified concerns about patients at their homes and had taken a proactive approach to safeguard people at risk of abuse.
- A trust report for December 2013 showed 49 safeguarding referrals (adult and children) had been made to social care by PTS.
- Training records for September 2014 showed 97% and 96% of staff had received safeguarding training for children and vulnerable adults respectively.

Cleanliness, infection control and hygiene

- Yorkshire Ambulance Service used a generic infection prevention and control annual action plan, policy and procedure which was available and accessible to staff and crew on the trust's intranet.
- Vehicles appeared visibly clean and tidy. However, some staff said on occasions they had difficulty in cleaning vehicles because they did not always receive protected time at the start of each shift.
- A deep clean of vehicles was carried out every 28 days by a dedicated team. Records showed deep cleaning schedules were up to date. Trust data showed vehicle deep cleaning for April – September 2014 was above the

Patient transport services (PTS)

trust target of 95%.Observations during the inspection showed staff wore appropriate personal protective equipment when required, and adhered to 'bare below the elbow' policy. Some staff wore wrist watches. We were told these were waterproof and washable however the trust policy did not contain guidance on how often wrist watches should be decontaminated or cleaned.

- This was not in line with current best practice which consider that bare below the elbows means that all staff in contact with patients could effectively decontaminate their hands and wrists between each episode of patient care or contact which is not possible to do properly when wearing cuffs, watches and/or jewellery.
- Gloves were available on vehicles, however in the North Yorkshire we did not see any spill kits for contaminated waste and staff were not aware of these being available.
- Team leaders carried out ten infection control audits per month within their own teams. Audit results were displayed in ambulance stations and crews were aware of the results. The infection control audit for October 2014 showed hand hygiene and cleanliness of vehicles were better than the trust target of 94%.
- PTS staff was able to obtain advice and support regarding infection control issues from their team leaders and the trust infection prevention nurse.

Environment and equipment

- Staff completed a vehicle check at the beginning of each shift. This was recorded on the PDA. Any faults were reported to team leaders and raised with fleet maintenance. Defects which took the vehicle off road (VOR) were addressed quickly. For example, during the inspection a vehicle breakdown was reported and repaired by the mobile mechanic within the hour. Records showed MOTs were all in date.
- In the Harrogate team records showed two services and eight safety checks were overdue.
- In some regions staff said there were delays in accessing vehicle repairs for minor defects. We looked at a sample of records which showed repairs for minor faults were completed within four to seven weeks.
- Records showed oxygen piping in vehicles had been serviced within 12 months. In North Yorkshire some staff were not aware of the servicing frequency for tail lifts, wheelchairs, carry chairs and fire extinguishers. We saw no labels on the equipment confirming the service history.

- All staff spoken with commented on the age of the fleet and said there were insufficient vehicles available because they were often off the road for repairs. The PTS fleet dashboard for all regions showed the percentage of fleet vehicle available between April – September 2014 was 96%; this was in line with the trust target of 95%. However more recent data showed targets were not being achieved in all areas. For example in Harrogate availability was 88% in January 2015.
- Minutes of the October 2014 PTS operations group showed discussions about the planned servicing project with fleet and how it could be made more efficient. The group acknowledged every area was working differently with planned servicing and the need to have a generic system. The project launch was due in April 2015.
- The trust had a five year fleet strategy which described how the service would configure its fleet in the future and this was aligned to its workforce plan. Risk of operational inefficiency and increased cost due to high VOR rates was identified on the PTS risk register. A task and finish group had been implemented to develop a fleet replacement programme - a business case for new vehicles had been submitted to procure 85 new vehicles in 2014-15.
- Some staff said they frequently reported problems with PDA network connections, the accuracy of maps, failure of batteries and issues with devices holding charge. The trust had identified the age of PDA devices as a risk and was reviewing the age of equipment and the number of available licences. In the event of connectivity issues staff were issued with paper log sheets to record patient information.

Medicines

- PTS vehicles did not carry any medicines for emergency purposes with the exception of oxygen.
- Staff said they did not administer or manage patients' own medicines.
- A procedure was in place for the safe administration and recording of oxygen therapy. Staff reported patients requiring oxygen during transport travelled on a double crewed vehicle which allowed the attendant to observe the patient. Only trained patient transport staff were authorised to carry out oxygen interventions.
- We found one oxygen cylinder was two years out of date. We raised this with staff and the cylinder was replaced immediately.

Patient transport services (PTS)

- The matter was brought to the attention of the trust pharmacist and guidance was amended to include the requirements for expiry checking which would be ratified at the next meeting of the Medicines Management Group.

Records

- Patient records were held electronically and contained information about the patients' medical history and risk assessments which were available for staff to access on their PDAs. The PDA system was linked to the trust's system and provided up-to-date information on people who used the service.
- Patients who had an end of life care plan were identified on the PDA system. The system sent a series of messages reminding staff of the patients Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) status and asking them to confirm the relevant document had been seen. The system provided an audit trail to evidence checks had been made prior to transporting the patient. Staff demonstrated an awareness of the relevance of the DNA CPR policy to their scope of practice.
- The PTS crew told us they did not usually handle patient's records, but if there were any changes to the patients' health during transfer the crew shared information with the receiving hospital when handing over the patient.

Assessing and responding to patient risk

- There was a clear pathway to manage patients who became ill during their journey. Staff told us if the condition was life threatening they would inform control and request an emergency ambulance for assistance.
- Risk assessments were carried out by team leaders. We saw an example of a home visit assessment for a patient who had specific mobility needs and required a wheelchair.
- Mandatory training records showed 94% of staff had completed adult basic life support and 95% child basic life support training which was in line with trust targets.
- Patient slips, trips and falls were identified as a moderate risk. Falls and injuries in transit were included in the safety thermometer dashboard and were a focus for the trust to reduce the number of falls. A comprehensive fall prevention and awareness learning

resource pack was available for staff. A series of questions formed part of the first stage of a multi-factorial falls risk assessment which was then followed up by the falls team.
- We saw the safety thermometer data for January 2015. There had been 4 reported falls across the trust in PTS services two of which were being investigated due to the severity of injury.

Staffing

- Performance reports showed staffing numbers and skill mix were reviewed on a regular basis and escalation plans were in place should staffing levels fall below the agreed roster. During November 2014 there was a 9.37% vacancy rate across the service. The service was actively recruiting with monthly recruitment drives. A recruitment centre was planned for 24 January 2015 and the trust had invited 120 people to attend.
- Staff in East and South Yorkshire said there was not always enough staff on duty to meet the demands of the service and staff struggled to hit their targets at times.
- There were staffing vacancies in the communication and control centre and staff felt stretched. A self-referral booking service had been introduced for patients accessing services in North Yorkshire which resulted in additional demands on staff. Trust information showed 115 whole time equivalent funded posts covered all aspects of communications and control including call handlers, patient reception centre staff, deployment schedulers and management team. As of February 2015 there was 101 whole time equivalent staff in post which left 14 whole time equivalent vacancies. Managers told us they were actively recruiting and posts would be filled by the end of March 2015.
- The trust used less than 1% agency and bank staff across the organisation.
- There were over 80 PTS volunteer drivers across the Yorkshire region. Drivers were home based and only had contact with bases for their reimbursement of expenses and equipment. Volunteers attended local induction training and on-going refresher training as required.
- 80 apprentices were currently in the Trust of which over half of them were in PTS.
- PTS staff were aware of the lone-worker policy and said any concerns would be reported to their team leader.

Anticipates resource and capacity risks

Patient transport services (PTS)

- A PTS business continuity plan was in place which followed the principles and structure required under the Joint Emergency Services Interoperability Programme (JESIP). This was a two-year programme aimed to improve the way in which police, fire and ambulance services worked together at major and complex incidents. PTS crews said they could be asked to transport patients from an incident to hospital once assessed by a paramedic.
- There were plans to manage and mitigate anticipated risks, including changes in demand, disruptions to staffing or facilities and seasonal weather. A winter plan for 2014-15 showed clear pathways were in place to maintain service delivery including staff rotas where resources were dedicated to a particular service; for example to provide discharge services and any services that provided admissions or inter-site transfers or were connected to hospitals being able to manage their bed capacity.
- PTS managers assessed priority patient movements which required access to essential treatment. These journeys were identified as being 'unable to remain undelivered' for any longer than four hours; for this reason the journeys would be conducted in all but the most extreme circumstances.
- Routine movements such as general out-patients worked to a different schedule in the event of normal service interruption and it was expected these journeys could remain undelivered for at least 24 hours pending regular review.
- If there was a need to suspend routine or general out-patients in the wider health community PTS worked closely with hospitals to identify urgent patients who would need to be conveyed as a priority patient movement. This was done when the acute trust was notified which transport had been suspended.
- Processes were in place to ensure staff were suitably equipped for winter weather working. For example appropriate footwear, high visibility jackets and provision of shovels and grit.
- The service had access to four by four vehicles for use in remote areas. These were used to transport staff into work at their nearest ambulance station during periods of severe weather.

Are patient transport services effective?

Requires improvement ●

The service followed eligibility criteria which covered patient health needs. The trust had been working with other providers to improve the coordination of care and some progress had been made. Outcome measures were monitored and shared with internal and external stakeholders.

The trust was not meeting performance targets particularly for renal dialysis patients and this was having an impact on patients' care and treatment. The Trust had been working with other providers to improve the coordination of care and some progress had been made.

Some staff had limited awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Assessment of eligibility was undertaken by PTS and hospital staff. An eligibility flowchart and checklist was available to assist staff when booking transport. This identified whether the patients' medical condition was such that they required the skills or support of PTS staff during the journey, or where it would be detrimental to their condition or recovery if they travelled by other means.
- Patients with specific medical conditions, such as haemodialysis and cancer patients, were given priority and eligibility to use the service.
- PTS monitored its quality and performance against Commissioning for Quality and Innovation indicators (CQUINS) which included improving the experience for patients with complex needs and to investigate and quantify the potential improvements related to patient experience in relation to transport to outpatient clinics. Between April – October 2014 CQUINS were delivered on time. There was some slippage relating to patients with complex needs and the service was working to test and implement the complex patient algorithm.
- The trust had a clinical audit programme for 2014/15 which largely identified clinical audits relating to emergency rather than PTS care. Examples of PTS audits included hand hygiene and vehicle cleanliness; action was taken where required.

Assessment and planning of care

Patient transport services (PTS)

- Patient transport services provided non-emergency transport for patients who, for example, attended hospital outpatient clinics, day hospitals, or who were admitted to or discharged from hospital.
- Staff were given details of patients who had advance care plans, 'special notes or 'do not attempt cardio-pulmonary resuscitation' orders. We saw these were detailed on the trust's computerised system and the information was passed to the ambulance crew via the PDA system.
- We observed team leaders attended patient homes and assessed and planned their care needs. For example records showed an assessment plan was in place for a bariatric patient and all care and transport needs were planned accordingly.
- Most renal dialysis patients using the service said their needs were assessed and care planned over the telephone prior to their first journey. They were advised of the two hour window either side of their appointment and felt staff were aware of their condition and their transport had been planned to meet their needs.
- In South Yorkshire crews said if they were delayed they contacted the control room so another crew could be allocated their work. However in the Hull area staff on the dialysis unit reported there had been a number of concerns regarding delays to patients transport and they were working with the ambulance service and commissioners to resolve this.
- The service was working to reduce high aborted journey rates due to incorrect patient mobility identified as part of the booking process. Dynamic risk assessments were carried out by the crew for each patient transport journey and an educational programme was in place which health care professionals could access regarding mobility assessments.

Nutrition and hydration

- PTS staff did not routinely provide nutrition and hydration for patients during their journey. Staff told us they reminded patients to eat and drink before travelling or to bring some food with them for the journey. We received no concerns from patients to indicate they were dehydrated whilst on vehicles.
- Staff were aware of the physically signs to look for if a patient became dehydrated and took appropriate action where required.

Patient outcomes

- During April to October 2014, there were 662,888 actual patient journeys against a planned number of 663,148 journeys.
- The trust's PTS performance indicators for September 2014 showed 94% of patients had been picked up within 120 minutes before their appointment time which was in line with trust targets.
- The thresholds for compliance against each key performance indicator were different for each consortia dependent on historic performance, activity profiling targets and historic funding streams. As a consequence compliance in one area was not equitable with performance in another. Trust data by region for patients arriving on time for their appointment during quarter two (July-September 2014) showed: East Yorkshire 74.9% (target 77%), North Yorkshire 77.3% (target 82%) South Yorkshire 86.4% (target 90%) and West Yorkshire 85.1% (target 82%) During July – September 2014 patients collected within 90 minutes (planned journeys) was 88% against a target of 91.3%.
- There were 92.8% of patients who were collected within 120 minutes (on the day and at short notice journeys) against a target of 93.8%.

Competent staff

- We found staff had the correct skills, knowledge and experience to do their job. All PTS vehicles were staffed by ambulance care assistants who had been trained in first aid, moving and handling techniques and specialist driving skills.
- The Department of Health NHS Staff Survey 2013 showed 74% of staff received job relevant training, learning or development in the last 12 months; this was within expectations with other trusts.
- The clinical delivery tutor told us the trust had developed a new induction programme for PTS staff. The training programme was comprehensive and included two weeks for band 2 staff and three weeks for band 3 staff with an additional week for driver training. The new induction programme included areas such as learning disability, dementia, patient experience and the Mental Capacity Act.
- Communication staff received training on the in-house computer system; in call handling and customer care. Staff also had access to a 24/7 online learning centre.
- Team leaders carried out annual performance development reviews (PDR) - for the period April –

Patient transport services (PTS)

September 2014, 79% of staff had a current appraisal against a trust target of 75%. Staff told us they were given sufficient notice to prepare and received protected time to attend their PDR.

- Team leaders told us they received development opportunities such as support to achieve additional qualifications including access to a leadership programme. In September 2014 39 first line managers in PTS had completed a development programme and eight managers had completed the leadership programme.
- We received positive comments about apprenticeships. Apprentices said they received four weeks training before 'going on the road' including two weeks shadowing trained staff. The training was comprehensive and there were opportunities to progress and obtain full time positions in different sectors of the service.

Coordination with other providers

- Service targets were set by commissioners for the different regions. PTS provided regional and local contracts to 23 clinical commissioning groups in Yorkshire. The Trust had been working with other providers to improve the coordination of care and some progress had been made.
- The trust had liaison offices in major hospitals across the region. PTS patient reception staff worked closely with hospital managers and attended regular meetings to discuss quality of the service, capacity and demand, delays and aborted journeys.
- Several patients told us when the service was delayed staff would contact the clinics and advise them of delays. Commissioners in some regions funded hospital staff to call patients the day before appointments to remind them of their appointment time and confirm their attendance. This had led to a reduction in the number of aborted journeys and cancellations.
- Within the PTS service, sub-contractors were used as a cost effective solution to deliver key performance indicators in times of peak activity, to meet short term demand increases or contract changes (e.g. over winter) or where internal resources were not available, for example owing to sickness absence.

Multidisciplinary working

- There was evidence of multidisciplinary working between staff and other organisations (for example,

hospitals and GP surgeries). During our visit, we observed cooperation between GPs, other healthcare professionals, the operation centre and PTS crews. However, a renal dialysis unit manager in North Yorkshire said when they contacted the control centre as they could not always access a team leader to escalate a concern.
- The service worked closely with the 999 service, other private providers or taxi services to ensure key services continued to be delivered to patients with time-critical needs during periods of adverse weather or other disruption.

Access to information

- Patient journeys were transmitted to the PDA direct from the YAS PTS database. This included journey details, real time data at point of action, satellite navigation and tracking of vehicles.
- PDAs provided staff with special notes and journey requirements. These were viewed by the driver prior to commencing the journey with the patient to ensure the correct support was provided and any relevant pre-booked equipment was transported.
- Team leaders told us urgent messages could be communicated to staff via the PDA. Other information was shared on noticeboards and staff briefings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a policy in place for patient consent to examination and treatment which followed the Department of Health consent guidance. Staff demonstrated a good knowledge of enabling patients to make decisions for themselves and how to gain patient consent.
- The trust training needs analysis showed the frequency of mental health and Mental Capacity Act 2005 training was every three years. Some staff confirmed they had recently received training in the MCA and dementia awareness. However, other staff said they had not received training and were unable to demonstrate an understanding of the MCA or Deprivation of Liberty Safeguards.

Are patient transport services caring?

Patient transport services (PTS)

Good 🟢

Patient transport services were delivered by caring and compassionate staff. Staff treated patients with dignity and respect that took account of patients' needs and wishes. There was a degree of continuity of staff for regular patients. Staff involved patients in their care and treatment and provided additional physical and emotional support where required.

Compassionate care

- Throughout our inspection we observed staff treated patients with dignity, courtesy and respect. The trust patient experience survey for August 2014 showed 100% of patients said they had been treated with dignity and respect within each of the regions.
- Patients and hospital staff spoke positively about the quality of PTS crews. We observed crews assist patients and explain procedures to them on accessing the vehicle and during their journey. Crews ensured patients were safely escorted to the hospital department or their home and made comfortable.
- Most patients told us they often travelled with the same PTS staff. We observed good interaction and staff awareness of patients' needs.
- The Friends and Family Test was being used in the trust from October 2014. We observed some leaflets and posters were available in most vehicles and patient reception centres. The trust's patient experience survey for August 2014 showed between 66% – 80% of patients across the four regions would be 'extremely likely' or 'likely' to recommend PTS to family and friends if they required transport to hospital. The Friends and Family test was also complemented by monthly postal surveys.

Understanding and involvement of patients and those close to them

- Comment and feedback cards were available in patient reception areas; including access to easy read, other languages, audio or Braille. Patients were encouraged to contact YAS patient services department if they wished to speak to someone about their experience of the service.

- Most patients were not aware of the patient experience survey. Two patients said they had completed the survey however they had not received any information about the outcome.
- Patients said they were informed of their care and treatment. We observed staff explaining the transfer process and asking patients about their personal capability and mobility choices which ensured patients were involved in the decision making process.
- We did not see any information being given to patients in the patient reception centres about waiting times unless they asked for these themselves. A postcard was left at addresses when patients did not respond when transport arrived. This advised patients to contact the hospital and rearrange their appointment. A PTS cancellation line was also available 24 hours a day.

Emotional support

- We observed staff supported patients to cope emotionally with their care and treatment. Staff ensured people were safe when travelling on vehicles and when being escorted to and from their destinations.
- Patients confirmed they always felt safe in the ambulance and said staff looked after them and spent time listening and speaking with them during the journey to alleviate any distress.
- Staff said they had been trained in conflict resolution techniques and were able to use distraction techniques if needed to support patients.

Supporting people to manage their own health

- Staff supported patients to manage their own care needs to maximise their independence. For example patients were encouraged to use their own mobility aids for stability and assistance. This involved staff listening to patients who were often expert in their own condition and had a way they preferred to be assisted. Staff said they encouraged patients to stand and sit independently were possible.

Are patient transport services responsive?

Requires improvement 🟠

Patients did not always have timely access to care and treatment due to delays in transport arrival and departure

Patient transport services (PTS)

times. The service did not meet prescribed response time targets and patients were not always informed of any disruptions. Booking systems were not always managed effectively on behalf of and by patients. A PTS performance improvement plan was in place to monitor access and flow.

There were systems which took account of the needs of different patient groups and used to inform the planning and delivery of services.

Complaints procedures and systems to give feedback were not fully understood by patients or staff.

Service planning and delivery to meet the needs of local people

- Records showed staff carried out assessments which covered patients' clinical, physical and mental health needs to ensure appropriate care pathways were planned and delivered in line with evidence based guidelines.
- In most areas the service worked closely with hospitals and commissioners to improve patient experience through a reduction in aborted journeys and communication of transport arrival times. For example in some regions, patients were contacted by the PTS driver before they were collected. Within East and South Yorkshire contact was made with patients the day before they travelled to confirm they still had an appointment and the information was correct.
- Following feedback from patients who travelled frequently (often up to three times a week) the service had changed processes so patients were contacted once a week to confirm the following week's travel.
- Customer Relations Managers told us they held regular quality meetings with hospital managers, this was particularly evident in South Yorkshire, to identify clinics which had the highest aborted journey rates and had introduced a combination of education, training and improved communication to reduce the number of journeys being aborted.
- PTS staff contacted hospitals when they were informed patients would not be attending clinics to ensure hospital appointments could be reallocated wherever possible.

Meeting people's individual needs

- PTS staff said they were made aware of vulnerable patients from the information provided by the operation centre. We observed that the PDA system was giving crews information about patients' needs.
- Patients told us their individual needs were being met, including patients with complex physical and mental health needs.
- The service had access to interpreters if needed. Escorts were permitted to travel with people for whom English was a second language, in order to support communication. Staff also told us interpreters were usually arranged by the receiving hospital and were available when the patient arrived.
- Staff in some areas had a sheet with pictures and symbols to help people with communication difficulties however this was not used in all regions.
- A guide dog could accompany patients with a visual impairment during their journey.
- Patients who were hard of hearing and used hearing aids told us ambulances could benefit from a "hearing loop facility" as they could not always hear what the crew were saying and it was difficult to let the driver know if they were not feeling well.
- There were a fleet of adapted vehicles to support patients with a high body mass index (BMI). Journeys to meet patient needs were planned in advance to ensure vehicles had the required number of staff with the correct manual handling skills to support patients.
- Some staff told us they had not received dementia awareness training other than during their induction. Patients with dementia were usually escorted by a carer for support. The trust PTS vehicles displayed information on the rear doors stating they were working towards becoming dementia friendly however some staff were unable to inform us about the initiative.
- Some vehicles were supplied with yellow seat belts to support patients living with dementia to make them easier to identify.

Access and flow

- We reviewed performance data from the PTS operational dashboard for 2014-15 for Quarter one and two. We saw there were a range of key performance indicators (KPI's) the trust was measured against which included patients picked up within 120 minutes of their appointment and patients arriving on time for their

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appointment. For example we saw for patients being collected 120 minutes before their appointment, the year to date position was 94.1% against a target of 93.2%.

- Although performance against indicators for patients collected within 90 minutes (planned journeys) was non-compliant, performance against this standard had improved over time. However, the PTS Locality Assurance Report for September 2014 indicated waits post-appointment remained a theme in relation to patient and hospital feedback and this continued to be an area of focus for PTS.

- Booking systems did not always support patients to easily access appointments. Patients and hospital staff in North, East and West Yorkshire told us they had difficulty in getting through to the control centre to book or cancel appointments. One patient said they had waited 45 minutes to book a journey another said they had tried to make a booking by phone on the 0300 number many times but could not obtain an answer; instead they had contacted Harrogate hospital who made the appointment for them. PTS call data up to October 2014 confirmed the target of 80% of calls were not being answered within 30 seconds.

- PTS for renal dialysis patients did not always meet prescribed response time targets in line with The National Institute for Health and Care Excellence (NICE) quality standard 15: Patient Transport (March 2011). The guidance stated that patients with chronic kidney disease receiving haemodialysis or training for home therapies should have transport within 30 minutes of their clinical treatment. Records for patients receiving dialysis in York showed that over a six month period, 21 patients had waited more than 60 minutes after their treatment had finished and seven had waited more than two hours. This impacted on waiting times and hospital staff who sometimes had to stay later than their contracted hours to accommodate patients.

- Targets for renal arrival times were not being met effectively. Records for York renal dialysis unit showed between 21 August 2014 and 5 January 2015 five patients arrived earlier than the 60 minute standard and 15 patients had arrived late for their dialysis with the greatest delay being two hours after the appointment time. This was also the case for West Yorkshire and Hull area renal patients; targets were not being met for inward arrival times and outward collections within 60 minutes of ready time.

- The service was aware of its challenges relating to waiting times for renal patients. A PTS renal patient performance improvement plan was in place. A number of actions had been taken including changes to staff rotas, reconfiguration of renal patient runs to align with dedicated resources wherever possible, regular meetings with renal teams and commissioners of service and on-going staff recruitment and training.

Learning from complaints and concerns

- The trust had a policy for managing complaints, comments, concerns and compliments. Staff gave various answers on the process for managing a complaint. These ranged from advising patients to talk to the Patient Reception Centre or Patient Advice and Liaison Service (PALS), providing a telephone number for making a complaint or asking patients to put their complaint in writing. In the North Yorkshire region some staff said they did not know the process and would telephone their team leader for advice.

- We observed vehicles in South Yorkshire displayed a sticker which informed patients of what to do in the event of a complaint including contact telephone numbers and email address. However this was not consistent across all regions. In other areas this information was not displayed and staff were unable to locate any leaflets on vehicles advising patients how to make a complaint.

- Although the trust had a process of service to service communication between PTS and other organisations to discuss complaints, there was a lack of clarity about the relationships between patients, the hospitals and the trust. This led to patients being confused about how, or whom they could make complaints or compliments about the service. For example, patients would go through the hospital PALS service; speak to staff in clinics or feedback using the trusts patient survey.

- Staff told us the majority of complaints related to delays in transport. One patient told us they had made a complaint two months prior to our inspection about delays and felt they had not been listened to as the delays were still continuing. Similarly another patient said 'delays had improved for about a week but reverted back to transport arriving late'.

- Staff told us they had not received any formal complaints training. However, there was complaint training included in the trust's mandatory training workbook issued to staff.

Patient transport services (PTS)

- Recording of complaints was also inconsistent. PTS Communication Centre staff said they would not routinely record verbal complaints on the system. This was not in line with the trust's complaints policy which stated 'If a person wished to give feedback verbally, they could expect a member of staff to make a written record and to receive a copy of the written record of their feedback should they so wish'.
- The PTS quality dashboard showed PTS services had received 556 complaints from April to September 2014. Based on the total number of PTS journeys undertaken for this period this equated to 0.10% of complaints.
- The trusts 'Being Open Policy' had been revised to include the recent changes to include duty of candour. However, the majority of staff we spoke with were not aware of the new duty of candour regulations. We saw examples of being open; a letter had recently been sent to renal patients apologising if the standard of service had not met their expectations in the last few months and providing an explanation as to the actions being taken.

Are patient transport services well-led?

Requires improvement ●

The service was aware of its key pressures and had a strategy for achieving the priorities to deliver good quality care however most staff did not have awareness or understood the PTS vision and strategy and their role in achieving it.

There were systems in place to monitor risks, quality and performance. Risk management processes were not effectively embedded across all regions and the quality of identifying, reporting and learning from risks was variable.

Leaders at the operational level were approachable and visible. Most staff felt supported to raise concerns. There was some evidence to show patient and staff views and experiences were reviewed and acted on to improve the service.

Vision and strategy for this service

- Throughout 2013-14 PTS had embarked on a significant programme of organisational change. Seven work streams (latterly expanded to eight to include Business

Development) have been in place to deliver specific pieces of work designed to improve the quality of service delivery, streamline the service delivery model and reduce cost.
- The PTS plan outlined its vision and strategic direction for the next five years. The strategy was aligned to the YAS five year integrated business plan and detailed the PTS transformational change programme, business case and implementation plans. The plans set out key priorities and timescales to deliver service objectives such as improvements to operational efficiency, resources and competition factors.
- The trust vision and values were displayed in staff areas and staff had access to a weekly briefing via email and through the operational update which published key performance indicators for PTS patients on a weekly basis. However most staff we spoke with did not have an awareness or understanding of the PTS vision and strategy, or their role in achieving it. Staff told us they 'didn't know what direction the service was going in'.

Governance, risk management and quality measurement

- The service had a risk management procedure which had been reviewed and was in date. The procedure set out the roles and responsibilities for managers and front line staff in the reporting of incidents, claims and complaints. However we found there were variances in the quality of incident reporting and continuous learning and improvement between regions.
- Local governance and quality indicators fed into the performance management framework and up to the trust board. This included a focus on safety, patient experience and workforce issues.
- PTS held a risk register which assisted the corporate governance groups to identify and understand the risks. There were 26 risks identified for PTS, none were classified as very high; 12 were identified as moderate risk and 14 as a low risk. The risks were regularly reviewed by the operations group and action identified for improvement. Key themes included financial viability of PTS, risks associated with the transformation programme delivery and patient slips, trips and falls.
- There were governance arrangements for sub-contractors delivering direct patient care for PTS. A

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governance checklist was completed to ensure compliance with safeguarding standards including DBS checks, infection control, health and safety and information governance.

- Meetings were held with commissioners to discuss local quality improvement indicators. Minutes of meetings showed areas such as waiting times for renal dialysis patients, duration of patient calls and booking processes had been discussed.

Leadership of service

- The management structure of the PTS was headed by two Associate Directors of Operations responsible for planning, strategy, performance and delivery. Each region was managed by a locality manager and customer relations managers.
- Most staff said local managers were approachable and they felt valued and supported by them. They told us they could go to them with ideas and concerns and were confident of a positive response.
- Morale amongst staff varied in different regions. PTS staff in South Yorkshire for example did not feel separated from the organisation and felt part of a wider team. Whilst other areas showed a disconnect between senior managers and staff, some staff felt managers were not visible and did not understand the impact of operational pressures.
- Staff meetings and 1:1 briefings were not held consistently or frequently across regions.

Culture within the service

- We observed staff working cooperatively with each other and respecting each other's roles. We found most staff were loyal and flexible. Many had worked for the trust for a number of years and were committed to continuing to do so.
- Employee guidance was available for staff to raise concerns at work. Most staff told us they could raise a concern or make comments directly with managers. However the culture in some regions did not encourage openness and candour and some staff felt unable to raise issues and concerns for fear of blame.
- The NHS staff survey 2013 showed most indicators scored positive findings or were within expectations with other trusts. The indicators for effective team working, percentage of staff receiving health and safety and equality and diversity training in the last 12 months scored negative findings.

- The overall figure for sickness absence in PTS was 6.5% against a trust target of 5%. (4.7% was long term sickness and 1.8% short term sickness).
- Employees had direct access to counselling service and health and wellbeing information 24/7 via both on-line and telephone services. The occupational health service provided a range of services treating mental health issues, including stress, anxiety and depression, bereavement and PTSD.
- Staff had access to physiotherapy services which provided telephone advice, exercises and access to a face-to-face physiotherapy service avoiding lengthy delays in the referral process.
- The trust was undertaking a cultural audit to identify engagement issues and staff expectations of leaders and managers at team and departmental level. The cultural barometer provided a platform for the development of a new behavioural framework.
- Staff gave examples of emails they had received when they had been involved in difficult and complex clinical interventions, in recognition of their prompt and swift actions.

Public and staff engagement

- There was some evidence PTS were engaging with the public to improve the service. For example, in South Yorkshire, following patient and user group feedback, it was decided to focus attention on reducing the waiting times patients experienced post-appointment. A South Yorkshire-wide action plan was developed which looked at how all elements of service delivery took place.
- A meeting was arranged with Healthwatch Sheffield, which YAS attended to hear about patients' experiences of moving and transportation. Topics included the experiences patients had of travelling on vehicles in wheelchairs; views on how to keep patients safe and provide a positive experience of ambulance care particularly for patients with complex conditions.
- A letter from the Associate Director for PTS Performance and Delivery had recently been sent to renal patients in West Yorkshire providing information about the changes to renal transport services and the improvements to achieve better performance and patient experience.
- The trust planned to survey all staff in February 2015 as part of the cultural assessment of working life in YAS 'Your Voice Our Future'.
- Results from the staff Family and Friends test showed 79% of staff scored positively on how likely they were to

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recommend the trust as a 'place of care or treatment' compared to 11% of respondents who gave a negative response. 43% of staff said they were likely to recommend the trust as a' place to work' with 40% who gave a negative response. Comments were being fed into the cultural audit and to managers through the leadership and learning service with a view to creating local action plans to address the concerns identified.

- A monthly team brief was delivered in the four geographical areas across East, North, West and South Yorkshire. This process was led by the Chief Executive and supported by appropriate YAS Directors and Senior Managers. Clinical Supervisors and other operational managers were the target audience, and all had the opportunity to input their ideas and views on how to improve the service.

Innovation, improvement and sustainability

- PTS planned to introduce a dynamic scheduling system which was being piloted in some regions. The system would enable bookings to be made closer to appointment times and recognise each vehicle's capability and grade of crew, and then allocate appropriate journeys. It would mean a better service for patients, and more efficient and effective use of resources.

- There was some evidence staff were involved in making improvements and innovation. For example the trust had introduced 'Bright Ideas' submissions which encouraged staff to provide innovative ideas to improve service delivery.

- Staff in South Yorkshire had been involved in the transformation programme providing input for the new staff rotas. However we found some staff reported a lack of involvement and consultation with changes to service provision at both local and regional level.

- The service was aware of the risk of loss of income due to the inability to secure and retain PTS contracts; resulting in financial and reputational loss. The launch of the PTS Transformation Programme had seen the introduction of new staff rosters to better match vehicle and staff availability to times of peak patient demand.

- PTS were nominated in a number of categories at the YAS 'We Care Awards' and had won the respect and dignity award.

Emergency operations centre (EOC)

Safe	**Requires improvement**	🟠
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Requires improvement**	🟠
Overall	**Requires improvement**	🟠

Information about the service

The Emergency Operations Centre (EOC) received and triaged 999 calls from members of the public as well as other emergency services. It provides advice and dispatches an ambulance service to the scene as appropriate. The EOC provided assessment and treatment advice to callers who do not need an ambulance response, a service known as "Hear and Treat". "Hear and Treat" is telephone advice that callers who do not have serious or life threatening conditions receive from an ambulance service after calling 999. They may receive advice on how to care for themselves or where they might go to receive assistance.

The EOC also managed requests from healthcare professionals to convey people either from the community into hospital or between hospitals.

The trust had two Emergency Operations centres (EOCs): one at the trust headquarters at Wakefield and the other in the North Yorkshire area based in York.

The EOC had three core sections: call takers, dispatchers and a clinical support desk. At the Wakefield EOC there was also a frequent caller section and safeguarding hub.

The call handlers were responsible for answering and triaging calls in accordance with clinical need. The clinical support desk was staffed by clinicians, including specialists such as paramedics and mental health nurses. It had responsibility for supporting the call handlers with advice for more complex calls, ensuring welfare checks were made (particularly if there had been a delay in a vehicle arriving on scene) and providing advice to emergency responders. The dispatch team was responsible for allocating calls to vehicles in accordance with clinical priority and location of vehicles.

We spoke with 37 staff, reviewed 29 records and listened to 25 calls.

Emergency operations centre (EOC)

Summary of findings

Overall the Emergency Operations Centre (EOC) was rated as requires improvement for safe and well-led and was rated as good for being effective, caring and responsive. Most of the staff we spoke with did not feel supported or encouraged to report incidents; instead of reporting incidents directly, they escalated them to their line managers to report. As a result they did not always receive feedback and learning was not shared.

Emergency operations centre services were delivered by caring and compassionate staff. We observed staff talking to people in a compassionate manner and treating them with dignity and respect. There was support for people who had difficulty accessing the 999 emergency call service because they could not speak English or they had hearing difficulties or speech impairment. Most staff we spoke to were unaware of the trust's specific vision or strategy for the service but recognised the trust's values. There was a disconnect between the risks and issues described by staff and those reported and understood by the leaders of the service.

Is emergency operations centre (EOC) safe?

Requires improvement ●

We observed staff taking calls made accurate and complete records, making sure they obtained all the necessary information for colleagues in dispatch and on the road.

Most of the staff we spoke with did not feel supported or encouraged to report incidents; instead of reporting incidents directly, they escalated them to their line managers to report. As a result they did not always receive feedback and learning was not shared.

The service had an escalation plan for when calls exceeded capacity and action was taken to shorten calls if safe to do so or divert calls to other operation centres. Staff had a good awareness of how to make sure vulnerable patients were safeguarded and there was a dedicated team at the Wakefield EOC who ensured safeguarding referrals were appropriately made.

Incidents

- The trust had an electronic incident reporting system. There was an incident reporting form that was accessible to all staff on the intranet. However, most of the staff we spoke with did not feel supported or encouraged to report incidents; instead of reporting incidents directly, they escalated them to their line managers to report.
- Staff told us that they did not always receive feedback from incidents in the EOC and that learning was not shared.
- The Trust had instituted a real time safety monitoring/ reporting process which is an ambulance service innovation where staff can raise concerns about delayed responses via supervisors and following assessment these are reported onto datix.
- We also saw there were internal safety notices issued within the EOC and we saw evidence of them being displayed in the control rooms.
- There were 179 incidents reported for the EOC between June and November 2014 but only 24 of those incidents were reported by EOC staff. There were 14 incidents resulting in harm reported within the EOC. EOC incidents reported involved delays or inappropriate

Emergency operations centre (EOC)

bookings of ambulances. For example an emergency call was placed for a non-responsive patient. The call was coded RED 2 (8 minute response) at 13:30. A Rapid Response Vehicle arrived on scene at 13:41 however a conveying vehicle did not arrive until 14:32.

- Staff told us on occasion IT systems, radios or telephone systems could fail and they had an operational business continuity plan in place for this. The supervisor and team leader did not report this type of incident through the incident reporting system and were unsure if this was done by the Duty Manager or Service Delivery Manager

- We found that not all incidents were reported in the trust's incident database. Reportable incident categories for the EOC would include delay in dispatching of appropriate vehicles, interpreters not being available for emergency calls from people whose first language was not English and verbal abuse towards staff by callers to the service. Staff told us they had been unable to access interpreters four times during Christmas week and they had not completed incident forms. Staff told us they were not encouraged to incident report abusive callers. We raised this with the managers of the service who corroborated that staff did not report the incidents of abuse but they escalated the incidents to their team leaders. We observed that incidents, such as abusive callers were reported to team leaders within the EOC, but few actions were taken to manage these incidents.

Mandatory training

- The EOC Manager, supervisors and team leaders reported staff were up to date with mandatory training. 95% of EOC staff had completed their mandatory training.
- Dispatch staff and call handlers confirmed they were up to date with mandatory training.
- Staff told us they had access to mandatory training mainly through the use of a workbook which needed to be completed annually.
- Staff also reported they could access some training through online courses and face to face training as and when this was available.

Safeguarding

- All staff told us they had had safeguarding training. 95% of staff had completed safeguarding training.

- We found there was a helpdesk which staff could call for advice. Staff had a direct number to ring concerns through to the safeguarding hub which was based at the EOC in Wakefield.
- Staff in the EOCs had a good understanding of what safeguarding concerns might be for children and vulnerable adults, and they gave us examples of when they had made a referral.
- Staff were aware of their responsibilities in relation to adult and children safeguarding issues and were aware how to raise an alert if needed and were clear that it was their responsibility to action any concerns they had.

Cleanliness, infection control and hygiene

- We saw there were appropriate hand washing and drying facilities available in toilets for staff and visitors.
- Posters were on display regarding the importance of hand washing.
- Call handlers could and did alert crew members of patient associated infection risks via the notes section on the patient record if needed.

Environment and equipment

- At Wakefield centre the buildings were secure and all areas needed ID access. However at the York Centre although ID access was required to access the call handler's room there were patio doors in the call handler's room which were permanently unlocked. The centre was in a remote area and staff told us at times especially at night they could feel vulnerable. Staff told has they had raised their concerns with the estates team but nothing had been done to secure the doors.
- Equipment was appropriate for the centre's function and adequately maintained. However the Computer Aided Dispatch (iCAD) system for managing calls had failed in September 2014 and staff told us they carried out regular drills using paper and runners in an event of a CAD failure.
- Staff had access to equipment required to do their work. For example there were headsets, touch screens / directory working telephones and IT systems.

Medicines

- The service used a triage system known as the Advanced Medical Priority Dispatch System (AMPDS). The AMPDS guided call-handling staff for example we found they did not give advice to callers about giving

medicines or injections in any circumstances. If callers needed advice about medication then the call would be transferred to clinical staff that would speak with the caller and provide information and advice.

Records

- The service used a computer-aided dispatch (iCAD) system to record details about patients who called. Records were initiated at the beginning of a 999 call. The call handlers took the caller through the Advanced Medical Priority Dispatch System (AMPDS) triage system by asking set questions to prioritise calls.
- AMPDS provided prompts for call handlers to ask the relevant questions and record the necessary information.
- Records were colour-coded to indicate priority and response. All records were visible to clinical support desk (CSD) clinicians, team leaders, call handlers and dispatch staff. Staff were able to update the records as more information became available. We reviewed a sample of 25 records and found that all patient records had been completed.
- Call handling staff told us that they recorded key information in the electronic records and this information was then available to both the dispatchers and the ambulance crews.
- The trust used 'special notes' about patients to share with ambulance crews. These detailed clinical information for patients with complex needs or risk information if there was a safety concern.

Assessing and responding to patient risk

- Staff told us the clinical hub monitored the system and made welfare calls to patients where they were nearing their allocated response time.
- Staff told us that clinical staff were also able to listen in to any red calls and intervene in calls through notes or ask for a call to be transferred.
- For all children under the age of 2 an ambulance was sent regardless of symptoms.
- Staff were aware of the skill mix of the crews (for example, whether the vehicles had paramedics or technicians on board). This helped with selection and speed in sending crews to incidents.
- Dispatchers managed a number of rapid response vehicles and ambulance crews sending them to the location of the calls. Dispatch staff told us that if a call came in that was determined as requiring the highest

response then a vehicle would be sent immediately, often as details from the call were still being gathered. This meant they would be able to arrive at the location in the quickest possible time.

- The dispatch team also monitored an alarm system used by ambulance crews if they needed urgent assistance and were not able to, or it was not safe to use a mobile telephone. The dispatch team would initiate calls to the police for urgent assistance if the alarm system was triggered giving the location of the crew needing help.
- Details of the duty control room manager and lead managers on duty for a shift were on display in the EOC offices. Also on display were the names and pictures of staff at different levels of seniority – bronze, silver and gold (the most senior) – in the organisation that would be responsible for dealing with major incidents.

Staffing

- During our inspection the EOC was appropriately staffed. There were 388 staff working in the EOC. There were 135 call handling staff, 137 dispatch staff and 24.8 clinical hub staff. We were told throughout the EOC there were 11 WTE vacancies which were being recruited to.
- Staff reported that under "normal" circumstances they felt they had enough staff to safely and effectively carry out their functions.
- At the time of the inspection, staff were allocated to six teams. Each team had one duty manager, one clinical duty manager, three dispatch team leaders, one Emergency Medical Dispatcher EMD team leader, call handlers, dispatchers and trainers. Clinical staff were not allocated to a team but worked across all six teams. However in February 2015 the teams were moving to a five team structure to give 20% more people in each team to allow greater flexibility.
- Sickness rates were high at 7% which meant there were currently 30-35 staff off sick however this was not impacting on the staffing of the EOC.
- The EOC did not use agency or bank staff in the dispatch or call-taking rooms because staff needed extensive training to become competent in the role and maintain their skills. Staff rotas included staff working as reliefs as part of their shift pattern which would cover any staff shortages and also staff were offered overtime to cover any shortage.

Emergency operations centre (EOC)

Anticipated resource and capacity risks

- Recent major incident training had involved all emergency services in the area and had been well evaluated as this had clarified the roles of each service using major incident scenarios.
- EOC staff understood the business continuity plans for loss of facilities or infrastructure and had practical experience of putting these into place when IT or telephone systems had failed. They were also very familiar with escalation plans for increased demand and these had been implemented over the autumn and winter period
- There were escalation procedures for all call centre staff to follow in the event of major incidents, such as chemical spills, explosions or bomb threats.
- The EOC had an escalation plan for when calls exceeded capacity and action was taken to shorten calls if safe to do so or divert calls to other operation centres.
- Staff were aware of the evacuation procedures; for example if the EOC at Wakefield had to be evacuated and the service had to be transferred to another location.

Is emergency operations centre (EOC) effective?

Good ●

Multidisciplinary working arrangements worked well internally at the Wakefield EOC. However the arrangements with the clinical hub at Wakefield and the York EOC needed to be improved. The EOC had good links with external organisations.

In 2013-2014 YAS response rate for responding to category A emergency calls within 8 minutes was 77.4%. However in the first two quarters of 2014-2015 information showed YAS had performed worse than the 75% rate with only between 68% and 71% of calls being responded to within 8 minutes.

Staff had an understanding of the Mental Capacity Act and the deprivation of liberty safeguards. Staff were also aware of the Mental Health Act.

Evidence-based care and treatment

- The AMPDS system allowed staff to assess the needs of patients in line with evidence based guidance, standards and best practice.
- Staff used the triage systems appropriately to triage patients. Emergency Call Takers (ECTs) used the question prompts that were displayed on the screen and asked the questions in order to progress the call and reach the appropriate clinical outcome. They would continue with the questioning until the triage system advised of the best clinical response. If necessary the system could be overridden by a supervisor or clinician working on the Clinical Support Desk (CSD).
- The dispatch team managed the allocation and prioritisation of vehicles in accordance with clinical need, and instructed vehicles to attend the scene. The dispatch operators had an overview of where ambulances were, and which call each crew was responding to. They allocated and reallocated calls as needed, in accordance with clinical priority.
- The trust had an audit team that audited all calls and monitored operational performance against national requirements on a daily basis. The computer system randomly selected 3% of all calls and then auditors picked 1% (700) of calls and these were audited and feedback was given to call handlers on a monthly basis.
- Auditors randomly select five calls to review at a monthly review group attended by auditors to ensure consistency of the audits and ensure any issues highlighted are dealt with appropriately.
- Commissioners had completed an audit of 100 calls in the West Yorkshire area of the service, 99 calls had been found to be satisfactory, one call could not be located and reviewed.

Assessment and planning of care

- All 999 calls were triaged through the AMPDS triage system. Calls are assessed and divided into Red 1 or 2 or Green 1, 2, 3 or 4. Red calls were 'immediately life threatening'.
- Red 1 (R1) and Red 2 (R2) calls were triaged through the Manchester Triage System (MTS) and during normal demand the clinical hub triage Green 3 (G3)/ Green 4 (G4) calls used the Priority Solutions Information Access Management triage system (PSIAM).

Emergency operations centre (EOC)

- Green 1 and 2 were serious but not immediately life threatening. Green 3 and 4 were neither serious nor life threatening in non-life-threatening emergencies, patients would be treated by an ambulance crew or a single responder.
- Calls which were rated as Green 1 required a blue light response within 20 minutes, Green 2 required a blue light response within 30 minutes, Green 3 required telephone assessment within 20 minutes and response within 1 hour and Green 4 required telephone assessment within 1 hour.
- The CSD was staffed by clinicians, such as paramedics. The clinicians could interject into calls and downgrade or escalate as necessary to ensure that appropriate assessment took place.
- Clinical staff such a paramedic staff in the clinical hub would use the MTS to re-assess red calls that were over 8 minutes. The MTS system was used for high acuity calls because it was a quicker than APDMS. It was also more flexible than AMPDS.
- The trust was had introduced mental health practitioners into the EOC at Wakefield to better support patients.
- Call handlers told us that they would follow the mental health pathway for patients under Section 136 of the Mental Health Act 1983 and would hand patients over to clinicians in the CSD for assessment and advice.

Response times

- The emergency call centre performance was measured against a number of targets such as, time respond to a call, time to obtain an address, and use of the triage script.
- In the EOC business plan December 2014 it stated the call pick up time was above the standard of 95% in 5 seconds with the year to date position being 95.3%.
- Calls were assessed and divided into Red 1 or 2 (category A) or Green 1, 2, 3 or 4. Red calls were 'immediately life threatening'. Green 1 and 2 were serious but not immediately life threatening. Green 3 and 4 were neither serious nor life threatening.
- During quarter one and quarter two of 2014-2015 the proportion of YAS calls resolved by telephone was 5.7% compared to the national average of 7.3%.

- Re-contact rates following discharge of care by telephone in quarter one and two in 2014-2015 was 5.1% which was an overall lower rate of re-contact than the England average of 7.8% however there had been an increase during quarter two of 2014-15.

Patient outcomes

- The 2013/14 Hear and Treat Survey contacted adult callers who had received telephone triage and advice when calling 999 in December 2013. The survey consisted of 25 questions relating to the call handler, clinical adviser, outcome and overall impression of the service provided. The trust performed, on average, the same as other ambulance trusts for 16 questions, and better than other trusts for nine questions.
- The triage script used by the operations centre staff was automated through AMPDS. Built into this system were tools to ensure good patient outcomes for callers being advised by non-clinical staff.

Competent staff

- Staff we spoke with told us the induction process was a positive experience and they were well supported through this period. Induction included face-to-face training sessions covering elements of mandatory requirements as well as training specific to the person's role. Time was spent listening to 'live' calls and undertaking role-play exercises.
- After the induction process, new employees were given a period of mentorship, which meant they were supported by a mentor for more than 20 shifts. All staff had their competencies assessed before working unsupported.
- Staff reported that they completed training during quiet periods and they completed a booklet for the mandatory training updates. The booklet was marked and returned to staff.
- Managers told us that the trust had included training time in staff shift rotas to enable staff to undertake training but they were in the process of changing the rotas from April 2015.
- Some staff said the trust was not responsive when staff experienced abuse during a call. Staff told us they did not have training specific in the management of the abusive caller.
- Performance audits were regularly undertaken in both the EOC and Dispatch areas. 1% of all calls were audited in relation to adherence to clinical protocols.

Emergency operations centre (EOC)

- Non-compliance was immediately triggered to the EOC supervisor who then dealt with the issues raised on a 1-1 basis with members of their team as soon as possible after the information was received. Discussions with staff were held to discuss areas of non-compliance and where improvement was needed.
- However some staff told us they did not have regular 1:1's especially during the last few months because of the pressures on the ambulance services nationally. We raised this with the manager of the EOC who told us staff having 1:1 meetings had been challenging during the recent pressures.
- Call handlers told us they would receive written feedback on their performance. Poor performance was followed up by line managers, and further training and support would be provided.
- The manager and staff told us that away days had been organised for staff to attend and these happened every six months.
- Staff within EOC told us they did not have regular team meetings but they did have meetings planned to re-introduce them when they implemented the new rotas. At the time of the inspection staff had not had a team meeting for 6 months.

Coordination with other providers

- Staff gave examples of how they worked with other providers of health and social care such as; pre-alerting A&E departments of patients in a critical condition on their way to hospital, facilitating urgent ambulance transfers for calls made by GPs and other professionals or services who may request urgent ambulance transfers including for patients with mental health conditions and or being detained under the mental health act.
- The ECTs and EMDs worked closely with the coastguard when dealing with emergencies at sea, and they would coordinate response depending on the nature of the incident.
- The trust had local arrangements to call for police presence as and when needed.
- Call handlers could describe how they communicated with the 111 service when patients were handed over to 999. The service was in the process of developing a standard operating procedure for staff to use.

Multidisciplinary working

- We observed good multidisciplinary team working between the ECTs, clinical advisors and dispatch staff.
- The IT system allowed the flow of information from call handling to dispatch to responders.
- The different teams worked well together and described how they supported each other's roles especially in times of peak demand or when there were IT or telephone issues.
- Although the call handling team was remote from the rest of the team based in Wakefield, the system enabled distribution of calls to the next available handler irrespective of their office base. This ensured the most effective use of resource across both sites.
- Ambulance crews could contact the CSD if they had any queries about a patient's condition or treatment and needed advice or support.

Access to information

- All staff told us they had easy access to policies, protocols and other information they needed to do their job.
- Special notes were in place for patients where additional needs had been identified or where patient suffered from long term conditions and were well known to services.
- Staff told us that there were management plans/ notes in place, for named patients, which had been developed and agreed by members of the clinical hub in conjunction with Community Matrons looking after a patient's long term care. These patients were flagged on the system so call handlers, dispatchers and responders were aware of a patient's individual needs where appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff could clearly describe potential issues regarding consent and mental capacity and had an understanding of best interest decisions.
- Staff had some understanding of the Mental Health Act and specific response times and vehicles needed for patients being detained / transported under the Mental Health Act.

Is emergency operations centre (EOC) caring?

Emergency operations centre (EOC)

Good 🟢

Emergency operations centre (EOC) services were delivered by caring and compassionate staff. We observed staff talking to people in a compassionate manner and treating them with dignity and respect.

The staff listened carefully to what was being said, checked information when necessary and were supportive and reassuring when responding to people calling in distress. Staff involved patients or those close to them in making decisions with support where necessary. Staff supported patients to cope emotionally with their care and treatment.

The patient survey for the (EOC) in October 2014 showed 87.3% of patients felt the ambulance call taker listened carefully and 86.7% of call takers were reassuring. In October 2014 95% of patients who responded the friends and family test would recommend the service to a friend or family member.

The trust also participated in the Hear and Treat survey for 2013-2014. The results showed the trust scored 9.1 out of 10 for patients who felt they were treated with dignity and respect by the clinical advisor and they scored 9.4 out of 10 for patients who felt the call handler listened to what they had to say.

Compassionate care

- Staff spoke to people in a compassionate manner and treated them with dignity and respect. They listened carefully to what was being said and re-checked information when necessary.
- The patient survey for the (EOC) in October 2014 showed 87.3% of patients felt the ambulance call taker listened carefully and 86.7% of call takers were reassuring.
- In October 2014 95% of patients who responded to the friends and family test would recommend the service to a friend or family member.
- The Yorkshire Ambulance Services participated in the 'Hear and Treat' survey for 2013-2014. This 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 for Yorkshire Ambulance Service NHS Trust.

- People were asked to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust was given a score out of 10 for each question
- The trust scored 9.4 out of 10 for patients who felt the call handler listened to what they had to say.
- The trust scored 9.1 out of 10 for patients who felt they were treated with dignity and respect by the clinical advisor.

Understanding and involvement of patients and those close to them

- Staff demonstrated an understanding of the importance of involving patients and carers in their interactions, particularly for patients with a learning disability, mental health problem, and dementia.
- In relation to children and other vulnerable adults, staff demonstrated an understanding of their needs whilst having regard for consent and mental capacity issues.
- The 'Hear and Treat' survey the trust scored 9.8 out of 10 for patients who spoke to a second person who understood the instructions about what to do if their situation changed.

Emotional support

- We saw in the 'Hear and Treat' survey the trust scored 8 out of 10 for patients who spoke to a second person who had any anxieties or fears, had the opportunity to discuss them with a clinical advisor.
- Staff were observed providing emotional support to patients awaiting the arrival of emergency responders.

Supporting people to manage their own health

- Pathways were available for EOC staff to refer callers to other services where patients were known to have a long term condition and had a management plan in place, and also when demand escalation plans were in place.
- Frequent callers were identified with flags on records or against an address and call handlers could sign post patients to other services where appropriate. For example to the mental health crisis intervention team.

Is emergency operations centre (EOC) responsive?

Emergency operations centre (EOC)

Good ●

Staff were aware they needed to know about a person's individual needs There was support for people whose first language was not English and who had difficulty accessing the 999 emergency call service or they had hearing difficulties or speech impairment. However there were concerns about the availability of interpreters.

The dispatch team had responsibility for ensuring that a suitable vehicle and crew were sent to the scene. The iCAD system allowed dispatch staff to monitor vehicles and crews, the system showed location and availability of vehicles and crews. Dispatch staff could also view vehicles in other locations and there were systems for transferring vehicles to other areas.

The trust had a complaints policy. Staff told us that they knew what to do if someone wanted to complain. They were aware of how to access the trust policy on handling complaints via the intranet. Learning from complaints, and operational updates were cascaded to managers at monthly team meetings and operational staff through a read and sign folder.

Service planning and delivery to meet the needs of local people

- Patients accessed the service directly by dialling 999 and were triaged according to the AMPDS triage system based on clinical needs. The clinical outcome was communicated to the caller and where appropriate an ambulance was dispatched
- During the first six months of 2014-2015 we found the trust had a low rate of abandoned calls compared to the England average. The trust proportion of calls abandoned before being answered was better than the national average at 1.0% compared to the national rate of 1.5%.

Meeting people's individual needs

- Staff had access to a telephone interpreting service for people who made 999 calls and whose first language was not English. However staff told us there were issues with accessing interpreters.
- We raised this with senior managers who told us they had contacted the company providing services but the issue of accessing interpreters appeared not to have

improved. However staff gave us examples when they could not access an interpreter during January they told us they had been unable to access interpreters four times in four weeks and they had been unable to access Slovakian interpreters.

- Staff were aware they needed to know about a person's individual needs. This may have an impact on the type of response vehicle sent or the equipment needed or the skill set of the crew needed. In addition whether back up needed to be sent either from the ambulance service or other emergency services.
- Staff were aware they may need to make reasonable adjustments to deal with patients with complex needs, learning disabilities or dementia, as well as for patients from other vulnerable groups. For example the system allowed alerts to be put on the system for frequent callers. Also if the caller had contacted the service before call handling staff could find the location of the caller using the landline telephone number recorded on the system. This allowed staff to be able to despatch a vehicle to caller even if they were unable to provide an address.
- Staff also told us they would use simpler language and allow time for the caller to respond to questions. However some staff reported they were aware of dementia but were unable to recall having training for these groups of patients.
- Staff had access to Type Talk, a text service for hearing impaired patients who contacted the EOC.

Access and flow

- The dispatch team had responsibility for ensuring that a suitable vehicle and crew were sent to the scene. This could be a community first responder or a rapid response vehicle (RRV), depending on who was closest to the scene and which was clinically appropriate. We saw a double manned ambulance (DMA) would also be dispatched at the same time.
- The iCAD system allowed dispatch staff to monitor vehicles and crews. The system showed location and availability of vehicles and crews. Dispatch staff could also view vehicles in other locations and there were systems for transferring vehicles to other areas. During the inspection we observed a vehicle transferred from Hull to Filey to meet the coastguard because there was not an appropriate vehicle available in the Filey area.

Emergency operations centre (EOC)

- The trust had a group of staff for frequent callers and this was used to follow up with these patients' GPs to coordinate care.
- The service used the Resourcing Escalatory Action Plan REAP escalation system. Resourcing Escalatory Action Plans (REAP) is a structured set of arrangements for managing services when 'normal' operating functions are challenged, either through loss of staff, resources, or external factors including periods of high demand. Level one is when there are enough resources and staff.
- Level six is used when there are high levels of demand and there is a risk that response performance for emergency calls would not be maintained. During the inspection the service was at Level four and there were enough resources to meet demand.

Learning from complaints and concerns

- There were patient relations coordinators based in the EOC who coordinated the handling of compliments, concerns and complaints.
- Duty managers and team leaders undertook fact finding investigations and the patient relation coordinators collated and provided responses to complainants.
- Themes from complaints were mainly in relation to response times and on occasion staff attitude.
- The EOC systems and calls were interrogated to establish the basis of complaints and any recommendations or learning were fed back to staff on an individual basis.
- Complaints records were mainly electronic with time limited paper records. We found records were stored safely and securely electronically or in a locked office.
- Learning from complaints, and operational updates were cascaded to managers at monthly team meetings and operational staff through a read and sign folder. We saw that there were themes about staff attitude and delayed response times had been cascaded to staff.

Is emergency operations centre (EOC) well-led?

Requires improvement ●

Most staff we spoke to were unaware of the trust's specific vision or strategy for the service but recognised the trust's values. There was a disconnect between the risks and issues described by staff and those reported and understood by the leaders of the service.

During the Christmas period there had been good operational support for staff including the use of a mental health nurse who provided advice and support to staff. Staff had mixed views about the leadership and culture in the service. Some staff reported they did not feel supported by managers. Staff felt well supported within their teams and worked well with colleagues.

There was a limited approach to obtaining views from the patients. The service participated in the 'Hear and Treat' survey but did not proactively seek the views of the patients who used the service.

Vision and strategy for this service

- We found the trust's vision and values were on display in the emergency operation centres.
- The trust sent an operational bulletin with information by email to all staff on the vision and values.
- However we found the clinical hub team did not know what the vision was for their service. The rest of the EOC had been grouped into teams, but the clinical staff were not aligned to the new teams.
- The vision for the EOC had been discussed at an away day but staff did not know how this linked with the trust wide vision and strategy.

Governance, risk management and quality measurement

- The EOC maintained a risk register. The head of the EOC told us that all the risks had been considered and incorporated into the operations directorate risk register. However, we did not see all risks listed, for example, the security risk about the patio doors at York was not on the risk register.
- In addition the failure of the iCAD system in the EOC was not on the risk register even though it was identified as a

Emergency operations centre (EOC)

significant risk. The system had failed in September 2014 and staff told us they carried out regular drills using paper and runners in an event of a iCAD failure. Risks and issues were not always dealt with in a timely manner and lessons were not always learned. Access to interpreting services had been identified as an issue but the access to interpreters was not being monitored following contact with the external interpreting service to raise concerns. The trust was unable to demonstrate if there had been any improvement in access to interpreters.

- The trust had an audit team that audited all calls and monitored operational performance against national requirements on a daily basis. All calls were recorded and audited on a random basis.
- An auditor told us that all call handlers had three of their calls audited each month, Call handlers told us they would receive written feedback on their performance. Poor performance was followed up by line managers, and further training and support would be provided to individual staff.
- We were told there were regular governance meetings and we saw copies of governance meetings minutes.

Leadership of service

- Staff told us there had been 5 directors of Operations in a 2 year period and the organisation had and still was undergoing major change.
- We found there was a clear leadership structure within the EOC. Roles and responsibilities within the teams were clear and well defined.
- Over the Christmas period there had been good operational support for staff including the use of a mental health nurse who provided advice and support to staff.
- Staff had mixed views about leadership. Staff in the Wakefield EOC told us they felt well supported by their line managers and worked well as a team. However, staff in the York EOC told us they felt there was lack of support from managers based at Wakefield.
- Staff told us about the monitoring of calls and the support if performance fell, but they felt there was little recognition from managers when they had done something well, for example dealing with a difficult call.

Culture within the service

- We found that staff were proud to work for the trust, liked the uniform and what it represented, and felt that they had an important role. They said they worked well as a team, supported each other and enjoyed their work.
- The York EOC teams told us they felt disadvantaged by not having easy access to senior managers and gave examples of inadvertently receiving delayed information from colleagues at the Wakefield site due to the team being missed off central circulation lists. EOC staff at the York site told us they were not confident they were up to date with strategic vision/ changes or what was going on across other areas of the organisation.

Public and staff engagement

- Staff reported that they had been invited to and had attended away days regarding proposed service changes but stated that although they may have been listened to they weren't sure they had been heard.
- Staff reported that 2 new shift patterns were to be introduced in the next few weeks rather than 1 as staff at the 2 sites had differing preferences. The trust planned to introduce a 10 week cycle for rotas to allow flexible use of staff to cover training and staff shortages.
- The service had participated in the national Hear and Treat survey and was similar or better than other trusts.

Innovation, improvement and sustainability

- Staff and mangers had a system called 'bright ideas' where staff were encouraged by the organisation to submit ideas on the intranet. For example an idea had been submitted for a recorded message in different languages to be available for staff to use whilst contacting the interpreting services so callers who first language was not English understood what was happening.
- The trust had introduced mental health practitioners into the EOC to better support patients.
- The Emergency Operations Centre has achieved AMPDS Centre of Excellence accreditation and a member of staff had won the international 'EMD of the Year' award in 2014.

Resilience

Safe	**Inadequate**	🔴
Effective	**Not sufficient evidence to rate**	⚪
Caring	**Not sufficient evidence to rate**	⚪
Responsive	**Good**	🟢
Well-led	**Requires improvement**	🟠
Overall	**Requires improvement**	🟠

Information about the service

The Resilience function was trust-wide and there were two specific bases, one located in Rotherham and another in Leeds. The bases contained specialist equipment and a range of vehicles to support the Resilience function and included vehicles containing equipment for mass casualty events.

The service had a single Hazardous Area Response Team (HART) co-located with Resilience function at the Leeds base in a new and modern facility.

During the inspection we visited both bases, Trust headquarters and also visited the trauma desk based within the Emergency Operations Centre. We inspected vehicles and equipment including medical bags and breathing apparatus. We spoke with a variety of staff including those working across the wider Resilience function, front-line HART paramedics and both junior and senior managers.

We conducted a planned inspection and two unannounced inspections; the unannounced visits were both to the base in Leeds. We were unable to observe direct patient care because the opportunity to accompany a crew to a call-out did not arise.

Summary of findings

Overall the resilience service was rated as inadequate for safe, responsive was rated as good and well-led required improvement. Effective and caring were inspected but not rated.

We had significant concerns within the service about the checking of equipment, a large number had passed their expiry dates and assurance processes had not detected this. There were also inconsistencies with checking of breathing apparatus and the processes observed did not follow best practice guidance. We re-visited the HART base two days after the announced inspection and one month later to check that changes had been implemented in response to our concerns.

Resilience, including HART, applied evidence-based practice during care and treatment and had gained ISO 22301 for Business Continuity Management Systems. Significant progress had been made in terms of staff education including the assessment of core competencies and performance outcomes. There were good examples of multi-disciplinary team working and coordination with other agencies. In relation to caring, there was no concerning information in terms of staff conduct and there were positive examples of how staff had supported patients and provided emotional support.

There were positive examples of Resilience planning and suitable on-going assessments of service demand and pro-active planning. In relation to the concerns

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highlighted with equipment and some vehicles, there was concern that the responsiveness of the Resilience function, including HART, had been compromised. This, potentially, could have had a negative impact on being able to provide a swift response to Resilience / HART related call-outs.

Is resilience services safe?

Inadequate ●

It was evident that staff understood how to report incidents and incident data was provided including incidents that impacted on patients. We saw evidence severe incidents were investigated. There were examples where learning from incidents had been applied to practice but, overall, feedback mechanisms to staff about reported incidents was limited.

The cleanliness of vehicles, mainly HART vehicles, was not to a suitable standard and the processes for ensuring vehicles were clean, both inside and out, were inconsistent. Roles and responsibilities were not clear and processes for checking vehicle cleanliness were not suitable. This was compounded by the fact that the vehicle cleaning team had stopped operating at the HART base without formal consultation.

Processes for checking and managing equipment were not effective and we observed high numbers of kit that were out-of-date. We also observed some missing items from within equipment bags where the replacement was available in the equipment store. There were also issues with storage of gas cylinders and the frequency of checks with breathing apparatus. Equipment lists, equipment checks and audit processes were not well established which affected assurances that equipment was available and safe to use during patient care.

Training provision was a mixed picture; improvements had been made in several aspects of training including training records and monitoring competency. Mandatory training across resilience and HART was a mixed picture and compliance with some areas of training, for example basic and intermediate life support, was relatively low.

Incidents

- We reviewed incident data for HART and Resilience between 25 March 2013 and 28 February 2015. For HART, there were a total of 79 reported incidents for that period; 39 no harm, 38 minor severity, one moderate and one catastrophic. Of the 79 incidents there were six that affected patients. Of the six, three were minor severity; two were classed as no harm and one as catastrophic.

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- The catastrophic incident centred on a patient who had fallen from height and delays with on-scene treatment. The incident had been fully investigated and we reviewed the serious incident analysis report (SIAR). Communication and planning between HART and the fire service were the key areas where lessons had been learnt.

- A number of recommendations were listed, and acted upon, in terms of learning from the incident including an inter-service debrief, Joint Emergency Service Interoperability Programme (JESIP) to focus on the importance of scene commanders working together, sharing of information about operational capabilities to be explored between the fire rescue service (FRS) and ambulance service through HART/FRS training programmes, Ambulance Service to work with FRS to understand the Aerial Ladder Platform capabilities, FRS to work with Ambulance Service to understand the Recovery pack capabilities and FRS and YAS to arrange visits across sites to raise awareness of control room procedures for staff.

- For the Resilience team, between the same dates, there were a total of 27 reported incidents. None of the incidents involved patients, 11 were minor severity and the remainder were classed as no harm.

- We spoke with the risk and safety manager based at the Resilience base in Rotherham (Magna base); as part of their role they had responsibility for the Trust's electronic incident reporting system known as DATIX.

- They described the processes by which staff, including staff within Resilience, was able to report incidents and the overarching systems in place for managing reported incidents and learning from incidents. Staff were able to report incidents in two ways, by completing an electronic DATIX form at a computer at their base or by calling a dedicated 24 hour telephone line, known as the clinical hub, where a person recorded the incident details over the telephone. During out-of-hours, staff dialled in to the 111 telephone line to report incidents.

- Paramedics we spoke with during a focus group, and those working within HART (Hazardous Area Response Team) felt the incident reporting telephone line, including the separate out-of-hours incident reporting line via 111, were useful because it was not always possible to access a computer, especially during a busy shift. However, the 111 out-of-hours line wasn't ideal because the calls from staff went in to a queuing system and staff said they often didn't have the time to wait on the telephone line in order to record an incident.

- The risk and safety manager at Magna base said incident reporting figures increased following the introduction of the 24 hour incident reporting line and this was because the process for reporting incidents had become more accessible to ambulance crews who were 'on the road' for most, if not all, of their shift.

- The Trust had a roll out programme over two years to provide computers within ambulances, known as Tough Books, as an additional way of reporting incidents, and providing feedback from incidents to staff, but the Datix reporting system did not support their use; the two systems were not compatible.

- The risk and safety manager at Magna base said that all reported incidents, including those from HART, were sent to a team based in Wakefield where they were briefly reviewed and then assigned to the appropriate manager. The risk manager, and other ambulance staff we spoke with, felt that incidents were under-reported and feedback from incidents was limited.

- We were told that team leaders, from a trust-wide perspective, who had a key role in feeding back learning from incidents to their team, were too busy managing front-line operational activity and did not have time to provide consistent and informative feedback from incidents. The risk manager said investigations in to incidents were not high on the agenda because of the demanding operational challenges. Incidents could be 'open' for a considerable period of time and closed after not being fully investigated because details had been forgotten; this affected the ability to analyse and learn from incidents.

- HART paramedics we spoke with said they reported incidents via Datix or the clinical hub. They said feedback from incidents was limited but some was provided via the weekly operational update sent to all staff every Friday but staff needed to seek this information on their own accord.

- It was felt that feedback and lessons learnt from incidents was not well established and processes could be improved. For example, HART paramedics had reported, via Datix, safety concerns with a device used to hold Midazolam ampoules. Issues had been reported on

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numerous occasions but no feedback or intended actions had been received back. This meant that on-going problems with the medicine holders went unreported because no action was being taken.

- A HART paramedic commented that the feedback loop was not done in full and a manager told us that that there was a perception amongst staff that the reporting system was bureaucratic and unwieldy and there was a mind-set of getting into trouble when reporting incidents.

- We asked about lessons learnt from incidents that took place across in other HART teams and staff told us they used the PROCULUS system to report incidents for national investigation. This is a nationally purchased computer system that all HART teams are required to use. However, one manager told us that the system had security concerns and for that reason not all incidents were logged on it. It was unclear if the concerns with the system's security had been reported to the necessary personnel.

- We asked about feedback and we were told that staff received HART specific bulletins which they were required to sign as having been read. We asked about a recent example of national learning and were told how the Polaris all-terrain vehicle had been fitted with doors as a result of another team's experience of rolling one over on its side.

- Staff also told us that lessons had been learnt internally from the serious flooding events that affected the area some years previously and how this had resulted in the adoption of additional equipment together with the appropriate training to rescue casualties in flooded areas.

- HART paramedics described how, in some situations, incidents were discussed 'on scene' through a debrief process; this was positive and promoted learning and improvements to practice. However, the sharing of lessons learnt from such 'on scene' debriefs to other HART paramedics within the service, and nationally, was unclear.

- From speaking with operational paramedics, HART paramedics and the risk and safety manager at Magna base, the thresholds for reporting incidents were not clear and there was no clear policy and/or guidance for what types / severity of incidents should be reported.

- At a more senior level, we were informed that there was an incident review group that met every two weeks to review serious incidents (SIs); there was also a

medicines management group that also reviewed certain incidents. Feedback was presented to staff via bulletins. The staff involved in reviewing SIs had received specific training in root cause analysis (RCA) and reflective practice was also part of the learning process.

- An external audit report produced in November 2014 highlighted the fact that lessons learnt from incidents and exercises were not well cascaded across all teams within HART; the report advised to review this and improve cascading of information. From our discussions, work still needed to be done in this area.

Safety thermometer

- The NHS Safety Thermometer tool was developed by the Health and Social Care Information Centre (HSCIC) to support patient safety, measure harm and reduce harm. The success of the NHS Safety Thermometer sits in enabling frontline teams to measure how safe their services are and to deliver improvement locally.

- The NHS Safety Thermometer is not relevant in some areas, such as ambulance trusts, but we asked about the processes for harm measurement and reporting. We found the trust produced a monthly safety thermometer briefing and included the number of harm-free days and incidents relating to the patient transport service (PTS) and Accident and Emergency (A&E) service. We reviewed the safety thermometer briefing for December 2014 and there had been nine harm free days.

- The executive director of standards and compliance described how the weekly operational update to all staff was a key way in which safety information was cascaded. Paper copies of the operational update were provided to locations across the service and it was also available on the Trust's intranet. The update included data on numbers of incidents and any patient safety concerns that have been raised as a concern.

- Staff we spoke with was aware of the operational update, but in most cases, said they didn't have time to read it. Staff described how team meetings were a useful time to discuss the content of operational bulletins but, again, operational pressures meant the time for team meetings was limited.

Cleanliness, infection control and hygiene

- We observed the environments at the Resilience bases, in Rotherham and Leeds. The Leeds base was where the HART team were situated. We also observed vehicles at

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both sites; some were associated with HART and other vehicles associated more broadly with Resilience, specifically the Mass Casualty Vehicles. HART specific vehicles included a command vehicle (CV), forward reconnaissance vehicle (FRV), heavy equipment vehicle, two four wheel drive vehicles, two urban search and rescue vehicles, a six-wheeled vehicle and its carrier and a crew cab.

- We inspected the general environment of the CV and we were informed by a HART paramedic that the CV could be used to assess patients within the vehicle but that was not its main function.
- The functional areas of the vehicle included several computer monitors, a computer chair, a table with seating around, a sink and a small fridge. The floor area was dusty and the overall environment was untidy. There were lose boxes behind the seating area and gloves, lose out of their box, on the floor behind a seat.
- We continued to inspect other vehicles including the two four wheel drive vehicles, the urban search and rescue vehicles and mass casualty vehicles. Overall, the majority of the vehicles were excessively dirty on the exterior; this took into account recent operational activity of the vehicles and the inclement weather. The HART crew vehicle in particular was very dirty on the exterior and it was difficult to see the plastic casing of the rear lights; the floor within the vehicle was also dirty. This wasn't a patient-carrying vehicle but staff we spoke with acknowledged it should have looked more presentable.
- The interior of the vehicles, in the majority of cases, were unclean, especially the front cabins. One of the urban search and rescue vehicles in particular had thick mud on the floor in the front passenger foot-well and there was an open box of gloves on the floor; this vehicle had last been used two weeks previously. One of the four wheel drive vehicles we inspected also had an open glove box on the floor in the passenger foot-well.
- We inspected equipment bags and these were, overall, in a good state of repair and relatively clean.
- Staff had access to personal protective equipment (PPE) and hand cleaning facilities were accessible, such as, alcohol hand rub and detergent wipes.
- In relation to equipment use, there was mixed practice in terms of testing the light and batteries on the endotracheal (ET) tube blade handles. Ideally, all blades ready for patient use should remain within the manufacture's packaging until the point of use. Some

staff used a tester blade and some used the blade that would be used on patients to test the light and batteries. This was not ideal as the blade would have been touched many times and potentially be inserted into a patient's mouth.

- The general environment of the buildings at the Magna base and Leeds base were clean and spacious but there were concerns with the sluice areas at both sites. The sluice area at the Rotherham base did not have a designated hand wash basin and staff were required to use the sluice hopper taps to wash their hands; this was not ideal as hands should be washed in designated hand wash basins that should not be dual purpose. There was wall mounted soap and paper towel dispensers.
- Also at the Magna base, there was no bin liner in the clinical waste bin and there was domestic waste in the bottom of it. There was an open-topped small bin on the floor for domestic waste; it did not have a lid.
- The sluice area at the Leeds base was untidy and the domestic waste bin was overflowing with rubbish. The three hand wash / hand-care liquid dispensers on the wall were empty; no soap was available for hand washing. There was also a damp used mop placed head-down on the floor; the mop head should have been thrown away after use as they were single use mop heads.
- We shared our initial findings, as described above, to the head of Special Operations during the inspection. They reported they were disappointed and there was a clear commitment to ensure short-falls were promptly rectified.
- We re-visited the HART base unannounced shortly after the initial inspection to assess the changes that had been implemented in response to our concerns. We found that immediate improvements had been undertaken and all equipment had been audited and replaced with new equipment where necessary.
- We visited the base on a further occasion unannounced to check the changes were still being implemented and found that they were.
- New processes had also been introduced to tighten up assurance including the introduction of a daily vehicle handover sheet and more frequent documented equipment checks.

Environment and equipment

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- We had significant concerns within the service about the checking of equipment, a large number had passed their expiry dates and assurance processes had not detected this. There were also inconsistencies with checking of breathing apparatus and the processes observed did not follow best practice guidance. We re-visited the HART base two days after the announced inspection and one month later to check that changes had been implemented in response to our concerns.

- We checked medical equipment on the CV within the red equipment bag and found several items had passed their expiry date. We continued to check other items within the bag and found more of the same. We checked the Automated External Defibrillator (AED) on the CV and it showed that it was not ready for use and was not suitably charged.

- There was confusion around the CV itself and its position within the Leeds station. The vehicle was connected to one electrical supply initially; staff were not certain if that ensured all 'systems' within the vehicle were being charged appropriately. During the inspection, the CV was started and the generator was also running which suggested all systems were not fully charged. A senior member of the HART team said that the vehicle would not be ready to dispatch if required and there had been confusion as to how the vehicle should be connected to the electrical supply.

- During our second inspection visit, the vehicle had been moved to a different position, two electrical cords were connected and laminated guidance had been attached to the electrical cords providing information on the correct procedures for keeping the vehicle on standby.

- We were assured during the initial announced inspection by a HART team leader that the equipment within the cube bags would be in order and within expiry dates. The HART team leader explained that some equipment which was missing was on order. However, we had observed that some of the equipment had arrived in stock and was in the main equipment store; it had not been placed within the necessary equipment bags. Within the cube bags several items had passed their expiry date including six ET tubes and two chest drains which expired in 2013. In addition, two of the airway management kits did not have ET tube blade handles.

- We spoke with two HART paramedics about the kit and they were surprised with some of our observations and described how, if at an incident, kit was missing, there would be other crews around with their own medical equipment that could be used as a back-up. However, this meant the service could not be assured the kit bags had all the equipment required for an emergency situation.

- We checked other important equipment including breathing apparatus (BA) sets. The HART team at the Leeds location had six BA sets and these should have been checked at the start of every shift. We were informed that the number of BA sets checked was dependent on the number of HART paramedics on duty and a minimum of four BA sets should be checked per shift. We noted that on one vehicle, two of the four sets had not been checked that day; one set had been checked the day before and the other set two days before.

- A HART paramedic we spoke with stated that any sets not checked could be checked 'at scene'. However, this is contrary to best practice guidance and the expectation that all BA sets arriving 'at scene' were ready for use. If any faults were detected whilst checking sets 'at scene' the options to repair the kit would be limited and this could affect any rescue operation.

- We also observed the BA cylinder oxygen refilling room where BA cylinders were attached to a compressor for refilling. We observed cylinders attached to the machine and asked three HART paramedics and senior managers if they were empty or full. Two paramedics said they were full and another thought they were empty. There was potential for staff to take a cylinder from the room expecting it to be full when it might be empty. This issue was rectified at the time of our visit and signage was placed on the door to say that no cylinders should be left in the room at any time; this mitigated any chance of confusion.

- We also had concerns about the storage of gas cylinders at the HART base in Leeds. We observed that full and empty Oxygen and Entonox cylinders we stored within the same rack; the different cylinders were not segregated. This was confusing and there was a risk of staff taking an empty oxygen cylinder or an incorrect type of gas out with them on a call.

- We checked the national resilience vehicles at the Rotherham Magna base and found that the necessary equipment and vehicle checks were being performed including ensuring tagged equipment bags were intact

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and vehicles were ready and able to start at any time. Some equipment had passed its expiry date, or was close to expiring, but there was an awareness of this and it had been documented and risk assessed.

- An external audit report produced in November 2014 highlighted areas for improvement in relation to equipment including checking of equipment. It was recommended that equipment should be checked on a regular basis to ensure all of the necessary equipment is on board the vehicles in case of an emergency call out. It was also suggested that checks should be recorded and signed by the individual on a log sheet to evidence that they have been carried out and that HART should receive feedback of the findings to ensure their records are complete in relation to checks carried out on equipment.

- The audit also pointed out that there were no up-to-date inventory records in place or held centrally by HART. The inventories in place for HART vehicles were found to be out of date and it was recommended to have separate inventories for each of the HART vehicles. During our inspection we found similar issues as highlighted within the November 2014 audit report but action by the trust to introduce the advised changes had not been effective.

- There were standard operating procedures (SOPs) in place for HART in relation to medical equipment, HART vehicles and daily shift requirements for operational HART staff. From our observations, the SOPs had not been consistently followed which negatively impacted on equipment and vehicle maintenance.

- Processes had also been improved for ensuring breathing apparatus was checked at the beginning of every shift and gas cylinders were stored separately including a having a separate rack for Oxygen, Entonox and empties. The inventory list for all vehicles had also been revised and was easier to follow and audit against.

Medicines

- We spoke with a HART team leader about medicines and the processes in place for managing medicines including storage and controlled drugs.
- Controlled drugs were stored securely and access to the controlled drugs store was closely controlled.

- Every night at mid-night, an audit was undertaken of the controlled drugs to ensure stock was being managed safely in in-line with best practice guidance. Audit records were sent internally on a monthly basis for review.
- The system for booking in and booking out medication at the HART base in Leeds was effective and there were no areas of concern.
- Drug checks were completed daily; this was evidenced by the controlled drug sheets held with each set of drug packs on the vehicles.
- Prescription only medications were noted in general stores and no evidence could be found for the booking in and out of these.

Records

- We were not able to observe patient record forms (PRFs) being completed by HART paramedics but we spoke with the team about the PRFs. The team used the same form as all operational staff and did not raise any concerns.
- We reviewed records for auditing and checking equipment on vehicles. There was a relatively new itinerary list on all vehicles which was laminated and staff audited equipment against the list on a monthly basis. It was evident, from the examples provided, that such checks had not been completed to the required standard and with the exception of the controlled drugs list, there was no documentation to refer to as part of an audit trail.
- Promptly after the inspection, the itinerary list was revised and included columns and space for signatures to enable an audit trail to be maintained.

Safeguarding

- We spoke with staff, mainly from HART, about their safeguarding responsibilities; all were knowledgeable and confident about the procedures that they should follow and were able to describe circumstances where they had needed to make a safeguarding referral.
- Staff explained that reporting was done through the clinical hub because the service covered so many local authorities this was a practical and safe way to do this.
- We asked staff if they got feedback following a safeguarding referral and they told us feedback was always provided.

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- Staff told us that they received safeguarding update training as part of their mandatory training updates and this included adult and child safeguarding. Updates were provided every three years.
- Safeguarding training data indicated the lowest compliance area related to safeguarding children was training at level 2. For staff who required this training, compliance was 48% for the HART division and 75% for the emergency planning division.
- Following the inspection, we were informed that staff from across the two divisions were to attend mandatory training sessions at weekends in order for staff to meet their mandatory training requirements.

Mandatory training

- The HART function operated within a service specification defined by the National Ambulance Response Unit (NARU) which required each HART team to have a one whole time equivalent training resource and for one week in seven to be a dedicated training week. We asked whether this expectation was adhered to and all staff told us that this was the case and that the training mandated by NARU was protected and delivered, whether this was done locally or delivered as national training alongside other HART teams. We asked about mandatory training mandated under other legislation such as that required for working safely at height and using breathing apparatus and staff confirmed they were up-to-date with such requirements.
- We also confirmed that staff participated in the NARU mandated On-going Physical Competence Assessments (OPCA) and that appropriate action was taken in respect of staff whose performance needed attention. We also saw that the HART facility had a gymnasium facility and that staff had time to use the facility to maintain their fitness.
- Staff training records consisted of certificates, reflective practice sheets and the electronic training records based on Resilience Web (Res Web). Res Web is an intranet based portal which all HART staff had access to and each member of the team and their respective clinical supervisors could access the training records and record a period of training which covers a specific element of HART core competency. The reference then corresponds to a reflective practice piece which is stored in the staff members training file which is held in the training manager's office.

- An external audit report produced in November 2014 highlighted concerns with training records and inconsistencies between the national training competencies and the competencies listed on Res Web. The report also stated that HART did not have a process, at the time, for identifying when an individual's training had lapsed or approaching expiry.
- We reviewed mandatory training figures for the HART division and the emergency planning division, these are tabled below. Compliance with mandatory training (excluding safeguarding), for HART, showed the majority of figures over 90%; the least compliant areas were basic and intermediate life support, fire safety, moving and handling, conflict resolution and information governance. It was surprising to note the low compliance with basic and intermediate life support taking in to account the job role.
- The training figures for the emergency planning division were more variable and the majority of figures were above 75%. Compliance in any subject was not below 45%. Areas with the lowest compliance, at around 47%, were basic life support and fire safety. Information governance was at just under 59%.
- A HART specific training plan had been developed in December 2014 with a focus on improving the processes for recording training and more generally, better facilitate staff development and education. Although in its early stages, there were distinct improvements in to how training was managed, recorded and monitored.

Assessing and responding to patient risk

- We spoke with a team of HART paramedics, including team leaders, about assessing and responding to patient risk. This was seen as an integral part of their role and a central component of the service provided.
- Staff described a range a set protocols relating to the assessment of risk including dynamic risk assessments and other assessments for different situations, for example, working near water or at height.
- Staff clearly described other tools that formed part of risk management including decision-making tools and certain SOPs.
- At a more strategic level, we spoke with Associate Director of Resilience and Special Services and it was evident that risk assessments were integral to the work of Resilience and HART.
- A comprehensive overview was provided in to how YAS managed risk including anticipated safety risks and

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changes in demand. It was also clearly explained how impact to safety was considered and how Resilience worked with operations to ensure appropriate response capability.

- We reviewed a 'live' document that set out the trust's management of forthcoming strike action and a key focus was to identify any potential compromises to YAS functions through risk assessment.
- Command and control structures were clearly set out within policy documents and staff we spoke with were clear about the processes and individual responsibilities when responding to patient risk in a variety of different events / emergency situations.

Staffing

- There was a clear hierarchy and structure in place for Resilience and HART which included the Associate Director of Resilience and Special Services, Head of EPPR, Head of Special Operations, Business Continuity Manager, Resilience Managers and Resilience Learning and Education Co-ordinator. There was also a resource co-ordinator, admin support and the seven HART teams.
- There were 42 staff members within HART that were grouped into seven teams of six including Alpha, Bravo, Charlie, Delta, Mike, Papa and Tango. This met the minimum level of staff as recommended in National Ambulance Resilience Unit (NARU) service specification (2012).
- Senior staff within HART felt that six staff per team was the optimum number in order to provide safe systems of work but other configurations were being considered as part of the stage 3 National HART Audit Review. Other options included having five teams of eight or six teams of seven.
- We were told that the Resilience function was currently staffed by six band seven managers plus a band 5 training coordinator, down from a previous staffing level of nine. This situation was described as 'challenging' but an additional manager had recently been recruited which had helped with workload.
- Because of the staffing challenges we were told how the team tried to work as efficiently as possible including using teleconferencing facilities to make best use of time.
- Senior managers told us that there were pressures on having enough staff trained for particular roles in the Resilience function, particularly as some of the roles relied on volunteers. An example given was that of staff

trained to respond to Marauding Terrorist Firearms Attack (MTFA) incidents. While all the HART team were trained to do this as part of their core job description another sixty were needed but only forty seven had volunteered and been trained.

- We spoke with the head of EPRR and the team included six band 7 managers, one band 6 and one admin support worker. The team had been reduced over time and the team had adapted to ensure work commitments were managed effectively. Some concern was raised about the turnover of operational leads and ten positions had been lost since 2006.
- Concerns with the reduction of operational leads was raised by other senior level staff as it reduced leadership capacity, visibility and the number of role models within the service at operational level.

Medical staffing

- We spoke with the interim director of operations about medical support within the trust, the medical director and interim director of operations were both medically trained and provided medical support where required. YAS also had six medical advisors who provided medical advice / support.
- The medical director (MD) fully supported HART paramedics in advancing their clinical skills and for HART; some medical interventions they could provide were particularly specialised. For example, insertion of chest drains and femoral nerve blocks.
- The interim operations director and MD supported HART having the specialised skills and the regional location of the HART had an influence on this, for example, entrapment in mines was a particular risk because of the mining industry.
- HART paramedics could only perform certain medical interventions after having specialist training and there was regular periodic testing. In addition, with chest drain insertion for example, the paramedic was required to get permission from a medical advisor before performing the procedure on a patient.

Is resilience services effective?

Not sufficient evidence to rate ●

It was evident that resilience, including HART, applied evidence-based practice during care and treatment and

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had gained ISO 22301 for Business Continuity Management Systems. There were effective processes in place for the management of pain relief and staff had suitable to information. Significant progress had been made in terms of staff education including the assessment of core competencies and performance outcomes. There were good examples of multi-disciplinary team working and coordination with other agencies.

Evidence-based care and treatment

- There were examples where it was evident that evidence-based care and treatment had been central to the development of policy, procedures and practice. An example of this was in relation to the Trust's business continuity management and business continuity management system; these were important for establishing the Trust's resilience.

- The trust was classified as a CAT 1 responder under the Civil Contingencies Act (CCA) 2004 which meant they had a legal responsibility to develop robust continuity management arrangements. The trust had effectively demonstrated its compliance with specific core standards and other frameworks in relation to its business continuity requirements.

- The trust had fulfilled all requirements in relation to International Organisation for Standardisation (ISO) 22301 (previously BD25999) - Societal Security – Business Continuity Management Systems – Requirements. The trust was the first ambulance Trust and second NHS Trust to have achieved this standard.

- We spoke with HART paramedics about evidence-based care and treatment and all were clear about where to access clinical guidelines and clinical updates; this was via the Trust's intranet site. The team acknowledged that their work patterns enabled them to have time to review clinical updates and any newly released guidance.

- HART paramedics, in-line with NARU specifications, had a protected training week, one out of every seven weeks. This was to ensure skills levels were maintained because with certain HART skills there can be rapid fade. During this week, new information and/or clinical updates were provided.

- At the trauma desk within the control room we noted that the assessments, care and treatment plans were made in-line with evidence-based guidance including the major trauma triage tool.

Pain relief

- Staff we spoke with were clear about the methods used to assess patient's pain which included the use of standard pain assessment tools.

- There was also clear guidance and training for HART paramedics in the use Entonox, intravenous Morphine and, since early 2013, some could administer Ketamine in small doses for patients in severe pain. HART paramedics also administered Midazolam. The use of Ketamine and Midazolam needed prior approval from the on-call medical advisor.

Nutrition and hydration

- Of the equipment we reviewed including equipment bags and equipment for mass casualty situations, equipment was available to enable intravenous access to provide hydration.

- The communication vehicle and the reconnaissance vehicle had the ability to provide hot and cold drinks.

Patient outcomes

- We spoke with the interim director of operations about patient outcomes and there was data available, particularly in relation to HART and patient survival rates.

- Return of spontaneous circulation (ROSC) rates of survival to discharge figures were captured and sent to HART staff. Staff got commendation for their work and ROSC figures were a part of this.

- We spoke with HART staff about patient outcomes and staff could also enquire about patient outcomes, for trauma patients, via the trauma desk.

Competent staff

- We spoke with the HART training lead and discussed the training needs of the HART unit. A key part of this included competency based learning. There were 6 sets of 'HART National Continuing Professional Development Modules' which included 176 competencies for the HART unit. There were also four practical exercises for each module area.

- It was noted that not all HART staff were required to complete all of the specific modules but every team had to have team members that were trained in each of the seven modules.

- The training lead acknowledged that concerns had been raised in a previous external audit in November 2014

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about training records and it was not always clear if HART staff were up-to-date with their training or not. The audit found some inconsistencies between the national training competencies and the competencies listed on ResWeb.

- Competence profiles for HART were on ResWeb and individual training records were stored in the HART training manager's office. In addition, individual CPD files were being developed which aimed to standardise the process across all teams and improve the process for flagging when someone's training needed updating. However, the training lead recognised that there was still some way to go in terms of finalising and embedding the new processes.

- We reviewed the process for assessing core competencies and performance outcomes and significant progress had been made. We tracked a HART paramedic's training log and completion of specific courses had been recorded accurately but their 'reflection of learning' record was not in their file. However, we reviewed some existing reflection logs and they were accurately completed.

- In terms of the wider Resilience we were assured that necessary staff had attended the Joint Emergency Services Interoperability Programme (JESIP) course, this included all CSs and tactical commanders.

- A key part of the resilience function was to have staff trained at Bronze Commander level to take immediate charge of an incident; the trust had 170 members of staff trained to this competence.

- We were told that it was difficult to get operational staff 'off the road' to participate in half day training for incident triage training and the trust had assessed the impact of this. However, it wasn't clear how the trust planned to support frontline staff to be released for such training. This was a particular challenge because Resourcing Escalatory Action Plan (REAP) levels had been at level 4 for several weeks prior to the CQC inspection. The levels of REAP ranged from 1 (normal service) to 6 (potential service failure).

- The trust was developing an electronic training package, like a video game, where participants could 'walk' through a scenario assessing risk and responding to events. An identified barrier to doing this was lack of IT

equipment on stations and a reluctance to stay behind after long shifts to use it. The trust was to approach this problem by encouraging staff to train in their own time and to pay them overtime on completion of the course.

Multidisciplinary working and coordination with other agencies

- We spoke with the head of EPRR and reference was made to the proactive engagement with other external providers / partners which supported co-ordinated care and planning. For example, working with the police, local community and local resilience forums (LRFs). The training rig at the HART base was also used by partner agencies.

- In addition, there was formal and informal sharing of resilience plans and joint exercises with multiple agencies, for example, recently, there had been two special firearms exercises.

- We spoke with staff about how they worked with other agencies such as the Fire and Rescue Service, Police and voluntary services. They explained how this was done under the Joint Emergency Services Interoperability Programme (JESIP) which used a Joint Decision Model (JDM) for working with fire and police.

- Staff also gave specific examples of working with Mountain Rescue and how they planned for working in confined spaces by training with Mines Rescue. We were also given an example of how, as a result of this, they had adopted the use of self-rescuer systems as used in the mining industry.

- We asked about how the HART and Resilience function worked with operational crews to ensure that incidents that required specialist support were triggered. HART operatives told us that road crews tended to trigger earlier rather than later and this was an appropriate risk adverse approach.

- In the Emergency Operations Centre (EOC) we saw that staff referred to a "Blue Book" which listed known locations and incident categories that would trigger the consideration as whether to send a specialist response.

- When we spoke to HART team operatives they also told us of this system and that in their opinion it was effective with the team being deployed appropriately.

Seven-day services

- The HART service was on standby and operational 24 hours a day, seven days a week.

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Access to information

- Members of HART felt that access to information was adequate and much of the information provided by the Trust was easily accessible on the intranet system.
- Staff also described a number of bulletins that were sent out to staff and these were usually displayed on the staff notice board and / or discussed at team meetings.
- Policy guidance documents, SOPs and other clinical guidance were also easily accessible via the intranet and internet.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- HART staff we spoke with were clear about their roles and responsibilities in terms of consent and the Mental Capacity Act. Staff described how the clinical hub was a key resource for support and advice.
- Staff were clear about referral pathways for patients presenting with mental health needs and examples were provided where referrals had been successfully made.
- Mental health awareness and mental capacity was a specific mandatory training topic and compliance figures with this have been shown earlier in the report.

Is resilience services caring?

Not sufficient evidence to rate ⬤

We were unable to observe Resilience and / or HART staff interact with patients but evidence supported the fact that staff effectively communicated with patients and offered appropriate support during, what were often, traumatic situations. We were assured that staff were respectful towards patients and there were processes in place to monitor staff behaviour and quality of patient interaction.

Compassionate care

- We were unable to observe Resilience and / or HART staff interact with patients during the inspection as the opportunity to attend a call-out did not arise. We were able to speak with paramedics who had worked alongside HART operatives and there were no negative comments made about their care or attitude towards patients.

- HART staff we spoke with described how they worked closely as a team, and with other teams, within and external to the trust. If there were concerns with staff attitude or their compassion towards patients, or colleagues, this would be flagged with senior staff. The team stated that no concerns had been raised about their conduct at scene and / or their interaction with patients.
- The team described a key principle of being a healthcare professional in that they were non-judgemental and professional with all patients no matter what the circumstance.

Understanding and involvement of patients and those close to them

- We were unable to directly observe Resilience / HART staff interact with patients but the team provided recent examples of the support provided to patients and those close to them. For example, on the night previous to one of our site visits, a HART paramedic described a situation where a patient was anxious about leaving the house. Staff comforted the patient and explained in detail their intended actions and alternative options; this provided reassurance to the patient and enabled them to make an informed decision.
- In another example a patient was in significant pain and staff described how, again, the patient was comforted and reassured in a timely way and given suitable pain relief.
- If there were concerns with a staff member about their interaction with patients and / or those close to them, staff said this would be reported to a senior member of the team and action would be taken. All staff we spoke with understood the process for raising concerns about the conduct of their peers.

Emotional support

- HART paramedics we spoke with described how providing emotional support to patients during an incident was an important aspect. Where possible, during an incident, patients were reassured and comforted and informed about the emergency treatment required. Support was also important to help manage fear, anxiety, shock and panic.
- Access to services following an incident was likely to be gained through acute hospital or community services.

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Is resilience services responsive?

Good 🟢

We found positive examples of Resilience planning and suitable on-going assessments of service demand and pro-active planning. We also found that, on the whole, HART operatives, if attending an operational job, were promptly relieved to attend a Resilience call-out if necessary.

In relation to the concerns highlighted with equipment and some vehicles, there was concern that the responsiveness of the Resilience function, including HART, had been compromised. This, potentially, could have had a negative impact on being able to provide a swift response to Resilience / HART related call-outs.

Service planning and delivery to meet the needs of local people

- The Resilience function took the lead in assessing and responding to events that affected both the demand on, and the delivery of, the service.
- Each day the service demands and constraints were assessed and a REAP level was assigned as required by national practice standards. REAP levels were discussed a least twice a day during scheduled planning conferences in the morning and afternoon.
- We saw how the trust had a database of information (ResWeb) which held guidance for dealing with particular incidents. These plans were available on the laptop computers of the Silver Commanders who would offer the information to the Bronze Commander at scene or attend as required.
- We looked at example plans and saw that they were written within the JESIP framework and involved other agencies as needed. For example, for a secure psychiatric hospital the fire plan involved the fire service, police, healthcare provider and the prison service. The flood plan for the building which was assessed as being at risk also involved the environment agency.
- We spoke with the head of EPPR and positive examples were given around the planning and delivery of the Resilience function, for example, protest marches. Such an event required liaison with the police and other agencies in order to meet the needs of local people.

- Other examples of Resilience planning we reviewed were around the challenges faced with severe weather. We found positive evidence of risk assessments and plans to deal with severe weather and at any time the Trust was assigned a status of Normal, Watch or Act.
- We spoke with the Associate Director of Resilience and Special Services and they provided several examples of service planning including major incident planning. The major incident plan (MIP) had been updated and was due to be presented to Trust Board; a quality impact assessment had also been completed.
- We reviewed a current Resilience plan which was around the expected strike / industrial action. The plan included 'tactical' level plans that the trust would need to have in place to deal with the 'worst case scenario.' The plan included the expected considerations including threat and risk assessments, planning, coordination and control and tactical options.
- A number of work streams were evident to support service planning and delivery to meet the needs of local people. Training and equipment was evident to support the ability to respond to specific scenarios. We were given an example of working with the local community in preparation for a march which took place.
- In relation to the concerns highlighted with equipment and some vehicles, including equipment bags, cubes, the command vehicle and BA sets, there was concern that the responsiveness of the Resilience function, including HART, had been compromised. However, following the inspection, staff were prompt to rectify the immediate concerns raised and ensure better preparedness.

Meeting people's individual needs

- Evidence was provided for addressing potential barriers to meeting people's individual needs, for example, liaising with community leaders prior to protest marches and involving people through local resilience forums.

- From speaking with staff working within Resilience and HART staff, we were told that the Emergency Operations Centre (EOC) were able to support front-line staff in meeting people's individual needs. For example, some patients are known to the service and staff are informed of the best way to meet certain people's needs based on previous experiences.

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- HART staff provided specific examples where they were able to plan their care in advance of arriving on scene. For example, when supporting bariatric patients on to ambulance for a transfer to hospital.
- At a more strategic level, we spoke with staff about mass casualty events and how people's needs were assessed and prioritised. Staff were clear about the command structures in place and risk assessment and triage processes.
- In relation to meeting staff needs, a HART paramedic felt there was little support provided to staff after incidents; this was a trust-wide issue in their view.

Access and flow

- We saw between 1 October 2014 to 31 March 2015 the resilience team responded to 1,411 calls.
- There were mixed views from staff about 'flow' and some HART paramedics felt that their responsiveness to Resilience work had been, on occasion, compromised. This was because, in their view, they were not always 'relieved' by other crews in a timely way when having been called out to support day-to-day operational work.
- We were informed by the Associate Director of Resilience and Special Services that one HART rapid response vehicle (RRV) was allocated to support day-to-day operational work and it was seen as a priority to relieve HART crews from an operational job if a Resilience call came through.
- We also spoke with the Associate Director of Resilience and Special Services about HART vehicles and the support provided to front-line operations. There were agreements in place for the level of support provided by HART, to operations, and we were informed that audit figures showed acceptable back-up times if a HART vehicle / crew needed to be released for a HART job.
- We reviewed specific data showing the average back up time for a HART RRV that arrived first on scene and between August 2014 – January 2015, for Red 1 calls, average back up times ranged between just under 1.5 minutes to just under 13 minutes. For Red 2, times ranged between 11 minutes to just under 19 minutes.
- Back up times for Green 1 to Green 4 calls were more variable and most were between 16 minutes to 26 minutes. There were two occasions for Green calls where back up times were over 40 minutes and two over 30 minutes.

- From a discussion with a group of HART paramedics, the team felt that, overall, the HART RRVs were well protected and only really used when REAP levels were particularly high.

Learning from complaints and concerns

- The complaints mechanism for the resilience function operated in the same framework as the rest of the organisation. Complaints could be made through the patient advice line and the website. We understood there were few complaints in respect of this core service.
- We spoke with the head of EPPR and a detailed explanation was provided in relation to the complaints process. It included being open and honest, meeting face-to-face with complainants where necessary and also involving the Patient Liaison Advocacy Service (PALS).

Is resilience services well-led?

Requires improvement ●

There was a clear strategy for the Resilience function and clear strategic direction. There was clear overview in relation to business continuity and HART staff understood the aims and vision for the service.

In relation to HART, and the issues identified with cleanliness and equipment, there were weaknesses in governance processes and assurance. Some feedback processes to the Head of Special Operations had not been effective which resulted in some risks to patient safety being misses.

The culture within the service was seen to be open and supportive and HART worked professionally with operational staff and other agencies such as the fire service and police.

Vision and strategy for this service

Strategy

- There was a clear strategy for the Resilience service, at a local level, and key elements included protecting lives, maintaining key services, managing capacity and capability and working together with multi-agency partners to mitigate risks.

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- Much of the strategic direction in terms of emergency preparedness was prescribed by NARU which was a small team set up in the summer of 2011. NARU worked with and on behalf of the Department of Health (DH) to provide advice and guidance on ambulance specific matters in relation to Resilience planning and preparation and being compliant with the Civil Contingencies Act 2004 and the NHS England EPRR Core Standards Framework 2013. One of the key NARU objectives was to maintain HART capability nationally.
- We spoke with the Head of EPPR who explained how they had worked to get the Resilience function 'well embedded' across the rest of the service and they were clear about the strategic objectives and vision and values, from both a local and national perspective.
- Vision and values, at a local level, were clearly established and included: working together for the patients; everyone counts; commitment to quality of care; always compassionate; respect and dignity and; enhancing and improving.
- The business continuity manager had a clear overview in relation to business continuity across the Trust including education and audit. They were also clear about the strategic direction of the service and how business continuity fitted in with the wider work around Resilience.
- HART staff we spoke with understood the aims and vision of the Resilience function and HART capability and described where key information about this could be located; most was via the Trust's intranet service.

Governance, risk management and quality measurement

- In relation to HART, and in light of the concerns we identified with cleanliness and equipment, there were weaknesses with governance processes and assurance. For example, some of the concerns we identified had been highlighted in two previous audits; an internal audit conducted September 2013 and an external audit conducted in November 2014, both of which highlighted non-compliance with maintenance of equipment.
- Attempts were made to improve maintenance of equipment and an equipment inventory was introduced on to vehicles. However, the checking of compliance and feedback processes to the Head of Special Operations was not effective.

- Assurance processes for HART had weaknesses and this was discussed within the external audit report produced in November 2014. It highlighted areas for improvement in relation to reporting mechanisms.
- Recommendations included sending reports to either to a senior management group / committee or the Board on a quarterly / bi-annual basis. We noted that the Board received a bi-annual report on Resilience and HART was a component of that report. However, the assurance provided to the Board, in light of the concerns highlighted, did not represent an accurate picture.
- As mentioned, the Board received a report on Resilience which ensured the executive team were cited on key information.
- In addition, the Trust's compliance with ISO 22301 in relation to business continuity, provided assurance that systems and processes were effective.

Leadership of service

- We spoke with the Head of EPPR, Head of Special Operations, Interim Director of Operations and Associate Director of Resilience and Special Services. All felt well supported by the trust in relation to their roles and acknowledged the challenges they faced in terms of increasing operational pressures and resource allocation.
- Concerns were expressed in relation to the high turnover of operational managers and the fact that ten had left the service since 2006. This impacted on the number people in leadership positions and the level of experience within the service.
- People in leadership positions within Resilience / HART were knowledgeable and experienced and many had worked within the ambulance service for a significant period; they clearly understood the challenges of the Resilience / HART function.
- From speaking with staff within Resilience / HART, the majority stated that their colleagues in leadership positions were approachable and encouraged staff development. However, one staff member we spoke with did not feel their team was well led; this was mainly in relation to confidentiality and people being respected. They explained how sickness absences were too openly discussed which made them hesitant to be fully open and honest with their manager.
- From a more operational perspective, the service had recognised that the Gold Commander role, which oversees the most significant incidents, was not suitable

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for members of the executive team who did not have suitable operational experience. The role had therefore been devolved to suitably trained and experienced staff with the executives offering oversight.

Culture within the service

- The Head of EPPR felt there was a positive leadership culture and the Interim Director of Operations stated that HART paramedics worked effectively and professionally with operational ambulance crews across the trust.
- We spoke with a group of HART paramedics about the culture within HART and across the service. Overall, there was mutual respect within the team but some felt that some staff from outside of HART were not always respectful as they did not fully appreciate the work they did; especially the on-going training behind the scenes.

Public and staff engagement

- We spoke to HART team members about their engagement with the public and we were told that this was done less frequently as compared to when HART was initially set up.

Innovation, improvement and sustainability

- The HART team led on the development of the national Urban Search and Rescue capability and is at the forefront of introducing extended skills to these specialist clinicians. YAS is the only ambulance Trust to fulfil the requirements of the MERIT model which was being adapted to fulfil the new guidance for mass casualty.
- The HART base in Leeds was a relatively new building and the facilities and environment were modern.
- Staff described how the new base was a significant improvement as compared to their previous base and the service could be provided from there for many years to come.
- The training rig and equipment was innovative and many types of incidents were able to be simulated, for example, floors collapsing within a building, scaffolding collapsing and working in a smoke filled building. The training rig was also used by other services such as the fire brigade.

Outstanding practice and areas for improvement

Outstanding practice

- The trust's 'Restart a Heart' campaign trained 12,000 pupils in 50 schools across Yorkshire.
- The trust supported 1,055 volunteers within the Community First Responder and Volunteer Care service Scheme.
- Green initiatives to reduce carbon in the atmosphere by 1,300 tonnes per year.

- The emergency operations call centre was an accredited Advanced Medical Priority Dispatch System (AMPDS) centre of excellence.
- Mental Health nurses working in the emergency operations centre to give effective support to patients requiring crisis and mental health support. This included standardised protocols and 24 hour access to mental health pathways and crisis team.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure that equipment and medical supplies are checked and are fit for purpose.
- The trust must ensure all staff are up to date with their mandatory training.

Action the hospital SHOULD take to improve

- The trust should ensure all staff receive an appraisal and are supported with their professional development. This should include support to maintain the skills and knowledge required for their job role.
- The trust should ensure risk management and incident reporting processes are effectively embedded across all regions and the quality of identifying, reporting and learning from risks is consistent. The trust should also ensure staff are supported and encouraged to report incidents and providing feedback to staff on the outcomes of investigations.
- The trust should ensure all ambulance stations are secure at all times.

- The trust should review the provision and availability of equipment for use with bariatric patients and ensure staff are trained to use the equipment.
- The trust should review the safe management of medication to ensure that there is clear system for the storage and disposal of out of date medication. The trust should also ensure oxygen cylinders are securely stored at all times.
- The trust should ensure records are securely stored at all times.
- The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.
- The trust should all staff have received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The trust should ensure performance targets in relation to patient journey times and access to booking systems continue to be monitored and improve.
- The trust should ensure there are appropriate interpreting and translation services available for staff to use to meet the needs of people who use services.

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
Treatment of disease, disorder or injury	**Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** HSCA 2008 (Regulated Activities) Regulations 2014. Regulation 12(2)(h): Assessing the risk of, and preventing, detecting and controlling the spread of infections. We found that the trust did not always have the facilities, systems and arrangements in place to protect service users from the risk of exposure to a health care associated infection. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must ensure all ambulances and equipment are appropriately cleaned and infection control procedures are followed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 17 HSCA (RA) Regulations 2014 Good governance** Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 Good governance We found the trust did not have robust governance processes to manage risks in a timely and effective way. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requirement notices

The trust must ensure that equipment and medical supplies are checked and are fit for purpose.

The trust should ensure risk management and incident reporting processes are effectively embedded across all regions and the quality of identifying, reporting and learning from risks is consistent. The trust should also ensure staff are supported and encouraged to report incidents and providing feedback to staff on the outcomes of investigations.

The trust should ensure there is an effective system for reporting incidents and providing feedback to staff on the outcomes of investigations.

The trust should ensure records are securely stored at all times.

The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.

The trust should ensure records are securely stored at all times.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18 We found that the Trust did not always protect patients from unsafe or inappropriate care as not all staff had received mandatory training and had an appraisal. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must ensure all staff are up to date with their mandatory training.

Requirement notices

The trust should ensure all staff receive an appraisal and are supported with their professional development. This should include support to maintain the skills and knowledge required for their job role.