SSG UK Specialist Ambulance Service Ltd

SSG UK Specialist Ambulance Service - Corporate HQ

Quality Report

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

Ratings

Overall rating for this ambulance location	Inadequate
Emergency and urgent care services	**Inadequate**

Summary of findings

Letter from the Chief Inspector of Hospitals

SSG UK Specialist Ambulance Service Ltd – Corporate Headquarters is operated by SSG UK Specialist Ambulance Service Ltd. The service provides emergency and urgent services and some patient transport service. NHS Ambulance trusts commission 92% of services with the remaining 8% of services being commissioned by the police, prison service and independent healthcare providers. For the purposes of this inspection we focused on urgent and emergency services only as patient transport services made up less than 10% of activity.

We inspected this service using our comprehensive inspection methodology. We made an unannounced visit to the service's headquarters in Rainham on 8 and 9 May 2019. Another inspection team, from the CQC's South Central region visited the provider's location in Fareham, Hampshire on 15 and 16 May 2019. We previously inspected the service in November 2018. At that inspection, we identified significant concerns with the service. Following that inspection, we issued five warning notices requiring the service to take immediate action to address certain concerns. In addition, we told the service that there were other actions they should take to improve the service.

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

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

We found the following issues that the service provider needs to improve:

- The service did not have an effective process for sharing the learning from incidents. In addition, staff said they did not routinely receive feedback when reporting an incident.
- Although the service was in the process of updating all staff records, there remained gaps in records, meaning that that there was limited assurance that the relevant safety checks and mandatory training had been completed. As such, the service did not have sufficiently accurate records to provide assurance that there were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- It was concerning that staff were not aware that a vehicle had been decommissioned. With the exception of this vehicle, however, all of the vehicles we inspected were clean and clutter free.
- Whilst there had been some improvements in the management of medicines since our last inspection, there were still some issues. For example, some staff kept controlled drugs (Controlled Drugs)s in their home, but there was no clear policy as to which staff were eligible to do so. There was no permanent independent witness to the destruction of Controlled Drugs.
- There was limited evidence of clinical audit activity and the service did not have a planned annual audit programme.
- Staff had variable knowledge of their roles and responsibilities under the Mental Capacity Act. The service's 'capacity to consent' policy was out of date.
- There was a disconnect and a level of distrust between frontline staff and the management team at all levels. Whilst senior leaders told us they continued to work to build trust with frontline staff, there was little evidence of this. Staff continued to describe bullying and unprofessional behaviours from senior staff and there was a perception that promotions were not always made on merit.
- We were not assured of the integrity or validity of information presented to the board. This meant the board did not have a complete corporate understanding of the risks and challenges to service quality and sustainability.

Summary of findings

- Risks, issues and performance was not managed effectively. Whilst progress had been made towards addressing the concerns identified by the CQC in November 2018, this progress had been slow and had, in many areas, yet to have demonstrable impact.

However, we found the following areas of good practice:

- The service was now following the Duty of Candour (DoC) and staff were aware of their responsibilities under the DoC.
- There had been some improvements in the management of medicines. For example, the service now routinely monitored drug fridge temperatures.
- The service had suitable premises and equipment.
- The service was meeting the national standards expected under its NHS contracts in respect of response and turnaround times.
- Since our last inspection, all the service's policies had been updated in line with national guidance and best practice.
- The service had introduced a patient survey.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Inadequate 	We have rated safe and well led as inadequate. Effective and responsive were rated Requires Improvement. We received insufficient evidence to rate caring. Whilst there had been some improvements since the last inspection. However, there remained significant concerns.

SSG UK Specialist Ambulance Service - Corporate HQ

Detailed findings

Services we looked at
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Detailed findings

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Background to SSG UK Specialist Ambulance Service - Corporate HQ

SSG UK Specialist Ambulance Service Ltd – Corporate Headquarters is operated by SSG UK Specialist Ambulance Service Ltd. The service was registered with the CQC in July 2017. The service was previously registered with the CQC under a different name. It is an independent ambulance service in Rainham, Essex. The service provides emergency and urgent services and some patient transport service and 92% of services are commissioned by NHS ambulance trusts with the remaining 8% of services being commissioned by the police, prison service and independent healthcare providers.

The service has had a registered manager in post since August 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

The organisation is registered with the CQC to provide:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

The Rainham headquarters location was last inspected in November 2018. The CQC issued the provider with five warning notices, requirement notices and 'should do' actions following the inspection.

We carried out a comprehensive inspection of the Rainham Headquarters location on 8 and 9 May 2019.

During the inspection, we spoke with 18 staff including; registered paramedics, emergency care assistants (ECAs), ambulance care assistants (ACA), technicians, managers and service leadership. During our inspection, we reviewed staff and 12 patient records and looked at organisation policies, documents and management information.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a CQC inspector and two specialist advisors with expertise in urgent and emergency care. The inspection team was overseen by Terri Salt, Interim Head of Hospital Inspection.

Detailed findings

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Requires improvement	Not rated	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Not rated	Requires improvement	Inadequate	Inadequate

Emergency and urgent care services

Safe	Inadequate
Effective	Requires improvement
Caring	Not sufficient evidence to rate
Responsive	Requires improvement
Well-led	Inadequate
Overall	Inadequate

Information about the service

SSG UK Specialist Ambulance Service Ltd – Corporate Headquarters is an independent ambulance service in Rainham, Essex. The service is commissioned by NHS ambulance trusts and other services to provide services across east, south east and south central England. The main service provided by the service is urgent and emergency care, with patient transport service representing a small proportion of work.

The organisation is registered with the CQC to provide transport services, triage and medical advice provided remotely, and treatment of disease, disorder or injury.

The service employed paramedics, emergency care assistants and technicians and ambulance care assistants, amongst other support and management staff. The service had a combination of emergency response vehicles, patient transport and secure transport vehicles. The Rainham headquarters hosted the organisation's senior leadership team, all business and clinical support services and a team of fleet maintenance staff.

Summary of findings

We found the following issues that the service provider needs to improve:

- The service did not have an effective process for sharing the learning from incidents. In addition, staff said they did not routinely receive feedback when reporting an incident.
- Although the service was in the process of updating all staff records, there remained gaps in records, meaning that that there was limited assurance that the relevant safety checks and mandatory training had been completed. As such, the service did not have sufficiently accurate records to provide assurance that there were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Whilst there had been significant improvements in the management of medicines since our last inspection, there were still some issues. For example, some staff kept controlled drugs in their home, but there was no fixed criteria as to which staff were eligible to do so. Further, there was no permanent independent witness to the destruction of Controlled Drugs.

Emergency and urgent care services

- There was limited evidence of clinical audit activity and the service did not have a planned annual audit programme. The service did not routinely monitor information on patient outcomes to improve practice.
- Staff had variable knowledge of their roles and responsibilities under the Mental Capacity Act. The service capacity to consent policy was out of date.
- There was a disconnect and a level of distrust between frontline staff and the management team at all levels. Whilst senior leaders told us they continued to work to build trust with frontline staff, there was little evidence of this. Staff continued to describe bullying and unprofessional behaviours from senior staff and there was a perception that promotions were not always made on merit.
- We were not assured of the integrity or validity of information presented to the board. This meant the board did not have a complete corporate understanding of the risks and challenges to service quality and sustainability.
- Risks, issues and performance was not managed effectively. Whilst progress had been made towards addressing the concerns identified by the CQC in November 2018, this progress had been slow and had, in many areas, yet to have demonstrable impact.

However, we found the following areas of good practice:

- The service was now following the Duty of Candour (DoC) and staff were aware of their responsibilities under the DoC.
- There had been some improvements in the management of medicines. For example, the service now routinely monitored drug fridge temperatures.
- All the vehicles we inspected were clean and clutter free. However, it was concerning that staff were not aware that a vehicle had been decommissioned.
- The service had suitable premises and equipment.
- The service was meeting the national standards expected under its NHS contracts in respect of response and turnaround times.
- Since our last inspection, all the service's policies had been updated in line with national guidance and best practice.
- The service had introduced a patient survey.

Emergency and urgent care services

Are emergency and urgent care services safe?

Inadequate

Incidents

Learning from incidents was not formally shared with staff. Reports of incidents were not collated.

There was an internal incident reporting system. We had sight of four incident reporting forms, of which two were incomplete and had no record of learning arising from the incidents.

Staff told us that they did not receive feedback from incidents they reported and that learning from incidents was not shared. Following our inspection, we received a copy of the service's staff bulletin, which had been started by the service in March 2019. This included a section on incidents, it identified common types of incidents and reported that more analysis of incidents was taking place. However, it made no reference to the specific learning from any of the reported incidents.

The service did not have a learning review group or equivalent to identify learning from incidents and means of disseminating learning to change practices, for example updates to mandatory training or information bulletins. Themes from incidents were identified and discussed at governance meetings. We were provided with the minutes of the governance meeting for March 2019, which indicated that themes were discussed. The board meeting minutes from May 2019 indicated that themes were being drawn out and shared with the board.

In addition to reporting incidents internally, urgent and emergency care staff had access to the incident reporting systems of the NHS trust to which they were contracted. Senior managers received feedback on these incidents at meetings with the trusts. However, staff told us they did not receive feedback or learning from these incidents.

The service's incident reporting policy stated that staff should receive feedback on incidents they reported and that any learning arising from incidents reported both internally and externally should be shared with all relevant staff. Senior staff accepted, however, that there was no formal process for doing so and that, consequently, this did not always happen.

The policy also set out the process for staff to alert senior managers to serious incidents which occurred during a shift at the time that they occurred. Staff were meant to contact the head of operations. However, there was no out of hours or on-call cover for the head of operations, which meant that in reality, there were times when staff could not report serious incidents when they happened. We were told that there was a plan to introduce a formal on call rota. However, this had not progressed since the last inspection.

The service discharged its responsibilities under the Duty of Candour (DoC). Staff understood the DoC.

The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw evidence that the service had appropriately discharged this duty.

Mandatory training

The service was not able to provide accurate up-to-date records of mandatory training completion during our inspection.

At the time of our inspection, the service was unable to provide a complete or accurate record of mandatory training compliance. During the inspection, we were told that a spreadsheet was being completed to record the mandatory training completion for all staff as it then stood, in order to identify any gaps.

However, following our inspection, the service provided a completed spreadsheet, which listed all of the mandatory training modules completed or due to be completed by all staff. This list was not comprehensively presented sufficient to provide assurance that each staff member had completed the training required of them.

In addition, at the time of our inspection, the service did not have an up to date, accurate list of all staff working within the service. Many of the staff were contractors, which meant that it was difficult to be assured that they had completed mandatory training. Senior staff told us they mitigated against this by requiring staff to confirm they had

completed the relevant mandatory training required by the service for which they would be contracted before they could book on for a shift. As such, this did not constitute formal assurance.

Safeguarding

The service had up to date policies and processes for safeguarding and most staff understood how to protect patients from the risk of abuse and harm. However, we were not assured all staff had completed relevant mandatory safeguarding training.

We had sight of the safeguarding policies for both adults and children. This was up to date and in line with national guidance. Staff were aware of the policy and could access it via the intranet or in physical form at the stations. All the crew members we spoke with were aware of their safeguarding responsibilities.

The director of governance was the named lead for safeguarding and had completed level 4 safeguarding training. He told us that since the last inspection, two other senior staff had undertaken level 4 safeguarding training, to decrease the pressure on him and to ensure that there was always someone of that level of training available to staff. These staff members had a list of all the safeguarding leads and their contact details for the trusts and local authority areas within which the service worked.

Staff told us that were they to identify a safeguarding concern, they would seek advice and make the referral through the named individual at the trust for which they were working rather than within the service.

Paramedics were meant to complete level 3 safeguarding adults and children training. All other crew members were required to complete level 2 training as a minimum. However, incomplete staff training records (see mandatory training section for more information) did not provide assurance that all staff had completed the required level of training for their role, so we were not assured all crew members had the competency to recognise and report abuse.

Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children (July 2018) sets out the following training guideline: all clinical and non-clinical staff who have some degree of contact with children and young people must have Level 2 safeguarding children training, which is the minimum level required. At the time of our inspection the service was not able to demonstrate it was compliant with this national guideline.

Cleanliness, infection control and hygiene

The service could not provide assurance that staff had been appropriately trained in respect of infection prevention and control.

Staff were required to complete infection prevention and control training as part of their mandatory training. However, due to incomplete records, we were not assured that this had been completed.

The service had an up-to-date infection prevention and control policy which reflected national guidelines and best practice.

However, infection prevention and control was generally managed.

There was a large vehicle garage at the site. The area was clean, tidy and well organised. The floor was sealed, and a floor cleaning machine was available. We observed the floor being cleaned. A large door was open which provided good ventilation.

We inspected six vehicles. All were clean and visibly tidy. Crew members were required to check vehicles were clean at the start of each shift. Staff told us that vehicles were usually cleaned to the required standard. There was a team of 'make ready' staff responsible for ensuring vehicles were ready for use. There was a deep cleaning schedule with all vehicles being cleaned every six weeks. The make ready team maintained a schedule for these deep cleans. Records showed that deep cleans were undertaken every six weeks.

If a vehicle became heavily soiled during the shift it would be brought back to base to be deep cleaned to minimise the risk of cross infection.

There was personal protective equipment on all the vehicles including gloves and aprons to reduce the risk of the spread of infection between staff and patients. There were spills kits for crews to manage small spillages. Staff were bare below the elbow in the back of vehicles and when delivering care.

Hand hygiene gel was available in dispensers on all the vehicles. In addition, staff carried small hand gels on their belts.

Crew uniforms were visibly clean. There was a washing machine and dryer on site for staff to wash their uniforms. If uniforms became soiled during a shift, staff could return to base and access spare uniform items.

Environment and equipment

The service had suitable premises and equipment, which was safety checked and generally well maintained. However, during our inspection, there was a lack of clarity as to whether a vehicle was service ready, when it had in fact been decommissioned.

The garage area where vehicles were stored and maintained was spacious and tidy.

We checked six vehicles. Five of the vehicles we looked at were ready to go out and were well maintained and well stocked. All equipment was in date and appropriately stored.

All the vehicles we checked were fitted with defibrillators that were in date. Oxygen cylinders on each vehicle were secured and within their stated expiry dates. Scoop stretchers were within date of their next service

However, one of the vehicles we checked was not fully equipped and some of the equipment was out of date. We raised this with the senior team, who informed us that the vehicle was off the road and was awaiting stripping-down prior to sale. Staff in the garage had informed us that the vehicle was operational and had been made ready and there was no sign on the vehicle to indicate it was not in use. We were provided with evidence by senior staff to confirm that the vehicle had been decommissioned. However, it was concerning that staff in the garage had not been made aware of this and believed that the vehicle was operational, presenting a risk that the vehicle could have been used by a crew. After we raised it with the senior team, the vehicle was removed from the garage.

The service had effective processes in place for ensuring electrical equipment was safe.

There were effective processes to ensure electrical and mechanical equipment was safe. A review of service stickers on equipment showed they were checked and serviced annually. Clinical engineering servicing was provided for the service by an external provider. Each item of equipment was serviced and provided with a sticker that showed the date of the service and the date of the next service. A register of work was available from the clinical engineering servicing provider which provided a copy to the service.

There was a medical gas store within the garage area immediately adjacent to the entrance door. The cabinets were secure and complied with the requirements of the medical gas supplier.

Vehicle keys were stored safely in the control room.

Vehicles were serviced if the engine management light indicated a service requirement, but they were also inspected and serviced on a mileage and interval basis. We had sight of a spreadsheet which indicated when a vehicle was ready for inspection. The provider had recently developed an electronic system to record service dates and was in the process of inputting data from the spreadsheet at the time of our inspection. The spreadsheet also recorded whether vehicles had in-date certificates for motor insurance. We checked a sample of vehicle records and saw all were within date. This ensured the vehicles were roadworthy.

There was a mechanic and support mechanic on site to repair vehicles. Where vehicles could not be repaired on-site, they were taken to a nearby garage.

Assessing and responding to patient risk

There was no formal risk assessments within patient transport services. Crews were not always appropriately briefed as to the needs of the patient they would be transporting.

The managing director told us that there were no formal risk assessments within patient transport services. This was confirmed by patient transport crews. Crews told us that commissioning services usually informed them if there were specific risks relating to a patient they were transporting before they collected the patient, but this was an informal process and was not always the case. Some staff said that they had reported incidents when they had arrived to collect patients with specific risks which had not been identified in advance.

Emergency and urgent care services

The use of restrain within secure services was not appropriately recorded. Therefore, there was no evidence of risk assessments for the use of restraint.

The service was not able to confirm whether any patients had been handcuffed in the reporting period. The policy on the use of restrain stated that the use of handcuffs, the type used, the duration for which they were used and whether the patient had consented to their use should be recorded. However, the service accepted that such records were not always completed. We spoke with one patient transport crew who were attending a secure patient transfer. They told us they had not provided with a risk assessment. They were taking handcuffs with them in case they were required, but had not been trained in the use of restraint.

Urgent and emergency care crews completed clinical observations on patients, as part of their care and treatment, to assess for early signs of deterioration.

There was equipment on board each ambulance to measure and record electrocardiogram, oxygen saturations, blood pressure, temperature and blood sugar levels. Crew could then relay these readings to the clinical support desk of the trust for which they were working, allowing for additional support to be dispatched, and the relevant information passed to the hospital to which the patient was to be transported.

Staffing

The service accepted that it did not have accurate records of staff qualifications, training or experience. As such they could not be assured that staff had the right qualifications, skills, training and experience to keep people safe.

The service accepted that they did not have an accurate record of the total number of staff employed or contracting with the service and of their qualifications, training or experience. They were working to address this by inputting all the information they did hold on staff onto a spreadsheet. We had sight of the spreadsheet which had significant gaps. The senior leadership team told us that once the spreadsheet was completed, they would then chase staff for the outstanding data. This meant that, at the time of our inspection, staff were working in the service who may not have undergone the necessary pre-employment checks, including disclosure and barring service (DBS) checks.

The service did, however, conduct checks to ensure all paramedics working for the service were registered with the Health and Care Professions Council (HCPC). Initial checks were conducted on employment, with annual checks subsequently. An annual audit was conducted each September, to coincide with the HCPC's re-registration cycle which required re-registration every two years. Identified sanctions or conditions on practice were escalated to directors for consideration and action as appropriate.

The HR manager told us that all contracting staff who had not worked for more than three months were no longer being booked for shifts as the service could not be assured their skills were up to date.

All recently recruited staff had up to date DBS checks in place. Where a DBS check indicated that a staff member had a criminal record, this was risk assessed by the service. The risk assessment was then shared with the contracting trust in order for them to determine whether the individual was safe to work with their service.

The majority of staff were self-employed contractors. This meant the service lacked oversight over its staff.

10% of staff were employed directly by the service, with the remaining 90% being self-employed contractors. The service recognised this as one of their highest risks to providing consistent care. In spite of efforts to recruit directly employed staff, this situation had worsened since our last inspection.

The senior leadership team told us they were continuing to work to address this issue. They told us that they had received home office approval to recruit directly employed staff from overseas.

Vehicles were staffed by emergency care assistants, ambulance technicians and paramedics. Ambulance technicians and paramedics staffed rapid response cars. There was an agreed number of vehicles provided on each day of the week for commissioning NHS ambulance trusts.

An electronic system was used to plan shifts. Shortfalls in cover were shown on this system and staff could request to work additional shifts. Shift patterns were dependent on the needs of the commissioning NHS ambulance trust and regular shift patterns were not always possible. Crew members used an electronic shift booking system they used on their smartphones.

The service had introduced a reporting system to ensure that staff did not work excessive hours for the service. However, managers acknowledged that it was difficult to monitor or control staff working for other providers as it was individuals' responsibility to declare if they were working for other providers.

For patient transport journeys commissioners were able to request staff with a specific skill mix to undertake particular journeys.

Records

There were insufficient processes to ensure that patient records were completed and shared appropriately.

The service used a paper patient care record system. The patient care records (PCRs) were returned to a secure box on site at the end of each shift. Completed PCRs were scanned and sent to the commissioning NHS ambulance trust daily. Since April 2018 the service had conducted monthly audits of 10 PCRs to check they were completed properly. We were told that any gaps and non-compliance was fed back to the individual staff member. At our last inspection, we were concerned that there were no records to demonstrate that all staff would have their PCRs audited. At this inspection we had sight of a record of the audits and the email feedback provided to staff. However, there was no evidence that themes were drawn out of the audits, and general learning shared. For example, upon reviewing the audits, we identified that significant number of staff were not recording patients' religion or ethnicity. This had not been identified or addressed with staff in general.

Vehicles had secure storage areas for patient records. We saw that these were locked to ensure only authorised individuals could access the documentation.

The Director of Governance was the lead staff member responsible for information governance within the organisation and had completed relevant training to undertake this role in April 2019.

At our last inspection, the service's information sharing policy had expired. At this inspection, the service had an up-to-date policy.

Medicines

The storage and administration of Controlled Drugs was not secure.

The room used to store controlled drugs was accessed via swipe card and had CCTV both external to the room and internally. The controlled drugs safe was secured to the wall and floor and was accessed via a combination code lock that was changed monthly. Only specific staff had access to the main controlled drug safe, controlled drugs were decanted into a locked cupboard that paramedics accessed to obtain their controlled drugs at the start of the shift.

It was identified that a technician who supported the checking of controlled drugs was issued with the main controlled drug code safe number. There was no rationale why they were given this number as they were unable to administer these medicines and we were told would never have unsupervised access to these controlled drugs. At our request this code was changed immediately.

All out of date or waste controlled drugs were meant to be disposed of in a pot which contained a chemical to destroy the drug or were stored in the main controlled drug safe until they were disposed of. It is a legal requirement that controlled drugs should be disposed of in the presence of an independent, appropriately qualified witness. Senior managers told us that until recently, the destruction had been witnessed by a local police officer on an ad hoc basis, until such time as a permanent arrangement could be made. Whilst the prolonged storage of controlled drugs awaiting destruction was not best practice, the service had made interim steps to ensure that this was done in a safe, secure way, until such time as a more regular arrangement could be made.

We were told six members of staff currently still held controlled drugs at home, this was reported to be due to the distance from home to the place they booked on. These staff had stated that they were willing to be audited monthly. We had sight of the audits.

In addition, there was no policy as to the specific distance away that a staff member could live and be eligible to hold controlled drugs at home. These staff were allowed a max of 12 ampoules. We were told that when these staff were not working for a period of two weeks or more, they were expected to return the controlled drugs.

There was also a controlled drug safe which staff accessed at the start of their shift. Staff signed any unused controlled

drugs back into this safe at the end of their shift. Where a controlled drug had been administered or disposed of during the shift, staff recorded this in the controlled drug book, recording the patient record number so that the use of the drug could be traced.

We were told that the first paramedic who booked on each day was expected to check the controlled drugs in the safe and alert the manager of any discrepancies. There were also weekly audits and we noted most, although not all had been completed and signed by two members of staff. National guidelines require that the audits should be signed by two members of staff.

Each NHS contract had a different medicine bag; these were different styles and colours. When staff booked on at the start of their shift, they collected the bag for the trust they were working for that day. Full bags were tagged as green, used bags but still with enough stock were tagged as blue and those that needed restocking were tagged as red.

Staff booked out their medicine bag at the start of each shift and this information was held on a database which allowed each bag to be traced to an individual. Each bag had a contents list and any medicine used was documented on the list including the patient who had received the medicine.

The service monitored the temperature at which medicines were stored appropriately.

There was an electronic temperature recording tag in the control room, medicine cupboard and controlled drug safe that recorded the temperature every 7 minutes, we were told data was monitored daily and downloaded twice a week and that the tag flashed red if out of range. The temperature tags were recalibrated annually by the supplier but also reset every time the data was downloaded.

Rooms used to store medicines and intravenous (IV) fluids were all locked with restricted access. There was a log of all medicines held and their quantity, stock levels were monitored daily. The only IV fluids kept were glucose 10% and sodium chloride. All bags were in date and stored off the floor in a locked room.

In March 2019, the service had introduced as system for the service to receive and act on medicine alerts. Following our inspection, we were provided with a copy of the log of actions taken in accordance with medicine alerts.

Are emergency and urgent care services effective?

Requires improvement

Evidence-based care and treatment

The service had suitable up-to-date policies and processes based on national guidelines and best practice.

All the service's policies and procedures had been updated in-line with national guidance. In addition, staff working under NHS contracts had access to the policies and procedures of the commissioning trust, which they were required to follow as part of the commissioning contract.

Staff could access the policies via the intranet and by a remote application.

Crew members were provided with clinical and procedural updates via the shift booking computer system. Staff were required to acknowledge they had read the updates, or they could not book shifts with the commissioning NHS ambulance trusts.

There was limited evidence that the service carried out audit activities to ensure policies were followed.

There was limited evidence of clinical audit activity and the service did not have a planned annual audit programme. Instead ad hoc and sample audits took place, such as local infection and prevention and control audits, and audits of patient care records by clinical governance managers. There was limited recorded evidence of learning or changes to practice from the audits that were carried out.

Staff followed the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. Staff on ambulance vehicles carried the JRCALC guidance and they told us they referred to it in their assessment and documentation of patient care.

Staff who undertook secure transfers of mental health patients were required to follow the commissioning NHS trust's guidelines for transferring patients who were under section. However, there was no assurance that this was done due to the poor documentation of the use of secure transfer.

Emergency and urgent care services

Pain relief

Patients' pain relief needs were assessed and addressed appropriately.

Pain scoring and pain relief administration took place in a timely manner. Staff asked patients to rate their pain on a numerical basis, ranging from zero to ten. This was then recorded on the Patient Record Forms (PRF). We checked 10 PRFs. All included pain scores and accurate records of pain relief administered.

Response times

The service responded to calls in a timely way.

During our inspection, we were provided with evidence from meetings with commissioning providers, which indicated that the service responded to calls in a timely way and met national standards.

Patient outcomes

The service was not able to collect or monitor information such as the number of patients seen, response times or performance against clinical quality measures as this data was held by the commissioning NHS ambulance trusts.

The service relied on commissioning NHS ambulance trusts to monitor response times for work undertaken as part of their contract management. Performance data were shared with the service at regular meetings.

However, patient care and treatment outcomes such as those of cardiac arrests were not routinely monitored or audited to improve practices. Staff were unclear what, if any, data was downloaded from the defibrillator and sent to the commissioning NHS ambulance trust and could not confirm if the data were included in the commissioning trusts national return. No feedback was provided to staff to improve patient outcomes.

Competent staff

There were inconsistent arrangements to ensure all staff were supported to develop the necessary skills and competencies for their roles.

The service was in the process of consolidating the HR and training records for each member of staff. However, there were significant gaps in the training records of several staff members. It was not clear whether this was because staff had not completed the training, or that accurate records had not been kept. Senior staff told us that once they had consolidated and collated all staff files, they would then work through them to ensure that all staff had received adequate training.

The majority (90%) of staff were employed on a bank basis, meaning that they worked shifts as and when they were able to do so. To ensure that staff's knowledge and skills remained up to date, the service had introduced a rule that staff must work at least one shift within three months, to remain actively registered on the bank. Self-employed staff were not paid for attending mandatory or additional training.

At our previous inspection, we found that self-employed staff had not received a yearly appraisal. At this inspection, we saw evidence that all staff had received an appraisal. However, staff told us that this was not always meaningful.

The provider checked all staff against the Driver and Vehicle Licensing Agency database for driving offences on an annual basis to ensure they were fit and qualified to drive. If checks identified any issues such as driver disqualification, the individual would be removed from driving responsibilities. The HR manager told us that, where possible, such staff would be re-deployed in a role that did not require driving.

There was an inconsistent approach to driving re-assessment. Some staff completed blue light training updates while other staff were reassessed every three years. The provider undertook some driving assessments as part of the recruitment process. However, this was not done consistently for all the staff employed and re-assessments were undertaken only for those individuals involved in road traffic incidents. The service had an in-house driving school.

All new staff who did not hold a blue light qualification undertook a four week 'blue light' training course, which they were expected to self-fund. If new staff already held a blue light driving qualification their driving was only assessed as part of the recruitment process if the recruiting manager requested it. At our last inspection, we found that there were no criteria to inform the recruiting manager which individuals would be required to complete the assessment. At this inspection, specific criteria had been introduced as part of job descriptions.

Emergency and urgent care services

The service had several staff who were working towards or had achieved the First Response Emergency Care (FREC) qualification at levels 3 and 4. This is a nationally recognised qualification for staff working in emergency ambulance services. The qualification provided staff with the skills to deal with pre-hospital emergencies such as life support, maintaining safe airways and recognising sepsis. Self-employed staff working for this service were expected to self-fund their training course.

Multi-disciplinary working

Staff working for the service told us that they worked with other healthcare professionals appropriately.

Frontline staff told us they had good working relationships with staff in commissioning NHS ambulance trusts and in the hospitals they relayed patients to. They felt supported and could contact them for support and advice.

The senior leadership team told us that, overall, they had a positive working relationship with commissioning trusts. They told us that they were taking an increasingly proactive role in the trusts' investigation of incidents relating to SSG staff. However, there was a lack of evidence of learning from incidents investigated by the trusts having been shared with staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service had suitable policies and processes to ensure staff could effectively care for patients who lacked capacity to make decisions about their care. However, as training records were not accurate, the service could not be assured that staff understood the policies or processes.

Among the staff we spoke with there was variable knowledge and understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 (MCA).

Some staff had limited knowledge of the MCA or deprivation of liberty safeguards. This meant that patients' individual needs may not be met and the fundamentals of best interest principles and decisions may not be understood and applied.

The service had an up to date policy on capacity to consent which included the key principles of the MCA. The policy outlined the responsibilities of staff when transferring patients who lacked capacity to make informed decisions for consent. This included reference to Deprivation of Liberty Safeguards (DoLS). These safeguards were introduced to ensure that people receive treatment without infringing on their liberty.

Are emergency and urgent care services caring?

Not sufficient evidence to rate

We have not rated Caring because as we did not have enough evidence to rate it. However, we spoke with staff about the principles and practice of caring for patients and we did undertake a ride-out with a patient transport crew, and observe one care interaction.

Compassionate care

Staff spoke with compassion about patients. They told us that patient wellbeing was their primary focus and described working to meeting the needs of individual patients. For example, we saw evidence that staff had encouraged the relatives of patients living with dementia to accompany them on journeys, to help the patient feel at ease.

We observed a positive, caring interaction with a patient undertaking a journey.

Emotional support

Staff members spoke about taking time to support and reduce anxieties of both patients and relatives at difficult times in people's lives.

Understanding and involvement of patients and those close to them

Staff described various ways they involved family members and carers and giving them clear explanation of their actions.

At our last inspection, we did not find any literature or guidance materials for staff to guide patients towards other sources of support or help them manage their own health. At this inspection, however, we saw examples of such leaflets in staff areas and on some vehicles.

Emergency and urgent care services

At our last inspection, the provider did not carry out patient surveys so feedback from patients was not available. At this inspection, however, the service had introduced a patient survey, although we were not provided with the results of this.

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

Requires improvement

Service delivery to meet the needs of local people

The service provided emergency and patient transport services in partnership with commissioning NHS ambulance trusts to support capacity with additional vehicles and staff. The service was planned and managed according to the needs of commissioning partners.

The service was commissioned mainly by three NHS ambulance trusts to provide additional capacity and support to help meet local demand for urgent and emergency care. There were more than 90 vehicles used per day across these three trusts. The work was evenly balanced across the three main providers, with approximately 90 per cent urgent and emergency care and 10 per cent patient transport services.

Referrals were sent to the call centre via the commissioning trusts and allocated to crews depending on priority by the call handling team. Details of the journey requirements, including destination, time, date and patient details were included on booking forms which were shared with crews.

Crews were allocated on a daily basis in accordance with the needs of the commissioning provider.

The service operated 24 hours a day, seven days a week and a duty roster was developed in advance to ensure the service had sufficient numbers of staff available to work. Line managers were available out of hours and at weekends to provide support and advice to staff. However, this support was via an informal agreement as there was no manager on call rota for out of hours support. This issue remained from our last inspection.

There were routine contract monitoring meetings with commissioning NHS ambulance trusts, with different levels of oversight. For example, monthly operational reviews were attended by the relevant station manager to review performance and quality data such as mobilisation, discharge, time at hospitals, complaints and booking on times. We had sight of the minutes from these meetings and saw evidence that the service was performing in line with agreed standards.

Meeting people's individual needs

Crew members understood their responsibilities to recognise and respect individual needs, but there were insufficient arrangements to ensure patients with specific needs were consistently supported.

Staff could describe situations where they made adjustments during the course of their work to better support patients, as well as the principles of patient-centred care and respecting individual needs and wishes. For example, we saw evidence that staff had encouraged the relatives of patients living with dementia to accompany them on journeys, to help the patient feel at ease.

Ambulance care assistants (ACAs) employed to service's secure transport contract told us the service transported patients with a range of mental health conditions, including patients who are detained under section of the Mental Health Act. Staff told us they usually received sufficient information prior to the journey to ensure they were aware of patients' specific needs while in transport.

At our last inspection, we noted that there were no specific in-house tools available to support patients whose first language was not English or those with communication support needs. However, at this inspection we observed signs in the vehicles in multiple languages. In addition, staff had access to a telephone translation service through the commissioning trusts. Senior staff told us that they were introducing a communication tool for patients who had difficulty communicating. However, these had not yet been installed on the vehicles.

Staff told us that were they to require advice or assistance in supporting patients in mental health crisis, they would contact the commissioning trust's mental health team.

Vehicle cells for secure transport were designed to reduce the risk of self-harm. Senior staff told us that all mental health patient bookings were discussed with the duty manager prior to staff undertaking them to ensure the safe

and effective transfer of the patient. However, we spoke with one crew who were attending a secure transport service job, who were not part of the secure transport team and had not discussed the patient with management prior to being dispatched.

There was a range of equipment on each vehicle, to support the individual needs of different patient groups, for example different sized splints and supports and specialist equipment for moving bariatric patients.

Secure patient transport was provided to mental health patients requiring transfer between hospitals as well as conveying patients to hospital who were newly sectioned under the Mental Health Act 1983. This work was on a needs basis, and therefore there were no planned shifts for secure transfer. At our last inspection, there was no service level agreement with the trust who commissioned the secure transport journeys. As such there was no trust oversight of the contract to ensure care was being delivered to the agreed standards. This continued to be the case. Senior staff told us that the service undertook very few secure transport journeys.

Access and flow

The service met performance targets and there were processes to ensure crews responded to calls in a timely way.

Commissioning NHS ambulance trusts monitored all response, on scene and turnaround times. Response times for emergency transport were measured by 'time on scene' and 'time at hospital'.

The service worked to key performance indicators (KPI) specified in the service level agreements with each of the providers by whom they were commissioned. The primary KPI was the number of crews provided against the number requested. There was a target to provide 95% of requested crews. Minutes of meetings with commissioners indicated that the service was generally meeting this target.

The service provided 'queue' support when the local NHS emergency department was under severe capacity pressure, monitoring patients who had been triaged but were awaiting admission.

All vehicles were fitted with emergency ambulance/A&E software on mobile data terminals and connected to the NHS Patient Administration System (PAS). For continuity and consistency, the service used the same software system as the contracted NHS trust.

Vehicles were fitted with the NHS Airwave radio system to ensure effective communication with the ambulance contract provider.

Learning from complaints and concerns

There was no evidence of a suitable system for handling, managing and monitoring complaints and concerns.

There was no formal process to identify themes of patient complaint and concerns. Whilst the service recorded complaints as they were received, there was no process in place for reviewing this system. This was a concern which we had highlighted at our previous inspection.

Since the last inspection, the service had started to investigate some complaints. However, there was no formal process to share the learning from complaints and concerns with staff.

In addition, we were told that the service sought feedback from the NHS providers' investigations of complaints relating to SSG patients. However, there was no formal process for sharing the learning from these complaints.

There was a poster on each of the vehicles we checked setting out how patients could raise a concern.

Are emergency and urgent care services well-led?

Inadequate 

Leadership of service

Leaders did not have the necessary capacity or capability to lead and develop the service, although there were steps in place to address this.

We were provided with a copy of the proposed leadership structure, which had been approved by the board shortly prior to our inspection. The service was in the process of

recruiting to a number of new roles which had been introduced, however, the majority of these remained vacant. Those who had been appointed had yet to start working within the service.

Since our last inspection, the service had introduced a critical change programme. This was a team of existing and newly appointed staff responsible for driving changes in the service arising out of the concerns identified during our previous inspection. We had sight of the change plan provided by the critical change team. This included a timeline of actions to address the concerns identified. However, the service had been slow to respond to the concerns. Frontline staff told us that they had not been consulted or involved in the critical change programme in any meaningful way. They told us that the critical change team were not visible within the organisation and did not understand the practicalities of the changes they sought to introduce. Following the inspection, however, we were told that four crew members were part of the critical change programme and were provided evidence of this in the minutes of meetings. In addition, the critical change team told us that there had been some consultation with staff, but that this had only included senior and managerial staff, and not frontline staff.

The service had appointed a new managing director. The managing director had experience of working in the independent ambulance sector. The managing director recognised that there had been and remained significant concerns within the service. He recognised that the senior leadership needed to obtain the trust of the frontline staff. Some staff told us that they had confidence in the new managing director, but that they lacked confidence in the leadership overall. The critical change plan had been written and approved by the board prior to the managing director starting at the service. This meant that he had not been involved in some of the changes which had already been made, and that the service continued to be in a state of instability.

The finance director remained the Nominated Individual for the services. The Nominated Individual is the main point of contact with the Care Quality Commission (CQC) and has overall responsibility for supervising the management of the regulated activity and ensuring the quality of the services provided. The directors of finance and human resources did not have previous experience of leading ambulance services. However, they did have NHS experience during which they had worked in acute settings and therefore had worked alongside ambulance providers. We were told that all the senior leadership team, a number of staff representatives, the clinical governance and training teams as well as the clinical governance supervisors and operational leads had undergone externally provided "CQC compliance training". This was not affiliated with the CQC.

At our previous inspection, the director of governance held several organisation-wide responsibilities, such as health and safety, Controlled Drugs Accountable Officer, training and development, safeguarding, Caldicott Guardian and anti-money laundering (in other organisations such roles may be more distributed amongst the leadership team or delegated to managers). At that inspection, we identified that they had not received appropriate training, development or resources to support them in their role.

At this inspection, the director of governance told us that some of his duties had been passed to other directors and that he was receiving increased support in meeting the responsibilities that remained. They had received training in Caldicot guardianship in April 2019 and told us that there were plans for them to undertake additional training. In addition, two staff members had been trained to Level 4 Safeguarding for adults and children, to reduce his workload in respect of safeguarding referrals. The director of governance told us that they received extensive support from the managing director, with whom he had weekly one-to-one meetings.

Whilst progress had been slow, the service had made a number of changes to its leadership since the last inspection. The service had begun to develop its own leaders to provide appropriate oversight. In addition, it was beginning to develop its own appropriate governance systems, although these were not fully embedded at the time of our inspection. At the time of the inspection, the service continued to look to the commissioning trusts for leadership and governance support, however, this was becoming less common as it continued to develop.

At the time of our previous inspection in November 2018, we were told that the service planned to introduce a leadership development programme. At this inspection, we were told that several managers were undergoing the programme. Director level staff had not received equivalent training.

Vision and strategy for this service

The organisational vision and strategy had been redeveloped to reflect new priorities for the service. This had not been developed in consultation with staff and had not been adequately shared and embedded.

At the time of our previous inspection, a new vision and values statement had been introduced at the service. Staff had attended values workshops to help embed the values. However, frontline staff that we spoke with told us that they did not feel that the values had been discussed with them when they were developed. Not all staff were aware of the vision and values for the service.

There was a strategy in place to address the concerns identified by the CQC at the previous inspection. Whilst staff were aware of this strategy, they were not aware of its implications and, in particular, its implications for them. They told us that communication around longer term strategies was extremely poor.

Culture within the service

We identified several concerns with the organisational culture within the service including reports of unprofessional behaviours and favouritism when promoting staff.

At our previous inspection, we found a disconnect between the leadership team and frontline staff. At this inspection, some senior leaders told us there were legacy issues from the previous leadership of the service and they described a previous culture of a hierarchical management style and an abrasive and aggressive management which still resonated in some parts of the service.

Staff told us, however, that this hierarchical management style and abrasive and aggressive management continued. In particular, staff expressed concern that there was a legacy of nepotism within the organisation and that this would be reflected and continued through the change programme, with staff being moved and having their responsibilities changed according to favour rather than skillset.

Staff expressed concern that the human resources team were there to support senior staff and that HR practices and the handling of grievances were not fair or transparent. The service had recently introduced a Freedom to speak up guardian, to whom staff could raise confidential concerns and seek advice before submitting a formal grievance. However, the Freedom to speak up guardian was also the director of HR, meaning that the role lacked independence.

The director of HR recognised that there remained a culture of bullying and harassment in the service. She had also been appointed a bullying and harassment champion, to help address this issue. She told us that there was due to be a bullying and harassment champion appointed from the front-line staff. However, this had not happened at the time of the inspection.

During our inspection, staff told us about various incidents of unprofessional behaviours at all levels, including physical violence which they did not feel had been dealt with appropriately. We were able to corroborate this through HR investigation records. Staff told us that there was camaraderie among road staff, but that as well as pockets of unprofessional behaviour and bullying, they had little or no positive interaction with the senior team.

The new managing director told us that to address this he intended to go on ride-outs with crews. However, he had not yet done so since his appointment.

Frontline staff recognised the need for change within the organisation. They told us, however, that they felt that the change process was being poorly handled, in particular in terms of the communication of change to them.

A number of staff told us that they did not feel valued by the service. For example, staff expressed disappointment that they were expected to purchase new uniforms, following a change to the uniform policy, when they had already purchased their original uniforms.

Governance

Governance processes were being redeveloped, but we were not assured of the validity and accuracy of governance information as there were insufficient processes to collect data or record actions.

At the time of our last inspection, the service had redeveloped its governance structures and was beginning to embed the structure. However, following the significant concerns highlighted at that inspection, the manging director had devised a new governance structure, which was shared with us. This new structure had received

sign-off from the board. However, it was not operational at the time of the inspection, with numerous posts still to be recruited to, and senior staff requiring training and time to get to know their new areas of responsibility.

At the time of our inspection, there were monthly board meetings attended by executive and non-executive directors. A formal board report was prepared by the Director of Operations each month. However, given the omissions in the staff records and training records, the report could not be reliable..

Whilst the provider did carry out audits on areas such as documentation, infection control or staff competency and performance of their roles, these were not performed routinely, to a timetable. The provider had recently introduced processes for reviewing specific standards such as the cleanliness of vehicles and handwashing observations. Outcomes of audits were shared with staff, and individual areas for improvement were identified to the staff members, however, there was no evidence of thematic learning from audit results.

At the time of our inspection, there was limited formal governance around staff roles and scope of practice. However, the service did have new job descriptions for each role which were due to be introduced.

Management of risk, issues and performance

Risks, issues and performance were not effectively managed because there were ineffective systems to monitor the quality or safety of the service provided.

Performance and quality data relating to compliance with policies and procedures were not fully developed. This meant that key risks to performance were not identified or formally monitored.

Senior leaders were able to identify key risks to service delivery. However, they were not always expedient in mitigating those risks. Following our November 2018 inspection, the service had drafted an action plan to address each of the concerns identified at that inspection. At this inspection, however, a significant number of those concerns continued. Some members of the leadership team acknowledged that they had not been as quick as they could have been in addressing the concerns identified. However, they spoke of the difficultly of the task of “turning the organisation round” and bringing staff with them.

The service risk register was presented to and reviewed by the board each month. The service used a RAG rating model to categorise risks according to severity and impact. The most serious risks (rated red) were escalated to the board. At our last inspection, we found that some board members did not speak English as a first language which presented issues with the informal translation provided to the board in accurately presenting risks. At this inspection, we were told that the board had been re-constructed to ensure that all board members involved directly in decision making in respect of the provider’s UK operations had an adequate understanding of English.

The risks recorded on the risk register reflected those identified at both the November 2018 inspection and this one. Further, senior staff were aware of the risks that were on the register. In addition, there were plans in place to address these risks. However, the plans were largely at a “planning” stage and there had been little concrete action to mitigate the concerns.

Information Management

There were limited formalised processes in place for managing information and information was not effectively disseminated to staff.

At our last inspection the service was in the process of introducing a new information management system that would support a more effective governance system. At this inspection, however, the service was still in the process of introducing these systems. As such, there had been little progress in developing a formalised system of information sharing with staff.

However, there had been some improvement since our last inspection in the recording and storage of minutes of meetings that took place since November 2018.

We could not be confident that the monthly reports presented to the board were accurate, given that some organisational data, for example staffing and training records were incomplete and possibly inaccurate.

There was an identified Caldicott Guardian, this is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. Some of the staff we spoke with were aware of this role, the named individual and how to access support.

Public and staff engagement

Emergency and urgent care services

Leaders of the service had taken some steps to improve engagement with staff working for the service, including surveys, newsletters and workshops with service leaders. However, there was limited evidence that the service actively sought patients' views to improve the service provision.

There was a staff newsletter to provide staff with organisational news and updates. It included thank you notices from directors, training courses, shift availability, contract news, recruitment updates and messages relating to social matters like staff birthdays and family news.

At the time of our last inspection, the director of human resources had commenced a programme of consultations, surveys and change management to engage staff in organisational changes. At the time of this inspection, the consultations had taken place and the decisions arising from them were being ratified by the board. Staff told us, however, that whilst their views had been sought, this was only after the decisions had been made. Furthermore, they felt that they had not been listened to within the consultations, and that they had been too late in the process and lacked rigour.

Some senior leaders recognised the need to build trust between leaders and frontline staff, and particularly with self-employed crew members. However, a number of senior leaders appeared to blame the staff themselves for their unwillingness to embrace change, whilst the staff were suspicious as to the motive for and nature of the changes management sought to bring about. All the senior staff recognised the difficulty of affecting change in an organisation in which 90% of frontline staff were self-employed contractors.

We did, however, see evidence that the ride-outs instigated following the temporary workforce questionnaires completed in 2018 continued. However, the new managing director had yet to undertake a ride-out.

There was an up-to-date whistleblowing policy.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Continue to address the concerns identified in the November 2018 report and make concrete progress in putting into place the actions it told CQC it would take.
- The provider must ensure the safe storage of controlled medication in line with national guidelines.
- The provider must ensure recruitment processes are followed and records of all necessary checks are completed prior to employment.
- The provider must take action to ensure that staff concerns around bullying and unprofessional behaviours from senior staff are addressed, as well as the perception that promotions were not always made on merit.
- The provider must ensure all members of staff holding management or leadership positions have the necessary skills, experience and knowledge to undertake their roles.

Action the hospital SHOULD take to improve

- Ensure that learning from incidents, complaints and concerns are shared with staff across the organisation;
- Ensure that records for all staff are accurate, complete and up-to-date. Where there are gaps, the service should take immediate action to address these;
- Share management information, for example the minutes of meetings with staff. Ensure that staff are kept informed about changes in the organisation and that their views and expertise are sought prior to decision-making;
- Ensure that all staff have a meaningful annual appraisal, and ensure greater engagement with self-employed workers;
- Ensure sufficient staff understanding of the Mental Capacity Act;
- Continue to identify learning and development needs of local leaders, including directors, to ensure all leaders have the necessary skills, knowledge, experience, capacity and support to lead and develop the service.
- Investigate and address staff concerns relating to organisational culture and professional behaviours within the service.
- Ensure all management information presented to the board is accurate, validated and presented in a way that enables the clear identification of risks and concerns.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The registered person must ensure that medicines are stored in line with guidelines. Regulation 12 (1)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.There was limited management oversight around risk management and its impact on the service provided. The governance processes had not been fully developed to support current practices. Regulation 17(2)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider must ensure that recruitment procedures are established and operated effectively to safeguard patients using the service. Regulation 19(2)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...