West Yorkshire Medic Response Team

WYMRT Registered Office

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 known to CQC and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

West Yorkshire Medical Response Team is operated by West Yorkshire Medical Response Team . The service is a charity and provides a specialist team of pre-hospital doctors and paramedics to the Yorkshire Ambulance Service NHS Trust to respond to emergency calls for the purpose of supporting life, preventing deterioration and promoting recovery prior to arrival at a hospital emergency department.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 5 March 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this service was urgent and emergency care.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There was an open culture in which all practices were reviewed and effective processes were in place to report, record and share learning from incidents.
- Staff were clear in their responsibilities to safeguard children and adults from abuse.
- The service had effective processes in place to protect patients from healthcare associated infections. The vehicle and equipment had been regularly maintained and serviced.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care.
- The service was committed to working collaboratively with the NHS ambulance trust and local hospitals to deliver joined-up, up to date evidence based care to patients.
- There was a comprehensive assurance system and audit process in place, which enabled staff to monitor performance and take actions to improve performance and patient safety as necessary.
- Staff showed a passion, commitment and drive to deliver the best possible care to patients. They offered their services voluntarily to provide this additional service for patients. There was high levels of staff satisfaction, staff were proud to volunteer their services.
- The leaders were credible, experienced, knowledgeable and demonstrated enthusiasm in their roles to both improve the care of patients and to increase the knowledge and skills for those who worked in the service.

However, we also found the following issues that the service provider needs to improve;

- The batch numbers on the medicines administered were not always documented on the patient report forms.
- Paramedics had not received an annual appraisal.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details of these are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals, on behalf of the 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 services		The main service was the provision of urgent and emergency care to critically unwell or injured patients by a team of experienced clinicians who delivered pre-hospital emergency medicine. There were effective processes in place to identify and learn from incidents. We found medical records to be complete, legible and reflective of the care and treatment provided. There was effective leadership and a comprehensive assurance system and audit in place, which monitored performance and actions were taken to improve performance and patient safety as necessary. The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care.

WYMRT Registered Office

Detailed findings

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Detailed findings

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Background to WYMRT Registered Office

West Yorkshire Medical Response Team is a registered charity that provides a trauma team to deliver pre-hospital care within West Yorkshire. The team is dispatched by the local NHS ambulance trust and works in partnership with the NHS ambulance trust. The team has one rapid response vehicle which is driven by the paramedic. The service is not contracted to any specific hours although it predominately operates on Friday and Saturday evenings or nights. The trauma team comprises of a doctor, specially trained in pre-hospital care, working alongside a paramedic. The paramedics have substantive employment with the local NHS ambulance trust and the doctors are employed within acute care trusts or general practice. All staff work as volunteers. The service provides ongoing education to the staff and is linked to a pre-hospital care development pathway for doctors, which is jointly supported by the three medical schools in Yorkshire.

The service has had a registered manager in post since 21 February 2014.

The announced inspection took place on 5 March 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Annette Wilkes and a specialist advisor with expertise in urgent and emergency care. The inspection team was overseen by Lorraine Bolam, Head of Hospital Inspection.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

West Yorkshire Medical Response Team is an independent registered charity that provides a trauma team as a response to emergency calls in West Yorkshire area. It is dispatched by an NHS ambulance trust emergency operations centre and provides an additional service to the NHS ambulance trust.

The service is not contracted to any specific hours although it predominately operates on Friday and Saturday nights. The trauma team comprises of a doctor, specially trained in pre-hospital medical care, working alongside a paramedic or emergency medical technician. The paramedic and emergency medical technicians have substantive employment with a NHS Ambulance Trust and the doctors are employed within acute care trusts or general practice.

All staff work as volunteers. The service provides ongoing education to the staff and is linked to a pre-hospital care development pathway for doctors, which is jointly supported by the three medical schools in Yorkshire.

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures.
- Surgical procedures.
- Treatment of disease, disorder or injury.

During the inspection, we spoke with 12 staff which were paramedics, doctors and the scheme coordinator. During our inspection, we reviewed 20 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC.

Activity (January 2017 to December 2017)

- In the reporting period January 2017 to December 2017 there were 90 shifts covered. The trauma team was dispatched to 543 incidents, which averaged four incidents per shift. This had increased from 401 incidents the previous year.
- The team were first on scene for 26% of the incidents and travelled with the patient in the ambulance to hospital in 24% of cases (92 incidents).

The staff volunteering for the charity were eight trustees and operational leads, six senior medical advisors, nine solo doctors, 15 paramedics and 23 junior doctors.

The accountable officer for controlled drugs was the trustee chairperson.

Track record on safety

- No never events
- No clinical incidents
- No serious injuries
- No complaints

Emergency and urgent care services

Summary of findings

We found the following areas of good practice:

- There was an open culture in which all practices were reviewed and effective processes were in place to report, record and share learning from incidents.
- Staff were clear in their responsibilities to safeguard children and adults from abuse.
- The service had effective processes in place to protect patients from healthcare associated infections. The vehicle and equipment had been regularly maintained and serviced.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care.
- The service was committed to working collaboratively with the NHS ambulance trust and local hospitals to deliver joined-up, up to date evidence based care to patients.
- There was a comprehensive assurance system and audit in place, which monitored performance and actions were taken to improve performance and patient safety as necessary.
- Staff showed a passion, commitment and drive to deliver the best possible care to patients. They offered their services voluntarily to provide this additional service for patients. There was high levels of staff satisfaction, staff were proud to volunteer their services.
- The leaders were credible, experienced, knowledgeable and demonstrated enthusiasm in their roles to both improve the care of patients and to increase the knowledge and skills for those who worked in the service.

However, we found the following issue that the service provider needs to improve:

- The batch numbers on the medicines administered were not always documented on the patient report forms.
- Paramedics had not received an annual appraisal.

Are emergency and urgent care services safe?

Incidents

- The service reported incidents directly using the NHS ambulance trust reporting systems and processes, as they worked in partnership with the NHS ambulance trust. They reported incidents by telephoning the clinical hub and an incident form was completed over the telephone. There was a drop down section on the form for incidents reported by the West Yorkshire Medical Response Team. All staff we spoke with were able to explain the process of reporting an incident.
- All incidents involving the provider were sent directly to the chair of the service, who was the clinical lead and a senior doctor. If required the incident was investigated jointly by the NHS ambulance trust and the provider.
- Any learning from incidents was discussed individually, and at the monthly training events.
- There were no reported incidents between January 2017 and December 2017.
- The chair of West Yorkshire Medical Response Team met monthly with the medical director of the NHS ambulance trust and would discuss any incidents.
- Staff understood the requirements of the duty of candour legislation; this was joint responsibility with the NHS ambulance trust.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care service to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support for that person.

Mandatory training

- The service required all clinical staff to have completed relevant statutory and mandatory training prior to being allowed to undertake independent practice.
- The training required was listed as infection prevention and control, information governance, safeguarding adults, safeguarding children, Mental Capacity Act and Deprivation of Liberty safeguards.
- The service did not provide the mandatory training in-house as all staff had other substantive posts and this training was a requirement of their substantive positions. Therefore, the board made a decision that rather than ask each staff member to repeat this

training; staff provided evidence that they were up to date with the training. We were told if staff had not completed the training and were unable to receive it in their substantive posts then this would be provided.
- We were told if a staff members training was not up to date they were given three months to undertake the training, if this was not completed, they were not permitted to undertake any clinical work.
- We looked at personal files and we saw evidence that mandatory training had been completed. There was a spreadsheet from the NHS ambulance trust with evidence of the three yearly programme of training for paramedics. Training figures showed that 100% of doctors had completed mandatory training between January 2017 and December 2017.
- Paramedics volunteering for the service drove the rapid response vehicle. They provided this as part of their substantive role in the NHS ambulance trust and their blue light driver training was delivered by the NHS ambulance trust. To assure the WYMRT that there has not been any change to their driving licence status; the member of staff had to produce evidence of this. As part of the annual membership declaration form, to work for West Yorkshire Medical Response Team , the staff member had to declare any change in status relating to driving and their ability to practice. Annually each paramedic obtained a code from the government licence check website, which provided an external check on their licence.
- We were told if there was any concerns regarding a member of staff driving and/or ability to practice then this would be shared with the NHS ambulance trust.

Safeguarding

- Staff underwent safeguarding training as part of their substantive posts. All doctors had completed level two safeguarding adults and level three safeguarding children training. Those who held consultant posts in their substantive role were level three trained. Paramedic staff had completed level two adults and children safeguarding training.
- The service followed the NHS ambulance trust safeguarding policy and a copy of the policy was accessible to staff.
- There was an effective system in place to report safeguarding concerns and incidents. Staff could describe the process which was to contact the clinical hub which was accessible 24 hours a day 7 days a week. The telephone number was located on a tag on the keys to the vehicle. This enabled safeguarding concerns to be reported in a timely manner.
- One of the consultants who volunteered for the West Yorkshire Medical Response Team was the safeguarding lead. They had level three safeguarding children training.

Cleanliness, infection control and hygiene

- The vehicle was cleaned at the beginning of each shift and staff documented this on an audit form. We observed the cleanliness of the vehicle and found it to be clean inside and out.
- A deep clean was undertaken every six weeks and we viewed the records of the six weekly deep cleans.
- The service had an infection prevention and control policy in place.
- Staff told us the importance of cleaning equipment after each patient use. Every six weeks a deep clean of the suction unit and boot liner was undertaken, this was documented and signed for on an audit sheet.
- Staff uniforms were laundered. Staff signed out uniforms each shift. All the uniforms were checked monthly to ensure they were clean and in good repair.
- Personal protective equipment and hand gel was available on the vehicle, to protect staff, prevent and control the spread of infection. Hand washing facilities were available at the hospitals and NHS ambulance station.
- Clinical waste was disposed at the hospital or ambulance station. Colour coded bags were available to segregate clinical waste. All sharps containers were dated and signed, none were over full.

Environment and equipment

- The vehicle used was a rapid response car, with the aim to get the trauma team as soon as possible to the incident so they could utilise their expert skills. The patients were transported to hospital in a NHS ambulance. The trauma team would travel in the ambulance with the patient when necessary. No patients travelled in the rapid response vehicle.
- The vehicle was kept in a NHS ambulance service garage and vehicle keys were stored securely in a key safe.

- Servicing, repairs and general checks on the vehicle were carried out by a local garage. Records showed the vehicle was compliant with Ministry of Transport (MOT) testing and there were appropriate records of insurance and road tax.
- If the vehicle were off the road for repairs, the NHS ambulance trust would provide another vehicle if one was available.
- There was a scheme support officer who was a paramedic, who had the responsibility of ordering and checking equipment and consumables, ensuring there was adequate amount of stock available. Staff told us they always had sufficient equipment and consumables available.
- At the beginning of each shift, crews checked the vehicle and the equipment and signed a checklist ensuring all kit and medications were restocked. This included checking the defibrillator. Both adult and paediatric equipment was available.

Medicines

- There was a medicine management policy for staff to follow for the ordering, receipt and storage of medicines and medical gases. This policy was based on current legislation and guidance.
- A clinical support officer was responsible for the day to day management, storage and ordering of prescription only medicines. The clinical support officer was accountable to the WYMRT chairperson who had overall responsibility and accountability for the management of medicines within the service.
- There was an agreed stock of POMs for the use by medical staff. Paramedics were able to administer prescription medicines within schedule 17 and 19 of the Human Medicines Regulations and the Joint Royal Colleges Ambulance Liaison Committee guidance.
- Medicines were stored in drug bags in the response car; these had tamper proof seals and were tagged. When the response car was not in use, the medication's remained in the locked car in a locked garage, to which only the designated healthcare professionals had access.
- Medicines were delivered to the local hospital and a small supply of replacement stock was kept at the local hospital where authorised staff had access to replenish the stock. In exceptional circumstances, there was an agreement that medicines could be restocked from the NHS ambulance trust stock at the local ambulance station. The NHS ambulance trust clinical supervisor would give access to the cupboard.
- Medicine stock and expiry dates were checked at the beginning of each shift. We checked the medicines and all were in date and there was adequate stock.
- Any medicine given was recorded in the service vehicle book and on the NHS ambulance trust patient care record.
- The service did not supply controlled drugs. The doctors carried and administered their own supply of controlled drugs. Paramedics were not permitted to supply or administer controlled drugs.
- Controlled drugs were stored in the vehicle safe during the shift. The doctors told us of the process they followed and we were assured that they handled controlled drugs safely and in accordance to the Human Medicine Regulations.
- When a doctor had administered a medicine, the doctor made a clinical judgement as to whether it was necessary to travel with the patient to hospital.
- Medical gases were carried on the vehicle. We found these were safely secured.
- We saw evidence of a monthly audit of medicines that was carried out throughout 2017. There was no discrepancies in the audit.
- When we reviewed the patient records we found not all medicines administered had a recorded batch number. We fed this back on the day of the inspection and this was to be highlighted with staff at the next training event.

Records

- The service used the NHS ambulance service patient report forms to record any care given to the patient. There was always a NHS ambulance crew attending the incident. Patients were transported to hospital by ambulance and the patient records went with the patient.
- We viewed 20 patient report forms and found them to be completed legibly, contained appropriate information and were signed and dated.
- There were blank patient report forms kept in the vehicle. We saw no evidence of completed report forms stored on the vehicle. These had been transported with all the patients to the hospital.

Emergency and urgent care services

Assessing and responding to patient risk

- Staff were trained to assess for the early detection and treatment of deteriorating patients.
- The NHS ambulance trust pathways and protocols were used. Staff had access to pathways and policies via the West Yorkshire Medical Response Team intranet which had a link to all the NHS ambulance trust policies and there was a hard copy of the policies kept in the vehicle. The staff we spoke with were familiar with policies.
- Staff were able to access the NHS ambulance service clinical hub and trauma desk if they required further information or advice. There was a WYMRT consultant on call for advice and who would support at an incident if necessary.
- The patient report forms we reviewed showed patients had appropriate observations recorded.
- The service had 21 standard operating procedures which standardised practice across the NHS ambulance trust and other services providing pre-hospital care such as the British Association for Immediate Care doctors and the air ambulance service. This provided consistency in the care provision and familiarity for those doctors with other posts.
- Paramedics had access to a software application that runs on a smart phone or tablet device that had Joint Royal Colleges Ambulance Liaison Committee guidance, which staff referred to in their assessment and treatment of patients.
- Staff could describe how they would deal with violent or aggressive patients. They had received training and had processes in place for escalation.

Staffing

- All staff worked on a voluntary basis for the WYMRT, none of the staff were directly employed as part of the charity. The clinical staff all had substantive positions with other organisations.
- There were eight trustees and operational leads. The trustees were formed from senior doctors ranging from the pre hospital medicine, secondary care doctors and general practitioners. The trustees were responsible for the strategic and operational management of the service.
- There were six senior medical advisors. Senior medical advisors volunteered to provide expert advice from their respective areas of expertise. These included neonatal and paediatric consultants, cardiothoracic surgeons, anaesthetists and emergency medicine consultants.
- There were nine solo doctors. Solo doctors were independent pre-hospital doctors who volunteer and respond alone or with a trainee, and had access to a senior, consultant level doctor for remote advice. Solo doctors had been assessed by a number of senior doctors and signed off as solo doctors by the clinical lead for the service.
- There were 15 paramedics. Paramedics volunteered as part of the trauma team, with the primary role as driver, and they supported the doctor as needed.
- There were 23 junior doctors/ trainee doctors. The junior doctors and trainee doctors volunteered as part of the trauma team to work with the solo doctors to gain experience in pre-hospital immediate care.
- The service was not contracted to any specific hours though they predominately worked Friday and Saturday evening/nights. As the staff worked voluntarily, the hours of work were dependant on the availability of the staff. The doctors were able to book their shifts ahead throughout the year and the coordinator would circulate any vacant shifts on a monthly basis.
- The minimum level of staffing was an approved medic response doctor and a paramedic.

Anticipated resource and capacity risks

- As a charity, providing a voluntary service the West Yorkshire Medical Response Team had acknowledged, and had on their risk register, the possible loss of approved medic response doctors due to hospital moves or studying for exams. This would limit the ability to cover shifts. However, these shifts were an additional resource to the NHS ambulance service.
- The charity held a waiting list of volunteer paramedics wishing to join the team; therefore, the risk of not having a paramedic was low, although on the risk register.
- The charity had one emergency response car. A risk on their risk register was if the car was not available due to breakdown or accident. They had controls in place to mitigate the risk and the possibility of using an alternative vehicle from the NHS ambulance trust.
- All the risks on the risk register matched the risks identified on inspection.

Emergency and urgent care services

Response to major incidents

- The West Yorkshire Medical Response Team was not a statutory service and therefore, did not have a statutory role in the event of a major incident. However, they had a major incident policy, which outlined their role if a major incident was to happen when they were on duty.
- Staff were familiar with the NHS ambulance service major incident policy and procedures and the guidance from National Ambulance Resilience Unit regarding the medical support at mass casualty incidents.
- Staff informed us in the event of a major incident they would liaise with the medical incident commanders.
- Some staff had been involved in joint training with the fire and rescue service and NHS ambulance service. They attended a mock exercise of a train and bus crash, a simulated major incident exercise of a motorway multi-vehicle crash and table top scenarios where they discussed what to do if they were first on scene.
- As a charity, providing a voluntary service the WYMRT did not require to have business continuity arrangements. However, they were aware of their risks of not providing the service they endeavoured to provide, and had controls in place to mitigate those risks.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- The service had 21 standard operating procedures that standardised practice across the local NHS ambulance service and other services providing pre-hospital care such as the British Association for Immediate Care doctors and the air ambulance. The standard operating procedures had been developed in consultation with published best practice for example, the National Institute for Health and Care Excellence guidelines; NG39 major trauma: assessment and initial management.
- They worked to the NHS ambulance trust policies and procedures that were based on national guidelines. Staff could access these through the provider's intranet.
- Staff had access to a software application that runs on a smart phone or tablet device that had Joint Royal Colleges Ambulance Liaison Committee guidance, which staff referred to in their assessment and treatment of patients.
- The chairperson, who was a consultant, audited every incident attended to ensure the correct care and treatment was given. Case studies were presented at the training events and feedback, reflection and learning was shared.

Assessment and planning of care

- The NHS ambulance trust pathways for care, including conveyance to the appropriate hospital, were followed. For example patients sustaining major trauma were taken to the nearest major trauma centre.
- The staff followed pathways for the care and treatment of children; for example, there were bypass pathways in place, allowing children to be taken directly to the nearest children's hospital.
- Staff had access to pathways via the website and hard copies were kept in the vehicle. The paramedics were familiar with the pathways to ensure patients were taken to the most appropriate hospital or specialist unit for treatment. For example, patients following a heart attack would go to the nearest specialist centre were they could receive early intervention.

Response times and patient outcomes

- The service was dispatched from the NHS ambulance trust and the monitoring of the response times was done via the NHS ambulance trust. However, the service received the statistics from the ambulance service to allow them to monitor their own performance. From January 2017 to December 2017 they were dispatched to 543 incidents, the average response time was 13 minutes. They arrived on scene within 8 minutes in 33% of incidents.
- The trauma team provided care and treatment on scene and supported the NHS ambulance crew. Not all patients would require the trauma team to travel with them to hospital; this was decided by the team based on the clinical needs of the patient. Patients were conveyed to hospital by ambulance. The trauma team travelled with the patient to hospital in 24% of cases between January 2017 and December 2017.
- Every patients care and treatment was audited. The NHS ambulance trust took part in national audits for example; the return of spontaneous circulation, therefore, the service did not audit this.

Competent staff

Emergency and urgent care services

- One of the main objectives of the service was to train doctors and paramedics in pre-hospital immediate care. The scheme provided training for doctors allowing them to progress from being an observer (usually as a junior doctor) to progressing to a solo doctor, which was working without direct supervision. As an observer, the doctor had to attend a minimum of five out of the 11 training sessions each year, to show commitment to the scheme prior to them observing on the response car. As an observer, the doctor's career progressed within their substantive posts and the chairperson of the scheme would assess the doctors continually, and they would not be allowed to be a solo doctor until they were assessed as competent.
- We were told at the end of each year, the chairperson who is a senior doctor, required each approved medic response doctor to submit a personal reflection of their work during the year, together with statistical data relating to the shifts which they covered. Based on this information, the chairperson conducted an appraisal with each doctor. We were told 100% of the doctors had received an appraisal between January 2017 and December 2017. The doctors received a 360-degree appraisal that included feedback from the paramedics.
- A senior paramedic was to undertake the paramedic appraisals. As this person was new in post, the system had recently been developed with a plan that paramedic appraisals would be completed by the end of the year.
- Paramedics and doctors received constant appraisal through the strong governance systems that were in place.
- All paramedics had given written agreement for the senior paramedic, who is a substantive employee of the NHS ambulance trust, to confirm with the NHS ambulance trust their mandatory training dates and compliance, and to be advised should they cease to operate as a paramedic for any reason. For example, if their practice was suspended, the senior paramedic would be informed. This ensured that patient safety would not be compromised during their work with West Yorkshire Medical Response Team..
- An induction programme was in place for staff. This included the training sessions and shadowing opportunities.
- All staff had received recent Disclosure and Barring Service checks.

Coordination with other providers

- Agreed care pathways with other NHS providers were followed ensuring the patients received the right care in the right place.
- There were arrangements for escalating issues with the NHS ambulance service and other NHS providers. The chairperson had a monthly meeting with the medical director of the NHS ambulance trust and would escalate any issues within that meeting, or before if necessary.
- Other agencies at times worked alongside the trauma team, such as the fire and rescue services, police and mountain rescue. We were told of the good working relationships with the wider teams and given examples when the teams worked well together. For example, the majority of the incidents the team responded to were road traffic accidents, which involved working alongside the traffic police and the fire and rescue services.

Multidisciplinary working

- The trauma team worked as part of the wider multidisciplinary team. They worked alongside the NHS ambulance trust and liaised with local hospitals as necessary.
- When the team travelled with the patients to hospital, they would pre-alert the hospital if necessary and provide a handover to hospital staff.

Access to information

- The trauma team was dispatched by the NHS ambulance trust; any special notes that may be on the system regarding the patient would be passed on to the team. For example, if the patient was known to be violent or had a safeguarding concern.
- The rapid response vehicle was fitted with an up to date satellite navigation system and mobile data terminal.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Due to the nature of the calls the trauma team would attend they would treat the patient in the patient's best interest if the patient was unconscious or was unable to provide consent to treatment.
- Staff we spoke with had an understanding of consent, mental capacity and deprivation of liberty safeguards.

Emergency and urgent care services

Are emergency and urgent care services caring?

We did not inspect this domain.

Are emergency and urgent care services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The West Yorkshire Medical Response Team were all volunteers, and provided additional support to the NHS ambulance trust.
- The West Yorkshire Medical Response Team did not have a contract with the NHS ambulance trust. They were dispatched to calls from the NHS Ambulance Trust. The numbers of incidents varied each shift. On average, they attended four incidents each shift.

Meeting people's individual needs

- The staff had access to translation services through the NHS ambulance trust if required.
- Due to the nature of the incidents attended, all patients were treated at the scene. Any additional support patients may need if they have complex needs, including dementia, were provided for at the hospital. Staff told us they would always try to communicate with patients in a manner they could understand.

Access and flow

- The trauma team was dispatched by the NHS ambulance trust and responded to calls as quickly as they could. Due to the large geographical area they covered as a specialist trauma team, they were not measured against the national response times. The average response time was 13 minutes between January 2017 and December 2017.
- Any delays with response times would be communicated to the NHS ambulance trust.
- The service did not monitor the on-scene and turnaround times. However, if they were on scene over 45 minutes the senior doctor who reviewed patient report forms would question if this was applicable.

Learning from complaints and concerns

- The WYMRT had received no complaints or concerns between January 2017 and December 2017.
- If a complaint was made regarding the service then a joint investigation would be carried out with the NHS ambulance trust and any learning would be shared across both services.
- The West Yorkshire Medical Response Team. followed the NHS ambulance trust complaints policy.

Are emergency and urgent care services well-led?

Leadership of service

- The trustees and operational leads were senior doctors ranging from pre-hospital medicine, secondary care doctors and GP's. An experienced business person guided the charity on all financial matters. The trustees were responsible for the strategic and operational management of the charity.
- The chair and clinical lead of the service was a senior doctor who had a consultant position in emergency medicine in a local hospital. The chair took the responsibility of staff training, ensuring they were up to date in their clinical expertise and undertook audits to monitor performance and quality.
- The senior paramedic was responsible for the appraisals of the paramedics and ensuring they had the necessary skills and knowledge. The scheme support officer was a paramedic, his responsibility was the day-to-day management of the equipment, consumables and medicines, ensuring the staff had the necessary equipment. The trustee (who was solo doctor) was the main link with the NHS ambulance service. This person was the nominated person for CQC.
- A coordinator of the scheme dealt with the legal and financial issues including fundraising. This person coordinated the rotas.
- Staff informed us that the leaders were approachable and they were able to contact them if they had any concerns. There was an on call senior doctor to contact for advice.
- Leaders were experienced, knowledgeable and demonstrated enthusiasm in their roles to both improve the care of patients and to increase the knowledge and skills for those who worked in the service.

- Leaders recognised that repeated exposure to traumatic events could affect a staff member's mental health and they offered support and an opportunity to talk.
- The trustees of the service had completed a fit and proper person self-declaration.

Vision and strategy for this this core service

- There was a clear vision and strategy that all the staff we spoke with portrayed. This was to continue with the provision of emergency pre-hospital care and the advancement of education in pre-hospital care for doctors and paramedics. The staff supported the charity to continue with this service by volunteering to work for the service. Fundraising and sponsorship was essential to continue service and this was continually monitored.
- The values of the team reflected the values of the NHS ambulance trust.

Governance, risk management and quality measurement

- The education of the staff in pre-hospital care was one of the main objectives of the service. There were monthly governance and training sessions. These enabled junior doctors to gain sufficient education and experience to progress through the training scheme from observers of the service to working as a solo doctor. It also enabled them to progress to become part of the regional British Association for Immediate Care Scheme . Within the governance and training sessions interesting cases were shared and learning as a result of these were discussed. The results of audits were shared and there were talks from experienced practitioners and practical sessions.
- The chairperson of the service signed off doctors to enable them to work as a solo doctor, when he was satisfied with their clinical skills and their confidence to work alone in the pre-hospital setting. Before this happened, they will have undertaken a number of observer shifts and the number would depend upon their level of seniority when joining the observer list. The doctors were interviewed, personal indemnity insurance checked, and Disclosure and Barring Service checked. We saw evidence of this within the personal files. If the shift had a solo doctor who is not of consultant status or a general practitioner in partnership, then an on call senior doctor provided telephone support. This was in line with senior middle grade doctors working in hospital emergency departments; a consultant on call would always be available for support and advice.
- Strong governance systems were in place around the paramedics. They all had substantive posts with the NHS ambulance service and a system in place to share information relating to training and any restrictions on their practice.
- The staff we spoke with had a clear understanding of their roles and their accountability and all showed a commitment to the service and showed enthusiasm for learning.
- The clinical governance processes were defined in partnership with the NHS ambulance trust medical governance lead and the NHS ambulance trust executive medical director.
- The service followed the NHS ambulance trust policies and procedures and staff had easy access to these and were familiar with them.
- There was a comprehensive assurance system and audit in place, which monitored performance and actions were taken to improve performance and patient safety as necessary.
- Trust board meetings took place every six months. We viewed minutes of the meetings that included a review of finances, fundraising and sponsorship, governance, the education programme, the response car, engagement with the NHS ambulance trust, publicity and public relations.
- The standard operating procedures were devised in partnership with the NHS ambulance trust, the air ambulance and the British Association for Immediate Care Scheme. This supported standardised practice and maximised patient safety. The operating procedures were referenced to national and international guidance, and other UK pre-hospital standard operating procedures .
- The service had a mechanism to identify and manage risk. They had a corporate and board risk register and assurance framework. There were nine risks, which were clinical and non-clinical. These risks were rated and they had controls in place to reduce each risk. The risks identified on the risk register matched the risks identified during the inspection. These were reviewed regularly and discussed and updated in the six monthly board meetings.

Emergency and urgent care services

Culture within the service

- The culture was described as open and centred on the needs of the patients. Staff were supportive of each other and by working as a team they were forward thinking and all shared the same enthusiasm about the service.
- The staff we spoke with felt respected and valued. They all enjoyed working for West Yorkshire Medical Response Team, which was portrayed in them volunteering their services. The staff we spoke with were all highly motivated, enthusiastic and positive.
- There was a strong emphasis on training and the team worked collaboratively with the wider multidisciplinary team to ensure the patients received the best care and treatment, based on up to date evidence.

Public and staff engagement

- Staff told us that they felt the senior team engaged with them well. They were available for advice and support and staff felt up to date with any changes.
- The senior team told us it was difficult to consult with the patients and public as their service supported the NHS ambulance service and the NHS ambulance service conducted patient engagement.

Innovation, improvement and sustainability

- The pre-hospital care training programme provided a platform for the progression of the junior doctors to enable them to become experts in pre-hospital care as they develop throughout their career. Gaining experience in pre-hospital care is sometimes difficult to gain, as there are not many forums to achieve this experience. By working for West Yorkshire Medical Response Team. this was done, through a training programme, which brought together theoretical knowledge and clinical skills and experience. The strong audit and scrutiny of the care given, by an experienced senior doctor, aided the continuous learning for staff and improvements in patient care. Through audit of the service and the introduction of the implementation of new evidence based practice the service strived to continue to provide high quality of care to patients.
- The partnership working and the combined standard operating procedures for pre-hospital care with the air ambulance and. British Association for Immediate Care Scheme allowed patients to receive a consistent provision of high quality evidence based care.
- The service had won three awards for their work, from the Sovereign Healthcare Charitable Trust, Yorkshire Ambulance Service and the British Medical Association.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should ensure that the batch numbers on the medicines administered are documented on the patient report forms.
- Following the recent appointment of a senior Paramedic the provider should ensure that the newly introduced formal appraisals process for Paramedics is completed on an annual basis.