Yorkshire Ambulance Service NHS Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Yorkshire Ambulance Service NHS Trust (YAS) was formed in 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. YAS is the only NHS trust that covers the whole of Yorkshire and Humber.

The trust serves a population of over five million people across Yorkshire and Humber and strives to ensure that patients receive the right response to their care needs as quickly as possible, wherever they live.

The trust employs more than 5,700 staff, who together with over 1,150 volunteers, provide a vital 24-hour, seven-days-a-week, emergency and healthcare service.

The Trust receives an average of over 2,500 emergency and routine calls a day through the 999 emergency operations centre. It also receives an average of 4,500 calls a day through the integrated urgent care/NHS 111 call centre.

In 2017/18:

- The trust responded to a total of 780,383 incidents through either a vehicle arriving on scene or by telephone advice.
- Clinicians based in the Clinical Hub, which operates within the emergency operations centre (EOC), triaged and helped just under 140,000 callers with their healthcare needs.

- The patient transport service made over 944,000 journeys, transporting patients to and from hospital and treatment centre appointments.
- The NHS 111 service helped 1.6 million patients across Yorkshire and the Humber, Bassetlaw, North Lincolnshire and North East Lincolnshire.

(Source: Trust website)

Locations at the trust

There are two emergency operations centres, York and Wakefield. Emergency and urgent care operates from 61 ambulance stations across the region and also from Nostell Air Support unit and RAF Topcliffe. Patient transport services operate from 44 ambulance stations across the region with logistic services based at a call centre in Wath–on-Dearne, South Yorkshire and 'Springhill 1' in Wakefield. There are also four teams that make up resilience: business continuity, community resilience, Emergency Preparedness, Resilience and Response (EPRR) and the Hazardous Area Response Team (HART).

The 26 provider wide teams include departments such as finance, workforce, governance and planning. A breakdown of the services at the trust by core service is shown in the table below:

Core service	Number of locations/teams
Emergency and urgent care	63
Patient transport service	52
Other	26
Resilience	4
Emergency operations centre	2
Integrated Urgent Care/NHS 111	2
Total	**147**

(Source: Trust Provider Information Request – Sites)

Is this organisation well-led?

As part of our inspection, to rate the organisation for how well led it was, we interviewed the members of the board, both the executive and non-executive directors, and a broad range of senior staff across the trust. This included a wide group of clinical and non-clinical service and specialty leaders. We met and spoke with a wide range of front line staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans; board meeting minutes, and papers to the board, investigations, and feedback from patients, local people and stakeholders.

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. There was clear leadership of the trust to drive and improve the delivery of high-quality person-centred care.

The trust was led by the board of directors who were responsible for the leadership, direction, control, and risk management of the trust. Its main responsibilities included:

- directing and managing the organisation's affairs
- leading the organisation within a framework of controls which enable risk to be assessed and managed
- setting strategic aims and ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives
- setting the values and standards of the trust to ensure the obligations to patients, and the local community.

The trust board was made up of seven directors with executive portfolios, five of whom were voting directors; there was a chairperson and five other non-executive directors. The chairperson led the board and the chief executive led the organisation.

The board was stable and was a unitary board which meant decisions were taken collectively. There had been some changes to the leadership team since our last inspection in 2016.

- The chairperson had been in post since July 2016
- The chief executive had been in post since May 2015. The chief executive had other leadership roles, including leading the Northern Ambulance Alliance.
- The executive director of quality, governance and performance assurance had been in an executive director role with the trust since 2009 and in the current role since 2015. They were appointed as deputy chief executive in February 2017.
- The executive medical director had been in post since October 2013.
- The executive director of finance joined the board in March 2017.
- The executive director of workforce and organisational development had been in post since November 2017.
- The executive director of operations joined the board in November 2018.
- The director of urgent care and integration came into post in May 2019.
- The Non-Executive Directors (NEDs) came from a variety of backgrounds and had each been on the board from one to six years.

This was the first time the trust had had a well led inspection at trust level.

Board Members

Of the executive board members at the trust, none were Black and Minority Ethnic (BME) and 16.7% were female.

Of the non-executive board members none were BME and 40% were female.

Staff group	BME %	Female %
Executive directors	0%	16.7%
Non-executive directors	0%	40%
All board members	**0%**	**27.3%**

At the time the trust submitted the RPIR (routine provider information request) the trust listed two board members positions as vacant: director of urgent care and integration and a non-executive director position. Both these positions were filled by the time of our inspection.

(Source: Trust Provider Information Request – Board Diversity)

We were concerned about the lack of diversity at board level. We discussed this with the senior leaders. The chairperson told us the lack of diversity was related to the remuneration which could be paid to NEDs. We were concerned that the chairperson did not articulate plans to us about improving diversity at board level when we asked. The chief executive described their concerns around the lack of diversity at board and senior manager levels; we were told of clear plans to make improvements. Diversity in the wider organisation will be described later in this report.

We had attended board meetings before the inspection. It was very clear to us and very positive that the culture of the organisation was set by the board; patients and staff needs were considered to be paramount.

There was a clear distinction between the executive leadership and non-executive roles and functions of the board. The NEDs provided constructive challenge and support to the executives.

The NEDs chaired the five board sub-committees and each committee had an executive lead. The committees comprised of;

- the audit committee,
- the finance and investment committee,
- the quality committee,
- the remuneration committee
- the charitable funds committee.

The committees provided support and oversight around performance and goals. When we met with the NEDs, they told us they each attended all of the committee's, even if they weren't a member of that committee.

The trust had worked with NHS Improvement to support the development of NEDs. At the time of our inspection, work was on going to give NEDs a portfolio and associated work streams. The trust also had an associate NED`s programme as part of a succession plan to fill future vacancies.

Since our last inspection, the board had commissioned an external review which took place in July 2018. It is good practice to have externally facilitated reviews of leadership and governance. Senior leaders told us the review identified areas of leadership and governance that would benefit from further targeted development work to support and sustain future performance.

Leaders shared the action plan with us and described how it had resulted in improvements to the function of the board and the trust as a whole. For example performance objectives for the executive team contained reference to providing and enhancing leadership. As part of the appraisal process, executive directors had to demonstrate how they had improved leadership within their team. The objectives were progressed and cascaded though a variety of programme boards and across teams.

The board development programme was reviewed for 2019/2020 to shift the focus towards more open discussion on strategic issues. The programme included external sessions on leadership for quality improvement from the Improvement Academy (funded by the Yorkshire and Humber Academic Health Science Network (AHSN).

As part of the external review, the executive portfolios were reconsidered and a new corporate services function was developed; this enabled clearer oversight of planning and engagement and communication with the community.

The chief executive undertook formal appraisals of the executive board, and the chair undertook appraisals of the chief executive and non-executive directors. The chair's appraisal was carried out by NHS Improvement, these appraisals were linked to objectives, and there was evidence of this within the personnel files we reviewed.

Leadership

The executive directors had the skills, knowledge, experience, and capability to lead the trust. During our inspection we saw compassionate and effective leadership. Throughout our inspection and from monitoring the trust throughout the year we saw that the board was forward thinking and a high performing team. They worked well together for a common purpose and were key leaders in positive cross organisational work for the benefit of patients.

The board considered matters which were vital to the success and strategic direction of the trust.

There was continued focus on strategy, the culture, talent management and succession, and investment for the business of the trust.

Senior leaders and the executive board members had a good understanding of issues, challenges and priorities in their service; for example, patient safety, quality care, and financial and operational performance, and beyond into the challenges and issues for the system.

The leadership, governance, and culture were used to drive and improve the delivery of high-quality person-centred care. We heard how the trust was striving to become a healthcare provider for the region rather than 'just' an ambulance service. The trust played a key leadership role in the health economy of the region and worked collaboratively in 'place-based' systems of care with other organisations to meet the needs of the people in the region.

For example, through development and implementation of a range of patient pathways such as paramedics rotating into roles in GP practice, and other front line staff supporting care homes in avoidance of hospital admissions where appropriate.

There was a programme of board visits to meet staff at their workplace. The visits enabled board members to speak to staff and consider their views and also to gain assurance with safety and quality requirements. Front line teams told us that leaders were visible and approachable. We saw that the chairperson and one NED had visited staff on ten occasions. Only one of the other NEDs had been out to meet staff between April 2018 and 5 March 2019. The chief executive had been out to meet with staff 26 times. Front line teams told us they held the chief executive in high regard. They told us he was authentic and 'made things happen'. We saw that other executives had each been out to meet with front line teams between four and 24 times during the year.

We carried out checks to determine whether appropriate steps had been taken to complete employment checks for senior leaders in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.

During inspection we reviewed of the files of 11 senior leaders, including executive and deputy directors, and six NEDs. Board members completed annual self-declaration forms to confirm that they complied with the regulation. Appropriate information was present in the files such as annual declaration in line with FPPR, references and bankruptcy and insolvency checks. This confirmed the trust was compliant with FPPR.

The board level lead for mental health was the executive medical director. The lead nurse for urgent care, (part of the urgent care and integration directorate team) led the mental health programme. There was a mental health plan, which was aligned to the wider clinical strategy.

We were told of a leadership and management portfolio governance board (PGB) which was chaired by the chief executive. The PGB planned and agreed which leadership training or programmes would be best for all leaders in the organisation. Leaders described to us how succession planning was an integral part of the talent development framework.

The PGB identified critical roles and through a talent identification process put in place individualised development to build the leadership which would be needed to continue delivering the service. From February 2018 to February 2019, a total of 878 staff attended a leadership development activity; (the activities often comprised of several modules). The talent identification process was still in development at the time of our inspection.

The talent development framework was underpinned by a cross-directorate talent board. There had been pilots of an accelerated development programme for nominated talented people (up to band 7). A strategic leadership programme was also being developed (for band 8a and above) which would align to succession planning for business critical roles. (Source PIR- P54)

There was a leadership induction programme for leaders who were new to the trust which introduced them to the expectations of the organisation in terms of leading people. There was also a ‘leadership in action’ modular programme which complemented the trust values and behaviours framework. The programme was designed to support existing leaders in their reflective and conscious practice to increase staff engagement and improve patient outcomes.

As of the end of April 2019, the following numbers of people had participated in the programme;

	Module 1	Module 2	Module 3	Module 4
Total	240	125	108	86

(Source; board papers, May 2019)

There were annual leadership summits which brought leaders together to revisit the trust values and behaviours. We were told about a strategic leadership forum which met on a quarterly basis. The forum comprised the top 200 leaders from across different parts of the trust. External speakers were invited to discuss topics such as compassionate leadership.

Vision and strategy

The trust had a clear vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

YAS's vision was to be trusted as the best urgent and emergency care provider, with the best people and partnerships, delivering the best outcomes for patients. The purpose was to save lives and ensure everyone in the communities received the right care, whenever and wherever they needed it. The vision had been developed through a structured process in collaboration with people who used the service, staff and external stakeholders. The staff workshops to develop the strategy were well attended, and there was much interest from front line teams.

The vision was supported by six core values;

- one team
- innovation
- resilience
- empowerment
- integrity
- compassion

Senior leaders described to us how the values underpinned the culture. They told us by sharing common goals, collaborating and celebrating success, they could achieve the 'one team' value. We saw how leaders supported each other and their teams especially through challenging times, for example after 999 emergencies. Leaders told us their innovation values were supported by new ways of working and putting the organisation at the forefront of system improvements in the region. All senior leaders we spoke with were positive and enthusiastic about opportunities to make improvements. We saw the leaders and teams were resilient and supportive of one another. Leaders described how proud they were of front line staff who remained professional under difficult circumstances.

We heard how staff and leaders felt empowered to go the extra mile for people who used the service and for each other. There was respect in the way leaders behaved with each other. We saw they were accountable for their portfolio, and remained accountable to each other. It was evident that the leadership team was passionate about the care of patients and wanting to do the right thing for them.

There were four ambitions that the trust aimed to achieve by 2023. Each ambition had a set of outcomes and key performance indicators (KPI) so progress could be measured. The ambitions were;

- "Patients and communities experience fully joined-up care response to their needs;
- Our people feel empowered, valued and engaged to perform at their best;
- Everything we do is of the highest quality, evidence based and achieves excellence
- We use our resources in the best way, so we can continue to invest in and sustain our front line services."

Senior leaders told us key elements of these ambitions would be achieved through the clinical strategy, ('One Team, Best Care Clinical Strategy- Person-centred, Evidence-based Care 2019-24'). Senior leaders told us this approach had been taken to support the delivery of an integrated urgent and emergency care service. We heard the ethos was to save lives and ensure people received the right care, whenever and wherever they needed it. There were three core aims:

- Continuous improvement and innovation of clinical care
- Enabling the multidisciplinary team to deliver high quality, person-centred, evidence-based care
- Ensuring that patients experienced a consistently safe, compassionate, high standard of care.

We were told the strategy would be delivered through the integration of all parts of the 'patient facing' aspects of the trust, such as NHS 111, 999 or non-emergency patient transport service, and by working more effectively with system partners, YAS volunteers, and communities.

There was a robust, realistic overall strategy which set out how the vision and aims would be achieved. 'One Team, Best Care' was the corporate strategy which had been developed to identify the key priorities for the next five years. The strategy was in draft form and was due to be signed off by the board in October 2019. The strategy had been influenced by local demands, national policy and it was fully aligned to the wider health economy. We saw the board were committed to system wide collaboration and leadership. The strategy had been developed using a structured process, through extensive consultation with staff and stakeholders. The strategy reflected the NHS long term plan, and the ongoing shift towards integrated care systems (ICS), nationally and regionally.

(ICS's evolved from sustainability and transformation partnerships (STPs). They bring together NHS providers, commissioners and local authorities with collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve).

There were eight priority areas which were intended to focus on and support overall delivery of the ambitions and strategy.

- Deliver the best possible response for each patient, first time
- Attract, develop and retain a highly skilled, engaged and diverse workforce
- Equip our people with the best tools, technology and environment to support excellent outcomes
- Embed an ethos of continuous improvement and innovation, that has the voice of patients, communities and our people at its heart
- Be a respected and influential system partner, nationally, regionally and at place
- Create a safe and high performing organisation based on openness, ownership and accountability
- Generate resources to support patient care and the delivery of our long-term plans, by being as efficient as we can be and maximising opportunities for new funding
- Develop public and community engagement to promote YAS as a community partner; supporting education, employment, and community safety.

During development of the strategy there had been engagement about the strategy with commissioners and the integrated care system leaders at joint strategic partnership boards. There was engagement with around 400 members of staff from different directorates, including support staff. Engagement took place across a range of forums, in different locations, to maximise the input from staff. A number of the events were open to the public and partners.

Leaders and front line staff told us the consultation and engagement were welcomed by staff and requested to continue, those highlighted (*) below were built into ongoing engagement programmes.

- Patient focus workshops
- Locality listening events* for all staff (now quarterly)
- Strategic leadership forum* for top 70 leaders (now quarterly)
- Annual Leadership Summit* for top 200 leaders
- Trust executive group strategy workshops
- Trust management group meetings
- Integrated business planning group

Delivery of the corporate strategy was supported by a range of enabling strategies and the clinical strategy. Senior leaders told us this was to ensure the right environment, infrastructure, skills and capacity was in place. We saw the enabling strategies were in line with the culture of continuous improvement, engagement, and innovation. They were;

Enabling strategy	
Community engagement	• This focussed on streamlining the approach to community engagement and volunteering; to forge closer links with local communities and provide education and support, to increase public health awareness and better health outcomes.
People	• The people strategy was launched in January 2019 and focussed on attracting, developing and retaining a highly skilled, engaged and diverse workforce. There were five areas of focus:– • Culture and leadership, • Recruitment, • Retention and resourcing, • Employee 'voice', health and wellbeing • Education and learning.
Quality Improvement	• The quality improvement (QI) strategy focussed on developing a culture, through skills development and supporting teams and individuals to take responsibility for quality improvement in all areas of the trust.

	• The QI Fellows programme supported existing staff from across the organisation to split their time between their usual roles and working on QI projects. • They acted as ambassadors for QI and focussed on developing improvement projects within their own areas or Trust-wide.
Digital	• The digital strategy focussed on providing resilient IT intelligence services for all core services, to extend digital capability, to meet the changing demands of patients, people and partners over the next five years. The priorities were; • sharing data across the health and care system to help improve patient outcomes and supporting integrated services • providing the right digital services to enable people to work productively • delivering safe and resilient digital services.
Fleet	• This was focused on investing in the fleet to modernise the vehicles and equipment, whilst improving the fleet management systems and processes. A priority was to address sustainability and recognise the responsibility to minimise any adverse impact of its activities on the environment.
Estates	• The estates strategy was focused on providing good quality, safe and environmentally friendly places of work that support the Hub and Spoke model of operations.
Finance	• The financial strategy was to deliver the best possible clinical services and patient outcomes within the financial resources available. It will be externally focused, working with stakeholders to drive greater Trust and system-wide benefits.

(Source 'One Team, Best Care 2019-2023 -Final draft)

Progress against the delivery of the overall strategy would be measured by the annual 'milestones. There was a five year 'road map', aligned to each of the eight key priorities. There were measures of success for each of the priorities, for example;

- In patient experience indicators such as 'hear and treat' and 'see and treat'
- In national and local performance standards
- The workforce representing the community served by the trust
- No clinical harm to patients
- Excel at applying learning from research, audit, staff and patient experience

Senior leaders told us the strategy would be achieved through the workforce. There had been a revision of senior job roles and portfolios, and front line staff told us they had been supported to better understand their role, and how that would help in delivering the strategy.

We heard how the quality of staff appraisals had improved, and were now aligned to outcomes.

Some of the improvements which had taken place since the draft corporate strategy was launched were;

- Investment in the emergency operations centre clinical hub to support decision making on dispatching an ambulance, on-scene paramedics and community first responders around appropriate conveyance (to hospital) decisions.
- Appointment of healthcare professionals to support decision making on appropriate care pathways and referrals for patients.
- Investment in ambulance vehicle preparation (AVP) facilities at some ambulance stations.
- Additional emergency care assistants to support provision of the right resource at the right time.
- Investment in new double crewed ambulances (DCAs), ensuring the right vehicle and skill mix was available for patients.
- Planned investment to increase the number of paramedics.

In board papers, we saw there was a well-established approach to reviewing and monitoring the operational plan. There was a monthly integrated performance report, which set a clear trajectory for the delivery of milestones. There were also key performance indicators in the transformation plan which the executives reported to the board.

Culture

Leaders modelled and encouraged compassionate and supportive relationships, so that staff felt respected, valued and supported. This created a sense of common purpose based on shared values.

The executive directors and NEDs displayed an open and honest approach. There was a clear drive for improvement for both patient and staff benefit. Leaders clearly articulated the culture they wanted to see in the organisation.

There were processes in place to support staff and to promote well-being. Staff we spoke with told us they said that they felt appreciated. Front line staff told us, and we saw during the inspection, there was an open culture within the trust. We saw that leaders within the organisation promoted the vision and values. Staff we spoke with felt empowered to make improvements and raise concerns. Within the organisation there was a focus on learning from incidents and sharing good practice. The quality improvement (QI) strategy supported a positive culture, through skills development and supporting teams and individuals to take responsibility for quality all areas of the trust.

We spoke with 76 front line staff during our two core service inspections. There had been further work to build on the culture we saw during our 2016 inspection. We saw and were told about positive working cultures. Staff helped each other out. Newer staff told us mentorship and support

was invaluable. Staff told us that the patient was at the heart of everything they did, and we observed this during our inspection. There were initiatives to support well-being, including supporting staff who were unwell and off work. The majority of staff spoke positively about working in the organisation and felt they were listened to. They felt more involved in decision making. They spoke highly of their managers and said they were open, friendly, and approachable. Senior leaders and manager told us how proud they were of their teams.

NHS Staff Survey 2018 results – Summary scores

The NHS staff surveys are used to inform local improvements in staff experience and well-being. Staff participation with the annual survey is not compulsory, although NHS trusts are strongly encouraged to use the survey as an opportunity to seek staff opinions and views.

We saw the response from the YAS workforce was significantly less than average for ambulance trusts, and had fallen by 1% from the 2017 survey.

The diagram below is from YAS board papers March 2019.

YAS 2018 Response	YAS 2017 Response	+/-	Average response for sector*	+/-
34%	35%	-1%	49%	-15%

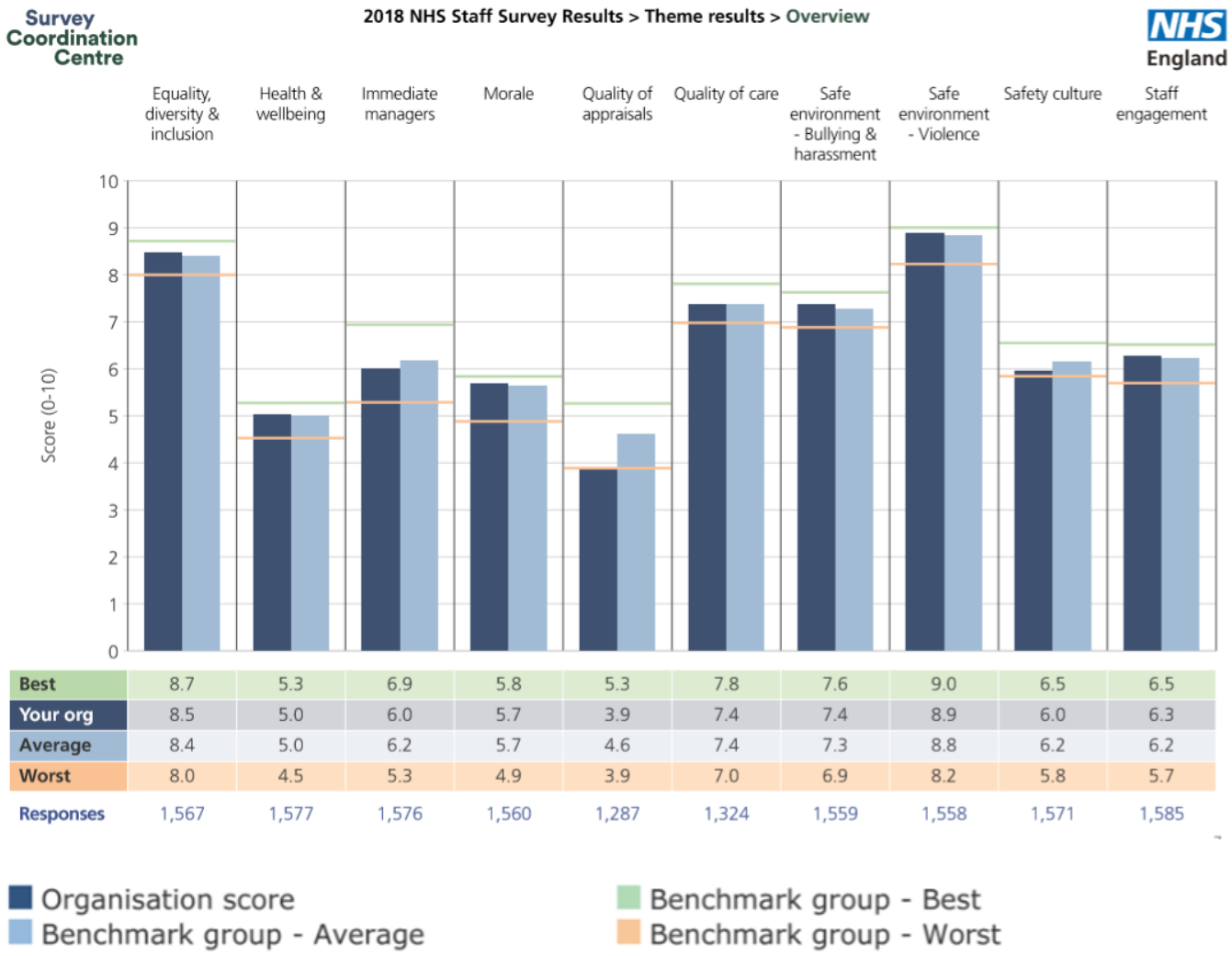
Compared with the ambulance sector, YAS scores were generally in line with the average. Out of nine themes;

- Three were above the sector average (equality, diversity & inclusion: safe environment – bullying and harassment: and safe environment – violence)
- Three were the same as the average for the ambulance sector (health and wellbeing: morale: and quality of care)
- Three were rated as below the sector average (immediate managers: quality of appraisal: safety culture)

(Source: National NHS Staff Survey 2018 results-board papers March 2019)

There was an action plan in place following the 2018 staff survey and leaders told us about a series of interventions which had been put in place to respond to staff feedback. The focus had mainly been on staff engagement and leadership and several programmes of work have been ‘rolled out’ in order to improve both these areas. Leaders were aware the response rate was an area for improvement and needed ownership for staff engagement amongst leaders at all levels.

The following illustration shows how this provider compared with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.



The trust's 2018 scores for the following themes were significantly higher (better) when compared to the 2017 survey for:

- Health and wellbeing
- Immediate managers
- Safety culture
- Staff engagement

There were no themes where the trust's scores were significantly lower (worse) when compared to the 2017 staff survey.

(Source: NHS Staff Survey 2018)

Following the results of the 2018 national staff survey results, listening events and team meetings took place across all parts of the service and directorates to further explore findings with staff. Findings from these discussions were used to agree 'people' priorities for the next 12 months.

A detailed corporate action plan was presented to the trust board in March 2019 and was being monitored through the strategic workforce group. There was an ongoing 'you said, we are doing' / 'you said, we did' communication campaign to keep staff up to date.

(Source: board papers May 2019).

In addition to the annual NHS staff survey, the trust carried out quarterly 'pulse check' surveys with staff. Staff were surveyed in different parts of the trust each time; for example in 2019/2010, urgent and emergency care staff were asked in quarter 1 (April – June), integrated urgent care in quarter 2 (July to September) and corporate services were planned for quarter 4. Staff were also asked questions around dignity and respect and how they saw colleagues and leaders displaying the values and behaviours *(Source: board papers May 2019).* Results of the pulse check surveys were not available for this report.

Actions in relation to staff safety were aligned to the national focus to protect staff from violence and aggression. The trusts risk team worked with and supported for staff who had been victims of violence and aggression. There was a support booklet for staff who had been victims of violence and aggression, and a checklist for managers was launched in April 2019. There was a security alerts portal. This enabled active engagement with other agencies to inform them about perpetrators. Perpetrators of violence or aggression towards staff were subject to a range of sanctions.

We were told a survey was going to be conducted for staff who had recently reported violence and aggression. The purpose was to evaluate the support provided by the trust to further improve support.

Reporting culture

There was a good reporting culture in the trust which focussed on learning, rather than apportioning blame when something went wrong. Incidents, including serious incidents, (SIs) were reported as required to the NHS national reporting and learning system (NRLS) or the NHS strategic executive information system in a timely way.

The majority of incidents (65.7%) were reported within 0-14 days which supported early learning from incidents.

Time taken to report	Number of incidents
0 - 14 days	23
15 - 30 days	4
31 - 60 days	4
61 - 90 days	1
90+ days	3

There had been 35 serious incidents from April 2018 to March 2019 which met the reporting criteria set by NHS England. These are detailed in the table below;

Core service	No. STEIS incidents (Apr 18 – Mar 19)
Emergency & Urgent Care	14
NHS111	8
Emergency operations centre	7
Other	4
PTS	2

Of the 35 serious incidents reported 4 were classed as 'other' including one where primary and secondary telephone lines within the EOC failed; there had been one medication incident.

Most of the serious incidents reported (51%) were related to treatment delays. The second highest group of incidents report were related to sub optimal care of the patient (20% of SIs reported).

During our inspection we reviewed six finalised randomly selected SI files. In the body of all the reports we reviewed there was a background summary of the incident and a description of events under the appropriate headings. All the files we reviewed contained an executive summary with the incident description, findings and recommendations.

In the files we reviewed the terms of reference for the investigation had been completed and had been set by YAS investigating staff and not the patient, family or carers. It is good practice to involve families in setting the terms of reference for investigations. There was however, evidence in the six files that had been people focussed with the patient, family and carers engaged.

In three of the files we reviewed there was evidence of Duty of Candour had been followed. The Duty of Candour principles places a responsibility on providers of healthcare services to be open and honest with patients and people acting for them, when things go wrong with care and treatment, giving them reasonable support, truthful information and an apology. In three of the files we reviewed there was evidence a face to face meeting had being offered to the patient, family and carers involved.

YAS staff who had been involved in the incidents had received support from their supervisors and specialists within the trust. There was evidence in the six files we reviewed the investigation focussed on learning. We saw investigators had identified improvements in service rather than apportioning blame. There was evidence as to how learning could be shared supported with recommendations and action. We saw in all six files we reviewed the investigation had been expertly led and was credible. The reports all contained clear conclusions and recommendations for further action to prevent a reoccurrence of the SI.

There was one file which evidenced collaborative working with YAS and an NHS hospital trust where investigation use a system-based approach across both organisations involved in the care. There was evidence of clear lessons learned being shared with the NHS hospital trust.

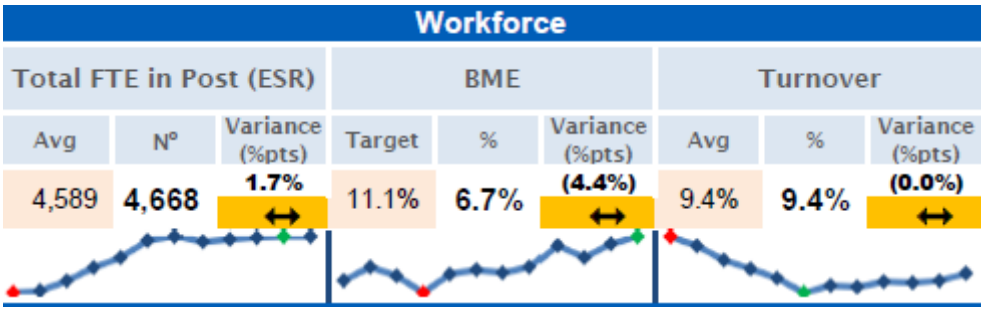
Staff Diversity

There was a three year diversity and inclusion strategy – 'Embracing Diversity – Promoting Inclusivity' (2017-2020), which provided direction and focus in embedding the principles of diversity and inclusion across the trust. The NHS workforce race equality standard (WRES) is a requirement for NHS healthcare providers. The purpose of an annual WRES report is to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

We were concerned that the workforce was not representative of the population it served. The percentage of black and minority ethnic (BME) people in the region was around 14% in July 2018. The percentage of the BME workforce was 6.7% in May 2019. This had increased marginally from 6.4 % in 2018.

(Source: YAS People Strategy 2019).

The diagram below shows how the BME population in the workforce had increased generally over the year, but remained below the 11.1% target.



(Source: Integrated performance report- May 2019).

The trust provided the following breakdowns of staff by staff group and ethnic group. They stated that 99.9% of their staff answered a question about ethnicity on their staff record. The table below indicated around 94% of the workforce were from a white ethnic group.

Ethnic group	NHS infrastructure support	Qualified ambulance service staff	Qualified nurses	Support to ambulance service staff	Other staff
A White - British	12.7%	38.3%	1.7%	40.4%	0.4%
B White - Irish	0.1%	0.2%	<0.1%	0.1%	<0.1%
C White - Any other White background	0.1%	0.3%	<0.1%	0.2%	0.0%
D Mixed - White & Black Caribbean	<0.1%	0.1%	0.0%	0.1%	0.0%
E Mixed - White & Black African	<0.1%	<0.1%	0.0%	0.0%	0.0%
F Mixed - White & Asian	0.0%	<0.1%	0.0%	0.1%	0.0%
G Mixed - Any other mixed background	<0.1%	0.1%	<0.1%	<0.1%	0.0%
H Asian or Asian British - Indian	0.2%	0.2%	0.0%	0.2%	0.1%
J Asian or Asian British - Pakistani	0.3%	0.4%	0.1%	1.6%	0.1%
K Asian or Asian British - Bangladeshi	<0.1%	0.0%	0.0%	0.1%	0.0%
L Asian or Asian British - Any other Asian background	<0.1%	<0.1%	0.0%	0.1%	0.0%
M Black or Black British - Caribbean	0.1%	0.1%	<0.1%	0.1%	0.0%
N Black or Black British - African	0.1%	0.1%	0.1%	0.1%	<0.1%
P Black or Black British - Any other Black background	<0.1%	0.0%	0.0%	0.1%	<0.1%
R Chinese	<0.1%	<0.1%	<0.1%	<0.1%	0.0%

S Any Other Ethnic Group	0.1%	0.1%	0.0%	<0.1%	0.0%
Undefined	0.0%	<0.1%	0.0%		0.0%
Z Not Stated	0.0%	<0.1%	0.0%	<0.1%	<0.1%
Percentage of workforce	13.7%	40.1%	2.0%	43.6%	0.6%

(Source: Trust Provider Information Request – Diversity)

There had been delays to delivering the actions following the 2017 WRES report. The percentage of BME representation at board level had fallen to zero since 2017. This made YAS joint bottom with two other ambulance trusts out of ten nationally. (Source: Appendix three national comparison- 2018-2019 WRES action plan).

The trust was below the national average for a number of indicators in the WRES survey. These were for;

- Indicator 1: The percentage of BME staff in each of the pay bands
- Indicator 2: The relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts
- Indicator 2: The relative likelihood of BME staff entering the formal disciplinary process, compared to white staff.
- Indicator 6: Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months.
- Indicator 9: Boards are expected to be broadly representative of the population they serve

The trust was better than average or on track with plans for the following:

- Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD
- Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (Note; Less BME staff surveyed in 2018).
- Indicator 7: Believing that trust provides equal opportunities for career progression or promotion
- Indicator 8: Experienced discrimination at work from any of the following- Manager/team leader or other colleagues. (for BME staff this had fallen from 29% in 2016 to 18% in 2018; see below)

Ethnic Origin	2016	2017	2018
White	8%	10%	10%
BME	29%	19%	18%

There had been a targeted approach to increasing the diversity of the workforce. This included a recruitment/ career event in April 2019, in partnership with a voluntary organisation. Around 240 people from diverse backgrounds attended the event, and around 12% of those registered an interest in call handler and emergency care assistant roles. Leaders told us the recruitment ream provided support to complete application forms with a focus on providing a ‘level playing field’ for applicants.

Some staff we spoke with told us applicants had proven literacy and numeracy qualifications, but were often not successful in their application. We spoke with senior leaders about this and they told us they would look into this.

We spoke with the head of equality and inclusion. They were passionate about making improvements with the support of the board. They told us told us that recruitment events and raising the profile of YAS careers in BME communities had not always been successful as working in an ambulance service wasn't seen as a career of choice in some BME communities.

We heard that over 500 managers across the trust had been trained on a one-day diversity and inclusion course covering fairness, diversity, and respect. The diversity and inclusion unit continued to address various team meetings, divisional management meetings, team away days, and team meetings. The purpose was to raise the profile of diversity and inclusion with a focus on roles and responsibilities in creating a culture of dignity and respect. The board and trust management group had received a number of presentations and training on diversity and inclusion.

At the time of our inspection, the board was overseeing the development of an 'aspire together' programme which planned to address immediate priorities to fill board level vacancies and improve board diversity. The programme was based on the developing people: improving care' framework for developing improvement and leadership capability in the NHS.

Staff networks

We were told about existing staff networks which provided an opportunity for staff to engage with the organisation about service and employment issues. The aim was to provide an opportunity for staff who shared one or more aspects of their identity such as their sexual orientation, race, or disability status, to communicate, network, meet and support each other. There was a lesbian, gay, bisexual and transgender (LGBT) staff network and a black and minority ethnic (BME) staff network. There was also a disability staff network and plans for a gender network in the future.

Freedom to speak up

An independent review into creating an open and honest reporting culture in the NHS was published in February 2015 (The Frances report). The aim of the review was to provide advice and recommendations to ensure that NHS staff felt safe to raise concerns, be listened to and the concerns will be acted upon. Freedom to speak up guardians (FTSUG) were introduced into NHS trusts to work with leadership teams to create such a culture.

YAS had a freedom to speak up (raising concerns) policy and a FTSU guardian. The role was well established; there were 10 advocates who supported the guardian.

From March 2018 to the end of February 2019, there had been 42 staff that had raised concerns.

Twenty concerns were raised during the period (January to March 2019). The majority of concerns originated from staff working in A&E Operations (9 concerns= 45%).

The remainder were from;

- The emergency operations centre (5= 25%),
- Two concerns had been raised from the corporate team (10%)
- Fleet (1= 5%)
- Community Resilience (1= 5%)

- Of the two remaining concerns one was reported anonymously and the second was from an NHS employee from another NHS trust who felt unable to report their concern through their own FTSU process.

We spoke with the FTSUG and the person who would replace them in their role. They were both passionate about the role and it was evident they had worked hard to support people and the process. They told us concerns could be raised anonymously and were recorded via 'datix', an electronic reporting system. We were told the three most reported concerns were;

- Recruitment and selection (6 concerns)
- Patient safety concerns (3 concerns).
- Inappropriate manager behaviours (bullying and harassment), (2 concerns)

We saw there were good processes in place for escalation and managing concerns. For example when it became apparent there was a theme around recruitment and selection, it was raised by the FTSUG with the director of HR and at the fortnightly concern review meeting. The recruitment and selection process was amended as a result of work undertaken.

FTSU was represented at the following trust working groups;

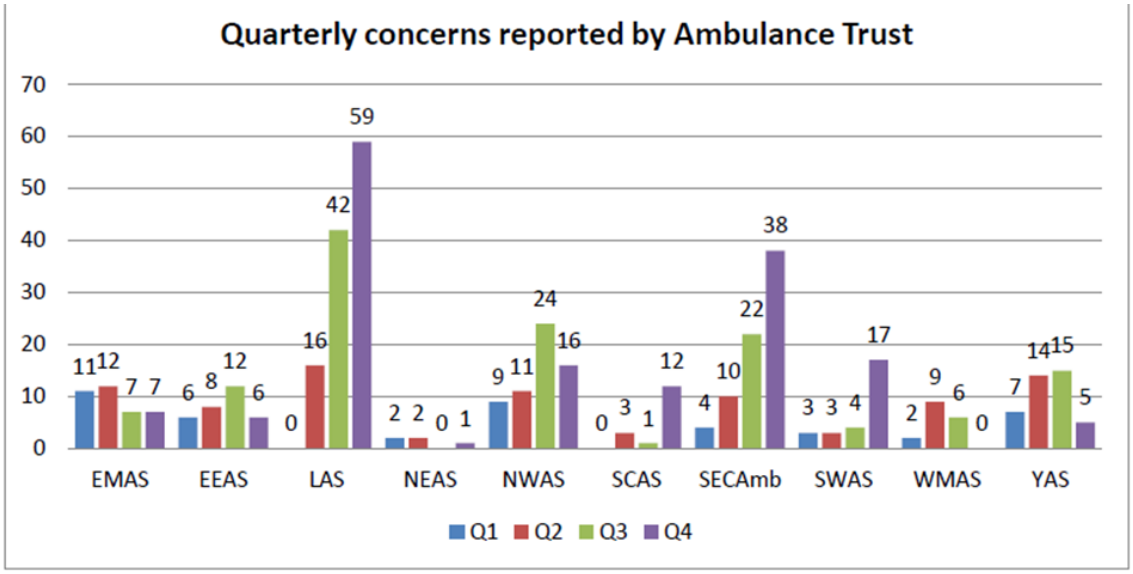
- NHS111 working group
- Health & wellbeing working group
- Post incident care working group

The FTSUG told us they were well supported by the chief executive, the executive director of quality, governance and performance assurance, and a named non-executive. The guardian met with the chief executive every two months, and could approach them outside of these arranged meetings. The guardian presented a formal report to the board twice a year.

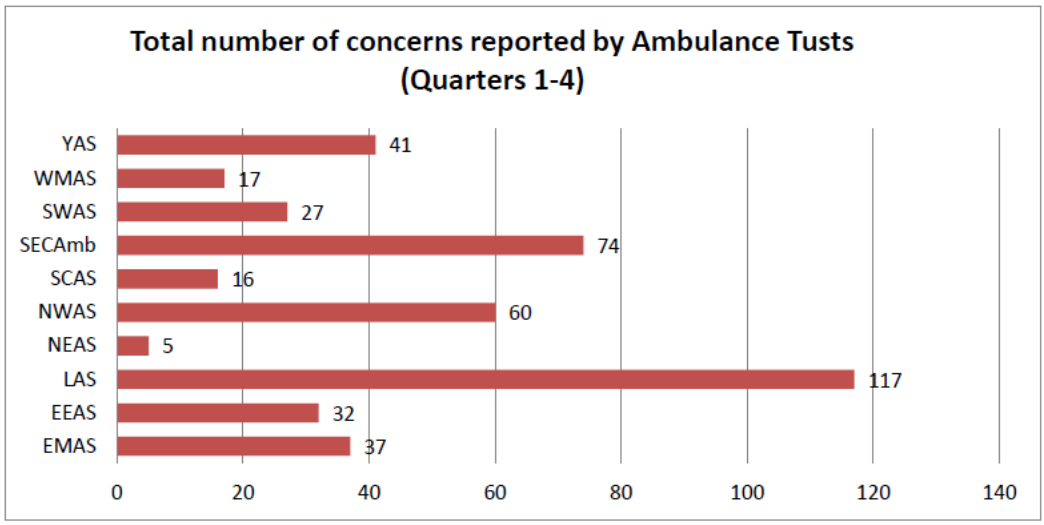
We were told of repeated concerns around manager behaviours in the NHS111 directorate. Some staff we met with told us there was a 'face fits' culture in NHS111. This had been raised with us before our inspection in 2016. The trust undertook a culture review in the area around that time. Senior leaders were aware of more recent concerns and had established a cultural working group led by the director of workforce.

Concerns raised;

The graph below is a comparison of concerns raised over time, in the ten ambulance trusts in 2018; Yorkshire Ambulance Service (YAS) is at the right hand side of the graph.

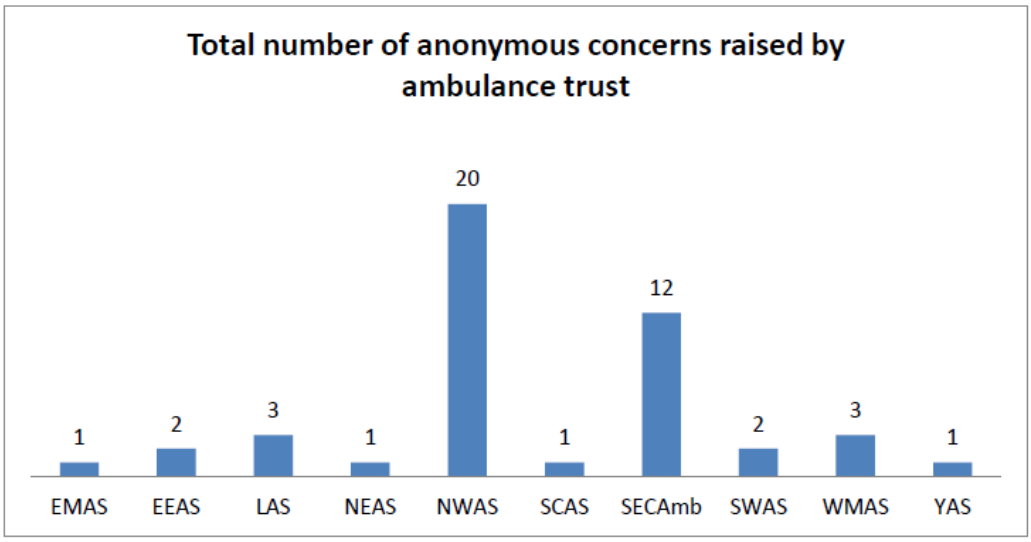


The graph below shows the total number of concerns raised in the same time period.

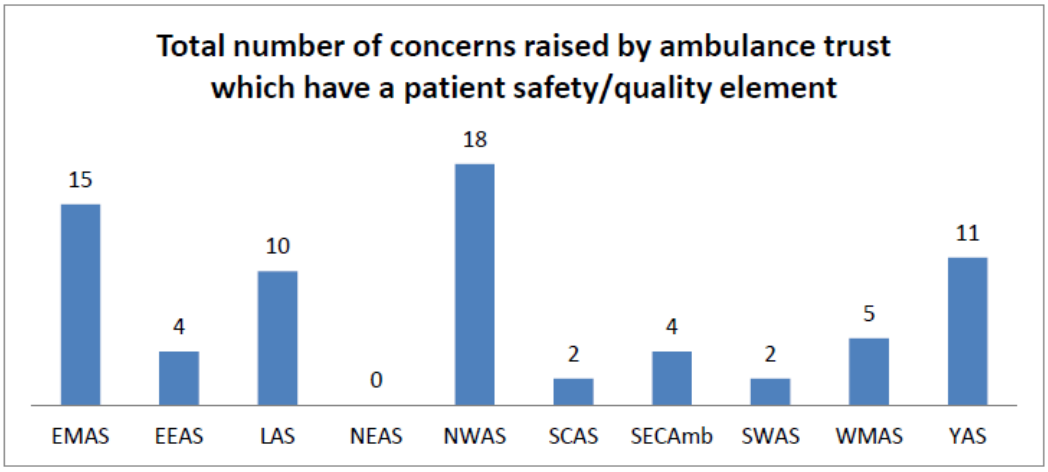


The graph below shows just one anonymous concern was raised at YAS.

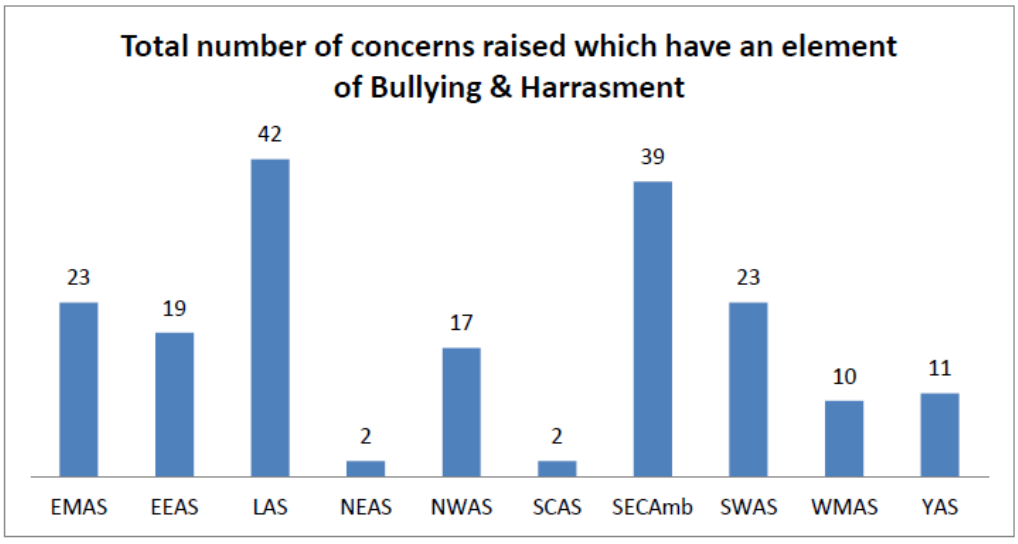
This could indicate people feel comfortable to raise concerns without protecting their identity .



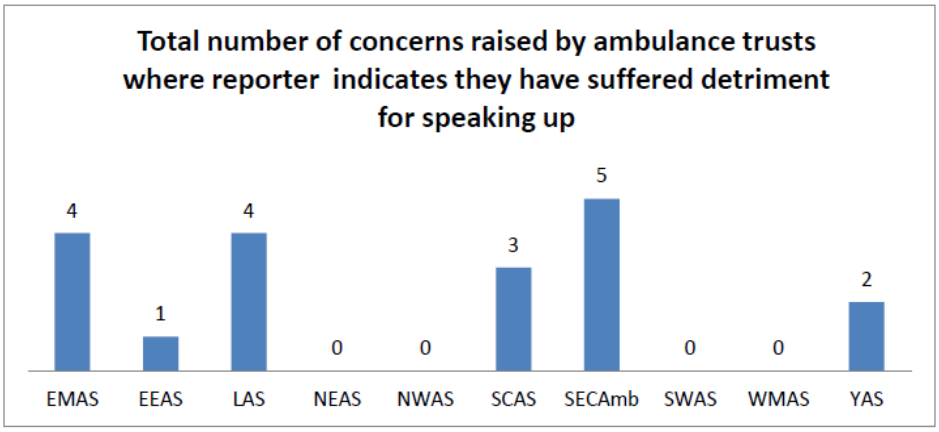
The graph below shows the comparison with other trusts of patient safety concerns raised in 2018.



This graph below compares concerns raised about bullying and harassment in 2018;



The graph below shows a comparison with other trusts where the person felt they had reported and suffered detriment as a result;

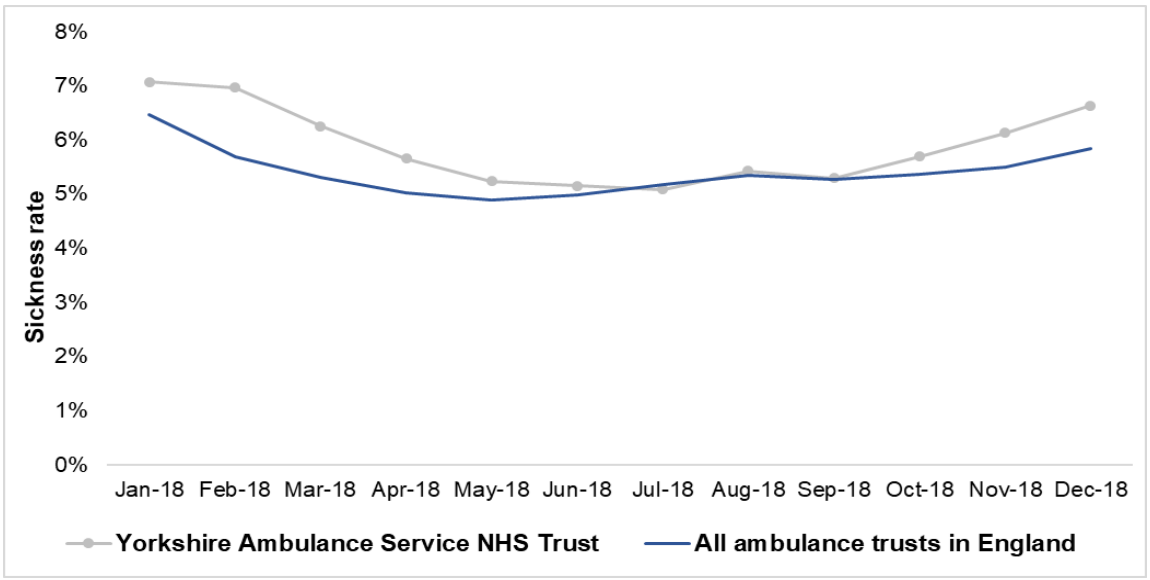


Sickness absence rates

The trust's overall sickness absence levels were generally worse than the ambulance trust average from January to December 2018. However, they were lower than the average NHS acute hospital trust.

The trust's sickness rates followed a similar trend to the average for ambulance trusts, with higher rates in the winter months.

July to September 2018 saw the trust's sickness absence levels fall in line with the ambulance trust average, but from October 2018 the trust's rate increased once again.



(Source: NHS Digital)

The results of a trust-wide sickness absence 'deep dive' analysis were presented at the strategic workforce group in April 2019. The analysis highlighted the main issues within directorates that impacted on the absence of the overall workforce over the reporting period from June 2017 to the end of May. This data was used to inform an action plan. The plan was to support a 1% reduction in sickness absence to 4.8%, in line with the trust operating plan.

(Source: board papers May 2019)

Staff leaving the trust

We saw information on the trust's attrition data was presented to the strategic workforce group in April 2019.

The data showed the number of leavers has reduced in 2018-19 (587) compared to 2017-18 (667). Despite the decrease in the number of leavers in 2018-19, around a third, 33%, left within the first 12 months of employment. This had increased from 27% in 2017-18. The most common reason for leaving was stated as work life balance. The area with the highest number of leavers was call handlers in the urgent care and integration call centre. Trust documents showed a number of staff were unable to meet the NHS111 pathway capability standards. We saw that a review of the exit interview process had been undertaken and was due to be presented to the strategic workforce group in July 2019.

Health and Wellbeing

The trust management group approved the 2019/2020 'Health and Wellbeing Plan' and associated funding in April 2019. This was based on a joint national plan (NHS England, NHS Improvement, and NHS Employers). Leaders told us the trust aimed to create an environment with opportunities, and encourage and enable staff to lead healthy lives and make informed choices that supported their wellbeing. There was a special focus on continuing to raise mental health awareness and manage identified issues. The plan was intended to run for one year, but the health and well-being team were working on a longer term three to five year plan. The plan was linked to the aims and objectives set out in the newly launched trust people strategy.

The focus of the plan was: -

- Leadership and management
- Data and communications
- Health working environment
- Healthy minds: mental wellbeing
- Healthy bodies: (musculo- skeletal focus)
- Healthy lifestyles

The trust measured itself against the above by using a dashboard of measurements, and an action plan of what it wanted to achieve.

The health and wellbeing group, strategic workforce group and trust management group along with the board were responsible for ensuring the plan and intended outcomes were delivered. Senior leaders told us the trust was working closely with Public Health England (PHE) to promote good mental health.

Appraisals

There were mechanisms in place for providing staff with appraisals or performance and development reviews (PDRs) which included career development discussions. We were told appraisals were also an opportunity to review personal objectives aligned to the trust objectives.

Compliance for the completion of PDRs at the end of April 2019 was 79.2%, against the trust target of 90%. We saw that managers had been reminded via the trust management group, of their obligations to complete their staff appraisals. In the core service inspections, we heard mixed views from staff with regards to appraisals being meaningful and supporting their development.

Learning and development

There were mechanisms for providing staff with development. There was a YAS 'academy' which had been established in 2016 following a review of education provision at the trust. An associate director of education and training led education and organisation development (OD). There was a head of the academy and a head of leadership and OD. There was a comprehensive department structure in place.

There were four programme governance boards (PGBs):-

- Clinical education and development; chaired by the medical director.
- The Leadership and management PGB; led by the chief executive.
- The non-clinical education and development PGB; chaired by the executive director of quality and governance.
- The command and resilience PGB; chaired by the executive director of operations.

Each PGB met on a quarterly basis, apart from the clinical and non-clinical PGBs which met approximately every 6 weeks.

Outcomes from the PGBs included: -

- investment in staff training and recruitment
- university partnerships across the region
- a well-established apprenticeship programme
- development of an associate ambulance practitioner role
- training which was aligned to the clinical strategy
- clinical best practice days run jointly with the Royal College of Paramedics
- Development of a career framework.

Leaders told us about developments in paramedic skill sets, including specialist paramedic roles and consultant paramedic roles. Support had been given by the trust for some paramedics to gain specialist skills and clinical knowledge. We also heard of comprehensive work on the supervision framework to support newly qualified paramedics in their first year in practice.

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

See and Treat

In the friends and family test (FFT) for see and treat (SaT) from March 2018 to February 2019 the trust had one month of reportable performance data, June 2018, with 80% of patients in this month recommending the trust as a place to receive care compared to the England average of 89.4%.

In all other months in the period data was not published as fewer than five responses were received. There were quarterly patient surveys in all service lines, which had a higher response rate then the FFT; it was 44% for PTS and 27% for urgent and emergency care.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months. Senior leaders told us they agreed a date for completion of the complaint with people who had complained.

Question	In days	Current performance
What is your internal target for responding to complaints?	Three days	95%
What is your target for completing a complaint	To meet the due date agreed with the complainant	85%
If you have a slightly longer target for complex complaints please indicate what that is here	n/a	
Number of complaints resolved without formal process in the last 12 months?	581 (March 2018 to February 2019)	

(Source: Trust Provider Information Request – Complaints Process Overview tab)

Summary of complaints

The trust received 990 complaints from March 2018 to February 2019. The NHS111 service received the most complaints with 270.

Core Service	Number of complaints	Percentage of total
NHS111	270	27.3%
Emergency and urgent care	208	21.0%
Emergency operation centre	195	19.7%
Patient transport services	160	16.2%
LCD (local care direct)	155	15.7%
Other	2	0.2%
Grand Total	**990**	**100%**

*Please note: NHS111 and LCD services are not within our inspection remit but data has been included here for context.

(Source: Trust Provider Information Request – Complaints)

Compliments

From March 2018 to February 2019 the trust received a total of 1,398 compliments. A breakdown by core service can be seen in the table below:

Core service	Number of compliments	Percentage of total
Emergency and urgent care	1,192	85.3%
Other	121	8.7%
Patient transport service	58	4.1%
Emergency operations centre	18	1.3%
Resilience	9	0.6%
Total	**1,398**	**100%**

The trust stated that the majority of compliments received related to the caring and professional approach taken by front line staff.

(Source: Trust Provider Information Request – Compliments)

Accessible information standard

From 1st August 2016 onwards, all organisations which provide NHS care have been legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to five stages:

- identifying,
- recording,
- flagging,
- sharing
- meeting

The information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. It covers the needs of people who are blind, d/Deaf, deafblind and/or who have a learning disability. The standard is also in place for people who have aphasia, autism or a mental health condition which affects their ability to communicate.

We found that the trust was not compliant with the standard despite it being in legislation for over three years.

The trust had set up an internal AIS implementation group. In February 2019 an AIS policy and guidance was launched and made available to staff. There were communication guides for staff which had been distributed to all ambulances. The trust had participated in national ambulance meetings to share best practice. In the patient transport service (PTS) call centre, staff captured communication needs when undertaking a booking and relayed them to operational staff. However, there was no way to share this outside of the organisation. PTS had also used a text service for patients to advise when a vehicle was dispatched. Before our inspection, the trust provided us with information which indicated some developments. They included:

- A section in the new electronic patient record which captured communication needs.
- The datix incident reporting system had been amended to capture communication needs of patients who had complained, sent compliments, concerns, or comments.

- The trust updated trust now included a ‘cloud’ based web tool which allowed people to customise the website for their own needs.

Gender pay gap

There is a requirement for public sector bodies in England with 250 or more employees to publish their gender pay and bonus gap. The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 bring in the gender pay gap reporting duty as part of the existing public sector equality duty.

The purpose of a gender pay gap audit is to focus on reducing any gaps in the pay of male and female employees by comparing and evidencing the difference in their average earnings. The legislation requires employers to publish the results of 6 calculations. Gender pay reporting is different to equal pay. The gender pay gap is the average difference between the gross hourly earnings for all men and women which is expressed as a percentage of men’s earnings. YAS published its latest gender pay gap report at the end of March 2019. Men and women were guaranteed equal pay when appointed to their roles; factors such as length of service for existing employees can impact on data showing overall pay gap information. For example, historically more men have been employed in the ambulance service and therefore will have been working for longer.

The table below shows the average gender pay gap as a mean average for years 2017 and 2018. This is calculated as the sum of all the values (hourly rates) divided by the number of staff)

Average Hourly rate	2017	2018
Male:	£12.72	£13.04
Female:	£11.88	£12.36
Gap:	**6.60%**	**5.25%**

The mean pay gap fell from 6.60% in 2017 to 5.25% in 2018. (Men’s average hourly pay increased by £0.32 and women’s by £0.48 over the two years). This meant there had been and improvement in the pay gap.

In common with the ambulance sector as a whole there was a difference in the profile of males as opposed to females. Males represented 52% of the YAS workforce and females represented 48%. There were men than women in the upper, upper middle and upper lower pay quartiles. There were more women in the lower quartile. The board report in May 2019 indicated the trust would continue to build on addressing disparity in pay and representation through the workforce.

Governance

Governance in an NHS trust is about the systems, process and lines of accountability used to ensure the trust run themselves efficiently and effectively in order to provide safe high-quality care.

We saw the board and other levels of governance functioned very effectively. There were clear lines of governance, accountability, and management of partnerships. Joint working arrangements were clearly set out. We saw a systematic approach was taken to working with other organisations across the health and social care system for the benefit of patients.

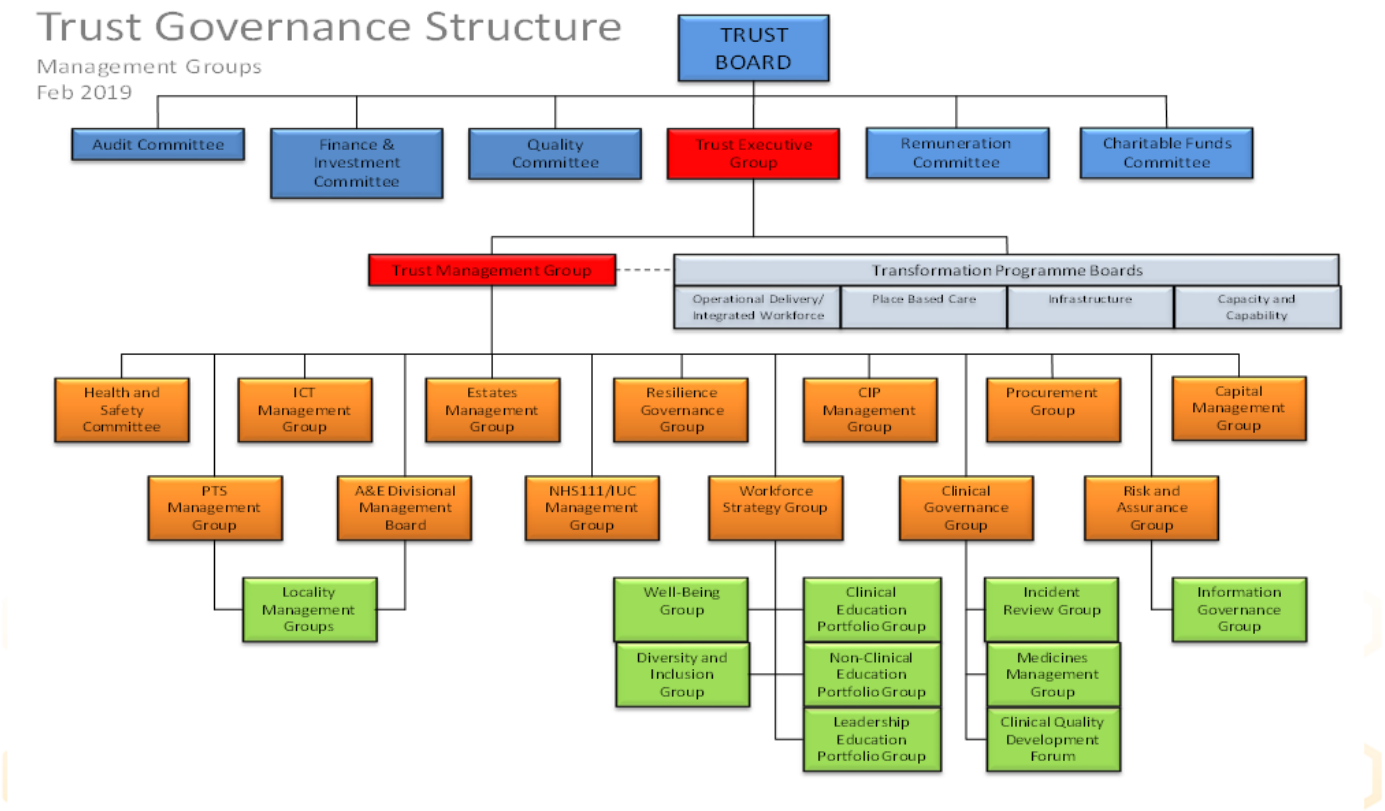
The governance structure enabled safety, quality, performance and risk information and assurance from front line services through to board. Assurance was provided by the structures in place in the form of groups, committees, and sub committees.

The board was underpinned by the assurance committees including the audit committee, quality committee and trust executive group (TEG), which in turn were underpinned by the trust management group (TMG) and transformation programme boards.

The TMG was underpinned by sub boards and groups such as the patient transport service management group, the workforce strategy group, and the risk and assurance group. These operational management groups enabled a detailed view of local performance and escalation of key concerns to corporate level where necessary.

These in turn were underpinned by sub groups such as the locality management group, the well-being group, and the medicines management group. These subject-specific groups provided an overview and additional assurance on key areas of activity. Leaders told us representation at these groups included frontline staff, managers, subject matter experts and staff side representation.

The governance structure is set out below:



Subcommittees of the board were chaired by a NED and comprised a mixture of NEDs and executive directors. The exceptions to this were the audit committee and the remuneration committee, which (in accordance with NHS guidance) comprised of NEDS exclusively. In line with good corporate governance, the chair of the trust was not a member of the audit committee and did not normally attend its meetings.

Membership of the committees is demonstrated in the table below:

Committee	Membership
Quality Committee	Three Non-Executive Directors Executive Director of Quality, Governance and Performance Assurance Executive Medical Director Director of Workforce and Organisational Development Executive Director of Operations Director of Urgent Care and Integration
Audit Committee	Three Non-Executive Directors including Chairpersons of the Quality and Finance and Investment Committees
Finance and Investment Committee	Three Non-Executive Directors Chief Executive Executive Director of Finance Executive Director of Operations Director of Planning and Development
Charity Committee	Two Non-Executive Directors Executive Director of Finance (or Head of Financial Services) Trust Secretary Fund Manager Head of Corporate Communications
Remuneration Committee	Chairman and all Non-Executive Directors

(Source: Annual report 2017-2018)

We reviewed minutes of committee meetings, for example the January 2019 Audit committee. We saw the committee assessed the effectiveness of the trusts governance processes. There was strong focus on the framework of risks, controls and other related assurances including financial statements. The audit committee also monitored performance and of external auditors, effectiveness of the local counter fraud function, internal audit and the freedom to speak up arrangements.

We saw the clinical governance arrangements had a clear remit and were effective in monitoring and improving quality. The clinical governance group was underpinned by sub-groups, the clinical quality development forum, the incident review group (IRG),and the medicines management group. Complaints, serious incidents, and any coroners' cases were reviewed and closed in the IRG which met every two weeks. We were told of regular monitoring and review of quality, safety and workforce indicators and we saw evidence of these on the balanced scorecard.

We reviewed minutes of the clinical governance and quality report (June 2019). This summarised the developments and delivery of clinical governance and quality. Specifically it looked at a number of priorities based on patient safety and clinical effectiveness:

- Patient safety
    - Quality priorities
    - Patient safety updates
    - Safeguarding
    - Infection prevention and control
    - Freedom to speak up

- Patient experience and complaints
    - Critical friends network update
- Clinical effectiveness
    - Ambulance clinical quality indicators
    - Medicines management and optimisation
    - Clinical audit quarterly summary
    - Mortality reviews
    - Health records audit
    - Public health

Medicines governance

There was a robust view of medicines management at an operational level; results were fed into action plans, and were escalated when needed through the appropriate governance group. The medicines optimisation group was an established multidisciplinary group and provided clear terms of reference for its members.

The medicines optimisation group was a sub group of the clinical governance group. It reported and provided assurance to the quality committee through the senior management group and trust executive group. We met with the chief pharmacist who told us the medicines group worked to maximise the beneficial clinical outcomes for patients from medicines, with an emphasis on safety, governance, professional collaboration, and patient engagement. This was across emergency care, urgent care and NHS 111. We were told the responsibilities of the service were to;

- Provide advice on all relevant aspects of policy and practice for medicines issues.
- Ensure policies, protocols and guidelines were in place.
- Ensure the procurement, administration, supply and disposal of medicines follows national guidelines, recommendations, and legislation.
- Coordinate and monitor the implementation of patient group directions (PGDs).
- Develop, monitor, and review procedures for procurement, storage, handling, security, and disposal of all medicines used in service.
- Establish a regime of regular medicines audit in all areas to ensure compliance with policy and procedures.
- Monitor incidents; medicines related incidents were reviewed monthly and there were clear lines for risk escalation. The service looked at medication errors, instigated any actions required and ensured lessons learned are cascaded both internally and externally.

In relation to controlled drugs the following governance was in place:

- The trust pharmacist attended the local pharmacy leadership group within West Yorkshire and also represented the accountable officer at the controlled drug local intelligence networks.

(Source: PIR)

The medicines optimisation group reviewed themes and training and system reviews were completed where themes were identified. A quarterly and annual report of medicines incidents was provided to board.

Board assurance

The trust board met publicly every quarter throughout the year apart from the month when the annual general meeting took place. Board meetings provided an opportunity for internal scrutiny and for member of the public to speak with and question the board. Senior leaders told us no members of the public had attended any board meetings. Meetings were held at the trust headquarters which was set in an industrial park, away from urban developments. We asked the board if they considered meeting elsewhere to attract more of the public, or their workforce to attend and observe. The board were considering video recording the meetings and putting them on the trust website.

The board had previously met at other locations, but this had not resulted in an increase in public attendance. The AGM was planned to be held at a local town hall later in the year to attract members of the public.

Board meetings consisted of two parts, the first part was the public board. The board also met every month in private to deal with confidential business, typically consisting of personal information and/ or information which may have been commercially sensitive. There were also have a number of board development meetings throughout the year.

As part of our ongoing monitoring and engagement with the trust, we observed a PTS improvement board meeting, a public and a private board meeting. At the meetings, we saw senior leaders within the organisation present papers to the board for consideration or assurance. There was a good balance between safety and quality of care, and finance and performance. During the meetings we observed appropriate challenge and requests for further information from the non-executive directors to the executive directors.

Board assurance framework

The board assurance framework (BAF) was the structure used by the board to identify the principal risks to the organisation in meeting its strategic objectives. The BAF identified the main threats to quality and safety across the organisation based on a range of information. The information included the corporate risk register, and directorate and service risk register records. The BAF for 2019 to 2020 had been developed following a board strategic risk workshop in February 2019 and subsequent discussions in TEG and TMG.

Senior leaders we spoke with recognised there were inherent risks in delivering its services.

The trust had to take some risks in a controlled manner. We saw there was a low tolerance of risk, or a low risk appetite in relation to issues of patient safety and quality of care. This meant the trust sought to control all risks which had potential to:

- Cause harm to people
- Have severe financial consequences which could jeopardise the trust's viability
- Jeopardise the trust's ability to carry out its normal activities
- Threaten the trust's compliance with regulation

Board assurance frameworks generally have risk scores over 15, indicating they are high or extreme risks. Risk levels were calculated as 'consequence multiplied by likelihood'.

Risk score	Risk band
1-6	Low risk
8-12	Moderate risk
15-25	High risk

The trusts BAF had risks with a score of less than 10, indicating a low tolerance of risk.

The BAF for 2019-2020 detailed the main risks as below:

Nature of risk	Initial risk	Current risk	Target
1a) Inability to deliver national performance targets and clinical quality standards.	20	15	10
2a) Lack of capacity and capability to deliver and manage change including delivery of cost improvement plans (CIPs).	16	12	8
2b) Inability to deliver the plan for integrated patient care services owing to multiple service tenders.	16	12	8
3a) System-wide lack of availability of workforce and impact of changes to funding streams on provision of education and training.	16	16	8
3b) Ineffective strategies promotion of wellbeing.	15	10	10
3c) Ineffective strategies for leadership and engagement and a developed organisational culture.	20	15	10
4a) Impact of external system pressures and changes in wider health economy.	20	20	15
5a) Inefficient joint working between corporate and operational services.	16	16	8
5b) Financial performance that fails to deliver the trust's Control Total in the context of the financial status of wider health economy and National drivers.	15	10	10

(Source: Risk management report- appendix 1; board papers May 2019).

We saw the BAF comprehensibly outlined key controls in place such as programmes or strategies to address the issues. It also highlighted internal and external assurance which was in place. Gaps in controls were recorded, such as the national shortage of paramedic staff and the lack of diversity in workforce not being reflective of wider population. The BAF also identified measures of success and achievements underneath the key risks.

Actions taken to address the gaps were detailed and updated each quarter when the BAF went back to the board.

The governance framework ensured people's mental health needs were met. Notably, a systematic approach was taken; the trust worked with other organisations to improve care for patients with mental health needs. The mental health work plan was heavily linked to developments in the wider health and social care system, and was overseen as part of the wider transformation programme, via the place based care programme board. This was chaired by the chief executive. A regular mental health dashboard was produced by the team, which was also shared with partners via the mental health crisis process and other local forums. Assurance around mental health was provided to the trust management group, quality committee, and board via the service transformation programme reports and also via assurance reports on delivery of the key work streams in the clinical strategy. We saw from May 2019 board papers that a focused presentation on the mental health programme was presented to the board by the executive medical director and lead nurse for urgent care.

External governance review

There is no requirement to have external reviews although it is good practice to have in-depth, regular, and externally facilitated developmental reviews of leadership and governance (NHSI 2017). Rather than assessing current performance, it is good practice that such reviews identify areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance.

The trust board commissioned an external well led and governance review which took place in July 2018. We saw an update from June 2019 on the action plan with some areas of low, medium, and high priority.

Areas for action on the plan included:

- Board and executive team working
- Accountability
- Trust executive group and trust management group
- Strategy
- Capacity and capability

We spoke with senior leaders about the action plan. We saw, and were told, that a number of the areas had been completed within the first six months after the review. There had been substantial progress on other actions which were dependent on other initiatives. For example, risk management would be further strengthened when the datix reporting system was updated.

Mental Health Act

The board level lead for mental health was the executive medical director. There was a mental health plan, which was aligned to the wider clinical strategy.

There was a clear policy and procedure for transporting patients detained under the Mental Health Act 1983 (MHA). While the trust was not a detaining authority, under the MHA they conveyed patients to hospital and had suitable policies in place. The referring healthcare professional booked the timeframe for transport. Mental health patients were given equity of access to the same time frames as those with physical health conditions. Patients under a section 136 of the

MHA were automatically matched to a category 2 response as per the ambulance response programme. There was a team of mental health nurses in the emergency operations centre (EOC) who monitored and upgraded incidents where appropriate. A monthly dashboard of Section 136 along with other mental health activity was produced reported to the executives.

People in mental health crisis who rang NHS 111 or 999 were identified through either the advance medical priority dispatch system or NHS Pathways by the call taker. The mental health nursing team was fully embedded in EOC and provided patients with early intervention in order to minimise or prevent a mental health crisis. The service worked in a coordinated and timely way to offers solutions for the patient at the first point of contact, with a strong focus on diversion rather than detention. The mental health nurses in the EOC were responsible for identifying codes associated with mental health such as code 25 - psychiatric/abnormal behaviour/suicide attempt. Further assessment and coordination of care was undertaken by the mental health nurse.

There was a frequent callers' team in the emergency operations centre. Some patients with complex needs who were are identified as frequent call, were managed by the frequent caller team who coordinated the development of a care plan which is flagged on the patient's address. The frequent callers' teams could signpost or refer to other specialist teams in the community.

Senior leaders told us the trust had developed a local CQUIN with the lead commissioners that had mental health focus. (CQUIN is -commissioning for quality and innovation.

The CQUIN payment framework is a national framework that enables commissioners to reward excellence, by linking a proportion of the providers' income conditional to the achievement of ambitious quality improvement goals and innovation). The trust were developing a process for assessment via video conferencing in EOC for patients who had complex mental health needs.

Management of risk, issues and performance

There were comprehensive assurance systems to manage risk, and we saw performance issues were escalated appropriately through clear structures and processes. Financial pressures were managed so that they did not compromise the quality of care.

Risk

There were robust arrangements for identifying, recording, and managing risks and mitigation against them. There was a comprehensive risk management strategy and a corporate risk register (CRR). The CRR was informed by local and directorate risk registers and other sources of information. It was reviewed by the risk assurance group (RAG) and TMG on a monthly basis. The register was then reviewed by the quality committee, audit committee and finance and investment committee, before final sign off at board. The CRR comprised of strategic and operational risks across the trust that had a current risk rating of 12 or above. There was a quarterly assurance of risk through the TMG, committees, and board. We saw the CRR was triangulated with internal audit recommendations.

There were embedded processes for taking account of potential risks when planning services. For example, risks around the possibility of a 'no deal Brexit' had been accounted for; there had been weekly meetings for some months to plan for the possible impact on services. The trust was also well versed in planning for potential risks around seasonal or unexpected fluctuations in demand.

The key corporate risks were aligned to strategic objectives and these were reviewed annually by the board. The processes were effective and comprehensive. There was oversight of risks at directorate level, and monthly review meetings took place at local and executive level. Corporate risks were calculated using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. Any risks entered on to a risk register were assigned a risk rating. Each risk had an initial, current and a target risk rating. The date that risks were added was included on the register, and review dates were seen. Each risk had existing controls, gaps and mitigating actions.

The trust provided their corporate risk register detailing their 49 highest profile risks, each of which had a current risk score of 12 or above (out of a total of 25).

Of the 49 risks, 16 had a current risk level of “high risk”; these were risks scoring 15 or above and are detailed below:

ID	Risk	Risk rating (current)	Risk rating (target)	Review
911	**Strategic impact of reconfiguration in wider health economy:** If the modelling of requirements to address the impact on YAS of reconfiguration of services in the wider health economy are not acknowledged and resourced then this will impact on performance, patient safety and compliance resulting in failure to deliver YAS strategic objectives.	16	8	30/06/2019
857	**Information communication technology (ICT) capacity:** If ICT capacity is not complete, there may be a failure to match business priorities resulting in impacts on delivery of core business and failure to progress projects.	16	6	26/03/2019
1128	**Avaya Telephony Platform:** If current Avaya telephony platform is not replaced there is an increasing risk that the trust will be unable to upgrade/expand the system. The manufacturer/suppliers will be unable to provide support and there will be increased likelihood of system failure due to the age of the hardware, resulting in complete failure of telephony services, significant delays/impact on patient care and trust reputation.	16	4	30/07/2019
989	**Vehicle availability for A&E**: If vehicle availability does not meet A&E rota requirements then staff will be on shift without a vehicle resulting in lack of utilisation of staff on rota and inefficient use of resources	15	3	29/03/2019
919	**BLS training and competency**: If there is a failure to deliver training and assess that all front line clinicians are adequately trained and competent to deliver basic life support and delivery of safe and effective defibrillation on a regular basis then inadequate resuscitation may be provided during cardiac arrest resulting in patient harm or death.	15	5	28/06/2019
931	**Cardiac centre capacity to accept primary percutaneous coronary intervention (pPCI) and protocol for divert**: If there are no arrangements	15	5	31/05/2019

	in place for where to take patients requiring pPCI when one cardiac centre reaches capacity then crews are required to telephone alternative centres resulting in potential for delays in the patient receiving treatment and adverse outcome.			
66	**Operational Performance:** If there continues to be increased demand across the A&E Operations service then there may be excessive response times resulting in a potential risk to patient safety.	20	5	14/06/2019
766	**Hospital handover monitoring**: If there are hospital handover delays then ambulance crews will be unavailable to respond to emergency calls resulting in delayed response times to emergency calls with potential for harm to patients.	16	4	28/06/2019
1096	**Other provider reconfiguration of services:** If the proposal to decommission services at *** Hospital is implemented then there will be a delayed response to patients with life-threatening and time critical conditions resulting in adverse patient outcome, an increase in complaints and serious incidents.	20	**10**	18/03/2019
1018	****** reconfiguration – A&E ops mobilisation**: If funding is not secured to allow YAS to continue to resource rotas to address the requirements of another hospital's reconfiguration then there will be an impact on performance, increased inter-facility transfers resulting in potential for delays in patient care and adverse patient outcome.	20	4	31/05/2019
814	**Impact of calculation of holiday pay to include regular overtime in remuneration:** If holiday pay calculation requires inclusion of overtime as part of normal remuneration then YAS would be required to address the financial impact of implementing this legislation resulting in a financial cost to the organisation.	16	**8**	17/07/2019
58	**Clinical Staff Recruitment and retention - NHS 111:** If NHS 111 are unable to recruit and retain Clinical Advisors due to poor responses to advertisements and poor retention rates then there is a potential risk to delivery of the workforce plan resulting in not being able to provide clinical advice in appropriate timescales.	16	6	31/05/2019
1108	**Revised approach in application of PTS eligibility criteria:** If the trust's revised approach to application of patient transport service eligibility criteria is not effectively communicated and managed then patients who receive a service currently may not understand the change in the trust's response resulting in patient dissatisfaction and potential reputational damage.	15	4	31/05/2019
1039	**Freedom Of Information (FOI) compliance:** If YAS do not respond to >90% of FOI requests within the 20 day statutory timeframe then the trust will be non-compliant with the Freedom of Information Act resulting in increased risk of possible regulatory enforcement action from the Information Commissioner's Office (ICO).	15	3	30/04/2019
146	**Annual Data Security (IG) training of all staff:** If YAS staff do not complete annual data security	15	3	01/04/2019

	awareness (IG) training then this is a breach of statutory duties and would result in potential for increased data breaches and non-compliance with the Data Security and Protection (DSP) Toolkit mandatory assertion.			

(Source: Trust Corporate Risk Register)

During our discussions with senior leaders, we found that there generally was alignment between what was on their 'worry list' and what was on the risk register.

Finances Overview

The financial strategy was an enabling strategy, and was in place to support the clinical services and patient outcomes within the financial resources available. We saw it was externally focused, there was work with stakeholders to gain benefit for the trust and the wider needs of the local care system.

We met with the executive director of finance. They had a sound grip of their portfolio. They told us their 'mantra' was to free up resource for front line care. We saw that 2018-2019 had been a year of significant transformation for the trust, underpinned by a finance and investment strategy (F and I) which has enabled the trust to deliver its objectives and financial responsibilities.

The trust had been successful in bidding for national capital funds, which provided 62 additional new ambulances and medical equipment. In 2018-19 the trust significantly changed the mix of types of ambulance vehicles. The number of double crewed ambulances (DCAs) was increased and number of single-crewed rapid response v Vehicles (RRVs) was reduced. This enabled the trust to respond more flexibly and effectively in line with new national standards. We saw that this project was completed ahead of time and within budget.

We heard there had also been successful national bids for ambulance vehicle preparation areas in two large ambulance stations. This meant there were dedicated teams working around the clock to ensure that frontline clinicians could access fully equipped, re-fuelled, and re-stocked vehicles at the beginning of each shift.

During our inspections, the emergency operations centre (EOC) was undergoing a re-design. This was intended to create an environment which would improve call handling performance, increase clinical support in the EOC, and improve dispatch of ambulances and RRVs. We were told that investment and work on the project so far had delivered a number of improvements, for example:

- system developments including introduction of 'auto dispatch' to support ambulance dispatchers in rapidly deploying the right resources to meet patient need
- refurbishment and redesign of the York EOC
- an increase in the number of clinical advisors within EOC

Following the inspection, the trust noted that they had planned to achieve a £2.1m surplus in 2018/19. This position secured £2.1m Provider Sustainability Funds (PSF), giving a planned control total of £4.2m.

The trust actually achieved a surplus of £3.7m in 2018/19 and was awarded additional PSF, giving £5.6m in total. This gave an adjusted financial performance figure of £9.3m. In the same financial year, the trust achieved its capital improvement plan (CIP) plan of £9.0m (3.2%).

Gross capital expenditure in 2018/19 totalled £18m. This was in line with plan which was made up of internally generated funds as well as significant national investment through successful capital applications.

Financial metrics	Historical data		Projections	
	Previous Financial Year (2016/17)	Last Financial Year (2017/18)	This Financial Year (2018/19)	Next Financial Year (2019/20)
Income	£254.5m	£263.5m	£276.4m	£269.1m
Surplus	£1.6m	£4.0m	£3.7m	£1.5m
Expenditure	£252.9m	£259.6m	£272.7m	£267.6m
Add Sustainability and Transformation Fund (STF)/ Provider Sustainability Fund (PSF)	£1.1m	£5.3m	£5.6m	£2.2m
Adjusted financial performance	£2.7m	£9.3m	£9.3m	£3.8m

(Source: Trust Provider Information Request – Finances Overview)

Year on year comparators are shown below:

	16-17	17-18	18-19	19-20
Income	254,516	263,530	276,366	269,100
Expenditure	252,937	259,546	272,679	267,559
Surplus	1,579	3,984	3,687	1,541
Add STF / PSF	1,140	5,320	5,563	2,232
Adjusted Financial Performance	2,719	9,304	9,250	3,773

The trust achieved the 2018/19 CIP target of £9.0m (3.2%). • In 2018/19, capital expenditure was £17.0m, compared to planned £13.4m. This overspend was a result of additional plans approved during the year, such as ambulance fleet replacement, which more than offset underspends elsewhere. The movement was reflected in the forecast in a timely manner.

Cash balances at 31 March 2019 were £36.1m, which is £1.1m favourable to the planned position.

(Source: NHSI)

NHS Improvement uses a single oversight framework (SOF) to oversee NHS trusts. It helps them to determine the type and level of support trusts need across five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

Under the SOF, the trusts overall rating for the year leading up to our inspection remained at '1' (1 being the lowest risk, '4' being the highest risk).

(Source: Integrated performance report May 2019)

Performance

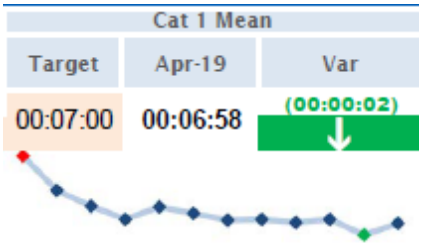
The YAS integrated performance report (IPR) was published on a monthly basis and provided an overview of all aspects of the trusts performance over the year. We saw the indicators were used to measure performance for each of the operational areas and the key services were being delivered. The IPR reported on;

- performance- such as response times
- quality-including incidents and patient relations
- workforce- including sickness, training, recruitment
- finances
- corporate services

There was a detailed report for each of the service lines:

- A & E operations
- EOC- 999 control centre
- PTS
- Integrated urgent care

In April 2019, response times for 'category 1' patients (see below for an explanation) had fallen by three seconds to six minutes and 58 seconds, see below. The trajectory over the year showed a trend of continual improvement'.



The IPR also contained national benchmarking against all the other ambulance trusts. Examples of this can be seen bin the next section.

Ambulance Quality Indicators

The ambulance quality indicators (AQIs) were introduced in April 2011 for all ambulance services in England. They consider the quality of care provided and the speed of response to patients.

The AQIs are ambulance specific and are concerned with patient safety and outcomes. They are designed to be consistent with measures in other parts of the NHS, most notably those from emergency departments. They comprise of system indicators and clinical outcomes. Statistics for all ambulance services are updated monthly by NHS England.

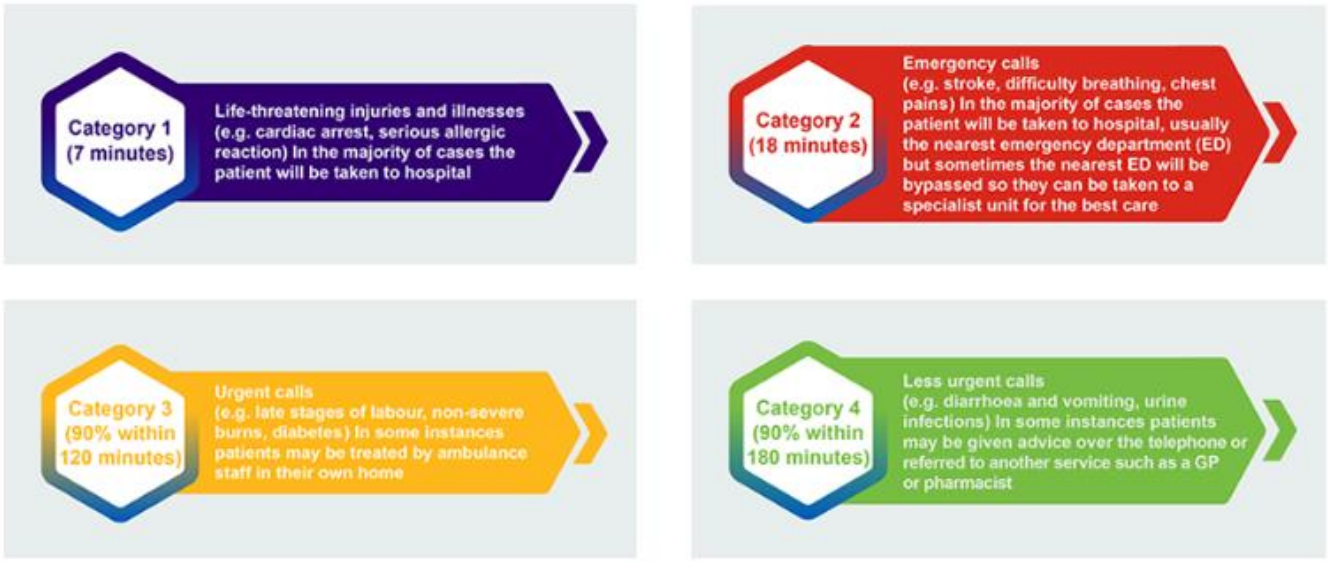
Senior leaders told us they constantly monitored their performance as it was a vital indicator of how well the trust responded to patients' needs and they can maintain and improve the standards of care. We saw for example on AQIs for June 2019 that the trust was 5th out of 10 trusts for category 1 responses in June 2019, and 3rd out of 10 trusts for category 2 responses.

New Ambulance Response Standards- Ambulance Response Programme

YAS was one of three English ambulance trusts to participate in the ambulance response programme (ARP) pilot, led by NHS England, when it began in October 2015. Throughout our ongoing engagement and monitoring of the trust, we saw it had been involved through all phases of the pilot. The pilot allowed extra time for the emergency call handlers to make a more detailed analysis of some 999 calls and to decide upon the most appropriate response for patients' needs.

The programme has since been implemented across England and call handlers are now given more time to assess 999 calls that are not immediately life-threatening, which enables them to identify patients' needs better and arrange the most appropriate response. The ARP has been designed to change the way ambulance services respond to 999 calls in terms of both response times (performance) and the prioritisation (clinical coding) of patient conditions.

The four categories of response within ARP are as follows:



During 2018/19 the trust was commissioned to deliver against a locally agreed trajectory for ARP. This was achieved by the trust through changing the way they delivered services. The only exception was the category '4' 90th percentile target. Category '4' is was the lowest acuity group and made up around only 1% of the total demand on services. The table below demonstrates the performance.

2018/19	Category 1 Mean	Category 1 90th	Category 2 Mean	Category 2 90th	Category 3 90th	Category 4 90th
Trajectory	00:07:41	00:13:16	00:21:37	00:46:30	01:59:58	03:16:08
Actual	00:07:21	00:12:37	00:20:26	00:42:34	01:58:44	03:24:20
Variance	- 00:00:20	- 00:00:39	- 00:01:11	- 00:03:56	- 00:01:14	+ 00:08:12

We saw that performance in ambulance response times had mostly been achieved or only narrowly missed from April to June 2019. Senior leaders told us this had been achieved despite a 6% increase in demand from4 the previous year.

April 2019

Performance	YAS
C1-Mean response time (Target 00:07:00)	00:06:58
C1-90th centile response time (Target 00:15:00)	00:12:06
C2-Mean response time (Target 00:18:00)	00:19:40
C2-90th centile response time (Target 00:40:00)	00:40:29
C3-90th centile response time (Target 02:00:00)	01:49:54
C4-90th centile response time (Target 03:00:00)	02:23:55

May 2019

Performance	YAS
C1-Mean response time (Target 00:07:00)	00:06:49
C1-90th centile response time (Target 00:15:00)	00:11:56
C2-Mean response time (Target 00:18:00)	00:18:38
C2-90th centile response time (Target 00:40:00)	00:38:09
C3-90th centile response time (Target 02:00:00)	01:42:58
C4-90th centile response time (Target 03:00:00)	02:00:56

June 2019

Performance	YAS
C1-Mean response time (Target 00:07:00)	00:06:49
C1-90th centile response time (Target 00:15:00)	00:11:56
C2-Mean response time (Target 00:18:00)	00:18:46
C2-90th centile response time (Target 00:40:00)	00:38:14
C3-90th centile response time (Target 02:00:00)	01:49:27
C4-90th centile response time (Target 03:00:00)	01:58:53

(Source: IPRs- April to June 2019)

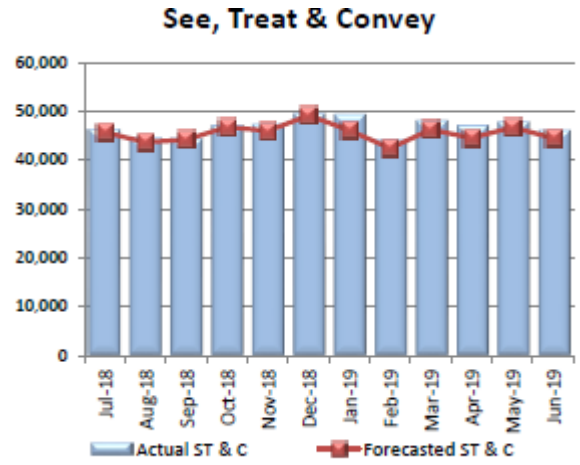
The Carter Review

The Lord Carter review (2018) into ambulance productivity in England made nine recommendations to improve patient care, efficiency, and support for frontline staff. Ambulance trusts have had to respond to a significant rise in demand for ambulance services in recent years. The report found that if more patients were better assessed over the phone when dialling 999 or treated at the scene by paramedics and thus avoid the need for an ambulance (if it was safe to do so), it could reduce unnecessary pressure on emergency departments (EDs) and hospital beds.

The trust measured activity for:

- Hear and treat: (telephone advice that callers receive who do not have serious or life threatening conditions after calling 999. They may receive advice on how to care for themselves or where they might go to receive assistance
- See, treat and refer (seeing patients, assessing their needs, and referring them to another health professional)
- See, treat and convey: (the patients is seen, assessed, initial treatment given, they are then conveyed, usually to an acute hospital).

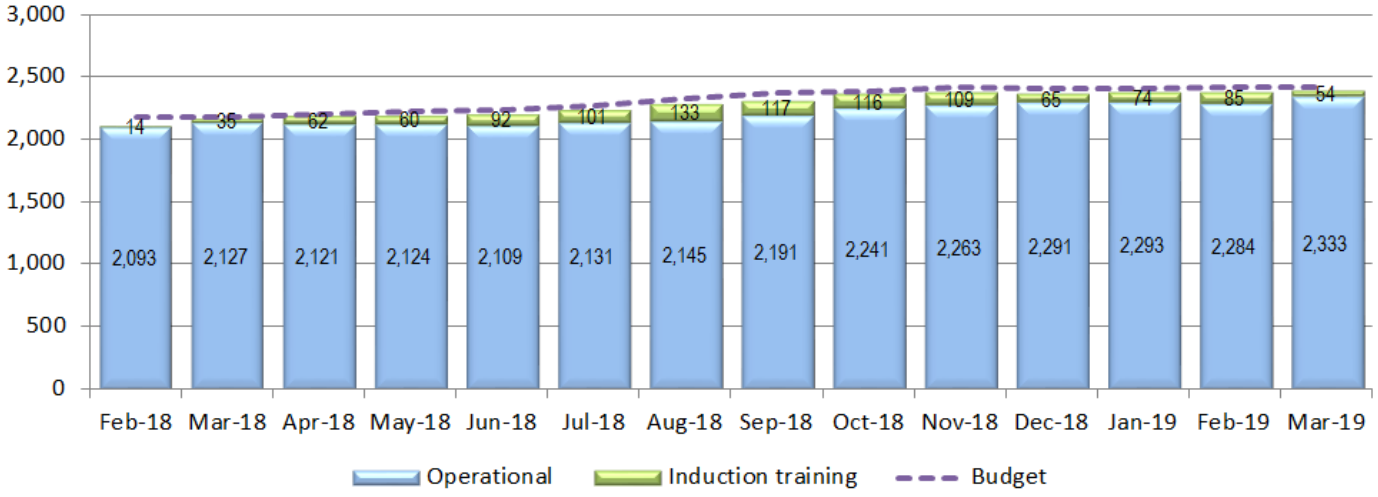
We saw YAS did well in forecasting activity for these activities, for example for see treat and convey; the graph below shows predictions and activity from July 2018 to June 2019.



We saw from board papers that the hear and treat activity in June 2019 decreased by 2.42% against the previous months performance, above forecasted position and 4.4% higher than June the previous year. The see, treat and refer activity for June was in line with May; 11% above the projected position and 8.5% higher than June the previous year. The see, treat and convey activity for June was 3.8% lower than May, above trajectory and 4.2% higher than June the previous year.

Use of operational hours

The Carter review (2018) recommended that ambulances services should review staff hours worked to ensure a balance between contracted and actual hours. We saw this had been a focus at the trust and was used in resource planning for ARP. At the start of the year the capacity planning and scheduling team forecast the total number of hours that would be needed each month based upon expected demand, the budget and the performance standard expected. Recruitment needs were identified and overtime was used to ensure the needs of the service could be met. We saw from board papers that the gap between budget and staff in post was very small. This meant the trust targeted overtime flexibly rather than to fill significant recruitment gaps.



(Source: board papers 2019)

Paramedic rotation

The trust was part of a pilot supported by Health Education England (HEE). This this involved a new working model for specialist and advanced paramedics, enabling them to rotate through a variety of settings in their role, including into GP practices and other community-based teams. We spoke with senior leaders about this, and they told us it had been very successful. They told us the skill set of paramedics enabled them to deliver care to patients across different settings. They told

us this made them a valuable resource, and was good for patients. We were told that when paramedics returned after rotation, they felt more skilled in making judgements about not taking patients to hospital unnecessarily. It has resulted in around 20% less patients being taken to hospital, when it was safe and appropriate not to take them.

Delayed Hospital Handovers

When patients cannot be handed over to hospital teams in emergency departments, due to the departments being full, it results in lost hours for ambulance crews at hospital due to delayed patient handovers. The trust had been doing targeted work locally, with local acute hospitals, regionally-with the NHS emergency care intensive support team (ECIST), and nationally with NHS England. We saw the trust participated in national calls where two Yorkshire hospitals have been in the top seven of handover delays in England.

The table below shows handover delays decreased from February to March 2019, a decrease of over 32%, however an average of 98 hours per day was still lost in June 2019

	Jan	Feb	Mar	Apr	May	June	Last 12 Months
Excessive Handovers over 15 mins (In hours)	3,484	3,768	2,527	2,977	2,726	3,053	30,602
Excessive Hours per day (Avg)	112	122	84	96	91	98	83

(Source: IPR June 2019)

Information management

The trust collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards.

There was a data quality policy which was the framework for ensuring data quality standards were adhered to. We saw the policy informed all staff of their roles and responsibilities with regards to data quality, and was intended to maintain and increase high levels of data quality within the trust.

The key principles of the data quality policy included validity, completeness, reliability, coverage, accuracy, timeliness, and anonymity.

The digital strategy focused on providing resilient IT intelligence services for all core services, to extend digital capability of the trust. The strategy was used to ensure data was shared across the health and care system to help improve patient outcomes and support integrated services.

We saw that integrated reporting supported effective decision making, for example in group meetings and committees. The trust made good use of data to make strategic and operational decisions to assist the delivery of quality patient care, performance management, and corporate governance.

Data from the trust was shared and used externally by a number of organisations to support the management of service level agreements for healthcare planning and accountability. There were robust data governance arrangements in place to help ensure the information supplied was timely, accurate, and reliable to support decision making, and protect the reputation of the trust

Before our inspection, we were told that a data quality governance strategy was being developed. The intention was this would set out the ways data quality would be addressed. For example, by report checks where data was validated and checked via a number of processes.

All NHS organisations have a legal duty of confidence to their patients and the law defines how information can be collected and handled. A set of guidelines, known as the Caldicott principles, apply to the use of patient information. There was a Caldicott guardian role, which was undertaken by the executive medical director. Their role as guardian was to protect the confidentiality of patient information and enabling appropriate information-sharing.

The trust had a data protection officer which was a mandatory requirement under the new general data protection regulation (GDPR) legislation.

There were a number of systems to capture information across all the service lines of the trust. . The computer aided dispatch system (CAD) was the main source of activity data, which included patient information and the response provided to the patient. A process was in place to manage retrospective changes to CAD data and required approval by the data quality team. Information was sent to a data 'warehouse' which fed the majority of reporting within the trust and also externally. The warehouse is governed within the trust and had security controls on reports. Cyber security was considered to be a priority. There was continued oversight of threats and systems in place to prevent a cyber-attack.

Commissioners had access to a 'share point' site for reports and they were automatically sent data such as ambulance arrival times, handover delays and turnaround times. We were told the trust had invested in an analytics system to transform data into 'real time' useable dashboards to support timely local decision making. We spoke with the lead manager for resilience planning and they told us the information was only 30 seconds behind real time, so performance could be used to ensure the delivery of quality care and enabled people to work productively.

Through our ongoing monitoring of the trust, we saw improvements have been made to the EOC call pick up system directly as a result of improved use of information. Hospital handover delays were understood in more detail and financial information had been linked to operational data to support the improvement of services.

We were told about the implementation and roll out of an electronic patient record (EPR). Over

2,400 members of operational staff had been trained before our inspection and over 430 vehicles have been fitted with rugged tablet type computers for crews to use. The EPR enabled transfer of the patient records from rapid response vehicles to double crewed ambulances. This meant the crews had up to date information by the time they reached a patient at the scene. We heard the EPR development team had also been working with the Yorkshire and Humber local health care records exemplar (LHCRE) on a pilot to transfer the ambulance patient record to hospital trusts in a standard format.

(Source: PIR)

The information governance (IG) toolkit is a self-assessment audit completed by every NHS trust and submitted to NHS Digital at the end of each financial year. The purpose of the IG Toolkit is to provide assurance of an organisation's information governance practices through the provision of evidence of a number of individual requirements. The trusts IG toolkit submitted in March 2018 contained evidence for all the 100 mandatory items required, and 40 of the 51 non-mandatory items with an action plan submitted for none complete standards. There were four requirements which were declared as not fully met:

- Deliver data security awareness training to 95% staff
- Data security improvement plan

- The organisation can name its suppliers, the products and services they deliver and the contract durations
- Basic due diligence of supplier contracts.

The external review carried out in July 2018 made some recommendations in relation to use of data. It suggested;

- Development of and investment in more automated process to free up analytic capacity in the business intelligence team
- Greater insight on the integrated performance report views on themes behind the data
- A follow up internal audit on data quality

We saw from the action plan that that elements had been achieved and others were being delivered by the introduction of the digital strategy, and the accountability framework programme. An external review of performance reporting and data quality had been completed and the findings were to be used for a programme of work from 2019 to 2020.

Engagement

The trust proactively engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The trust had a structured and systematic approach to engagement and we saw services were developed with participation of people who used them.

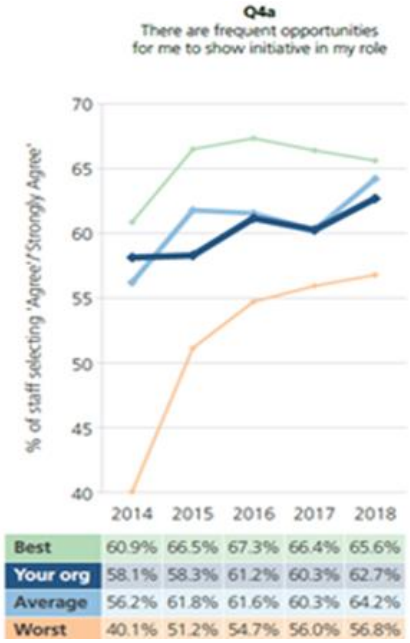
There was a communications and engagement team who kept staff up to date about operational and corporate developments through newsletters, and other mechanisms such as a phone app; they also highlighted news and successes to external stakeholders.

There was a prestigious annual award ceremony where staff and the public attended. Awards were presented to staff, volunteers, and the public where they had gone above and beyond usual expectations. Awards given included; compassion and kindness, integrity, empowerment, resilience, innovation, team of the year, volunteer of the year, and apprentice of the year.

Staff engagement

The people strategy had a focus on engagement with staff and their ‘voice’. We saw that proactive engagement with staff and their views were reflected in planning and delivering services. The overall staff engagement score for the trust in 2018 was 6.3 out of a possible score of 10; this was higher than the 2017 (5.9), and slightly better than the average for the ambulance sector (6.2).

There was a general trajectory of improved results from staff engagement. The graphs below show firstly, the trajectory of staff who felt they could frequently show initiative in their role (the trust is represented by the dark blue line). The second graph shows improvement over time for staff who reported they were able to make suggestions to improve the work of their team. Both results in 2018 were better than average for the ambulance sector.



	2014	2015	2016	2017	2018
Best	60.9%	66.5%	67.3%	66.4%	65.6%
Your org	58.1%	58.3%	61.2%	60.3%	62.7%
Average	56.2%	61.8%	61.6%	60.3%	64.2%
Worst	40.1%	51.2%	54.7%	56.0%	56.8%

	2014	2015	2016	2017	2018
Best	72.4%	59.2%	64.6%	59.4%	67.0%
Your org	45.3%	45.0%	45.6%	47.2%	54.5%
Average	48.4%	49.1%	50.7%	49.9%	54.0%
Worst	32.9%	40.5%	43.4%	45.0%	42.6%

The director of work force and organisational development (OD) told us a staff engagement group was being established and there was to be a YAS 'culture ambassador' role. Around 70 staff were being invited to be culture ambassadors. There would be an employee voice forum chaired by the trust chairperson, supported by the director of workforce and OD. The forum planned to meet on a quarterly basis. For example the career development framework was being developed as a result of staff views. Staffing rotas were being reviewed in order to balance the needs of the workforce and the service. The culture ambassadors were champions for improvement initiatives, such as health and well-being, and diversity and inclusion.

Listening events had been held at ambulance stations and hospitals to gather views of ambulance staff, and senior managers undertook 'back to the floor' days with crews and call centre teams. Leaders told us about engagement with staff via social media. A Facebook group 'one YAS' had been created so staff could feedback. There was 'YAS TV' in ambulance stations where messages could be shown to staff on television screens.

The clinical pathways team conducted a pathways roadshow resulting in engagement with over 250 members of staff, about alternative pathways of care for patients, such as a new referral pathway to a local mental health crisis café.

We spoke with staff side (union) representatives as part of our inspection. There was support given for staff side representatives to have the time to dedicate to the role. As a group they considered they had a voice in the organisation and a good presence and attendance at a range of forums. Their main link was with the director of workforce and OD. We were told of an example where a decision had been reached and staff side appealed against it. After further discussions, plans were put on hold until staff had been consulted; thus we saw evidence of listening and responding by the trust. There was a mutually respectful working relationship between the staff side representatives and senior leaders.

There had been reinvigoration of the staff equality networks. The LGBT, BME and disability staff network were all members of the trust's diversity and inclusion steering group (DISG), chaired by the director of workforce and OD.

Public engagement

Every board meeting included a patient story to showcase the work of the service, share patient experience, and set the tone for the meeting.

We spoke with managers and leaders who went to patients' home to meet them and their families if something had gone wrong. Leaders told us this was a way of being held to account and it was the right thing to do in order to gain feedback from people and apologise.

There was an annual programme of community engagement events where the trust met with local people to raise awareness of how to access the services appropriately. The trust team also highlighted topical public health issues, and taught cardiopulmonary resuscitation (CPR). There was a 'restart a heart' annual campaign where hundreds of off-duty staff and volunteers give up their time to provide CPR training in local schools. Over the last five years training had been provided to over 105,000 young people at 72% of the secondary schools across Yorkshire. We heard that 172 schools signed up for the 2019 event, which means around 40,000 pupils would be taught CPR skills on the day.

In the 12 months before our inspection, the community engagement team delivered 203 free first aid awareness courses to over 3,000 people. Community engagement events were also held to promote career and volunteer opportunities at the trust. Various towns and cities across the region had been targeted to raise the profile of the trust and to promote recruitment from diverse communities. Events earlier in 2019 attracted over 400 people.

The trust worked with around 1,150 volunteers. These were valued and considered as a key part of the trust.

The trust recognised that involving patients, networks, and members of the public in service development and delivery was essential to ensure patient experience was of a high quality. There was a member of the public on the medicine's optimisation group.

There was a critical friends network (CFN) made up of a range of people, patients and members of the public, from a variety of backgrounds. The people involved with the network had some contact with the ambulance service within the last three years to make sure their contribution was relevant.

Members stayed in the network for up to two years. There were quarterly meetings with the CFN, and contact at focus groups and by email or surveys to ensure the patient and public voice was incorporated. The CFN received a bespoke quality improvement (QI) training session from the QI team. This approach was taken to enable the CFN to work more collaboratively with service users and patients to ensure they are part of any improvement work.

Improvements which had resulted from input of the CFN included:

- PTS calling cards - the network advised on the information and layout.
- Website development - members of the network were directly involved in the design and functionality of the trust website with improved accessibility.
- A learning disabilities' communication booklet
- A pilot of 'always events within the PTS service regarding 'the patient will always be briefed on the travel itinerary before they commence their journey'

There was a trust coordinator who reported to the head of investigations and learning. We heard of some work with networks for people living with dementia; it was planned that this would feed

into the trusts work in this area of care. There were plans to undertake this approach over the next 12 months with groups for people with learning disabilities.

A bi-annual newsletter was sent out to over 8,000 public members of the trust to keep them up to date on developments at the trust.

Stakeholder engagement

The trust took a leadership role in the health and social care system to identify and proactively address challenges to meet the needs of the population. There was positive collaboration with external partners to build a shared understanding of challenges within the system.

Services from the trust were commissioned by 23 clinical commissioning groups (CCGs) across all service lines. There was one lead CCG for 999 services and another lead CCG for integrated and urgent care/NHS 111 service. Patient transport services were commissioned in separate lots across the county by individual or groups of CCGs. The trust engaged with CCGs through a joint strategic partnership group (which the trust chaired), a joint quality board, and a contracts management board. There was also engagement outside the formal committee arrangements. There were regional quality groups which inputted into regional arrangements about specific developments. Leaders told us this had resulted in better co-ordination and a more strategic approach to commissioning across service lines.

The trust was a key partner and leader in the integrated care systems across South Yorkshire, West Yorkshire and Harrogate, Humber, Coast and Vale. It was involved in range of place based partnerships and associated works streams. Involvement from the trust was at strategic leadership level through to operational engagement in key work streams relating to specific place plans or thematic work. For example in emergency and urgent care, service reconfigurations, mental health, integrated transport, and other key topics. The trust covered all three local maternity systems (LMS) in the region and had membership on those boards, and the Yorkshire and Humber maternity clinical expert group.

Senior leaders told us local arrangements were still evolving and the key challenge is the trust was to ensure they were involved at the right level, and to target the leadership team in a co-ordinated way

The trust engagement with other care providers including acute, mental health and community trusts, out of hours providers and other health and social care providers such as local authorities. This engagement was through the place based partnerships and A and E delivery boards in each area. There was also direct engagement on specific issues for example to ascertain outcomes for patients.

The trust engaged well with Police and Fire services through tri-service collaboration arrangements which varied across the region. These were in the form of local resilience forums, focused on co-responding emergency planning and resilience. The lead pharmacist sat on national and local networks to develop service links and improve information sharing.

An innovative approach had been taken to collaborate with other ambulance services. The Northern ambulance alliance (NAA) had been created in 2016 and composed of four ambulance trusts, and trust which had been an associate member since 2018. The chief executive of the trust led the NAA as its chief executive. The NAA collaborated to share good practice, improve efficiency and value for money. We were told of a number of significant projects, including the joint procurement of a new fleet management system. This supported fleet managers to reduce vehicle costs.

Joint procurement through the NAA meant there was only one tender process for three organisations, one lot of set-up costs and a single system helps to drive efficiencies across the three ambulance fleets. It was estimated to have saved around £1 million across the three ambulance services.

We were told about other cost-saving initiatives worth just over £1.5 million collectively. They included:

- Joint specification for new vehicles
- Change of medical gases supplier which resulted in organisational discounts
- The introduction of electric vehicles

There was a collaborative approach to workforce, quality, and operational projects, including:

- Sharing best practice on promoting the national NHS staff survey and the flu vaccination uptake
- Improving key equality and diversity indicators to address key challenges and share ideas across organisations
- Sharing best practice to help prevent and/or better manage falls
- Exploration of joint research projects

The trust was part of the national partnership of NHS ambulance services, the Association of Ambulance Chief Executives (AACE). This provided a structure to co-ordinate, and implement key national work programmes to improve patient care. There was also active engagement with other ambulance services and NHS England through the national ambulance improvement programme.

Senior leaders told us the trust worked closely with a number of universities, to support education and research activity. Some university partners had also been involved in YAS community engagement events.

There was engagement with charities, local voluntary and third sector organisations as part of the community engagement strategy. For example with AGE UK Leeds, British Red Cross, St John Ambulance, Community Action Bradford, and Voluntary Action Leeds.

We heard there was a partnership with the Yorkshire Improvement Academy and the academic health sciences network as part of the patient safety collaborative and to support the quality improvement strategy.

Learning, continuous improvement and innovation

There was a focus on learning and improvement throughout the trust and there was commitment to improving services by learning from when things went well and when they went wrong. There was a good record of sharing work locally, regionally and nationally.

The trust participated in appropriate research schemes. It was top of the national league table of the National Institute for Health Research (NIHR) in 2019 for the trust that undertook the most clinical research studies and recruited the highest number of participants last year. This showed good commitment to improving patient care through research in the challenging environment of emergency and transitory care

We saw a range of standardised improvement methods in place such as the PDSA cycle (plan, do, study, and act), rapid process improvement workshops,

There were service transformation programs. Four programme boards which had oversight of;

- service delivery and an integrated workforce model
- place based care
- infrastructure
- capacity and capability

We saw good practice had taken place at the trust in relation to learning from deaths by the mortality review process. In the absence of national guidance for ambulances trusts, in 2017, YAS developed and piloted a mortality review process. This process looked at all deaths which occurred when patients were in the care of the trust. It also helped to identify any patients where there were concerns that the management of their care may have contributed to their death. The trusts mortality group consisted of lead clinicians and safety leads, and they met to look at themes and trends so that improvements could be made and lessons learned. The medical director told us the group comprised a group of clinicians who met sporadically.

The trust developed and piloted a process to audit and screen all deaths that occurred when the patients was under the case of YAS. Patient deaths were categorised as being either:

- anticipated (due to terminal illness)
- unexpected (and occurred despite interventions),
- preventable (where steps may not have been taken)
- unexpected (following intervention)

In 2018, over 1750 deaths were reviewed. Around 8% (148) had been anticipated; 1541 (82%) occurred despite intervention. There had been 61 deaths (around 3%) which may have been preventable, and none that were unexpected. Ten deaths (0.5%) had been reported to the learning disabilities mortality review programme. (Source: Clinical governance and quality report June 2019.)

In 2017, the trust asked their lead commissioners for a CQUIN (commissioning for quality and innovation) related to learning from deaths, which was achieved. (The CQUIN payment framework is a national framework that enables commissioners to reward excellence, by linking a proportion of the providers' income conditional to the achievement of ambitious quality improvement goals and innovation)

Where the coroner had made recommendations following a patient's death, the trust maintained an action log to record the concerns and responses. As part of our monitoring processes we reviewed reports sent to the coroner throughout the year. The action plans and responses to the coroner indicated that robust investigations were completed and lessons were learnt. Where actions were identified these were followed through.

We heard that there was support offered to the families of patients of who had died. Senior staff attended coroners' courts with families if they wished them to. Records were shared with families in order to support them. We were told the trust attended around 160 inquests a year.

A bi annual report on learning from incidents complaints and deaths went to the board. We reviewed the report presented to the March 2019 board meeting. We saw the trust investigated, analysed and learned after things went wrong.

There was good knowledge of improvement methods, and there were systems to support innovative work including staff objectives, rewards, and ways of sharing improvement work.

The quality improvement strategy incorporated a quality improvement (QI) methodology and this supported the implementation of the clinical strategy. This focussed on developing a culture, through skills development and supporting teams and individuals to take responsibility for quality improvement in all areas of the trust. We saw staff took time out to work together on processes which would lead to improvements.

A fundamental element of the QI strategy was to increase QI capacity across the trust via the 'QI Fellows' programme. This was a 12 month programme designed to be repeated over the five years in line with the QI Strategy. Throughout the course of the programme, the QI fellows were trained and coached in QI methodology which they then used to test and measure ideas for improvement. We attended the first QI fellows' awards event in June 2019. We saw first cohort of the QI fellows had successfully completed a wide range of QI projects.

It was noticeable how well the QI fellows worked together as an enabling team of individuals. They spoke of evidence based practice and continuous quality improvement as a key theme across all of their respective projects. We heard how they had engaged with their colleagues on the frontline and demonstrated their use of newly developed QI skills to make quality improvements.

The trust, led by the core QI team, were supporting '#ProjectA', which was a programme of improvement for ambulance services, supported by NHS Horizons and AACE. The trust were one of three ambulance services to have been selected to work with NHS Horizons in this way. The aim of the work was to allow front line ambulance staff and patients to have a voice in the improvement of ambulance services.

The trusts head of QI was seconded to #ProjectA for one day per week to support the design of the work streams. There was focus on the prevention of falls, non-conveyance of patients with mental health needs, and working with patients, the community and staff health and wellbeing.

Senior leaders told us there were opportunities to openly share their work in these identified areas and to promote learning from within the ambulance sector. Senior leaders told us the trust had been pivotal in the construction of the work streams

The trusts head of equality and inclusion told us innovative approaches had been taken to support staff. An ambulance had been converted into a health and well-being 'bus', and this was driven to ambulance stations to provide information on health promotion related to well-being.

The national rotational paramedic pilot scheme (which involved YAS as one of the main pilot trusts) was nominated and subsequently won the Royal College of General Practitioners 'Good Neighbour' Award, which recognised excellence in collaborative practice.

We were told about a network of end of life care (EoLC) champions across the region that had EoLC qualifications. They utilised an international system known as ECHO (extension of community healthcare outcomes). This used remote telecare technology to increase access to specialty treatment in rural areas. The EoLC champions were partnered with a mentor who had specialist knowledge and supported them in learning and development to gain the knowledge and support they need to manage patients with complex end of life conditions.

There had been innovations in the medicines team.

The lead pharmacist was actively involved in service development and was participating with the research team to look at patients who were not transferred to hospital and how these patients could be followed up. A pilot was also underway to review how medicines were stored and tracked to enable the service to comply with new legislation in addition to streamlining and providing time saving efficiencies for staff. There was a research project considering the use of an inhaled pain relief to improve the pain relief of patients compared with traditional pain relief.

There was innovative practice in collaborative work with local care homes. There were two programmes in different parts of the region. Using QI methodology, work was being done to reduce the number of calls for an ambulance for incidents such as falls without harm. Care home staff were being supported to develop skills and experience to care for patients following a fall. The trust had provided some additional equipment and supported staff to build confidence to move patients from the floor where there are no obvious signs of injury.

Ambulance services

Patient transport services

Facts and data about this service

Yorkshire Ambulance Service's patient transport service delivered planned transport for patients with a medical need for transport to and from premises providing secondary NHS healthcare.

Patient transport services catered for those patients who were either too ill to get to hospital without assistance or for whom travelling may cause their condition to deteriorate. The trust's patient transport service is one of the largest ambulance providers of non-emergency transport in the UK, undertaking almost one million non-emergency journeys every year.

The service aimed to create a sustainable solution to patient transport which provided high quality, safe and efficient patient care that was flexible to the needs of those who used it, and those who commissioned the service.

Patient transport services was supported by a volunteer car service, members of the public who volunteer with transporting patients to routine appointments.

(Source: Routine Provider Information Request (RPIR) – Context tab)

The trust had contracts with 18 taxi services and 17 independent providers which it used to provide patient transport services.

(Source: Routine Provider Information Request (RPIR) – Ind Providers tab)

Prior to the inspection we reviewed a range of information from and about the service. During our inspection we visited each of the five geographical localities within patient transport services; we visited nine ambulance stations, the headquarters communication centre, eight hospitals and four patient reception centres. We spoke with more than 30 patients and their relatives and carers, engaged with more than 40 staff, including managers of the service, team leaders and ambulance crew, volunteer drivers, call centre operations staff, maintenance staff and cleaning staff. We checked 25 vehicles.

We saw there had been significant improvement in this service since our last inspection, for example in response times and infection prevention and control.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

The trust set a planned level of 90% for completion of mandatory training.

A breakdown of compliance for mandatory courses from April 2018 to February 2019 for all staff in patient transport services is below:

All staff groups

Training module name	Year to date (YTD): April 2018 to February 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust planned	Met (Yes/No)
Dementia Awareness	657	664	98.9%	90.0%	Yes
Fire Safety & Awareness	629	664	94.7%	90.0%	Yes
Infection Control	628	664	94.6%	90.0%	Yes
Moving and Handling - Loads	623	664	93.8%	90.0%	Yes
Information Governance	621	664	93.5%	90.0%	Yes
Moving and Handling - Patients	431	468	92.1%	90.0%	Yes
Equality, Diversity and Human Rights	611	664	92.0%	90.0%	Yes
Conflict Resolution	430	468	91.9%	90.0%	Yes
Health Risk & Safety Awareness	610	664	91.9%	90.0%	Yes
Investigation of incidents	606	664	91.3%	90.0%	Yes
Waste Management	606	664	91.3%	90.0%	Yes
Paediatric BLS	553	664	83.3%	90.0%	No
Adult BLS	553	664	83.3%	90.0%	No

At trust level, for all staff groups in patient transport services, the 90% planned level was met for 11 of the 13 mandatory training modules for which staff were eligible.

The trust also provided a breakdown of mandatory training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in patient transport services is shown below:

Support to ambulance service staff:

Training module name	Year to date (YTD): April 2018 to February 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust planned	Met (Yes/No)
Dementia Awareness	597	604	98.8%	90.0%	Yes
Infection Control	573	604	94.9%	90.0%	Yes
Fire Safety & Awareness	572	604	94.7%	90.0%	Yes
Moving and Handling – Loads	568	604	94.0%	90.0%	Yes
Information Governance	565	604	93.5%	90.0%	Yes
Equality, Diversity and Human Rights	557	604	92.2%	90.0%	Yes
Moving and Handling – Patients	431	468	92.1%	90.0%	Yes
Health Risk & Safety Awareness	556	604	92.1%	90.0%	Yes
Conflict Resolution	430	468	91.9%	90.0%	Yes
Investigation of incidents	552	604	91.4%	90.0%	Yes
Waste Management	551	604	91.2%	90.0%	Yes
Paediatric BLS	504	604	83.4%	90.0%	No
Adult BLS	504	604	83.4%	90.0%	No

In patient transport services the 90% planned level of compliance was met or exceeded for 11 of the 13 mandatory training modules for which support to ambulance service staff were eligible.

NHS infrastructure support staff:

Training module name	Year to date (YTD): April 2018 to February 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust planned	Met (Yes/No)
Dementia Awareness	60	60	100.0%	90.0%	Yes
Fire Safety & Awareness	57	60	95.0%	90.0%	Yes
Information Governance	56	60	93.3%	90.0%	Yes
Waste Management	55	60	91.7%	90.0%	Yes
Infection Control	55	60	91.7%	90.0%	Yes
Moving and Handling – Loads	55	60	91.7%	90.0%	Yes
Investigation of incidents	54	60	90.0%	90.0%	Yes
Equality, Diversity and Human Rights	54	60	90.0%	90.0%	Yes
Health Risk & Safety Awareness	54	60	90.0%	90.0%	Yes
Adult BLS	49	60	81.7%	90.0%	No
Paediatric BLS	49	60	81.7%	90.0%	No

In patient transport services the 90% target was met for nine of the 11 mandatory training modules for which NHS infrastructure support staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training)

Staff in patient transport services achieved or exceeded the trust's planned level of compliance of 90% for the year to date April 2018 to February 2019. Staff we spoke with had completed their

mandatory training and protected work time was available for this purpose. Some training could be completed via the internet on the staff member's palmtop computer.

Patient transport services provided mandatory training for its volunteer staff.

At our previous inspection in 2016 we found some patient transport services staff experienced difficulty in accessing appropriate mandatory training. At this inspection we found some staff required the support of their manager in completing mandatory training, including e-learning. Managers were taking action regarding training support.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse.

Safeguarding training completion rates

The trust set a planned level of 90% for completion of safeguarding training, with the exception of safeguarding children level 2, for which an 80% planned level was set.

A breakdown of compliance for safeguarding courses from April 2018 to February 2019 for all staff in patient transport services is below:

All staff groups

Training module name	Year to date (YTD): April 2018 to February 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust planned	Met (Yes/No)
Safeguarding Children Level 1	648	664	97.6%	90.0%	Yes
Safeguarding Adults Level 1	645	664	97.1%	90.0%	Yes
Prevent Awareness	644	664	97.0%	90.0%	Yes
Safeguarding Children Level 2	450	468	96.2%	80.0%	Yes
Prevent WRAP	441	499	88.4%	90.0%	No

At trust level, for all staff groups in patient transport services the safeguarding training planned levels of compliance were met for four of the five safeguarding training modules for which staff were eligible.

The trust also provided a breakdown of safeguarding training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in patient transport services is shown below:

Support to ambulance service staff:

Training module name	Year to date (YTD): April 2018 to February 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust planned	Met (Yes/No)
Safeguarding Children Level 1	592	604	98.0%	90.0%	Yes
Safeguarding Adults Level 1	589	604	97.5%	90.0%	Yes
Prevent Awareness	588	604	97.4%	90.0%	Yes
Safeguarding Children Level 2	450	468	96.2%	80.0%	Yes
Prevent WRAP	434	490	88.6%	90.0%	No

In patient transport services the safeguarding training planned levels of compliance were met for four of the five safeguarding training modules for which support to ambulance service staff were eligible.

NHS infrastructure support staff:

Training module name	Year to date (YTD): April 2018 to February 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust planned	Met (Yes/No)
Safeguarding Adults Level 1	56	60	93.3%	90.0%	Yes
Prevent Awareness	56	60	93.3%	90.0%	Yes
Safeguarding Children Level 1	56	60	93.3%	90.0%	Yes
Prevent WRAP	7	9	77.8%	90.0%	No

In patient transport services the safeguarding training planned levels of compliance were met for three of the four safeguarding training modules for which NHS infrastructure support staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training)

Staff in patient transport services consistently achieved a high level of compliance with planned safeguarding training. Staff achieved or exceeded the trust's planned level of compliance for safeguarding training for the year to date April 2018 to February 2019. Staff we spoke with had completed their safeguarding training and protected work time was available for this purpose.

We saw the patient transport services clinical action card which staff could use to provide immediate guidance about safeguarding concerns. If they remained in doubt, staff were informed to call the clinical hub which was available 24 hours a day seven days a week to provide advice and support. As well as being on a card, this information was available on the staff palmtop computer by selecting 'Safeguarding'.

We spoke with patient transport services staff as to their awareness of their responsibilities in relation to safeguarding and of the correct procedures to follow when they encountered safeguarding issues. Team leaders we spoke with in patient transport services were familiar with safeguarding procedures. However, although some staff were confident in reporting and escalating safeguarding concerns, this did not apply to all staff we spoke with. Some patient transport services staff we spoke with were aware of the telephone number they could use to raise concerns, but did not see it as their responsibility. Some staff we spoke with said they had never

reported a safeguarding concern, nor were they fully conversant with how they would identify a safeguarding concern.

At our previous inspection in 2016 we found staff did not always receive feedback after they had made a safeguarding referral. At this inspection we found that although staff received an acknowledgement of a referral, whether they received any subsequent feedback was dependant of the context of the safeguarding referral. Patient transport services had made 40 safeguarding referrals in the 12 months prior to our inspection.

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 and the premises visibly clean.

At our previous inspection in 2016 we found the service did not have a robust system to monitor the daily cleanliness of vehicles and staff did not have sufficient time to clean the vehicles thoroughly. We required the service to ensure that for patient transport services, all ambulances and equipment were appropriately cleaned and infection control procedures were followed.

At the May 2019 inspection we found a vehicle checklist had been implemented to standardise vehicle equipment, consumables and daily or weekly vehicle inspections. The vehicle checklist provided a record that regular checks of cleanliness were undertaken. To support the auditing of cleaning tasks undertaken, the vehicle checklist was available on the staff member's palmtop computer.

In addition, we observed a yellow sticker was used on the vehicle to remind staff to wipe down after each patient journey. Patients and their carers who travelled with patient transport services described ambulances 'as always being clean'.

In the ambulance stations we visited, we observed the infection prevention and control audit results for each ambulance station were displayed on the patient transport services staff notice board. The audit information showed compliance levels for hand washing consistently achieved 100% and for vehicles exceeded 98%.

We found evidence of good practice in the ambulance vehicle preparation service which was in the process of implementation across the service at our inspection and additional protected time had been introduced for cleaning and carrying out infection prevention and control procedures. A clean of patient transport service vehicles was undertaken every three days using a vehicle preparation system and a deep clean of the vehicle was undertaken on a rolling five weeks basis.

We observed that patient transport services staff followed infection prevention and control procedures. Staff were bare below the elbows and used hand gel between patients. Personal protective equipment including disposable gloves and aprons was available on the vehicles. However, staff in a focus group expressed some concern as to the lack of a recognised procedure for the cleaning of hospital chairs and other shared equipment, which may have presented a cross-infection risk.

Environment and equipment

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

At our previous inspection in 2016 we found there were patient transport services vehicles with faulty equipment and fittings in place, which were still in operation and had not been properly reported. We required the service to ensure that vehicle equipment was checked and was fit for purpose.

At the May 2019 inspection we found the patient transport services fleet had been reviewed and the systems and processes used for the management of defects and repairs had been updated. The service had procured new vehicles and a programme of vehicle replacement was ongoing. A 'moving patients safely' working group had reviewed equipment available to support the safe movement of patients and equipment including motorised chairs and specialist moving slings had been introduced in the service.

Patient transport services staff were requested to report all issues they identified with vehicles using defect books and fleet managers had reviewed the timeliness of responses to vehicle defects within patient transport services.

At our previous inspection in 2016 we found there was no standardisation as to the type of equipment to be carried on patient transport services vehicles. There was no consistency in the quantity of equipment and supplies stored on board vehicles and where on the vehicles these should be stored.

At the May 2019 inspection we found patient transport services had introduced a load list and vehicle checklist on each vehicle which provided information as to equipment and supplies to be carried and checked. The load list and vehicle checklist included checks of the dates of consumables in the daily and weekly checks. First aid bags were tagged with the earliest expiry date recorded. These checklists were monitored by patient transport services team leaders.

At our previous inspection in 2016 we found it was not always possible for patient transport services crews to access secure vehicle seating for children. At the May 2019 inspection we found the service had undertaken a review of the process surrounding transporting children which included equipment held as well as arrangements for access and storage.

A patient transport services standard operating procedure had been developed and was in process of implementation across the service. We observed that child safety restraints were fitted to stretcher vehicles and child safety seats were observed in ambulance stations we visited.

The ambulance vehicle preparation service confirmed that vehicle and equipment faults were identified and ambulance vehicles were 'off the road' until vehicle faults or equipment defects were rectified. Equipment used on vehicles had been standardised and identical layouts used in the ambulance saloon wherever possible. Stock control had also been improved.

We found evidence of notable practice in the provision of equipment for patient transport services vehicles, which were equipped with an automated external defibrillator. Staff told us about an incident in which this equipment had been used to save a life.

For one ambulance station we visited, we found that a patient transport services vehicle was insecurely parked outside the station. The vehicle was unlocked and unattended. We entered another ambulance station without being challenged to present identification. A similar risk to staff safety and vehicle security was encountered at our 2016 inspection. We discussed our concerns

as to ensuring station and vehicle security with the service at the time and received assurance that immediate action was taken to meet our concerns.

Assessing and responding to patient risk

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

Escalation processes for deteriorating or seriously ill patients were in place. We observed escalation policies were displayed in ambulance vehicles and also in ambulance stations we visited. Patient transport services staff were able to recognise and respond to patients who become ill during their journey.

Staff were familiar with procedures to follow to request additional resources when this was required. Typically if a patient deteriorated on a journey patient transport services staff contacted ambulance control as soon as possible to request the despatch of an emergency ambulance.

Since our 2016 inspection the service had introduced clinical action cards for patient transport services staff. Staff could use the action card to provide immediate guidance when they encountered unfamiliar incidents or concerns. If the staff member remained in doubt, they could call the clinical hub which was available 24 hours a day seven days a week to provide advice and support.

As well as being on a card, this information was available on the staff palmtop computer. Patient transport services staff we spoke with confirmed the cards were used. Patient transport services staff were able to provide recent examples where they had escalated concerns about a patient's condition.

We observed that automated external defibrillators were located on patient transport services vehicles and staff were trained in the use of the equipment.

Procedures were in place to support patients with additional needs. Patient transport services would arrange to visit patients with identified risks before transport was arranged. Staff received training in conflict resolution.

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.

Planned vs actual

The trust has reported their staffing numbers below for patient transport services as of March 2018 and January 2019.

Staff group	As at March 2018			As at January 2019		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Support to ambulance service staff	461.0	448.0	97.2%	463.6	438.4	94.6%
NHS Infrastructure support	138.0	119.0	86.2%	141.0	122.8	87.1%
Total	**599.0**	**567.0**	**94.7%**	**604.7**	**561.2**	**92.8%**

(Source: Routine Provider Information Request (RPIR) – Total staffing)

Vacancy rates

From April 2018 to January 2019 the trust reported an annual vacancy rate of 2.8% for patient transport services.

The trust did not have a planned vacancy rate, but had a vacancy threshold rate of 5%.

A breakdown of vacancy rates by staff group is shown below:

- Qualified ambulance service staff: -4.0%
- Support to ambulance service staff: 0.7%
- NHS infrastructure support staff: 9.7%

Please note: vacancy rates have been calculated using budgeted WTE vs worked WTE data as provided by the trust. Where there are negative rates this is due to more WTE worked hours than were budgeted for.

(Source: Routine Provider Information Request (RPIR) – Vacancy)

Turnover

From March 2018 to February 2019 the trust reported an annual staff turnover rate of 8% for patient transport services. The trust did not have a planned turnover rate.

A breakdown of turnover rates by staff group is shown below:

- Support to ambulance service staff: 7%
- NHS infrastructure support staff: 13%

(Source: Routine Provider Information Request (RPIR) – Turnover)

Sickness

From March 2018 to February 2019 the trust reported an annual sickness rate of 7% for patient transport services. This was higher than the trust planned sickness rate of 5%.

A breakdown of sickness rates by staff group is shown below:

- Support to ambulance service staff: 8%
- NHS infrastructure support staff: 5%

(Source: Routine Provider Information Request (RPIR) – Sickness)

Nursing and medical bank and agency/locum staff usage

From March 2018 to February 2019 the trust reported no bank, agency or locum staff usage in patient transport services.

(Source: Routine Provider Information Request (RPIR) – Bank agency locum tab)

Temporary staff usage

From March 2018 to February 2019 the trust reported no temporary staff usage in patient transport services.

(Source: Routine Provider Information Request (RPIR) – Temp staff tab)

At our previous inspection in 2016 we found there were vacancies equating to 20.9 wte staff or a rate of 16.4% in administration and clerical positions of all grades in the patient transport services communications and control team. We required the service to ensure that sufficient numbers of suitably skilled, qualified and experienced staff available in the service.

At the May 2019 inspection we found the service had taken action to remedy the staff shortages. The patient transport services operating model and workforce plan had been reviewed and a fundamental review of staffing requirements for patient transport services had been conducted. In particular we found there were no current vacancies in patient transport services control room logistics (previously known as communications and control).

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient transport services used an electronic patient record system which was developed in house by the service. Staff informed us that electronic patient records were being introduced across the service between April and August 2019. Using electronic records to capture patient's data electronically at the time of patient contact was replacing the previous method of capturing data electronically from paper records which was more resource intensive and vulnerable to system failure.

Patient records were accessed by the crew member through their palmtop device, linked to the central logistics team. Patient transport services team leaders were able to access the records and to update information, for example to reflect a patient's changed mobility needs. Electronic records supported the sharing of information with other agencies.

Information about patients with known conditions was flagged and patient transport services crew members were made aware of special notes about the patient's pre-existing conditions or safety risks through their palmtop. Tick boxes enabled information to be selected which was relevant to the patient and accessible by crew members for example, patients requiring oxygen.

For palliative care patients using patient transport services, end of life care planning and do not attempt cardiopulmonary resuscitation information was available on the staff member's palmtop. The staff member was required to confirm they had reviewed the information.

Patient records appeared clear and complete. However, we did not review a selected sample of electronic patient records during our inspection and we did not review audits of records undertaken by the patient transport service.

At the ambulance stations we visited we observed that confidential waste was disposed of in designated blue bins.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Patient transport services vehicles did not carry medicines for use by patients, with the exception of medical gases which were carried on some vehicles. Patient transport services staff were trained in the administration of medical gases. Where patient's own medicines were transported with the patient, this was recorded in the patient's record.

At our previous inspection in 2016 we found medical gas cylinders in some patient transport services vehicles which were not securely fastened and posed a risk to patients and staff. We required the service to ensure that the security of medical supplies on vehicles was checked to ensure they were fit for purpose.

At the May 2019 inspection we found the service had taken action to address our concerns. For vehicles we inspected, we found medical gas cylinders were securely stowed either by being secured in a bracket provided on the vehicle or where this was not available, cylinders were kept in a zipped bag and strapped securely in the foot well of the passenger side of the vehicle. Medical gas cylinders we checked were in date.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2018 to March 2019 the trust reported no incidents classified as never events for patient transport services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two incidents which met the reporting criteria set by NHS England from April 2018 to March 2019 occurring within patient transport services.

Both incidents were slips/trips/falls meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

At our inspection in 2016 we found particularly in the patient transport service, that learning from incidents was not always consistently shared across staff groups. We required the service to take action so that for patient transport services, learning from incidents was shared.

At the May 2019 inspection we found patient transport service managers and staff we spoke with told us they were encouraged to report incidents and near misses and they could do so using their palmtop. Staff had the option to select to receive feedback. Staff we spoke with gave examples of incidents they had reported and of feedback they had received. The service investigated and learned from incidents to maintain the safety of the service. If an incident occurred they reflected and learned to avoid the same thing happening in the future.

We observed in the ambulance stations we visited that learning from incidents was displayed on the staff notice board. For example, for incidents of patients being transported with moving and handling slings in situ the information described the risk and instructed staff not to transport with slings in place. Another notice informed staff when it was appropriate to transport patients in wheelchairs and gave the preference to use vehicles seats where possible. Advice displayed for staff about incident reporting gave examples of the type of incidents which were to be reported.

Training was provided for team leaders and staff in the management and recording of incidents. The service and standards team had been introduced for patient transport services. We found evidence of good practice in the patient transport services service and standards team linked to the implementation of an action plan for the service from the 2016 inspection. The service and standards team worked with the quality and safety team to implement training and awareness of incident reporting and learning for patient transport services staff.

Themes and trends were examined by area. Incident management and learning from incidents formed part of the agenda for patient transport services leadership away days. Incidents and actions required were discussed at the patient transport services governance group which reported to the clinical governance group.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Patient transport services use national and local guidelines for the provision of transport to patients. The service used guidance agreed nationally for the ambulance service which was supplemented by local standard operating procedures. Guidance could be accessed through the staff member's palmtop.

The service used nationally agreed assessment criteria to determine the eligibility of patients to use the service. Eligibility criteria for transport was applied and patient transport services staff handling transport requests used specific questions and a checklist about the patient's condition and mobility before agreeing to arrange transport. Patients with recognised medical conditions were prioritised, for example, renal dialysis patients, and also patients with dementia and other mental health needs.

Patient transport services ambulance staff also made their own assessment of the risk of transporting the patient. This may involve a visit to the patient's home, usually by a team leader, to assess risk before accepting the patient for transport.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey. The service made adjustments for patients' religious, cultural and other needs.

In patient transport services steps were taken to meet patients' nutrition and hydration needs if necessary 24 hours a day and special dietary requirements were catered for. Journeys were planned and delivered to reflect the patient's need of hydration and nutrition and comfort breaks particularly when journey times were expected to be longer, as in rural areas.

Patient transport services staff and team leaders we spoke with told us that patient needs for nutrition and hydration were assessed and food and drink was made available for the patient appropriately for their needs.

Patient transport services staff were aware of the needs of patients and engaged with them as to their dietary needs. Diabetic patients were asked about their blood sugar levels. We found evidence of notable practice in the patient transport services palliative ambulance service where ambulance vehicles were fitted with a fridge for patient hydration needs.

Response times

The service monitored, and met, agreed response times so that they could facilitate positive outcomes for patients. It used the findings to make improvements.

Patient transport services prepared response time and patient outcome information monthly for submission to the board. We reviewed the response time information for patient transport services for the May 2019 board meeting.

The integrated performance report for April 2019 showed patient transport services activity in April 2019 increased by 2.3% from the previous month and had decreased by 3.2% against the same month last year.

For inward journeys the service measured whether patients were picked up no more than two hours before their appointment time. Performance increased by 0.2% in April 2019 to 96.4%, which we were informed was the highest year-to-date performance over the previous 12 months and remained above the 93.2% planned achievement level.

The service measured arrival prior to appointment. Performance increased to 90.3% in April 2019 which was the highest achieved in the past 12 months and remained above the arrival-prior-to-appointment planned level of achievement.

The service measured departure after appointment. Performance increased to 92.3% in April 2019 against a planned achievement of 92% which represented the highest performance in the previous 12 months.

The service measured short notice bookings which were picked up within two hours after the service was informed the patient was ready. The achievement for short notice bookings picked up within two hours increased by 1.5% to 79.8% in April 2019 but remained below the trusts planned achievement level of 96%. We acknowledged the trust was working to manage the challenges for short notice requests.

Patient transport services monitored its performance information and used it to compare each geographical locality's achievement. Levels of performance achieved were shared with staff. Performance information was also shared with other ambulance providers to compare performance.

Patient transport services operations managers attended monthly meetings with commissioners to report on the performance of the service against planned levels of achievement. Performance data demonstrated a consistently high level of achievement and an improving trend overall.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff work performance and held supervision meetings with staff to support their development.

Appraisal rates

As of February 2019, 85.7% of staff within patient transport services received an appraisal compared to a planned level of 90%.

This represented an improvement from the previous period, March 2018, in which 83.4% of staff within patient transport services had received an appraisal.

The breakdown by staff group is shown below:

Staff group	Number of staff received appraisal	Number of required staff	Appraisal rate	Trust planned	Met (Yes/No)
Support to ambulance service staff	479	554	86.5%	90%	No
NHS infrastructure support	50	63	79.4%	90%	No

(Source: Routine Provider Information Request (RPIR) – Appraisals)

At our previous inspection in 2016 we found that within patient transport services there were no formal arrangements for one to one meetings or supervision sessions between team leaders and ambulance care assistants, neither was there a formal record of individual staff performance. We required the service to ensure that action was taken to address supervision and performance development arrangements for patient transport services staff.

At the May 2019 inspection we found team leaders accompanied patient transport services staff on selected journeys and saw staff regularly either through 'huddles', accompanied journeys or appraisal. The team leader job description had been reviewed and revised to reflect this.

At the ambulance stations we visited staff told us their personal development reviews were up to date. We reviewed the schedule of personal development reviews in ambulance stations we visited and we saw evidence that appraisals had been completed for 86% of patient transport services staff. Appraisals were also conducted for other grades of staff, for example in vehicle preparation. Developmental opportunities were identified at staff appraisals although we found some variation between areas. Staff spoke positively about their appraisal.

At our 2016 inspection we found that there was a lack of specific training for patient transport services staff to enable them to undertake their role effectively. We required the service to take action to address role specific training for patient transport services staff.

At the May 2019 inspection we found that core band 3 training had been revised as part of a review of statutory and mandatory training. Patient transport services update and listening events provided information for staff. Additionally, bariatric training for all patient transport services staff had been included in the training delivery plan for 2019-20.

At our 2016 inspection we found patient transport services staff were undertaking excessive manual handling activities due to insufficient training in the use of a particular carry chair and the limitations of the carry chair. We required the service to take action to address this. At the May 2019 inspection we found chairs with motorised tracks had been introduced to assist staff to convey patients using stairs which had improved patient safety and reduced the risk of injury to staff.

Multidisciplinary working

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

Since our previous inspection we found the service had implemented some key strategic developments. It liaised effectively with commissioners and had re-tendered and extended key contracts for patient transport services. Operations managers attended monthly meetings with commissioners.

The service commissioned and liaised with independent ambulance providers and taxi services in providing patient transport services. The service liaised with other ambulance services through the northern ambulance alliance to support collaboration about procurement and sharing of notable practice.

Patient transport services liaised with hospital outpatient departments and wards and coordinated with other providers of healthcare to support effective transport for patients. GPs and other

healthcare professionals who may have regular scheduled appointments with patients were pre-alerted about transport arrangements where this was possible.

Patient flow coordinators based in selected hospitals worked closely with clinicians and hospital administrators to support bed management and discharge arrangements and liaised with independent transport providers including taxi companies to coordinate transport.

Patient transport services used multidisciplinary working to support joint decisions about the care and transport of patients. For example, patients with mental health needs were supported with special notes and palliative care patients with information about advanced care plans and do not attempt cardio pulmonary resuscitation orders.

Health promotion

Staff gave patients practical support and advice to patients to lead healthier lives.

Patient transport services identified patients requiring extra support during their initial assessment and ensured they accessed support services. The service worked with external agencies to provide services which were appropriate for the patient's needs.

Patient transport services had introduced a "Respect" form which supported staff in getting to know the patient's needs. Patients could supply as much or as little information as they liked.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguard

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion rates

The trust reported that from April 2018 to February 2019 the Mental Health Awareness and Mental Health Capacity training module had been completed by 93.7% of all staff in patient transport services. This was lower than the previous year (April 2017 to March 2018) where 97.6% of all staff had completed the training.

The breakdown by staff group is show below:

Staff group	Year to date (YTD): April 2018 to February 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust planned	Met (Yes/No)
Support to ambulance service staff	567	604	93.9%	90.0%	Yes
NHS infrastructure support	55	60	91.7%	90.0%	Yes

(Source: Routine Provider Information Request (RPIR) – Training)

We found staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance.

Consent was included in the e-learning that staff undertook about the mental capacity act. We observed patient transport services staff noted the patient's consent to personal care in the patient

record form. The palliative care crew told us they obtained the patient's consent for personal care before starting a journey with the patient.

We found staff did not undertake the journey with the patient until the 'do not attempt cardiopulmonary resuscitation' form was reviewed and recorded on their palmtop. The Respect form we found was in process of implementation at our inspection included information about do not attempt cardiopulmonary resuscitation.

Is the service caring?

Compassionate care

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

Friends and Family test performance

The friends and family test asked people who used services whether they would recommend the services they had used, giving the opportunity to feedback on their experiences of care and treatment.

In the friends and family test for patient transport services from February 2018 to January 2019 the trust had one month of reportable performance data, October 2018, with 83% of patients in this month recommending the trust as a place to receive care.

In other months in the period data was not published as fewer than five responses were received.

(Source: NHS England Friends and family test)

We found positive evidence of compassionate care in patient transport services. At patient reception centres in hospital locations we visited we found evidence of staff sometimes going 'above and beyond' in care for patients. For example, patients we spoke with told us they particularly appreciated that crew provided additional consideration for their mobility needs and called them about 20 minutes ahead of arriving to give them time to get their coats on and mobilise. Crew also rang ahead if they were delayed.

Patient transport services staff we spoke with in focus groups gave examples of how they ensured patients being conveyed by the service had received care appropriate to their needs as they were reassessed by staff during their journey.

We observe staff as they supported patients requiring assistance with moving and handling and we saw this was done sensitively and appropriately. We spoke with patients waiting in patient reception centres who spoke very positively about the service. Patients told us patient transport services staff were experienced in supporting their needs and genuinely nice. They told us the service had always been caring and considerate of their needs. They felt the service was faultless; staff were polite, kind and thoughtful and they had no problem with timeliness.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Patient transport services staff understood the emotional impact receiving care and treatment had on patients and potentially on their relative's overall wellbeing.

Patient flow coordinators we spoke with told us that they frequently facilitated joint transfers with the control room for certain patients who wished to travel together for emotional support.

We found evidence of good practice in the emotional support provided by staff in the end of life patient transport service which worked closely with hospital based palliative care services. Counselling and support were provided to relatives, carers and other patients in connection with patient deaths.

The palliative care crew had won external awards for its delivery of care and support to patients. In addition to their planned destination, the service occasionally supported an end of life patient's last wishes by taking them to a favourite destination.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patient transport services staff explained to patients relatives and carers about their transport needs, what they needed to do and explained why this was. People we spoke with told us that staff had kept them updated about what was happening next. Text messaging was used where appropriate for contacting patients using the service.

We observed staff in patient reception centres as they discussed their transport arrangements with patients relatives and carers and answered questions and responded with appropriate information.

Patients and their relatives and carers spoke positively about how patient transport services staff communicated with them. They told us staff had been very helpful in organising their transport for them. They felt comfortable asking staff so they understood about their transport arrangements.

Is the service responsive?

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.

For each operational area, the service undertook resource forecasting of patient transport services annually which was reviewed quarterly to reflect in-year contract changes. Capacity and planning teams worked closely with commissioners in the preparation and review of patient transport services delivery plans. Since our previous inspection in 2016 we found the service had taken further steps towards the full implementation of computer-assisted route scheduling for patient transport services.

Automated route scheduling provided additional flexibility in planning service delivery for patient transport services which meant the service could be more responsive to patient and commissioner requirements. Commissioner requirements for patient transport services for each part of the Yorkshire ambulance area could more easily reflect local requirements.

We found evidence of notable practice in the implementation of computer-assisted route scheduling for patient transport services. Use of the computer-assisted system supported scheduling staff in looking ahead at the planning of patient transport services routes. Route scheduling supported planning which reflected the capacity of patient transport services and the differing levels of demand for the service in each locality. Response time performance information for patient transport services in some geographical areas where route scheduling had been introduced had shown improvement.

At our inspection we observed the scheduling system in process of implementation. The service planned to use the route planning tool for all patient transport journeys. Planners in the resourcing team and day controllers within the logistics team could use the scheduling tool to support route planning decisions which fell outside of planned response times where they saw this was warranted by patient requirements. The system included the facility to look ahead and supported audit of planned routes.

Meeting people's individual needs

The service was working to be inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients' access services.

At our previous inspection in 2016 we recommended that patient transport services should review the training requirements for operational staff about vulnerable groups such as patients living with dementia and patients experiencing mental health concerns.

At the May 2019 inspection we found the service had taken action to address our concerns. The content of initial core training as well as statutory and mandatory training had been reviewed so that the content reflected patients including patients living with dementia and mental health needs. Additional resources had also been made available to patient transport services staff to support opportunities for additional training and development.

Ambulance vehicles fitted with specialised equipment were available to support the needs of bariatric and other patients with complex needs. Patient transport services team leaders undertook pre-journey risk assessments for complex patients where their needs had changed or in response to reported concerns. Completing risk assessments helped to ensure the availability of suitable equipment to support the patient was planned. This meant the patient journeys undertaken resulted in a successful outcome rather than being aborted.

We found that one locality was undertaking a trial of the use of smart phones to support crew review of the risk assessment undertaken by the team leader. Staff told us that when a risk assessment was required, a longer turnaround, typically 72 hours, needed to be planned for before the journey was expected to be undertaken.

On patient transport services ambulance vehicles we observed that bariatric equipment was available. An 'incident support vehicle' fitted with a bariatric stretcher was also available in the service. Patient transport services staff received training in the use of equipment supporting the needs of bariatric patients although some staff we spoke with queried whether the training was still available. Clinical supervisors were available to provide telephone support for crew involved in transporting a bariatric patient.

Patient transport services staff gave examples of meeting the transport needs of patients with impaired vision. Patients with a learning disability or dementia were usually escorted during their journey. On patient transport services vehicles we observed that a guide was available for staff supporting people with communication needs. The guide was also available on the crews' palmtop. Patient transport vehicles we observed were marked as Dementia Friendly.

A specialist patient transport services palliative care team met the need of patients receiving end-of-life care.

Patient transport services provided a service for patients with mental health needs and crew received training to support the needs of these patients.

We found some patient transport services staff carried a British Sign Language phrasebook on the ambulance vehicle and other crew told us phrasebooks and translation apps were available on their palmtop.

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.

In patient transport services we found evidence of notable practice in the function of patient flow coordinators at some hospital locations. The patient flow coordinator was based at the hospital and their role involved the daily management of patient flow for patient transport services. The coordinator role was available only during business hours on weekdays.

The allocation of a patient to a route was decided centrally but the coordinator liaised with hospital bed management staff and visited discharge wards to review any backlogs and check with clinical staff whether patients were ready to leave. They provided information about patient's mobility needs and types of ambulance vehicle available.

The patient flow coordinator sometimes assisted with tasks on the ward where the patient was delayed, for example by following up the patient's prescription medicines. At one hospital location

we visited, the patient flow coordinator provided a desk for liaison with patients and marked them as ready for transfer, allocation or provided information about their transport.

Patients we spoke with in the hospital reception centres were very positive about the service they received from patient transport services. Patients told us they had no problem with the timeliness of the service. However, on some occasions patients could be delayed if their outpatient clinic was running late and they missed their arranged pick-up time. Although patients could be waiting for transport for up to two hours they were kept informed with progress in arranging their transport. We acknowledged the issue was in relation to hospital clinics running late, and was not solely the responsibility of the PTS service.

Nursing staff in the dialysis units we visited told us patient transport services was very responsive to their challenges and the service was described positively with patients not waiting around. For dialysis and outpatient clinics, booking of patient transport was done online and telephone calls were only required for cancellations. Patients monitored their wait times on line. There had been significant improvements in the service provided to patients who were using PTS for dialysis.

The dialysis service had a designated liaison person within patient transport services who was accessible and supportive. The service told us the liaison person was very responsive to their needs and visited the unit occasionally. Staff in outpatients clinics we visited told us they had no particular complaints about patient transport other than there were some delays as waiting times were variable.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

The complaints process had been much improved since our last inspection

Summary of complaints

From March 2018 to February 2019 the trust received 160 complaints in relation to patient transport services (16.2% of total complaints received by the trust)

Of the 160 complaints, 130 were closed at the time the trust submitted information we requested for this inspection. The trust took an average of 33 working days to close complaints.

The trust did not have a planned time for completing complaints, instead they agree a completion date with each complainant.

A breakdown of complaints by subject is below:

Subject of complaint	Number of complaints	Percentage of total
D-Collected Late from Clinic	27	16.9%
O-Patient Care	22	13.8%
X-Eligibility Criteria	20	12.5%
B-Staff Attitude	19	11.9%
F-Driver Arrived at Home Late (Pick Up)	11	6.9%
W-Transport Unsuitable for Condition	10	6.3%
H-Driver did not Arrive at Home (Pick Up)	9	5.6%

N-Injury to Patient on Vehicle	8	5.0%
G-Driver did not Arrive at Clinic	7	4.4%
K-Failed Discharge-YAS	5	3.1%
I-Driving Issues	5	3.1%
T-Patient Early for Appointment	4	2.5%
A-Administration Error	4	2.5%
M-Injury to Patient off Vehicle	3	1.9%
U-Patient Made Own Way Home-PTS too Late	3	1.9%
P-Length of Time on Vehicle	1	0.6%
E-Condition of Vehicle	1	0.6%
J-Duration to Answer Phone	1	0.6%

(Source: Routine Provider Information Request (RPIR) – complaints)

The number of complaints about late collection of patients before or after appointments was very small in relation to the number of journeys made by the service (0.004%)

Number of compliments made to the trust

From March 2018 to February 2019 there were 58 compliments collected by the trust about patient transport services. Two were in relation specifically to patient transport communications and the other 56 related to operations staff.

(Source: Routine Provider Information Request (RPIR) – compliments)

Since our previous inspection in 2016 we found that complaints about patient transport services had reduced substantially.

Contact information for patients wishing to make a comment or complaint was displayed in the patient transport vehicles we observed. On some vehicles we also found a complaints and comments folder. Staff we spoke with could describe the information they provided to patients, relatives and carers that wished to complain. Staff explained that if adverse feedback was received they tried to take immediate action to address the cause of the complaint.

Staff gave us examples of how the service responded to complaints it received and how it learned from complaints. An example of learning from a complaint we were informed of was the incident support units used jointly by patient transport services and emergency ambulances which were introduced as result of patient needs not been met. In a second example a new standard operating procedure was developed because of a complaint about an injury to a patient.

Is the service well-led?

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.

Since our previous inspection in 2016 we found patient transport services had developed leadership of the service and changed the management structure. At area level team leaders had been appointed and centrally the service had appointed a head of quality and other senior roles.

Some changes in leadership roles were still in development. A leadership development programme for patient transport services had been introduced. The programme provided quarterly away days for leaders within patient transport services. The away days aimed to promote and develop best practice in all aspects of patient transport services work. We found evidence of notable practice in staff support provided by line management at some locations.

The managing director and senior managers of patient transport services were seen as visible and approachable. Staff told us that the manager director had recently done a job swap for a day. Some team leaders we spoke with told us communication from the top down had improved since 2016. Managers felt supported in their role but some managers felt decisions from the top were not communicated very well. Some staff spoke highly of their managers although others felt they did not see enough of them.

Team leaders managed the day to day running of the service. Managers felt their role in providing leadership involved stepping in when there was a problem and changing it, encouraging staff to come forward to make suggestions and to undertake things themselves. Patient transport services managers we spoke with told us the service was investing more in its leaders through training, leadership days and ‘leadership in action’ events.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust’s strategy 'One Team, Best Care' launched in October 2018 included its vision for patient transport services. The service’s vision was of having the best people, working with its partners, and being focused on delivering the best outcomes for patients. The strategy included the service’s core values of one team, innovation, resilience, empowerment, integrity and compassion.

The strategy included four stated ambitions which it aimed to achieve by 2023 and was supported by outcomes and performance measures. The ambitions aimed to ensure that: patients and communities experienced fully joined-up care response to their needs; staff felt empowered, valued and engaged to perform at their best; everything the service did was of the highest quality, evidence based and achieved excellence; and resources were used in the best way, so the service could continue to invest in and sustain front line services. For patient transport services,

this involved integrated working across other services provided by the trust and effective working with system partners, volunteers and the community.

Patient transport services managers we spoke with were aware of the overall vision and strategy. Managers explained that the strategy was supported by a five-stage operating model which included forecasting, resourcing, logistics, sub-contracting, and delivery. It was patients that were driving the plan. Team leaders and staff we spoke with were clear their role was delivery of agreed outcomes and performance measures for patient transport services.

Culture

Staff were focused on the needs of patients receiving care and felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns and promoted equality and diversity.

Since our previous inspection in 2016 the service had taken further steps to develop a positive culture in patient transport services. Managers told us progress was linked to action taken in recruitment and resourcing and education and training which supported the health and well-being of staff in the service. Some changes were in progress at our inspection.

A positive culture was evident in patient transport services. Staff spoke positively about working in the service and felt they were listened to. Staff felt more involved in decisions. They spoke highly of their managers and said they were open, friendly and approachable. Staff gave examples of managers being supportive. We spoke with team leaders who said they felt staff had taken the changes in their stride. There was now better communication between team leaders and staff. Staff looked after each other.

Staff said they enjoyed working in patient transport services and that they particularly cared about their patients and community. This meant teams had a ‘community’ feel. Staff told us they treated patients as they would wish to be treated themselves. Some staff we spoke with said they were excited by the cultural change. However, other staff expressed some misgivings as to whether the culture was embedded.

In ambulance stations we visited we observed that positive staff experiences were displayed on notice boards. Details for the freedom to speak up guardian were displayed which included the process to use to raise concerns. Staff told us they felt confident to speak out where necessary.

Governance

The service operated effective governance processes including with partner organisations. Managers and staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Clear governance procedures were in place in patient transport services. Since our previous inspection in 2016 we found governance of the service had been developed. Linked to changes in the management structure we found evidence of good practice in the patient transport services service and standards team and the implementation of the action plan from our 2016 inspection.

A focus on consistency of practice in patient transport services was linked to improved quality and governance procedures and included a review of sub-contractor performance. Sub-contractors were managed by an alternative resource team.

We found local operational management team meetings were held with dates and timings of meetings recorded in the action log for monthly performance meetings. Following the restructure of the service in July 2018 the agenda for area meetings included a review of practice in other areas of the service to enable comparison and learning. Quarterly away days for patient transport services which followed board meetings complemented this.

Operations managers attended a monthly operational board for patient transport services. Monthly performance and quality meetings were attended by operations managers and team leaders following the operations board meeting. Information from the operational board was shared with staff.

Operations managers chaired monthly team meetings for their area which included service delivery managers and team leaders. Operations managers also attended monthly meetings with commissioners. A quality report prepared by business intelligence was shared prior to the meeting. Service delivery managers and their deputies held a weekly meeting with logistics managers. The agenda for the meeting included operations and logistics.

The overarching clinical governance group was attended by operations managers and their deputies and the head of service and standards. A governance coordinator captured themes and trends and information for the governance group. Patient transport services was a standing item at this meeting.

Team leaders held daily ‘huddles’ with their staff and we saw these meetings were recorded using a standard template and were available to staff. Staff worked to agreed performance outcomes for patient transport services and understood the importance of this. Checklist ‘books’ were reviewed daily. Standard operating procedures were being developed to support this. The team leader’s role included managing staff flexibly and appropriately.

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.

At our previous inspection in 2016 we found within patient transport services there were identified risks missing from the risk register, so it was unclear what actions had been taken to mitigate these risks. We required the service to ensure that identified risks were included in the risk register.

At the May 2019 inspection we found the service had taken action to address the identification of risks in patient transport services. Individual risk owners were met with to review risk actions and timeframes. Regular meetings took place with the head of risk for assurance and advice. We found risk assessments for patients with complex mobility needs were undertaken by team leaders before patients were transported which allowed for tailored selection of mobility aids and the correct selection of staff member numbers.

The service maintained a corporate risk register and a patient transport services risk register. Risk assessment reports were prepared by business intelligence. The patient transport services operations board meeting included risks and the risk register as a standing agenda item. Patient transport services risks were included for review in the agenda for governance meetings. Risk and

safety concerns were included as agenda items for patient transport services operations manager meetings with service delivery managers and team leaders.

Managers and team leaders we spoke with told us risk was discussed regularly. They understood the application of risk to the service and were able to identify the main risks to patient transport services as specified in the risk register.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service used a recognised transport logistics system to support computer-assisted route scheduling for patient transport services. At our inspection we observed the scheduling system in process of implementation.

Patient transport services was also in the process of introducing a personal palmtop device for each staff member which provided access to operational data including patient information and special instructions, incident and safeguarding reporting, a link to the route scheduling system through use of an app, an email facility and access to standard operating procedures and other guidance information. Patient transport services were involved in pilots and represented on the working group for the implementation of the palmtop device. The introduction of the palmtop had improved communication for patient transport services staff.

Information governance was included in mandatory training for patient transport services staff. The service had taken steps to ensure it met the requirements of the accessible information standard. Information relevant to the implementation of the accessible information standard had been shared with the service through the staff update, March 2019 edition.

Monitoring and reporting of service performance measures was supported by the business intelligence unit. Business intelligence provided assurance as to the consistency and accuracy of the data prepared to support management and board meetings and meetings with commissioners.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Public engagement

The NHS England friends and family test asked people who used services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment. In the friends and family test for patient transport services from February 2018 to January 2019 the service had one month of reportable performance data, October 2018, with 83% of patients in this month recommending the trust as a place to receive care. In other months in the period data was not published as fewer than five responses were received.

For the patient transport service, we found a patient experience survey was sent quarterly to a sample of 550 patients, with a response rate of about 30%. In addition, the patient transport service had undertaken face to face surveys with 483 patients over a period of five months prior to our inspection. We were informed feedback received was very positive. Respondents highlighted the caring, reassuring and professional approach of the service. Less positive themes from the surveys were eligibility, waiting times and the use of taxi companies for patient transport services.

At this inspection we found the service had taken some actions to strengthen public engagement conducted through the patient engagement officer, which previously was mainly for renal patients. We found the scope of patient engagement had been widened. The service operated a critical friends network of patients and members of the public. The service engaged through the network about key service developments and held quarterly meetings and other engagement events. An online survey was accessible via the trust website.

Patient transport services received compliments about the service which were shared through the weekly staff update. Crew members that received a compliment were also notified by post with a thank you letter.

Staff engagement

The staff engagement score achieved by the service overall was 6.3 out of a possible score of 10 which represented an improvement from the equivalent score in 2017 (5.9) and was slightly better than the average for the ambulance sector (6.2). The staff test scores for 2018 for work and care had improved and were both above the sector average. The service informed us it took from the staff survey results the need for further engagement with staff.

A newsletter specific to patient transport services had been introduced to inform staff of new operational developments. The newsletter was distributed electronically as well as being printed locally. The newsletter supplemented an electronic team site which contained the latest standard operating procedures for equipment or ways of operating.

Focus groups we held with patient transport services staff confirmed that there remained room for improvement in staff engagement by the service.

Commissioner engagement

Patient transport services engaged effectively with commissioners and had re-tendered and extended key contracts for patient transport services. Operations managers attended monthly meetings with commissioners. Operational concerns related to patient transport services were the subject of ongoing engagement, for example eligibility criteria for the service.

Learning, continuous improvement and innovation

Patient transport services encouraged innovation and participation in research. Staff were committed to continually learning and improving services. Managers and senior staff understood and applied the concept of quality improvement.

Patient transport services had fitted automated external defibrillators on each frontline ambulance vehicle. The defibrillators provided for lifesaving intervention immediately in the event of a patient or a member of the public suffering a cardiac arrest.

We found evidence of notable practice in the patient transport services palliative ambulance service. Specially equipped ambulance vehicles were fitted with a fridge for patient hydration needs. Emotional support was provided by staff working closely with hospital based palliative care services. Counselling and support were provided to relatives, carers and other patients in connection with patient deaths. The team had received awards for outstanding palliative care.

A clinical action card for patient transport services staff had been introduced. The card provided a structured guide for staff in the event of patient becoming unwell during their care. It allowed for timely clinical advice to be sought directly from the clinical hub and also provided guidance about safeguarding concerns.

In patient transport services we found evidence of notable practice in the function of patient flow coordinators at hospital locations. The patient flow coordinator was based at the hospital and their role involved the daily management of patient flow for patient transport services.

We found evidence of good practice in the ambulance vehicle preparation service which was in the process of implementation across the service at our inspection. A ‘daily’ clean of patient transport service vehicles was undertaken every three days using a vehicle preparation system and a deep clean of the vehicle was undertaken on a rolling five weeks basis.

Clear governance procedures were in place in patient transport services. Linked to changes in the management structure we found evidence of notable practice in the patient transport services service and standards team. The quality lead led an improvement initiative and the team worked with the quality and safety team to implement training and awareness of incident reporting and learning for patient transport services staff.

We found evidence of notable practice in the implementation of computer-assisted route scheduling for patient transport services. Use of the computer-assisted system supported scheduling staff in looking ahead at the planning of patient transport services routes. Route scheduling supported planning which reflected the capacity of patient transport services and the differing levels of demand for the service in each locality. Response time performance information for patient transport services in geographical areas where route scheduling had been introduced had shown improvement.

Emergency operations centre

Facts and data about this service

Yorkshire Ambulance Service NHS Trust has two 999 Emergency Operations Centres (EOC); one in Wakefield and one in York.

- Wakefield Emergency Operations Centre (EOC): The EOC is located at the Yorkshire Ambulance Service NHS Trust headquarters and is a dedicated 999 call centre providing 24/7 call taking and dispatching capabilities. The clinical hub is located there along with the EOC management team, frequent caller team and data flagging team.
- York Emergency Operations Centre (EOC): The EOC is a newly refurbished 999 call centre with offices used for other areas of the business.

Staff at both 999 EOCs handled all the emergency calls and deployed the most appropriate response. Staff were trained to deliver instructions and advice to callers over the phone on how to care for patients until the arrival of the ambulance crew.

(Source: Routine Provider Information Request (RPIR) – Sites and context tabs)

Yorkshire Ambulance Service reported that they received 998, 731 emergency and routine calls in 2018-19 in the EOC.

(Source: Quality Account 2018-19)

During the inspection we spoke with 36 staff and listened to 45 calls. We reviewed four complaint responses, 3 incident root cause analysis reports, and reviewed call audit reports for three months including call compliance levels and audit numbers.

A breakdown of the different teams at each EOC is shown below

Wakefield EOC	York EOC
Call handlers (EMD)	Call handler (EMD)
Dispatchers	Dispatcher
Team Leaders	Team Leaders
Clinical Advisors	Clinical advisor
Duty Manager	Duty Manager (SDM)
Service Managers	Supervisors
Clinical/Duty Managers	
Practice Developers	
AMPDS Auditors	
Knowledge Management	
Health Desk	
MTCTC	
Mental Health Nurses	
Alternative Response Team	
ECP team	
Real Time Analysts	

(Source: Routine Provider Information Request (RPIR) – Centres tab)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and was close to meeting the trust target for completion.

Mandatory training completion rates

The information provided by the Yorkshire Ambulance Service (YAS) NHS Trust below highlights the levels of mandatory training and role specific training levels staff had achieved. The trust set a target of 90% for the completion of mandatory training.

The service had systems and processes in place to ensure staff could access mandatory training and staff we spoke with confirmed they had enough time to complete mandatory training. Staff told us if they attended training on their day off, they were given the time back in lieu. Managers we spoke with confirmed this and told us staff were not asked to attend training on their days off, it was at their discretion.

Mandatory training completion was monitored by managers in both EOCs. They tracked the progress of mandatory training for staff using an electronic system and managers we spoke with gave examples of escalating to the training team when the number of training sessions available did not meet the demand required for all staff. The training team arranged further sessions to meet the demand.

Staff we spoke with told us the induction training for new staff in the EOC was suitable, valuable and included mandatory training modules, written assessment and assessment of live calls.

Training updates were provided in the EOCs by team champions and we saw there was a system in place to ensure this was delivered to all staff across different shift patterns. We saw evidence of training updates that had been delivered to staff at both EOC sites.

A breakdown of compliance for mandatory courses from April 2018 to February 2019 for all staff in emergency operations centre is shown below:

All staff groups

Training module name	Year to date (YTD): April 2018 to March 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust Target	Met (Yes/No)
Fire Safety Lecture	361	405	89.14%	90.0%	No
Dementia Awareness	395	405	97.53%	90.0%	Yes
Fire Safety & Awareness	379	405	93.58%	90.0%	Yes
Infection Control	377	405	93.09%	90.0%	Yes
Equality, Diversity and Human Rights	376	405	92.84%	90.0%	Yes
Health Risk & Safety Awareness	376	405	92.84%	90.0%	Yes
Information Governance	370	405	91.36%	90.0%	Yes
Investigation of incidents	368	405	90.86%	90.0%	Yes
Waste Management	367	405	90.62%	90.0%	Yes
Moving and Handling - Loads	368	405	90.86%	90.0%	Yes
Adult BLS	338	405	83.46%	90.0%	No
Paediatric BLS	338	405	83.46%	90.0%	No

At trust level, for all staff groups in the emergency operations centre, the 90% target was met for nine of the 12 modules for which all staff were eligible.

The trust also provided a breakdown of mandatory training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in the emergency operations centre is shown below:

Qualified ambulance service staff:

Training module name	Year to date (YTD): April 2018 to March 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust target	Met (Yes/No)
Dementia Awareness	46	47	97.87%	90.0%	Yes
Paediatric BLS	44	47	93.62%	90.0%	Yes
Adult BLS	44	47	93.62%	90.0%	Yes
Information Governance	45	47	95.74%	90.0%	Yes
Fire Safety & Awareness	45	47	95.74%	90.0%	Yes
Investigation of incidents	43	47	91.49%	90.0%	Yes
Infection Control	43	47	91.49%	90.0%	Yes

Moving and Handling - Loads	43	47	91.49%	90.0%	Yes
Waste Management	42	47	89.36%	90.0%	No
Equality, Diversity and Human Rights	42	47	89.36%	90.0%	No
Health Risk & Safety Awareness	42	47	89.36%	90.0%	No

In the emergency operations centre the 90% target was met for nine of the 11 modules for which qualified ambulance service staff were eligible. The target was almost met for three modules.

Support to ambulance service staff:

Training module name	Year to date (YTD): April 2018 to March 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust target	Met (Yes/No)
Fire Safety Lecture	266	292	91.10%	90.0%	Yes
Dementia Awareness	283	292	96.2%	90.0%	Yes
Fire Safety & Awareness	275	292	94.18%	90.0%	Yes
Health Risk & Safety Awareness	274	292	93.84%	90.0%	Yes
Equality, Diversity and Human Rights	274	292	93.84%	90.0%	Yes
Infection Control	274	292	93.84%	90.0%	Yes
Information Governance	267	292	91.44%	90.0%	Yes
Adult BLS	246	292	84.25%	90.0%	No
Waste Management	265	292	90.75%	90.0%	Yes
Paediatric BLS	246	292	84.25%	90.0%	No
Moving and Handling - Loads	265	292	90.75%	90.0%	Yes
Investigation of incidents	265	292	90.75%	90.0%	Yes
Risk Management	274	292	93.84%	90.0%	Yes

In the emergency operations centre the 90% target was met for 11 of the 13 modules for which support to ambulance service staff were eligible. The 90% target was almost met for two modules: Adult BLS and Paediatric BLS

NHS infrastructure support staff:

Training module name	Year to date (YTD): April 2018 to March 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust target	Met (Yes/No)
Dementia Awareness	52	52	100.0%	90.0%	Yes
Equality, Diversity and Human Rights	46	52	88.46%	90.0%	No
Health Risk & Safety Awareness	46	52	88.46%	90.0%	No
Infection Control	46	52	88.46%	90.0%	No
Fire Safety & Awareness	45	52	86.54%	90.0%	No

Waste Management	46	52	88.46%	90.0%	No
Moving and Handling - Loads	46	52	88.46%	90.0%	No
Investigation of incidents	46	52	88.46%	90.0%	No
Information Governance	44	52	84.62%	90.0%	No
Paediatric BLS	36	52	69.23%	90.0%	No
Adult BLS	36	52	69.23%	90.0%	No

In the emergency operations centre the 90% target was met for one of the 11 modules for which NHS infrastructure support staff were eligible. The target was nearly met for six modules.

Qualified nursing and health visiting staff:

Training module name	Year to date (YTD): April 2018 to March 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust target	Met (Yes/No)
Dementia Awareness	14	14	100%	90.0%	Yes
Waste Management	14	14	100%	90.0%	Yes
Investigation of incidents	14	14	100%	90.0%	Yes
Health Risk & Safety Awareness	14	14	100%	90.0%	Yes
Equality, Diversity and Human Rights	14	14	100%	90.0%	Yes
Infection Control	14	14	100%	90.0%	Yes
Moving and Handling - Loads	14	14	100%	90.0%	Yes
Information Governance	14	14	100%	90.0%	Yes
Fire Safety & Awareness	14	14	100%	90.0%	Yes
Paediatric BLS	12	14	85.71%	90.0%	No
Adult BLS	12	14	85.71%	90.0%	No

In the emergency operations centre the 90% target was met for nine of the 11 modules for which qualified nursing and health visiting staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training, Data request EOC31)

We asked the trust for information about their plans to increase training compliance in adult and paediatric basic life support (BLS) training modules, which did not meet the trust target across three of the four staff groups. The service had increased the availability of these modules and were booking relevant staff spaces on the training.

During the inspection, we were told the service was in discussions with their training team to have trust-based trainers in adult and paediatric BLS to allow internal management of the delivery and compliance of these modules. The trust told us this was completed and implemented following the inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

Following the last inspection, YAS were given a must do action by CQC to ensure eligible nursing staff in the EOC had undertaken safeguarding training. We found nursing staff had met the trust safeguarding training target in 3 out of 4 modules during this inspection.

We asked the trust for information about their plans to increase training compliance in the 'Prevent WRAP' training module. The compliance for quarter one (2019/20) workshop to raise awareness of prevent was 88.6% of staff. The service told us there was no longer a requirement to deliver WRAP training face to face.

Prevent basic awareness was delivered to non-clinical EOC staff through their statutory mandatory training workbook and was delivered within the safeguarding level 2 e-learning product.

The trust issued the prevent annual update to all staff in April 2018.

The service was undergoing a training needs analysis to identify staff who required WRAP level 3 training and were revising the statutory mandatory training matrix to reflect these requirements and were arranging for access online for these staff.

(Source: Data request EOC38)

There were high levels of compliance of safeguarding training at levels one and two, and all staff required to complete level three training, had done so.

The trust set a target of 90% for completion of safeguarding training, except for safeguarding children level 2, which had an 80% target.

A breakdown of compliance for safeguarding courses from April 2018 to February 2019 for all staff in the emergency operations centre is below:

All staff groups

Training module name	Year to date (YTD): April 2018 to March 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust target	Met (Yes/No)
Safeguarding Children Level 2	313	405	77.28%	80.0%	No
Safeguarding Children Level 1	383	405	94.57%	90.0%	Yes
Prevent Awareness	382	405	94.32%	90.0%	Yes
Safeguarding Adults Level 1	380	405	93.83%	90.0%	Yes
Prevent WRAP	47	70	67.14%	90.0%	No

At trust level, for all staff groups in the emergency operations centre, the safeguarding training targets were met for three of the five modules for which all staff were eligible. The target was almost met in one of the remaining two modules.

The trust also provided a breakdown of safeguarding training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in the emergency operations centre shown below:

Qualified ambulance service staff:

Training module name	Year to date (YTD): April 2018 to March 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust target	Met (Yes/No)
Prevent Awareness	47	47	100%	90.0%	Yes
Safeguarding Children Level 1	46	47	97.87%	90.0%	Yes
Safeguarding Adults Level 1	46	47	97.87%	90.0%	Yes
Prevent WRAP	34	42	80.95%	90.0%	No

In the emergency operations centre the safeguarding training targets were met for three of the four modules for which qualified ambulance service staff were eligible.

Support to ambulance service staff:

Training module name	Year to date (YTD): April 2018 to March 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust target	Met (Yes/No)
Safeguarding Children Level 2	230	292	78.77%	80.0%	No
Safeguarding Children Level 1	276	292	94.52%	90.0%	Yes
Safeguarding Adults Level 1	274	292	93.84%	90.0%	Yes
Prevent Awareness	274	292	93.84%	90.0%	Yes
Prevent WRAP	1	4	25%	90.0%	No

In the emergency operations centre the safeguarding training targets were met for three of the five modules for which support to ambulance service staff were eligible. The target was almost met in one of the two remaining modules.

NHS infrastructure support staff:

Training module name	Year to date (YTD): April 2018 to March 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust target	Met (Yes/No)
Prevent Awareness	47	52	90.38%	90.0%	Yes
Safeguarding Children Level 1	47	52	90.38%	90.0%	Yes
Safeguarding Adults Level 1	46	52	88.46%	90.0%	No
Prevent WRAP	8	13	61.54%	90.0%	No

In the emergency operations centre the safeguarding training targets were met for three of the four modules for which NHS infrastructure support staff were eligible. One module was almost met. The target was almost met in one of the two remaining modules.

Qualified nursing and health visiting staff:

Training module name	Year to date (YTD): April 2018 to March 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust target	Met (Yes/No)
Prevent Awareness	14	14	100%	90.0%	Yes
Safeguarding Adults Level 1	14	14	100%	90.0%	Yes
Safeguarding Children Level 1	14	14	100%	90.0%	Yes
Prevent WRAP	4	11	36.36%	90.0%	No

In the emergency operations centre the safeguarding training targets were met for three of the four modules for which qualified nursing and health visiting staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training)

We reviewed safeguarding documents, policies and procedures which facilitated safeguarding reporting in the service. Staff we spoke with could explain the internal safeguarding reporting procedures relevant to their roles and gave examples of having completed a safeguarding referral.

During the inspection, we saw examples of safeguarding processes working practically. We saw evidence of appropriate verbal communications with partner agencies, staff were allocated time to complete necessary paperwork following a safeguarding incident and we saw an example of correctly completed safeguarding paperwork. All the fields on the forms we reviewed were completed which provided partner agencies with the information they required to deal with the concerns identified.

The EOC had a health desk that coordinated safeguarding referrals which helped to lighten the load of front-line staff. They took safeguarding information over the phone and assisted staff raising a concern by using the information to complete the referral. During the inspection we saw an example of staff phoning the health desk for assistance raising a safeguarding concern.

The trust had an internal safeguarding team who were available Monday to Friday between 09:00 and 17:00 for advice and support. Out of these hours, staff could contact the emergency duty team for advice about a child, young person or adult at risk; details were held centrally in the EOC for these contacts.

Safeguarding information was shared with other agencies using a secure electronic recording system and by email. Staff we spoke with described frustrations with the reliability of the clinical hub platform used to share this information as the system was said to be slow and it could delay other referrals. We saw an example of the system in use during the inspection and we found that it was sometimes slow to respond. The service was developing a new electronic referral system that was due to be introduced from October 2019 to enable direct referral by paramedics via the Electronic Patient Record.

Staff we spoke with described receiving support from managers following safeguarding incidents and the trusts safeguarding policy reflected the need to provide staff with incident support and a debrief following incidents. Staff we spoke with told us they could take time away from their desk following difficult calls or incidents and managers supported this.

The trust had a computer-based address flagging system which was used to identify the address of a person with a safeguarding care plan in place. This meant operational staff were aware of the background information in relation to the patient to provide in accordance with the agreed care plan.

The trust had clear safeguarding arrangements in their policies and procedures and had representation at local safeguarding children and adult boards. We saw evidence of updates to standard operating procedures and policies resulting from recommendations made following serious case reviews (SCR) and safeguarding adults reviews (SAR).

The executive director of quality, governance and performance assurance and deputy chief executive acted as the director responsible for safeguarding and were present at all YAS board meetings where safeguarding was on the agenda. The safeguarding agenda was discussed at relevant meetings with clear monitoring and reporting up to the executive board level.

(Source: Routine Provider Information Request (RPIR) – Safeguarding overview)

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.

Staff we spoke with had knowledge and awareness of infection prevention and control issues and took this into account when dispatching crews and when giving advice to callers. Ambulance crews were provided with as much information as possible about potential infection issues. This aided the completion of a risk assessment carried out by the crew. Decisions were in relation to the wearing of personal protect equipment (PPE).

Ambulance crews had FFP3 face fitted masks which were masks that provided respiratory protection against viruses. The hazardous area response team (HART) had full enclosed PPE available if required. Dispatch teams and clinical managers described situations when they would advise the use of both kinds of PPE equipment. Following the inspection, the trust told us they had purchased respiratory protection hoods for all staff which were to be rolled out in the coming months to replace the FFP3 masks. The trust would be one of the first ambulance trusts nationally to do this.

EOC staff and ambulance crews could seek advice and support regarding infection control matters through clinical supervisors who had the clinical knowledge and skills needed to give higher levels of information.

Environment and equipment

The Wakefield EOC site was undergoing refurbishment during inspection. The refurbishment enabled an increase in the staffing capacity of the EOC. The final plans for the working environment were ongoing at the time of the inspection. Staff we spoke with told us they had opportunities to feedback on working environment proposals.

The fire exits in both EOCs were clearly signposted, and accessible and staff we spoke with were aware of the protocol for emergency procedures.

During the inspection we reviewed the EOC fire alarm activation guidance and risk assessments for both EOC sites. There were plans in place for different scenarios that might trigger the fire alarm on either EOC site, and there were clear fire alarm action cards for duty managers and team leaders to follow in the event of an incident. The action cards gave instructions for assessing the risk level and appropriate levels of evacuation if that was required.

We reviewed the fire safety risk assessment log and found the risks were relevant and there were appropriate actions given. Each risk was rated and had a completion by date.

In the event of a full evacuation of Wakefield EOC, there were plans in place to relocate to other sites and to inform the York EOC of the disruption. Staff could be relocated using trust transportation. The trust had clear staff guidance to follow in the event of a partial or full evacuation in their business continuity plans.

(Source: Data request EOC34)

Staff we spoke with told us about business continuity arrangements and staff at all levels could articulate what would happen in the event of a major system outage, for example total loss of power to the site. Back up systems for live records were checked daily.

We saw there was a cabinet in the EOC at Wakefield which contained the required paperwork in sufficient quantities to continue the service in the event of a complete system failure.

The arrangements for system failure were tested regularly. Staff we spoke with told us business continuity was tested regularly and following a test, there was a debrief where learning was identified and implemented.

We reviewed three workstation assessments that had been completed in the last 12 months. We found they had been fully completed and there was evidence of recommendations and adjustments for staff members.

(Source: Data request EOC33)

We saw evidence of specialist office equipment in the EOC, such as standing desks. There was enough staff cover for meal and wellbeing breaks which gave staff breaks from computer screens. We reviewed guidance for staff to take breaks from display screen equipment.

We saw evidence of policies relating to health and safety in the work place which were in date and relevant to the activities in the EOC.

Assessing and responding to patient risk

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

The EOC used the nationally recognised and accredited system for call handlers to process 999 calls and prioritise them based on risk and need. The system prioritised patients based on their responses to questions asked by the emergency medical dispatchers (EMD). The questions were scripted and EMDs could not deviate from them. The call would then be coded into categories by the automated system to determine the level of risk to the patient and the dispatch staff took over managing the stack of calls awaiting resource.

The ambulance response programme (ARP) was a national programme and was used by the EOC with the aim of providing the best response for the patient, rather than the fastest. The ARP

is a system of grading response times to calls which is dependent on the seriousness of the patient's illness at the time of call out.

There ARP system had four categories. Category one identified a life-threatening risk to the patient. The remaining three categories reduced in priority and response time in accordance with the assessed need of the patient. The level of risk identified was automatically coded by the EOC system based on the questions and responses the EMD recorded. This determined the response, and responses were coordinated by the dispatch team.

If a caller made a further call to the and the condition of the patient had changed, the EMDs completed a new assessment which meant the level of risk was reassessed. If appropriate, the initial designated response would be reviewed following consideration of the revised patient risk assessment to ensure the patient received the correct resource.

Clinical staff used the Manchester Triage System to further triage calls received into the EOC. This system was used to assign a clinical priority to patients, based on presenting signs and symptoms, without making any assumption about any underlying diagnosis. Staff we spoke with told us that patients who rapidly deteriorated were triaged by clinical staff, however, if they required telephone instructions, such as Cardiopulmonary resuscitation (CPR), the call was passed back to EMD staff as they were more experienced at delivering this instruction.

Staff in the clinical hub monitored the patients waiting to be allocated a resource. Staff told us if there was a spike in a category of response, this would be escalated to the duty manager who dynamically assessed the resources available and made sure that patients received the appropriate care. A clinician was also allocated to monitor category one responses to ensure the correct category and coding had been given to these patients. They used clinical knowledge and skills to verify that the patient had a life-threatening illness or injury.

Mental health nurses worked in the EOC. Their shift pattern covered 24 hours a day, seven days a week, however there was no planned cover for annual leave or sickness. This meant when there were gaps in the rota, there was no specialised provision to monitor mental health patients, however EMDs would follow the usual clinical escalation routes if this was required.

Mental health nurses triaged call information from patients that had been coded as having overdosed or a psychotic episode. These calls were placed on the amber stack which was monitored by the mental health nurses to reduce clinical risk for the callers.

If the call was not reviewed within the required time frame of 19 minutes, or a more urgent response was required, they were dispatched in line with the EOCs response time frames. Alternative pathways could be used by clinicians to refer patients to community services where this was appropriate.

Mental health nurses were also available by telephone to support other clinical staff who worked for YAS. This was done in line with Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance where on scene YAS clinicians required further support for a mental health related emergency which included agree care plans for the patient.

(Source – Data Request EOC 5)

The EOCs responded to changing risks to patients to ensure their level of need was safely met. For example, clinical staff members, such as a nurse or a paramedic working as part of the clinical team, used their clinical judgement to change the priority of calls if necessary. The clinical team reviewed decisions made by the EMDs and the electronic triage system. They reviewed the

information in the patient's notes or called the patient or person calling on their behalf and obtained further information. The clinical assessment hub team were also available to give advice to EMDs if they were concerned the triage system had not produced the right priority, response or resource for the patient.

There was a system for monitoring the welfare of patients when the ambulance response time exceeded what was expected in accordance with the grading of the call. We saw evidence these jobs were flagged to clinical staff and duty managers when the response time limit was reached. These staff then conducted welfare checks on patients where the ambulance response time had been exceeded in addition to patients they were concerned about. The calls could be re-categorised based on any new information received through these calls, and through clinical triage. If patients or people calling on their behalf called back, EMDs followed the electronic triage system pathway to re-assess the patient's status, based on any new information and this would re-categorise the job.

There was a process in place to ensure the appropriate staff with the correct skill mix was dispatched to patients. The member of staff with the correct skill mix was automatically assigned to a job based on the code generated from the call. If the appropriately skilled staff were not available, the EOC dispatch managers were responsible for assessing the skills required and re-allocating resources to the patients who needed an ambulance resource most.

There was a trauma desk in the EOC to identify and manage potential major trauma patients. This was staffed by clinical staff. The staff on this desk monitored the call stack and could take over calls from EMDs to assess the risk of an incident and ensure the most appropriate response was sent. They also liaised with local emergency services to get the most up to date information about an incident. This service was also responsible for dispatching British Association for Immediate Care (BASICS) doctors and liaised with the hazardous area response team (HART) if the nature of the incident the meant they were identified as the most appropriate resource to dispatch.

EOC managers held safety huddles every morning to discuss staffing, issues and operational performance. These meetings were being developed and staff told us they were not yet fully embedded. We observed a meeting and read minutes from a meeting held in May 2019 and found the content matched the discussions held in the huddle. There was a committee meeting monthly to develop the content of the safety huddle.

The trust had a frequent caller team who managed the special patient notes and patient flagging process. Flags were added to patient records by address and were used to flag important medical information about a patient, frequent caller plans or potential violence and aggression of a patient.

Patient flag information was used by EOC staff and crews to ensure the patient received the correct medical care by an appropriate staff member and to keep staff and members of the public safe. Patient flags were also used to identify patients where a response was required from a silent call, for example patients with laryngectomy or tracheostomy who could not verbalise their needs.

Medical flags were reviewed by healthcare professionals and updates to the system were made as and when required by the frequent caller team.

Special patient notes and flags were reviewed monthly by case officers who had community links to refer frequent callers and they discuss patient needs with primary medical services. The team gave examples of good partnership working with GPs and community staff as well as attendance at vulnerable adult panels and Multi-Agency Public Protection Arrangements (MAPPA), Multi Agency Risk Assessment Conference (MARAC) and safeguarding multi agency meetings.

There was a process to update the patient transport service and 111 systems with flag information once it was received as they ran on a different software system.

Between 1 March 2019 and 21 March 2019, the trust identified 1014 frequent callers and had 55 care plans in place. They used the nationally agreed baseline of five or more calls per month or 12 or more calls in three calendar months from private addresses for patients aged 18 or over. Flags were audited three times per year at the team's governance meeting which included the 111 service.

Clinical staff in the EOC gave examples of patients with special notes where there was an approved plan from their GP to manage their care appropriately. This meant the patient received the most appropriate clinical care and avoided conveyance to hospital unless it was clinically required. These patients were managed by the clinical EOC staff and EMDs described the process they would follow to pass flagged calls to a clinician.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm. Managers regularly reviewed and adjusted staffing levels and skill mix, however there was not always enough mental health nurses to cover the projected shift pattern. The trust was taking action to mitigate this.

Shift patterns for EMDs were aligned with the projected demand. The service recognised that peaks and troughs in demand meant the traditional 12-hour core rota did not effectively meet their projected demand. There was mapping exercise for all EMD staff that allowed them to request flexible work requests for eight and 10-hour rotas and individual rotas. These shift patterns met the service demand and allowed an improved work-life balance for EMD staff.

Managers we spoke with told us this was reviewed every 12 months and this review was due to be completed by duty managers and the head of scheduling to ensure the rota still met the projected demand.

During the inspection we spoke with staff told us that EMD staffing had improved over the last 12 months and was no longer a risk to the service.

The dispatch team covered core dispatch shifts differently to EMDs. They were also part of the mapping exercises and were able to request flexible working arrangements that met the demands of the service.

We reviewed staff rotas during the inspection and saw that staff received adequate breaks and time off in between shifts.

The EOC had changed its approach to annual leave cover following issues in the previous year. Annual leave had been approved based on each team but that did not consider the service demand and shift pattern. Following some issues in annual leave cover, this was identified as a risk and managed by changing the annual leave system in the EOC.

The EOC reduced its whole time equivalent (WTE) of EMDs based on evidence from the outcome of a demand and capacity review, and in line with the trusts cost improvement programme (CIP). To mitigate the reduction in EMD WTE, the service was looking to change its business model to handle calls in a different way and had started to develop plans to introduce added capacity by splitting emergency and lower grade urgent calls. The introduction of an apprentice scheme was

anticipated to assist in this and the service was working through how to do this without reducing performance and quality of care.

Demand management tools were visible in the EOCs and used by the duty managers to monitor performance. Each site was a virtual site so there was no difference in the allocation of calls to EMDs and dispatchers by the site they worked at.

During the inspection we saw examples where resources were lower than planned levels in a specific area. We observed dispatchers pooling resources and dynamically relocating them to ensure sufficient cover.

There was a dedicated role for mental health nurses in the EOC. We saw that turnover in these roles was high and the rota did not allow for annual leave or sickness cover. This meant there were times when this role was not available to support the EOC staff. Staff gave examples of times when this resource would have been helpful for patients, but there was no cover.

We reviewed the mental health nursing rota for four consecutive weeks and found there were 23 unfilled shifts and five partially unfilled shifts in that period. There were days on the rota with one mental health nurse per shift, and on other days there were multiple staff and agency staff on duty covering full and partial shifts. Sometimes this meant there was the equivalent of two or more nurses on duty at the same time on one day, and no nurses on duty on others in the same week.

(Source – Data Request EOC4)

All ambulance trust providers, as category 1 responders, under the Civil Contingencies Act 2004 (CCA), must ensure they embraced best practice national guidance. Each ambulance trust provider must have a resource escalation plan (REAP) which is a clinical plan designed to ensure that an appropriate response is maintained at times of unexpected increases in demand.

Although the trust had a REAP policy and appropriate demand management plan in place, there was limited visibility of the REAP status in the EOCs and staff at middle manager level and below did not describe REAP actions when we asked about them. We were not assured that REAP was embedded at service level.

Planned vs actual

The trust has reported their staffing numbers below for the emergency operations centre as of March 2018 and January 2019.

Staff group	As at March 2018			As at January 2019		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Qualified ambulance service staff	48.0	46.0	95.8%	49.0	55.5	113.3%
Support to ambulance service staff	319.0	309.0	96.9%	327.5	315.0	96.2%
NHS infrastructure support	20.0	30.0	150%	34.5	31.3	90.7%
Qualified nursing & health visiting staff (Qualified nurses)	3.0	2.0	66.7%	3.0	2.0	66.7%
Total	**390.0**	**387.0**	**99.2%**	**414.0**	**403.8**	**97.5%**

Between March 2018 and January 2019 staffing numbers increased in the EOC in three out of four staff groups.

In January 2019 the total staffing rate for the emergency operations centre was 97.5%. This was slightly lower than March 2018 where the total staffing rate was 99.2%.

January 2019 saw an increase in the fill rates for qualified ambulance staff, decrease in fill rates for NHS infrastructure support staff (where the planned staffing WTE had increased) and similar fill rates for all other staffing groups.

(Source: Routine Provider Information Request (RPIR) – Total staffing)

Vacancy rates

From April 2018 to January 2019 the trust reported an annual vacancy rate of 0.3% for the emergency operations centre.

The trust did not have a target vacancy rate but had a vacancy threshold rate of 5%.

A breakdown of vacancy rates by staff group is shown below:

- Qualified ambulance service staff: -4.9%
- Support to ambulance service staff: 0.2%
- NHS infrastructure support staff: 6.3%
- Qualified nursing and health visiting staff (qualified nurses): 30.0%

Please note: vacancy rates have been calculated using budgeted WTE vs worked WTE data as provided by the trust. Where there are negative rates this is due to more WTE worked hours than were budgeted for.

For qualified nurses care should be taken when interpreting the rates as this is based on much lower numbers than other staff groups.

(Source: Routine Provider Information Request (RPIR) – Vacancy)

Turnover

From March 2018 to February 2019 the trust reported an annual turnover rate of 8% for the emergency operations centre.

The trust did not have a turnover target rate.

A breakdown of turnover rates by staff group is shown below:

- Qualified ambulance service staff: 4%
- Support to ambulance service staff: 8%
- NHS infrastructure support staff: 5%
- Qualified nursing and health visiting staff (qualified nurses): 29%

(Source: Routine Provider Information Request (RPIR) – Turnover)

Sickness

From March 2018 to February 2019 the trust reported an annual sickness rate of 7% for the emergency operations centre.

This was higher than the trust target sickness rate of 5%.

A breakdown of sickness rates by staff group is shown below:

- Qualified ambulance service staff: 7%
- Support to ambulance service staff: 7%
- NHS infrastructure support staff: 3%
- Qualified nursing and health visiting staff (qualified nurses): 5%

(Source: Routine Provider Information Request (RPIR) – Sickness)

Nursing and medical bank and agency/locum staff usage

From March 2018 to February 2019 the trust reported no bank, agency or locum staff usage in the emergency operations centre for clinical staff.

(Source: Routine Provider Information Request (RPIR) – Bank agency locum tab)

Temporary staff usage

This refers to staff that are not qualified nursing or medical and dental staff. It can apply to paramedics, operations centre staff or any other core service specific roles within the trust.

From March 2018 to February 2019 the trust reported no temporary staff usage in the emergency operations centre.

(Source: Routine Provider Information Request (RPIR) – Temp staff tab)

Records

Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient records were managed, completed and stored appropriately and confidentially. Patient records were held electronically, and staff required a password and login details to access them.

The EOC used the computer aided dispatch (CAD) system to record patient details, triage calls and deploy ambulance resources. A new record was created at the start of every 999 call and patient details were recorded on the CAD system. The systems then guided EMDs through a series of questions to identify the patient's condition and the category and coding generated the ambulance response required. EMDs updated information as the patient's situation developed during the call which crews could access.

The was a dedicated team who ensured flags and special patient notes were held in records to alert EOC staff and crews to important patient information. The flags provided information which supported EMDs and clinicians in decision making and assisted them to manage certain patients, situations or known risks. If EMDs identified a potential patient where a flag would be appropriate, they would raise an incident on their incident reporting system for the frequent caller team to deal with.

Flags and special patient notes existed on the EOC system and flashed up on the patient's record if there was an alert about the patient based on the address in the system. Information to populate the warning markers came from healthcare professionals, GPs, patient families or the patients themselves. Alerts included whether the patient had written resuscitation decisions, a key safe code, complex care instructions or an approved care plan.

Frequent callers were identified on the system when they called the EOC to enable staff to manage these patients in accordance with multidisciplinary developed care plans.

Medicines

Staff gave advice on medicines in line with national guidance.

There was approved clinical guidance on medicines for the clinical team to reference. The clinical team used the Joint Royal College Ambulance Liaison Committee (JRCALC) for medicines guidance. These were available electronically to ensure staff had access to the most up to date version.

Although the advice provided to patients at the EOCs was required to be limited, the patient triage system provided the EMDs with some advice for patients. For example, the triage system directed EMDs to prepare patients for a possible hospital stay. Callers were advised to gather any medicines taken regularly.

The EMDs we spoke with told us they felt confident in following the clinical pathways and if they were unsure they could contact a clinician for further advice.

Safety Performance

EOC managers held daily safety huddles to discuss staffing, issues and operational performance. We observed a meeting and read minutes from May 2019 and found they reflected the conversations in the safety huddle. There was a committee meeting monthly to develop the content of the safety huddle. Staff from both sites attended the safety huddle which was held by teleconference.

We saw some gaps where safety huddles had not taken place. These meetings were being developed and staff we spoke with told us they were not yet fully embedded.

Staff we spoke with told us about actions they would take to improve safety performance. This involved dynamic and proactive changes to the workforce in the EOC to mitigate risks identified, such low resource or high demand in certain geographical areas.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, however lessons were not routinely shared in the wider service or with partner organisations.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2018 to March 2019, the trust reported no incident(s) incident classified as a never event in emergency operations centre.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident (SI) framework 2015, the trust reported seven incidents in emergency operations centre which met the reporting criteria set by NHS England from April 2018 to March 2019.

All seven incidents were recorded as treatment delays meeting SI criteria.

(Source: Strategic Executive Information System (STEIS)

As part of this inspection, we reviewed three serious incidents and associated root cause analysis reports. The content was comprehensive and there was clear learning to be shared with staff, as well as an action plan with realistic implementation dates for each action.

(Source: Data Request EOC22)

YAS had an incident and serious incident management policy which in date. It was accessible to staff electronically and set out the incident investigation process, timelines, incident closure and learning processes for incidents and serious incidents.

The policy included an incident flow chart, risk matrix, approval structure and an investigation guide for managers. Action plans resulting from incident investigation and root cause analyses were monitored locally.

There was also an investigation and learning policy which was in date; it complemented the incident management policy and provided structure and clarity around the investigation process.

Staff we spoke with understood their responsibilities to raise concerns and report them internally. The trust had an electronic incident reporting system which all staff had access to at their desks and there was a 24/7 incident reporting telephone line.

The senior management team were responsible for ensuring incidents were properly investigated, findings fed back, and learning shared with staff across the EOCs.

Staff we spoke with gave examples of appropriate incidents they had raised through the online incident reporting system and said they often received feedback, but this was sometimes limited, especially if another service was involved in the incident.

During the inspection, staff we spoke with at the York EOC told us they would report IT issues to the IT service desk, but if a core system had an error, such as telephone lines or the CAD, they would not report this as an incident on the trust incident reporting system.

We saw evidence of sharing information with staff in the EOC about incidents through a wall board presentation that was produced quarterly and reviewed the EOC quality measures. This included numbers of reported incidents, incident examples and learning from the investigation.

We saw three examples of EOC alerts where a change was made to a process as part of the learning from the incident investigation. One of the alerts referenced that the change was due to learning from an incident.

Staff we spoke with could articulate that changes had been made to the service they provided, but could not always describe when changes were as a result of shared learning from incidents.

We were not assured that staff were always aware of the rationale for changes made in the service, or where changes had been made as a result of learning from incident investigations.

(Source: Data Request EOC6)

Staff gave examples of changes to processes due to patient safety that had been implemented but the reasons for change was not always made clear. This meant that shared learning from incidents was not always clear to staff. Managers we spoke with told us that they tried to move the focus to the process change and the incident itself.

Updates following incident feedback were rolled out in the EOC by team champions and there was a system in place to ensure this was delivered to all staff across different shift patterns. We saw evidence of updates that had been rolled out to staff at both EOC sites.

Staff we spoke with gave examples of joint incident reviews with partner agencies. We were told by staff there was a single point of contact in the EOC who liaised with other agencies and learning was then shared by email with the relevant EOC staff.

As part of the inspection we looked at a review of an incident undertaken with partner agencies. This review debriefed the incident and identified lessons learned to be implemented when planning for a response to similar type of incident in the future. Eight recommendations were made by the debrief sponsor.

(Source: Data Request EOC23)

During the inspection, we asked staff about debriefs following serious incidents. Staff told us this was done on a case by case basis and there was a system to allow EOC staff to come away from their desks for individual debrief and support. Staff we spoke with told us they were confident in using this system when they needed to.

The trust had a Duty of Candour (Being Open) policy and associated standard operating procedure to govern this process. All duty of candour contact was recorded on the electronic incident reporting system and a log was kept that tracked open cases. Monthly, quarterly, bi-annual and annual audits were completed on moderate and above harm cases recorded on the incident reporting system to ensure all incidents were captured appropriately and acted upon.

The trust completed a serious untoward incidents internal audit programme in September 2018 which reviewed reporting of serious incidents at the time of reporting. They found they had good assurance from the sample audited, however a small number of the sample of serious incidents

were not reported at the time of the incident. An action plan and standard operating procedure was produced following this audit and the trust analysed relevant data.

As part of the inspection we reviewed the analysis of this data for January 2019 and the excessive response standard operating procedure. We found there were actions and learning identified from this data analysis and this was mitigated through the standard operating procedure.

(Source: Data request EOC35)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

The EOC used the recognised and accredited system for call handlers to process 999 calls and prioritise them based on risk and need. The system prioritised patients based on their responses to questions asked by the emergency medical dispatchers (EMD) and the call was then coded into categories by the system to determine the level of risk to the patient. The ambulance response programme (ARP) was used by the EOC with the aim of providing the best response for the patient, rather than the fastest.

EMDs could gain clinical advice or support by raising an assistance card; a team leader would assist the EMD and find available clinical staff to support them if this was required. We observed examples of this during the inspection. Clinical staff could also listen in to live calls and provide advice through the CAD system by adding in notes or take over the call if that was required.

EMDs routinely advised patients and people who cared for them to contact 999 if there was deterioration or new symptoms and, when the pathway determined it, stayed on the line with patients until a crew arrived. We saw examples of this happening during the inspection.

Clinicians had access to Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines which was supported by documents stored on the YAS internal systems, including clinical guidance and patient group directives (PGDs). We saw evidence of staff members using the guidelines and supporting documentation during the inspection.

Published National Institute for Health and Care Excellence (NICE) guidance was reviewed and updated monthly by a clinical audit review group as well as other clinical audit and governance groups and forums. Lessons learned were acted upon and reported to the clinical governance and quality committee.

The trust developed clinical pathways with local networks and in line with JRCALC and NICE guidelines.

The trust had a clinical audit programme where any areas of implemented NICE guidance was audited. Audits were also performed on any current NICE guidance to gain assurance they were up to date.

(Source: PIR – P.31 Guidelines)

YAS was required to meet certain audit criteria to become an accredited centre of excellence (ACE) and to meet the requirements for the license agreement for the call prioritisation system they used. The criteria included the quantity of audits completed (a target of 1% of the total call volume) and the compliance of EMDs with the standards measured in those audits.

As part of the licence for the triage system, all calls were recorded, and regular call audits were carried out to identify the EMDs performance and ability to effectively use the triage system. Call audits were carried out monthly to ensure EMDs were following the right guidance, giving the right advice to the patient or caller and generating the correct ambulance response for patients.

During the inspection we saw evidence of the appropriate number of call audits for January, February and March 2019. Staff we spoke with told us that academy approved software was used to randomly select the correct number of calls to audit. If EMDs were not audited through the random selection in the software, the audit team would complete additional audit checks to ensure each EMD received some feedback on a regular basis.

Staff we spoke with told us they received call audit feedback by email. If they received non-compliant feedback, they told us they had one-to-one time with a team leader, discussed the call and were put onto an action plan which facilitated improvement.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief advice in a timely way.

We saw evidence during inspection that staff in EOC assessed pain remotely using the clinical pathways and provided information to patients, carers and ambulance crews involved in the call. Dependent upon the clinical pathway followed, patients could be provided with advice to take pain relief medication if needed.

EMDs we spoke with during the inspection gave examples of being asked by patients about medications where they asked advice from clinicians. Additional notes were added to the patient record by both the clinician and the EMD to keep ambulance crews informed of advice given to patients, or medications taken.

Response times

The services Ambulance systems (AmbSYS) indicators were consistently better than the England average in the inspection reporting period.

The trust started reporting data to the new Ambulance Response Programme metrics in September 2017.

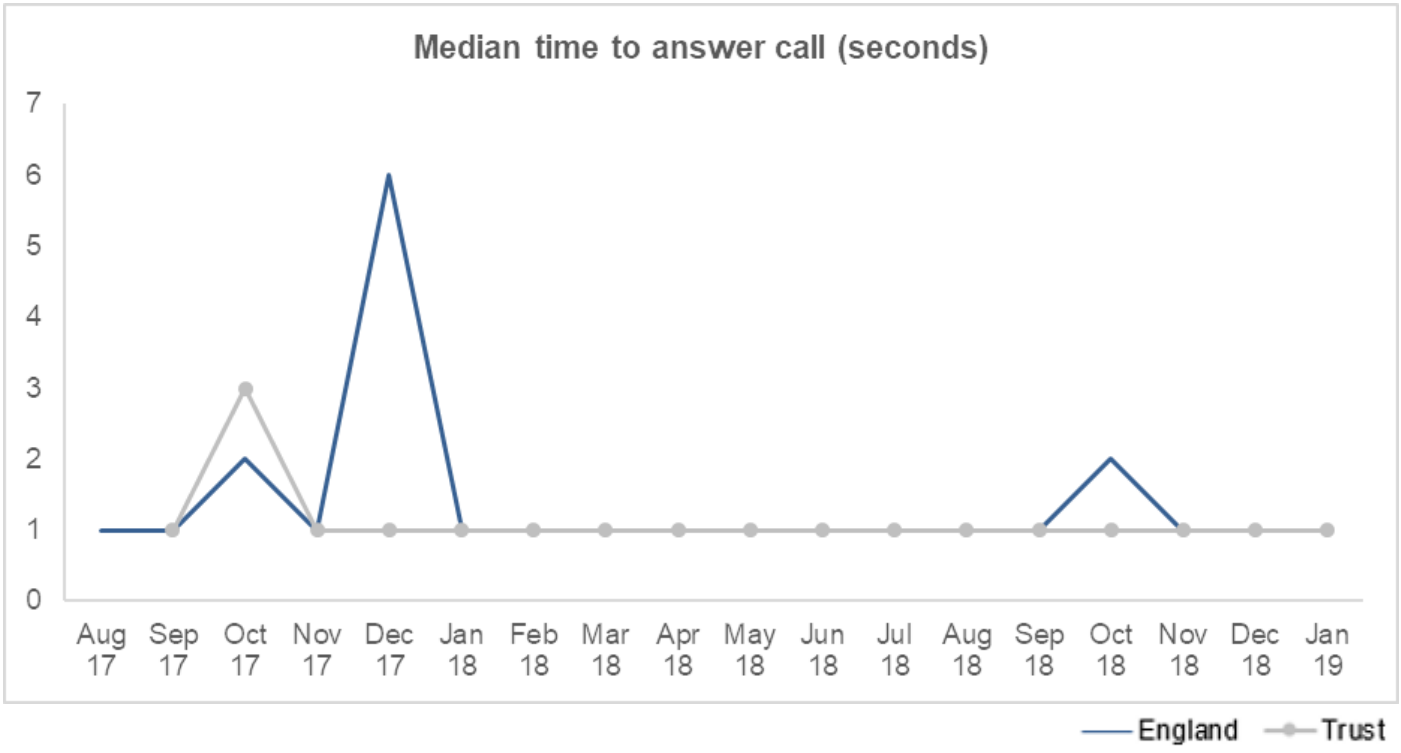
Ambulance systems (AmbSYS) indicators introduced under the NHS England Ambulance Response programme (ARP):

Time to answer call

The time to answer each call is the time between call connect and call answer.

The four metrics used to measure time to call answering are:

- Median time spent between call connect and call answer (i.e. the time below which 50% of calls were answered)
- Mean average time from call connect to call answer (i.e. total call answer time divided by calls answered)
- 95th percentile of times from call connect and call answer (i.e. the time within which 95% of calls were answered)
- 99th percentile of times from call connect and call answer (i.e. the time within which 99% of calls were answered)

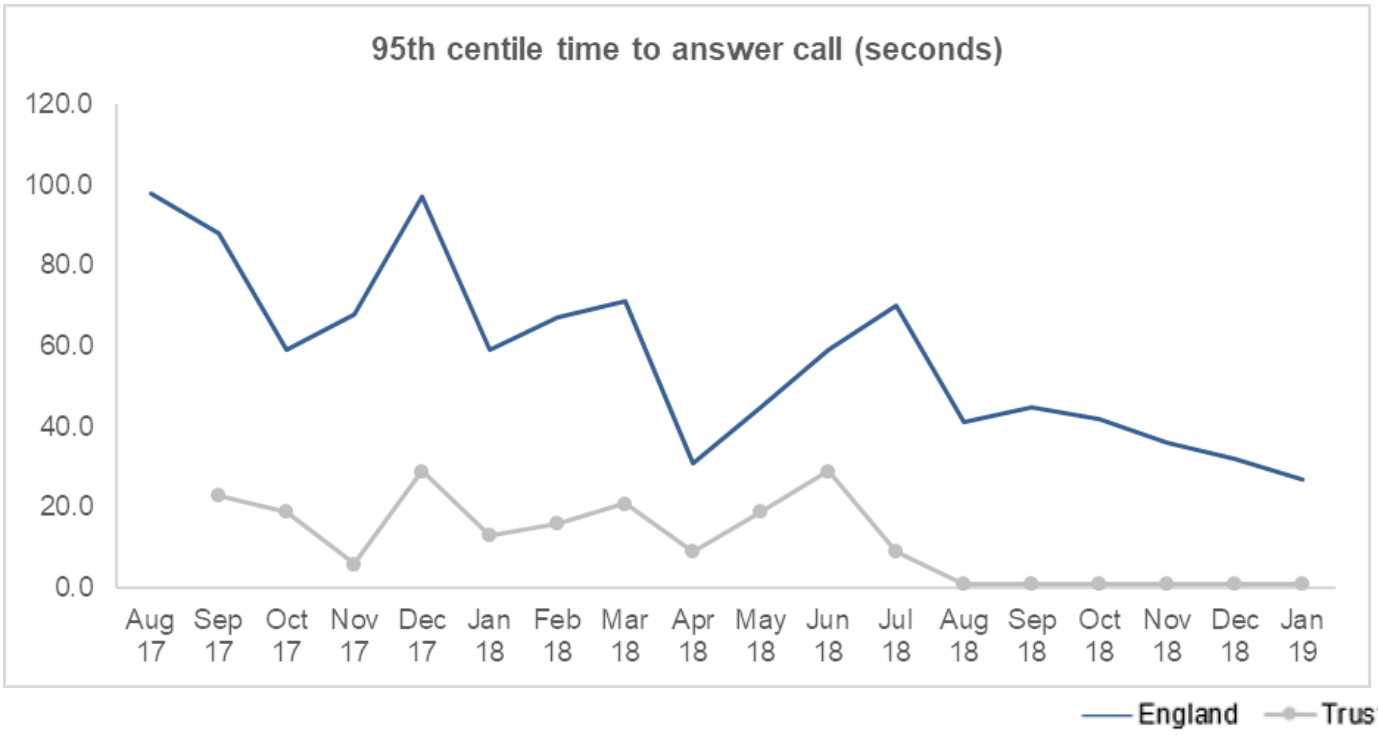


From September 2017 to January 2019 the trust's median time to answer calls had been the same as the England average in 14 of 17 months, and better than the England average in two months. The trust median was one minute in 16 of the 17 months in the period.

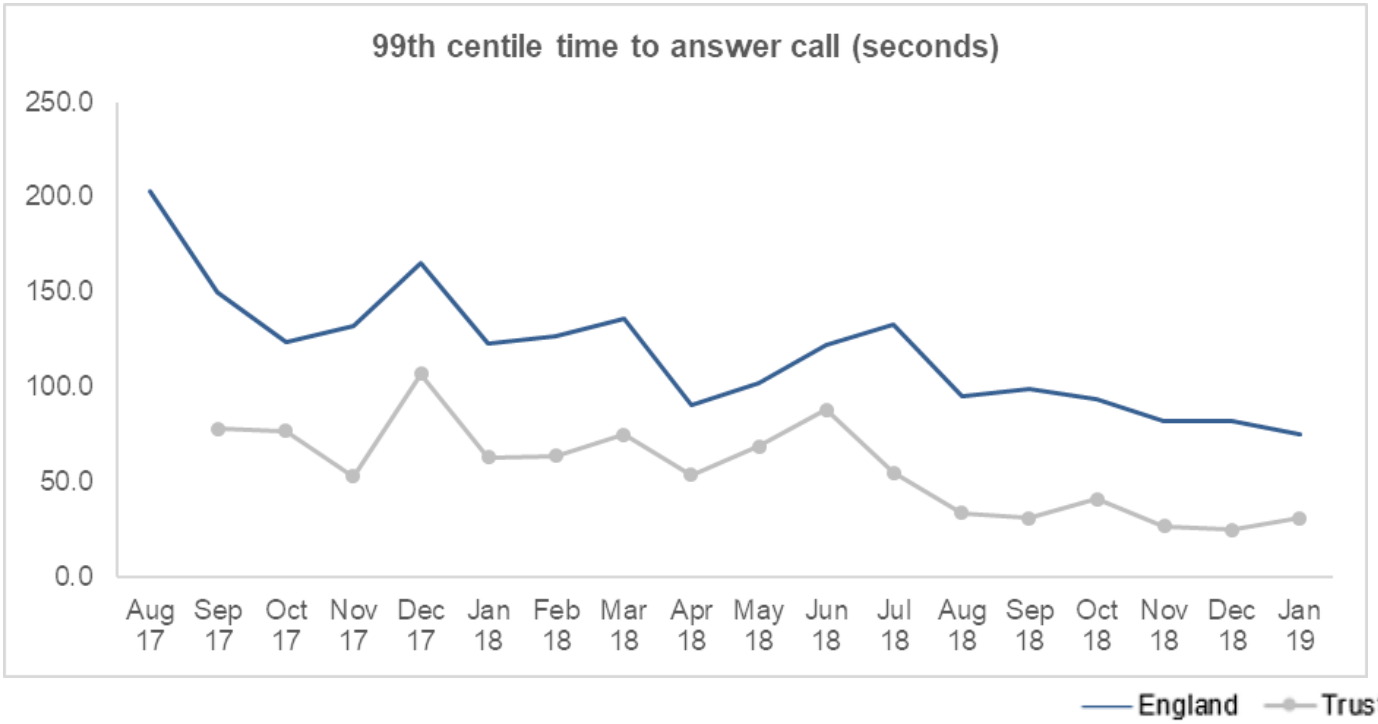
The trust monitored, recorded and measured the real-time performance of the EMDs to ensure patients calls were answered as promptly as they could be. Electronic screens were visible to all

staff at both EOC sites and displayed the number of calls waiting and the length of time the caller had waited for a response. The York and Wakefield EOC sites ran as a virtual centre, so calls were shared equitably between the sites based on EMD availability.

From September 2017 to January 2019 the trust's mean time to answer call had been consistently better than the England average.



The service had the quickest 95th centile call answering performance rate of all 11 NHS ambulance providers from July 2018 to January 2019.



From September 2017 to January 2019 the trust's 99th centile time to answer call had been consistently better than the England average.

(Source: NHS England – Ambulance Quality Indicators – System Indicators)

Real time performance of response times was monitored by the EOC management team. They used web-based reports to manage the performance and this was overseen by senior managers in the service's regional operations centre (ROC), part of the "Gold Cell" which was the services' resilience team.

The audit team in the EOC completed regular audits of calls taken by EMDs. This included reviewing reports which showed staff members responses to audited calls and could determine if a response to a call was correct or if there was an over or under response allocated. In the case of under or over responses, which meant there could have been a risk for patients or waste of resources, staff received feedback from the team.

(Source: Data Request EOC21)

The service had appropriate resource escalation action plan (REAP) and demand management plans which clearly outlined considerations and actions to be completed based on performance and demand levels. Managers and resilience staff that we spoke with were able to articulate actions they had taken when performance fell and related this to the relevant plans.

(Source: Data Request EOC14)

The hazardous area response team (HART) were centrally located to provide optimal access to the transport networks. Due to the size of the geographical area covered by YAS, staff told us the response times may be outside the HART service specification, however we found a common-sense approach had been applied to the situation and the best possible configuration was in place.

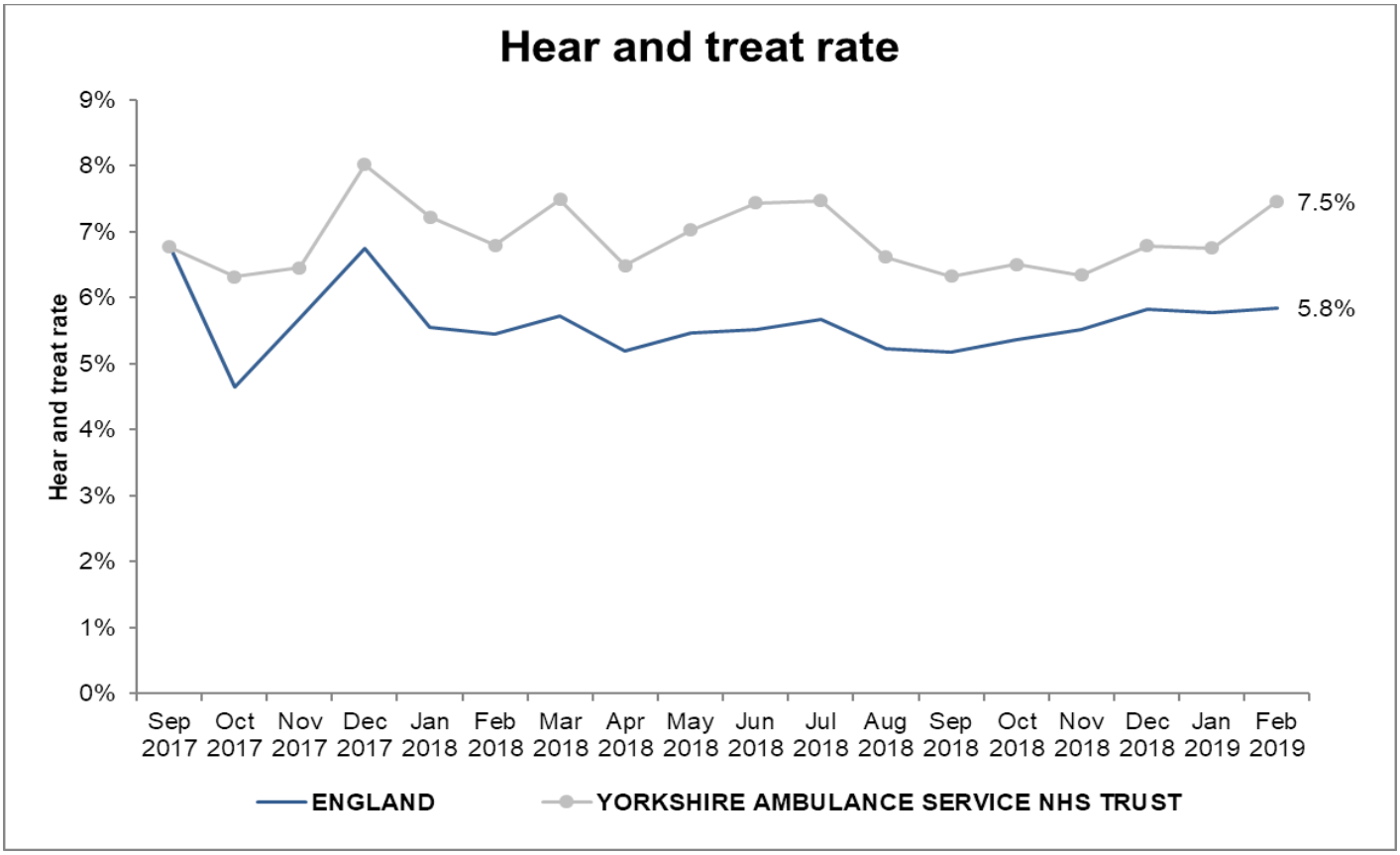
Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Calls closed with telephone advice / hear and treat

This measure relates to all calls to the emergency operations centre that are resolved through telephone advice or by referring to another service and where an ambulance is not dispatched.

The trust's performance against the metric for the period from September 2017 to February 2019 is shown below.



From September 2017 to February 2019 the trust's proportion of incidents resolved without a face to face response has been higher than the England average. Trust performance ranged from 6.3% to 8.0% compared to the England average of 4.6% to 6.8%.

In February 2019 7.5% of the trust's incidents were resolved without a face to face response compared to the England average of 5.8%.

(Source: NHS England – Ambulance Quality Indicators – Systems indicators)

We saw evidence that the service used quality and outcome data to inform service improvements. We looked at three examples of service changes that occurred based on this kind of data; staff we spoke with during the inspection articulated these examples and the changes that had been made to their practice.

(Source: Data Request EOC15)

The EOCs data warehouse was used to ensure data used in reporting was accurate, valid and of good quality; this function was outside of the EOC structure but supported the service. Data

warehouse reports were used by the EOC team to monitor and improve the quality of care provided.

HART resources were deployed in accordance with the trusts' pre-determined attendance (PDA) list based on the coding of the incident. Managers we spoke with told us they used their discretion to overrule the PDA in discussion with the HART team leaders to ensure HART resources were only deployed to appropriate incidents.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development, however EMD staff were not always confident they had received the training and knowledge they needed to manage patients in a mental health crisis.

YAS ensured new starters were competent to operate the assessment and triage systems. New EMD staff participated in a comprehensive induction and training programme which included classroom based training and live call mentoring. Staff we spoke with told us they found this experience invaluable. New staff were required to pass an examination to become a certified emergency medical dispatcher (EMD) and this was assessed by EMD practice developers.

All EMD and dispatch teams had team champions who rolled out updates to guidance, training and other updates relevant to staff. Champion staff we spoke with told us they received the updates from senior managers and had one week to review the information and ask any relevant questions before they delivered the update or training to staff.

EOC managers had final oversight of sign-off, but team champions took day to day responsibility for making sure updates were delivered to staff on shift. There was a system in place that ensured updates were delivered to all staff across different shift patterns; we saw evidence of updates that had been rolled out to EMD and dispatch staff at both EOC sites.

Staff had to sign to confirm they had read and understood the update given. Staff we spoke with gave examples of spending various lengths of time with different staff to ensure updates were fully understood and staff were competent.

Staff we spoke with told us there was a supportive process for re-training following prolonged absence which included re-validation for accredited status if this had lapsed. EOC managers also described the relevant process that would be taken to ensure staff competence following a long absence, including re-validation if this was required.

During the inspection, we observed EOC managers using the 'YAS 247' system which showed the status of individuals regarding training requirements and recertification deadlines to ensure staff were on target.

Staff we spoke with told us that the audit process for EMDs was well embedded and worked well, providing assurance to managers of staff competence. YAS was an accredited centre of excellence, and managers were also assured of staff competency through these externally monitored audits.

The service was working to develop an audit process for dispatchers, but this was not completed at the time of the inspection.

The EOC had an initiative called “welfare Wednesday” where staff who were booked off for 5 days or more had a supportive contact call from a manager which was recorded in their electronic management system.

During the inspection, staff spoke positively about the training and mentorship process for induction. Staff voiced concerns that the level of mental health training they received was not sufficient to deal with complex mental health patient’s needs. There was not always sufficient mental health nurse cover to escalate these calls to.

Staff we spoke with told us they worried they might say the wrong thing to a person in crisis that could escalate them, and they did not think they had been provided with the appropriate level of knowledge and skills to deal with these patients appropriately.

During the inspection period, we asked the service for evidence of EMD mental health training and any relevant guidance to support staff supporting patients in mental health crisis. From the information provided, there was limited coverage of mental health in the training package and we were not assured that there was sufficient training for EMD staff in managing mental health patients in crisis.

(Source: Data Request EOC24)

Clinical staff we spoke with told us there was sufficient clinical supervision available on shift and they were supported to complete continuing professional development. Nursing staff we spoke with told us they were able to maintain their PIN.

We saw evidence that mental health nurses completed reflective practice as part of their clinical supervision which was required to maintain their nursing registration. The trust was reviewing access to group supervision as part of the long-term mental health plan and aimed to utilise external mental health trusts across the Yorkshire region, in line with recognised best practice. At the time of the inspection this work was in development.

(Source: Data request EOC36)

EOC Clinical managers completed 4 audits per month of clinical staff using the Manchester Triage System (MTS). EOC clinical managers also described being proactive in making joint decisions for complex patients and staff had access to on call doctors if their input was required to make a complex clinical decision.

Managers we spoke with told us they were assured of the competence of staff working in the EOC through call auditing, live call auditing and business intelligence colleagues who escalated concerns found in the data sets they analysed.

We reviewed information about an exercise for operational staff which detailed establishing a response to a major incident. This exercise was debriefed, and recommendations were made to improve the response to such an incident. One of the recommendations was to regularly exercise EOC staff in these scenarios to ensure they were confident in the skills required to manage a major incident. This exercise was completed in April 2019.

(Source: Data Request EOC23)

Appraisal rates

As of March 2019, 70.89% of staff within the emergency operations centre at the trust received an appraisal compared to a trust target of 90%.

This is similar to the previous period, March 2018, where 70.5% of staff within the emergency operations centre had received an appraisal.

The breakdown by staff group is shown below:

Staff group	Number of staff received appraisal	Number of required staff	Appraisal rate	Trust Target	Met (Yes/No)
Support to ambulance service staff	195	272	71.69%	90%	No
NHS infrastructure support	35	52	67.30%	90%	No
Qualified nursing & health visiting staff (Qualified nurses)	11	11	100%	90%	Yes
Qualified ambulance service staff	140	178	78.65%	90%	No

(Source: Routine Provider Information Request (RPIR) – Appraisals)

Managers in the EOC tracked appraisal data on a monthly basis and could also drill down to individual staff level to monitor compliance rates.

We asked the trust for information about their plans to increase training compliance. We were told there had been some difficulties capturing appraisal completion on the trust's electronic system because of structural changes. We were told this was being resolved during the inspection period and the appraisal rates were expected to improve once all data was captured. The trust did not provide any evidence of improved appraisal compliance.

(Source: Data request EOC39)

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.

We saw evidence of good multidisciplinary working in the clinical hubs. The triage systems used by the EOCs enabled all staff to provide a multidisciplinary approach to patient care and there were various community pathways patients could be referred to as an alternative to ambulance conveyance to hospital when this was clinically appropriate.

During our inspection we saw an example of multidisciplinary working between dispatch staff in both EOCs, ambulance crews, other local emergency services and local transport services to deliver safe and effective care to patients and ensure the safety of members of the public.

There was a team in the regional operations centre who coordinated with communications and press teams to ensure appropriate information was released to the media when this was required.

Staff worked in a coordinated way between both EOCs and systems were configured in a way that resources could be used by remote dispatchers.

If the EOC was the first response to an incident that needed the involvement of other authorities, staff on the health desk would assist in coordinating this with the trauma desk. Staff we spoke with explained this process and understood their roles and responsibilities.

The trust had signed up to a national memorandum of understanding for all ambulance trusts that aided in managing incidents and calls that crossed trust or national boundaries.

(Source: Data Request EOC16)

The frequent caller team referred frequent callers to teams in the community. The team gave examples of good partnership working with GPs and community staff as well as attendance at vulnerable adult panels and Multi-Agency Public Protection Arrangements (MAPPA), Multi Agency Risk Assessment Conference (MARAC) and safeguarding multi agency meetings.

There was a pilot being trialled where crews and mental health nurses could have teleconference calls with GPs to give the most appropriate help to patients in mental health crisis.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

There were several pathways available to staff to refer callers to other services when they were not calling with a medical emergency or there was a more appropriate service in their local area that could meet their needs.

The clinical advisors accessed a web-based information system from their computer to find relevant services in the patient's local area. Staff we spoke with gave examples of using these resources to refer patients to more appropriate care and support than an ambulance response.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguard

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The trust reported that from April 2018 to February 2019 the Mental Health Awareness and Mental Health Capacity training module had been completed by 83.8% of all staff in emergency operations centre.

This is lower than the previous year (April 2017 to March 2018) where 89.4% of all staff had completed the training.

The breakdown by staff group is show below:

Staff group	Year to date (YTD): April 2018 to February 2019				
	Staff trained YTD	Eligible staff YTD	Completion rate YTD	Trust target	Met (Yes/No)
NHS infrastructure support	52	60	86.7%	90.0%	No
Qualified nursing & health visiting staff	19	22	86.4%	90.0%	No
Support to ambulance service staff	273	325	84.0%	90.0%	No
Qualified ambulance service staff	45	57	78.9%	90.0%	No

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust employed a team of nine WTE mental health nurses to support callers with a mental health need. Initially, this was run as a pilot with agency staff. A mental health nurse was assigned to each shift group. The service was still developing, and the trust told us they had plans to have at least two mental health nurses assigned to each shift but no timeline for this was given.

EOC staff were not expected to complete mental capacity assessments over the telephone. They noted any concerns regarding consent on the electronic patient record and asked for clinical advice or team leader support if they had concerns about a patient's capacity.

Clinical staff we spoke with told us they would always try and speak with a patient directly to determine consent if they could, but if they had concerns about the content of the conversation, they may dispatch a crew without agreed consent. Staff gave examples of appropriate situations they would do this to ensure vulnerable people were safe and told us they were supported by the health desk staff to raise appropriate safeguarding referrals or incident reports.

Is the service caring?

Compassionate care

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

During the inspection we listened to 45 live calls in the emergency operations centres. During those calls the staff were observed to be calm, professional and considerate of the patient's needs. We heard staff interact with people in a respectful and considerate way while ensuring they asked specific questions to follow the electronic pathways and assess the patient. We listened to calls where staff took time to ensure questions were answered, where possible, by the patient rather than supporting family members or carers to ensure the information was accurate.

There was a patient centred culture at the EOCs. Staff demonstrated their compassion and commitment to each caller on each of the calls we listened to. Staff were consistently reassuring, empathetic and kind.

During our observations we observed staff consistently demonstrated their commitment to caring for patients. Staff showed compassion, kindness, respect and professionalism throughout each call despite at times, the challenging nature of the call. Staff treated callers with compassion and empathy.

EMDs provided reassurance for patients during the calls and continually reassured callers about their situation. We observed staff acting with compassion and they checked on patients when they waited on the line until the ambulance response arrived with the patient. On some calls, staff had to continue to assess the patient while waiting for an ambulance response; this was always clearly explained to patients and people who cared for them.

EMDs had calls audited based on the performance standards set by the International Academies of Emergency Dispatch. We reviewed audit results relating to customer service which audits EMDs on skills which relate to patient care, including, tone, compassion, and providing reassurance, attitude.

We looked at data from March, April and May 2019 and found that less than 0.1% of calls audited had areas of non-compliance relating to customer service. This gave evidence that EMDs provided compassionate care consistently to patients.

(Source: Data Request EOC1)

As at July 2019, the service had received 51 compliments from patients and members of the public. We looked at 6 examples of the compliments received and found they reflected our findings that staff showed compassion and caring to patients in situations that were difficult and distressing for the caller.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

During the calls we listened to, staff were observed to be confident in delivering advice and supporting the caller.

EMDs provided continuous emotional support to the most unwell patients and callers while an emergency ambulance response was on its way. Where necessary advisors remained on the line until the ambulance crew arrived at the scene. This provided reassurance to callers they were not alone during a distressing time.

Staff demonstrated respect and empathy for callers experiencing a mental health crisis. Staff were caring, compassionate and respectful despite being restricted by the procedural demands of the triage tool. Staff told us they would complete the required stages of the triage tool and then offer emotional support to patients as required.

However, staff we spoke with told us that although they tried their best during these difficult calls, they did not always feel they had the appropriate knowledge and skills to deal with these types of calls.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Clinicians communicated with people to ensure they understood the information they were providing them and communicated in a way which a lay person could understand. Clinical staff we spoke with showed us resources they used, for example, to determine pain scores using alternatives to 0-10 pain scores. This was adapted for children and adults.

EOC staff clarified their understanding of the information they received from callers to ensure they had heard the information correctly. This ensured assessments were accurate to enable effective triage and the most appropriate ambulance response.

EMDs tried to manage the expectations of patients and people caring for them regarding the ambulance response sent to the patient and the potential wait time.

Staff we spoke with gave an example of going above their role during a rescue operation when they were on the phone with a family member at the scene of a time critical incident. The EMD stayed on the line after initial emergency services arrived to provide support to the family on the phone until there was enough resource on scene to adequately support the caller.

We also observed an example of EMDs referring a family to clinical staff for help following discharge from hospital where social and community interventions were required and not an ambulance response. Staff were understanding of the complexities of the situation and offered empathy, reassurance and support where possible.

Is the service responsive?

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.

The EOC had a 'Gold Cell' who had a strategic overview of operations performance and any pressures on the service. They proactively managed incidents until a command structure was established at the scene.

The hazardous area response team (HART) were centrally located to provide optimal access to transport networks; the best possible configuration was in place to meet the needs of the population.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

During the inspection we observed an example of dispatch staff coordinating a patient's care to bypass the nearest emergency department at the request of the patient. This was appropriately discussed and authorised to best meet the needs of the patient and their ongoing care.

Staff we spoke with told us they had access to an interpreting service. We were told that sometimes it was difficult to get an interpreter using this service if they were busy or a less common language was being requested. We were given an example of a time this happened; appropriate action was taken by EMD staff. It was raised as an incident and acknowledged by the translation service company who looked into the matter further.

There were systems to manage frequent callers to the ambulance service to make the best use of ambulance resources. Care plans were developed with input from the individual patient, their GP and other relevant community services.

Staff we spoke with gave an example of the frequent caller team liaising with a local district nursing team to increase a patient's visits from community nurses and reduce calls for an emergency ambulance response that would not be the best care for the patient.

Known patients who had speech difficulties were flagged with directions for staff when they called the EOC or when ambulance crews attended a call to ensure they received an ambulance response.

The EOC had mental health nurse provision on site. The mental health nurses were available to triage calls from mental health patients and could refer these patients to services other than ambulance response if this was more appropriate.

The EOC also had a process for mental health nurses to liaise with local out of hours GPs and the crisis team. The EOC had a standard operating procedure for a 3-way specialist triage between an onsite crew, EOC mental health nurse and local out of hours GP or crisis team. The purpose of this process was to support patient care, ensuring the patient received the right care first time, and

to reduce lengthy on scene times for crews. This also created capacity in the service for their increasing demand. Staff we spoke with in the EOC told us about this process and that it was currently being piloted.

(Source: Data Request EOC24)

Mental health nurses also provided telephone support to clinicians on scene for patients in a mental health emergency to implement care plans and give relevant clinical advice.

Clinical staff in the EOC had access to a directory of local services which they used to refer patients who did not need an emergency ambulance response. This meant patients received tailored support without using emergency ambulance resources that were not required.

The trust had a diversity and inclusion policy statement which outlined staff responsibilities that reinforced equality and diversity to staff, patients and partners and staff could articulate this.

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.

Dispatchers allocated ambulance resources according to the categories allocated by the prioritisation system. During the inspection we observed staff managing clinical stack in line with internal processes and procedures.

Staff we spoke with told us that the system generated a review time for patients who had been waiting for an ambulance response for longer than the recommended time frame and clinicians would contact these patients to complete a welfare check and check the patient's status. If the patient had deteriorated, or their condition had improved, clinicians would reassess the patients and recategorize the call appropriately.

The service had mental health nursing provision scheduled for 24 hours a day. This was being implemented into the service at the time of the inspection and when there was no mental health nursing cover on shift, the service had other mechanisms in place to meet the needs of patients with a mental health need.

The EOC had a regional operations centre (ROC) that had strategic overview of operational performance and any unexpected pressures on the service. The staff working in ROC we spoke with told us they proactively managed incidents until a command structure was established on the scene of a major incident. This allowed coordination of emergency services and of ambulance and EOC resources. The EOC escalated decisions about incidents directly to the ROC and out of hours, the ROC provided senior decision making and support to the EOC and other parts of the ambulance service.

Staff we spoke with told us a clinician was allocated to review category one calls and could re-triage them if it was appropriate to ensure the correct response was given to the patient using their clinical skills and judgement. Clinical managers told us that they also considered the next potential category one response required and how to manage the resources they had to divert to the potential critical patient.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff involved, however there was limited shared learning with staff in the wider EOC or organisation.

Staff we spoke with told us they received a risk bulletin by email on a quarterly basis which shared themes of learning from complaints.

We asked the trust to provide examples of shared learning from complaints and concerns in the EOC. We saw evidence of information sharing through a wall board presentation that was produced quarterly and reviewed the EOC quality measures. This included incidents in the EOC, learning from the investigation and positive feedback from patients and people who cared for them.

We also reviewed two EOC alerts sent to EOC staff. We saw evidence that there had been a change to processes from these documents. These documents did not give staff the level of information to understand changes in process were linked to complaints or concerns that had been raised and investigated by the trust.

(Source: Data request EOC6)

When a complaint was received about an EMD, patient outcome or ambulance response time, staff we spoke with told us relevant calls were audited and they received individual feedback.

When the audit team identified a theme or trend in errors by EMDs, staff told us they sent an audit newsletter to all staff to identify the issue. Staff we spoke with told us this communication did happen, but it was not as regular now as it had been.

During the inspection, we spoke with staff about learning from complaints and concerns. Generally, staff we spoke with were not aware of learning being as a result of complaints or concerns unless it related to their individual practice.

We did not see evidence of sharing wider learning across different staff groups. Staff told us they assumed changes in practice came from learning from complaints and concerns, but they were generally not given that level of detail when changes took place, unless it was learning from a serious incident.

Senior managers we spoke with told us that there were mechanisms in place to share learning, including the introduction of safety huddles and internal workshops and roadshows.

We were given examples of learning from complaints and concerns where a coding error was identified through a spike in serious incidents. Staff told us the safety team worked with staff, identified learning, retrained staff and took the example on a roadshow as a quality improvement study.

Summary of complaints

From March 2018 to February 2019 the trust received 195 complaints in relation to the emergency operations centre (19.7% of total complaints received by the trust)

Of the 195 complaints, 174 were closed at the time the trust submitted the RPIR. The trust took an average of 36 working days to close complaints.

The trust did not have a set target for completing complaints, instead they agree a completion date with each complainant.

A breakdown of complaints by subject is below:

Subject of complaint	Number of complaints	Percentage of total
Category 3	65	33.3%
Category 2	49	25.1%
Category 4	34	17.4%
Admission	16	8.2%
Telephone Manner	8	4.1%
Communications Skills	6	3.1%
Clinical Hub	6	3.1%
NHS111 Triage	5	2.6%
Category 1	4	2.1%
IHT	1	0.5%
Other	1	0.5%

(Source: Routine Provider Information Request (RPIR) – Complaints)

The trusts complaints policy detailed timescales for resolution of complaints ranging from 25 to 90 working days depending on the risk scoring and subsequent grading of the complaint.

(Source: Complaints, concerns, compliments and comments policy v61)

As part of this inspection we reviewed 4 recent complaint responses relating to the EOC. The responses were sufficiently detailed, responded to within the trust time frame, and where necessary, offered an apology.

(Source: Data Request EOC25)

Number of compliments made to the trust

From March 2018 to February 2019 there were 18 compliments collected by the trust about emergency operations centre.

(Source: Routine Provider Information Request (RPIR) – Compliments)

Is the service well-led?

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 leadership team of the EOC consisted of heads of service, sector commanders, service delivery managers, duty and clinical duty managers and team leaders.

There was dedicated and experienced leadership within the EOCs. Senior staff had often been part of the ambulance service for number of years and had worked in various roles before progressing into senior roles.

During the inspection we saw evidence of clear responsibilities, roles and systems of accountability within the EOC. Managers and supervisors were easily accessible, and staff were clear on who they were accountable to.

Managers of all levels working in the clinical hubs understood the challenges to good quality care and could identify actions required to address them. Managers told us about how they managed increasing call demand. Managers told us every day was unique and they had to be flexible with the resources and staff to ensure an efficient high-quality service.

We observed positive examples of leadership from EOC managers at all locations. Staff told us team leaders would support them during difficult or concerning calls if they requested this. However, some staff we spoke with said this was often reactive to them asking for support. Staff we spoke with said that EOC managers allowed them to take a welfare break following distressing calls when they requested it.

Senior managers we spoke with told us there were leadership development programmes being cascaded out across the service for staff in a managing role and was expected to be completed by 2019/20. They were also developing a pathway for aspirant progression into management for non-managerial staff. There were local development plans in place for management roles and frameworks that staff could work on to develop the competencies for these roles.

Staff we spoke with told us there was limited visibility of senior and executive leadership in the EOC.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The trust had a shared purpose, vision and strategy which was displayed clearly at the headquarters site.

The ‘One Team, Best Care’ strategy was launched in October 2018 and centred around six values and the following four ambitions that the trust aim to achieve by 2023:

- Patients and communities experience fully joined-up care response to their needs;
- Our people feel empowered, valued and engaged to perform at their best;

- Everything we do is of the highest quality, evidence based and achieves excellence; and
- We use our resources in the best way, so we can continue to invest in and sustain our front line services.

Staff we spoke with told us there were opportunities to visit each EOC site. There were more opportunities to learn and develop at the main EOC site in Wakefield because of the capacity of the team and organisation there; staff told us they were able to access these opportunities.

Managers we spoke with told us that the vision, values and strategy of the organisation were embedded with staff through their PDR and 121 conversations.

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.

During the inspection, we observed a positive working culture between staff in the EOC. Staff we spoke with told us their peers and colleagues were supportive and there was a positive culture of helping each other out. Newer staff told us that the mentorship they received during their training programme was valuable as the environment was supportive.

Some staff we spoke with had worked in the service for many years, and often staff progressed to other roles in the organisation, or internally in the EOC. The service had awarded three staff members 10 year service awards, and one staff member a 40 year service award in the fourth quarter of 2018.

Staff expressed that the patient was at the heart of everything they did, and we observed this in interactions between staff at all levels during the inspection.

The service had a staff recognition scheme. This included recognition for staff who were achieving the Accredited Centre of Excellence Standards across all audits within a 12 month period.

Between March 2018 and February 2019, 10 EMD staff received the Blue Heart Award (<10% partial or low compliances and <7% non-compliances in audit results) and two EMD staff received the Silver Background Blue Heart (all audits have no low or non-compliance ratings).

The service also gave recognition to staff that when compliments and commendations were received. In October to December 2018, 48 green heart recognitions were given to EOC staff, 27 from colleagues, 14 from the public and seven from other staff in the trust.

In October to December 2018, the EOC had also awarded 30 EOC staff the gold star for no sickness within a 12 month period.

(Source: Appendix 1 – Evidence for EOC)

Two EOC staff were shortlisted finalists for the dispatcher of the year national award 2019 held by the International Academies of Emergency Dispatch. There were 53 nominations from across the UK.

The EOC had an initiative called “welfare Wednesday” where staff who were off work for five days or more had a supportive contact call from a manager which was recorded in their electronic

management system. Staff we spoke with also told us there was an employee assist programme available to staff to support them.

Some staff we spoke with articulated a culture of “if your face fits” regarding development in the EOC, however other staff told us there were opportunities in both EOCs, and they gave examples of cross site promotion.

Managers we spoke with told us that after the EOC refurbishment in the Wakefield office, they would be more visible in the control room, however, due to the current building works, they were not able to situate themselves in the same room.

Governance

Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and managers had regular opportunities to meet, discuss and learn from the performance of the service.

Within the EOC, senior managers we spoke with could confidently describe the governance processes. The service had an information and performance team whose function was to check and manage data quality and a team whose remit covered EOC systems that provided assurance on systems and any issues.

Audits from these teams fed into a weekly senior management team meeting and senior managers attended monthly governance meetings where processes and changes were reviewed, and incidents and reviews were discussed. Information from these meetings fed into a clinical governance group which feedback to the relevant executive directors.

There was also a joint EOC and 111 clinical governance group attended by senior managers to where governance which was a strategic clinical group that fed into the overall clinical governance group to ensure information was shared and discussed in a multi-faceted way.

Managers in the EOC were developing a safety huddle that we observed during the inspection

Service level agreements (SLA) with third party organisations were managed externally to the EOC control room. Managers we spoke with in the EOC described sufficient knowledge of the limitations of these SLAs with other organisations, for example mountain rescue or voluntary ambulance services.

The trust had a secondary employment policy in place for any staff who had secondary employment or volunteer positions. We saw evidence that staff who had secondary employment were monitored and recorded by HR following authorisation by the head of service; we saw evidence that there was a low number of EOC staff that engaged in secondary employment.

(Source: Data Request EOC19)

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. However, there was limited risk awareness at middle manager level that was not day to day operational risk.

Senior managers we spoke with regularly reviewed the risks on the EOC risk register and participated in the trusts governance meetings to monitor them. When we spoke with managers in the EOC, they had awareness of operational risks that affected the day to day running of the service, but they evidenced little awareness of strategic risks affecting the EOC. Senior managers responsible for the EOC were aware of these risks and when we spoke with them, they evidenced understanding of the risks and mitigating actions

During the inspection, we saw evidence of incident planning in the ROC 'Gold Cell'. The plan identified command and control structures with defined roles for staff.

The EOC had business continuity plans in place with back up equipment that was regularly tested. The staff regularly tested the plans to ensure, in the event of a major system failure, they could continue to operate. Staff we spoke with told us they were able to continue to tweak the plans to make sure the most efficient and effective plan was in place following these trial runs.

Staff we spoke with gave us examples of risks identified in the service and mitigating actions that were taken to ensure patient safety.

The EOC managers had calls twice a day with the ROC to escalate concerns about resource and performance and this was dynamically assessed and responded to.

The trust had a relevant demand management plan and adverse weather guidance that was used to manage foreseeable risks to the service and operated using REAP to manage resource and capacity during high levels of contact.

(Source: Data Request EOC26)

We saw examples of major incident response plans being tested within the EOC and were assured that appropriate learning was taken from these exercises. We saw evidence that the service had planned different exercises and tests for 2018/19 and staff we spoke with told us they had been involved in these kinds of exercises.

(Source: Data Request EOC27)

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

During the inspection we found the appropriate information was effectively and accurately processed and managed using the trust CAD and triage system.

All levels of staff that we spoke with described and understanding of performance requirements attached to their role and staff had a good level of access to real time and historical performance reporting.

The demand management plan escalated in accordance with poor performance and helped the EOC to instigate additional processes to aid performance recovery.

The data warehouse was responsible for ensuring data used in reporting was accurate, valid and of good quality; this function sat outside of the EOC.

The service had a mental health performance dashboard which was shared with partners and stakeholders to identify areas of priority.

Engagement

Leaders and staff engaged with members of the public to improve public information about the services delivered by the EOC. We saw wider patient engagement and engagement with equality groups and local organisations to plan and manage services.

Engagement with staff

Staff we spoke with told us that the service had engaged them in the redesign and refurbishment of the EOC and staffside and unions were involved in this. Initial engagement was held at both EOC sites to give all staff the opportunity to have their voices heard.

There was a link person from the EOC who took feedback from staff to the working group, and staff had been consulted on the initial plans and the roll out of the refurbishment. Staff received weekly updates about the progress.

During the refurbishment, some ideas were trialled in the EOC and staff told us changes were made to plans after they gave constructive feedback to the project team.

There was limited engagement with staff who were on long term leave from the service about changes to the EOC, however staff told us these changes would be mentioned in ‘keeping in touch days’ held with these staff.

Staff had the opportunity to feedback on system issues that had become apparent in the York EOC. Managers told us they set up a mailbox to coordinate this feedback and that updates are sent to EOC staff from this mailbox.

The EOC conducted a shift mapping exercise where staff were given the opportunity to make flexible working requests to meet the needs of the service and to aide their work life balance. This was mapped across the centre and meant that the service could dynamically cover peaks and troughs in their demand while meeting staff needs. Managers told us these arrangements were due to be reviewed to make sure they still worked for the service and staff.

Engagement with the public

The trust had an annual programme of engagement with the public and have used this to address ringing the 999 service appropriately.

In August 2017, the trust conducted a 24 hour 'tweetathon' from the EOC in Wakefield. This was approaching a bank holiday weekend and was an opportunity to raise awareness of the work of the trust and to stress the importance of appropriate use of its services.

The trusts website had pages with information for members of the public which included what happens when they called 999 and situations where it was appropriate and not appropriate to call 999 for an emergency response.

(Source: Data Request EOC20)

The trust had a Critical Friends Network (CFN) made up of a range of people, patients and members of the public, from different backgrounds who provided input into their ongoing work. Members of this network were directly involved in the design and functionality of the trusts external website which was launched in August 2018; there was improved accessibility and intuitive navigation.

(Source: Routine Provider Information Request (RPIR) – P65)

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Staff told us about the bright ideas initiative and gave examples of submitting improvement ideas to be considered. Managers we spoke with told us that all ideas were considered and, even if an idea could not be implemented, staff received feedback about their ideas.

The trust had a quality improvement (QI) process and had supported staff in the EOC to become QI fellows. This was a rotating process where staff had been given the opportunity to spend time on developing and implementing QI initiatives into the workplace.

Staff gave examples of implementing changes using the QI process. A safety huddle process had been implemented and was being developed it to meet the needs of the EOC. Managers told us they had seen improvements and the huddles were valuable and were developing to include quality as well as performance.

The service was looking to add capacity to EMDs following cost saving in whole time equivalent posts by looking at how resources were allocated. The service had plans to introduce lower grade call handlers to take urgent calls so that EMDs were available for emergency calls. Managers we spoke with hoped the introduction of an apprentice scheme would aid this work. The service was still working through this during our inspection but were hopeful to implement a new working model by quarter three of 2019/20.

The main EOC site was undergoing refurbishment during the inspection. The refurbishment aimed to increase the capacity of the EOC and was due to be completed in the summer of 2019.

There was an ongoing functional redesign in the service. The project aims were to review and explore new methods of incident management and analyse future options, including changing the

dispatch zones to better meet demand and resource. The changes were to improve allocation time to incidents and response times to patients, increase workforce capacity and optimise resource management.

As part of the functional redesign and refurbishment of the EOC, the service has proposed a redesign of seating and teams within the EOC to match the new dispatch zones. Staff we spoke with during the inspection said they were not sure it would work very well, however they said they were still able to give feedback and the plans weren't finalised yet. The trust planned to trial and evaluate the functional redesign which would include staff feedback.

The EOC had an approved business case to increase their clinical hub staff membership by 30 clinicians. The implementation of this was ongoing at the time of inspection. This was to provide more appropriate care and treatment in the community to keep patients at home and provide improved clear sign posting and single access points to patients. The service was completing this work to transform the operating model to better meet the needs of the local community. They planned to integrate the clinical hub more with the 999 calls service to further improve hear and treat rates. We were not informed of the likely implementation dates for this service improvement.

There was an ongoing business case to increase the resilience of the frequent caller team and mental health nursing team by adding specific roles to manage complex callers. The service identified that some complex case patients required a higher level of resource, both front line and in the EOC, and this increase in specialist staff would better support the patient and their outcomes, provide an effective pathway for patients, improve local joint working and reduce pressure on front line responses by implementing clear individualised care plans. We were not informed of the likely implementation dates for this service improvement.

(Source: Data Request EOC28)