Yorkshire Ambulance Service NHS Trust

Emergency and urgent care

Inspection report

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Ratings

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

Our findings

Emergency and urgent care

Inspected but not rated

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

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

West Yorkshire.

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

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

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

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

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

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

Our findings

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

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

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

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

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

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

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

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

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

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

• The service generally controlled infection risk well. Staff used equipment and control measures to protect themselves and others from infection. They kept equipment and the premises visibly clean. The design, maintenance and use of facilities, premises and equipment kept people safe.

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

Our findings

• All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

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

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene

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

Staff cleaned equipment and vehicles after patient contact and labelled equipment to show when it was last cleaned. Vehicles were clean and well-maintained. After returning to the station each ambulance vehicle was subject to cleaning, maintenance and replenishment of stock in a designated ambulance vehicle preparation area. Equipment was standardised and checked regularly including medical and infection prevention and control supplies. Staff followed infection control principles including the use of personal protective equipment (PPE). Cleaning records and audits were up-to-date and demonstrated that all areas were cleaned regularly.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance and reflected best practice. Staff followed a clinical safety plan which ensured a safe service. A 'drugs pouch trial' was currently in progress in five ambulance stations. The service had enough suitable equipment to help them to care safely for patients. Staff carried out daily safety checks of specialist equipment and disposed of clinical waste safely as part of ambulance vehicle preparation.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues. Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe.

Our findings

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Team based working has been implemented trust wide. For example, Wakefield Ambulance station has 126 WTE operational staff in post supported by 11 FTE team leaders and management staff with responsibility for attendance, staff welfare and disciplinary matters.

Ambulance staff attending an emergency department may be rotated with staff coming on duty to ensure that staff finished their shift on time.

The provider had commenced a rotational paramedic scheme in which specialist paramedics undertook additional training in primary care which improved advanced skills, knowledge and clinical confidence in decision-making.

Staff undertook statutory and mandatory training which included weekly updates for staff during COVID-19.

Is the service effective?

Inspected but not rated

Response times

The service monitored agreed response times, so it facilitated appropriate and satisfactory outcomes for patients. It used the findings to make improvements.

All A&E breaches exceeding one hour were reported daily. Following the pandemic, response times had decreased recently.

Ambulance Response programme (ARP) categories and current performance:

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

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

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

The trust stated it is typically mid-range (5 or 6) when it is benchmarked against other NHS ambulance services. The YAS area included multiple local large emergency departments which each impacted on the ambulance trust performance.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved appropriate and satisfactory outcomes for patients.

Outcomes for patients were positive, consistent and met expectations when compared with national standards. Patient experience outcomes for the trust showed mainly positive feedback.

Our findings

Where incidents occurred, it enabled review and learning from incidents. Managers and staff used the results to improve patients' outcomes. Improvement was checked and monitored. An Incident Review Group (IRG) met weekly to review incidents as a team.

The service participated in relevant national clinical audits. Managers and staff undertook a comprehensive programme of repeated audits to check improvement over time. Managers used information from audit to improve care and treatment. Managers shared and made sure staff understood information from the audits.

The trust monitored patient outcomes by analysing the Electronic Patient Record Form (EPRF) which recorded key information about the patient's clinical condition and treatment. Key Performance Indicators (KPI's) were supplied by the clinical team or could be requested specifically for ST-elevation myocardial infarction (STEMI) , Stroke, Return of Spontaneous Circulation (ROSC) etc.

Multidisciplinary working

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

To support its work with other providers, the trust had a 'pathways department' in Wakefield headquarters with overall responsibility for all pathways. Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff worked across health care disciplines and with other agencies when required to care for patients. During the pandemic, for example, collaborative working with patient transport services and extended training for PTS staff had supported the transfer of 30 WTE to frontline emergency response. Ninety percent of these staff had returned to their substantive role from 1 April 2022.

The trust had also increased its use of independent ambulance services, focusing on patient transfers to free capacity for emergency care. Independent ambulance providers went through an assurance process before working with the trust and all providers were required to be rated by CQC as 'Good' or above. The trust had a dedicated engagement team to all independent providers had a single point of contact with the trust to ensure that compliance with the trust standards were continually assessed and met.

Hospital Ambulance Liaison Officers (Halos) roles were also used to support emergency departments experiencing pressure. Ambulance service clinical leads were involved in assessing the deployment of Halos. Halos were on-call 24/07. The ambulance operations commander is brought in first to act as the HALO. If the situation was escalated, rapid handover was put in place. Cohorting was also used in emergency departments to manage and support appropriately. For example, in the local NHS trust emergency department, the main x-ray room was used as the YAS cohorting area.

A multi-disciplinary mental health pilot was to commence, seven days a week from 16:00 hours to 02:00 hours. in Wakefield from 2 May 2022. Laptops deployed in vehicles enabled staff to access information appropriately.

Is the service caring?

Inspected but not rated

Compassionate care

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

Our findings

Patients said staff treated them well and with kindness. Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff followed policy to keep patient care and treatment confidential.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Facilities and premises were appropriate for the services being delivered. The service had systems to help care for patients in need of additional support or specialist intervention.

Mental health ambulances with dedicated specialist staff were being commissioned in the West Yorkshire from May 2022. For example, the mental health ambulance based in Wakefield provided support for access to the local NHS mental health facility. If staff were concerned about a patient's mental health they used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Staff supported patients when they were transferred between services.

Daily lost hours for the service, reflecting ambulance waits at hospitals, had been decreasing in the most recent two weeks.

The service used the JRCALC (clinical guidelines) App which included the range of clinical pathways live. The trust used "pathways champions" (there are three in the local area) to support delivery of the Path. The Area Operations Manager sat on the A&E delivery board for Mid-Yorkshire which allowed for the sharing of key information between the local NHS trusts.

To minimise handover delays and maintain access and flow a 'Self-handover' standard operating procedure was supported by a rapid process improvement workshop (RPIW) collaborative improvement plan.

Our findings

Is the service well-led?

Inspected but not rated

Leadership

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

The trust had four deputy heads of operations in post; two were based in West Yorkshire. Wakefield area had an area operations manager. Eleven team leaders report to the area operations manager This 'team-based working' was a recently introduced new structure. Staff had more support through more contact with team leaders. Rotas were still to be changed to reflect this.

Communications with staff were supported through weekly updates. Staff currently had a quarterly one-to-one with their team leader. Staff were also issued with a personal smartphone and staff had access to the apps they needed.

Career development opportunities were supported by senior leadership. We saw examples of expressions of interest being encouraged for staff to work in Wakefield in the mental health response vehicles.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff reported that management was visible and supportive. All staff felt that they were able to raise any issues or suggestions and were confident that they would be listened to.

Management of risk, issues and performance

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

The service had operated at REAP level 4 since December 2021 which reflected the operating risks. The trust's clinical safety plan reflected its assurance of a safe service. The service has a risk register for each ambulance station. The head of operations for West Yorkshire (based in Leeds) was responsible for the risk register, which was revised monthly. The risk register allowed learning to be captured and supported the escalation of any concerns identified.

Procedures to manage performance and planning for unexpected events were linked with governance processes. For the Wakefield area, for example, following the pandemic, procedures had been reviewed and an action plan prepared to reflect changes implemented and support learning. The 'inspection for improvement' programme of work was supported by audit.

Our findings

Areas for improvement

The service should consider how it can improve response times and overall performance.

Our inspection team

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

For our emergency and urgent car inspection, we inspected one ambulance station, and three vehicles. We talked with ambulance crew in different grades and roles. We also interviewed senior managers. After the inspection we requested further information and documents from the trust.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation

Regulated activity	Regulation