SSG UK Specialist Ambulance Service Ltd

SSG UK Specialist Ambulance Service - South

Quality Report

J Ten Trade Park
Wickham Road
Fareham, Hants
PO16 7FF
Tel: 01329225040
Website: www.uksas.net

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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
Patient transport services (PTS)	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

SSG UK Ambulance – South is operated by SSG UKSAS. The service provides emergency and urgent services and some patient transport service and all services are commissioned by NHS trusts.

We carried out a responsive review of the service to follow up on some concerns we had received relating to medicines, staffing, overall management of the service and one of the provider's ambulances being involved in a road traffic collision (RTC). This RTC is subject to a Police investigation and as a result this inspection did not examine the circumstances of the incident.

We carried out the unannounced part of the inspection on 23 August 2018 along with another unannounced inspection to the provider's headquarters on 04 September 2018.

The service had a combination of patient transport, emergency response ambulances and five secure vehicles. The secure vehicles were used for the transport of mental health patients, these vehicles all had a secure area or cell.

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:

- Medicines were not managed safely and securely which may impact on the safety of patients. This included receipt, storage and disposal of controlled medicines.
- There was no evidence that paramedics and technicians had completed the appropriate training and competency to administer medicines safely.
- The administration of medicines via patient group directions was not effectively managed which posed risks to patients' safety.
- Incidents which affected the health and welfare of patients were not reported in line with the Care Quality Commission's requirement as part of the provider's registration.
- The staff who undertook the transfer of mental health patients did not follow national practice guidance and risk assessments were not completed. We were not assured that patients were adequately safeguarded from the risks of harm.
- The use of mechanical restraints had not been risk assessed and procedures for their usage were not fully developed to ensure the least restrictive means were used on potentially very vulnerable patients.
- The recruitment process did not ensure only suitable individuals were employed. Records of checks and fitness of staff were not available or incomplete.
- There was a lack of an effective system to review fit and proper persons being employed. Pre- employment checks for directors were not all available to assess the fitness of the directors.
- Not all staff had completed training appropriate to their role. Training such as practical intermediate life support, medicines management and safeguarding children had not been completed by all staff.
- There was no competency framework to provide assurance that staff were competent to undertake their role in line with best practice.

Summary of findings

- There were limited clinical policies and guidelines to support staff and provide evidence based care and treatment. Those policies and guidelines that were in place included out of date information, referred to roles that were not in place.
- There was no effective incident reporting system and process in place and limited evidence of learning from incidents to improve practices and minimise the risks of these re-occurring.
- There was an ineffective governance process that did not provide assurance and leadership.
- There were limited systems to monitor the safety and quality of the service. Audits were not undertaken and therefore learning did not take place from the review of practices and procedures.

However, we also found the following areas of good practice-

- There was a process that was followed to ensure vehicles were serviced regularly and they were roadworthy.

The service was rated as inadequate overall. I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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

We also issued the provider with two Warning Notices and four requirement notices that affected SSG UK Ambulance – South. Details are at the end of the report.

Nigel Acheson

Deputy 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 	At the factual accuracy stage, the provider told us that urgent and emergency services were the main service provided. These were carried out under contract with NHS ambulance trusts. We have rated safe, effective and well led as inadequate. Responsive is rated as requires improvement. The caring section has not been rated, as we do not have enough information to rate this section. There were no patients receiving care during the inspection. We were unable to observe care and speak to patients.
Patient transport services (PTS)	Inadequate 	Patient transport services were a small proportion of activity provided. The main service was urgent and emergency services. Where services were the same we have reported this in the urgent and emergency care section. We have rated safe, effective and well led as inadequate. Responsive is rated as requires improvement. The caring section has not been rated, as we do not have enough information to rate this section. There were no patients receiving care during the inspection. We were unable to observe care and speak to patients.

Inadequate

SSG UK Specialist Ambulance Service - South

Detailed findings

Services we looked at
During this inspection we looked at Urgent and emergency services which was the main service provided and patient transport.

Detailed findings

Contents

Background to SSG UK Specialist Ambulance Service - South

SSG UK Ambulance – South is operated by SSG UKSAS. The service provides emergency and urgent services and some patient transport service and all services are commissioned by NHS trusts.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, another CQC inspector, and a specialist advisor with expertise in emergency and non-emergency patient transport services. The inspection team was overseen by Helen Rawlings, Head of Hospital Inspection.

How we carried out this inspection

We carried out a responsive review of the service to follow up on some concerns we had received relating to medicines, staffing, overall management of the service and one of the provider's ambulances being involved in a road traffic collision (RTC). This RTC is subject to a Police investigation and as a result this inspection did not examine the circumstances of the incident.

We carried out the unannounced part of the inspection on 23 August 2018 along with another unannounced inspection to the provider's headquarters on 04 September 2018.

The service had a combination of patient transport, emergency response ambulances and five secure vehicles. The secure vehicles were used for the transport of mental health patients, these vehicles all had a secure area or cell.

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?

Are services safe?

We rated safe as inadequate because:

Detailed findings

- Medicines were not prescribed, administered, recorded and stored safely. This also included the overall management of controlled drugs.
- The process for reporting and investigating incidents, including root cause analysis was ineffective. This could impact negatively on patients and lessons may not be learnt and shared.
- Processes designed to identify deteriorating patients were not available. This may pose risks of inconsistent approach in the management of these patients.
- The provider did not follow the duty of candour process when things went wrong to provide support to patients and their relatives.
- Technicians were administering medicines via patient group directions (PGDs) which was not within their scope of practice.
- Infection control management was not effective, particularly in the secure vehicles which posed risks of cross infection to patients.
- The use of restraint was not audited to ensure that any type of restraint used was legal and proportionate, to facilitate learning, improve practices and safeguard people from the risks of receiving inappropriate care.

However, we also found the following:

- There was an up to date policy and procedures which reflected current guidance in place for safeguarding children and adults which staff were confident in using.

Are services effective?

We rated effective as inadequate because:

- There were no effective audits processes in place. Patients' outcome data was not audited to improve practice and learning.
- The provider undertook some driving assessments; however, this was not consistently applied for all staff.
- There was limited assurance that all staff had completed mandatory training and updates relevant to their roles.
- We found limited evidence of the service using National Institute for Health and Care Excellence (NICE) guidelines when delivering care.

However:

Staff planned secure transfers in advance to ensure patients received food and fluids and breaks when undertaking long journeys.

Are services caring?

We have not rated caring as we do not have enough evidence to rate this section.

During the inspection, we were unable to speak with patients or observe care. There was no one receiving care at the time of the inspection. The provider did not carry out any patients' surveys and feedback from patients was not available.

Are services responsive?

We rated responsive as requires improvement because:

- There were no specific tools available to support people whose first language was not English or those with communication problems.
- There was no process for reviewing concerns or complaints at service level and for identifying themes to share learnings and improve care.
- Complaints were investigated by the commissioning trusts and the provider did not seek or receive feedback. There was no learning from complaints.

However;

- The service had an internal process which staff followed when they undertook secure transfers of mental health patients.

Are services well-led?

We rated well-led as inadequate because:

- Managers did not demonstrate they had the necessary skills, knowledge or experience to effectively manage the service.
- There was limited evidence that the local leaders understood the challenges to quality and sustainability of the service.
- Incidents were not effectively managed, there was no evidence of learning from incidents and improvement in practice.
- The risk register did not identify the numerous risks we found during this inspection. There was limited assurance of how risks were managed and actions taken to mitigate these.

Detailed findings

- There were no specific management or user groups at the time of inspection which enabled discussion of operational and strategic issues by staff.
- Minutes of meetings were not recorded and information was not consistently shared with staff.

However:

- Staff told us they had good working relationship and felt supported by their team leaders.

Facts and data about SSG UK Specialist Ambulance Service - South

SSG UK Ambulance – South is operated by SSG UKSAS. At the factual accuracy stage, the provider told us urgent and emergency care services was the largest proportion of their work. They also provided a patient transport service.

The service was registered in 2017. It is an independent ambulance service in Fareham, Hampshire. The provider has two other locations with their headquarters situated in Rainham Essex. SSG UK Ambulance -South primarily serves the communities of the Hampshire, Southampton and Portsmouth areas.

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.

Our ratings for this service

Our ratings for this service are:

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

Emergency and urgent care services

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

Information about the service

At the factual accuracy stage, the provider told us the main service provided by this ambulance service was urgent and emergency care services. Where our findings on patient transport service for example, the management arrangements, also apply to the other service, we do not repeat the information but cross-refer to the urgent and emergency care services section.

The service provided, emergency and urgent transfers on behalf of NHS trusts. At the time of our inspection, the provider had three NHS contracts; and work was being commissioned by two NHS ambulance trusts.

Summary of findings

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

- Medicines were not prescribed, administered, recorded and stored safely. This also included the overall management of controlled drugs.
- Processes designed to identify deteriorating patients were not available. This may pose risks of inconsistent approach in the management of these patients.
- The provider did not follow the duty of candour process when things went wrong to provide support to patients and their relatives.
- Technicians were administering medicines via patient group directions (PGDs) which was not within their scope of practice.
- There were no effective audits processes in place. Patients' outcome data was not audited to improve practice and learning.
- We found limited evidence of the service using National Institute for Health and Care Excellence (NICE) guidelines when delivering care.
- Incidents were not effectively managed, there was no evidence of learning from incidents and improvement in practice.

Emergency and urgent care services

- The risk register did not identify the numerous risks we found during this inspection. There was limited assurance of how risks were managed and actions taken to mitigate these.

However, we also found the following:

- There was an up to date policy and procedures which reflected current guidance in place for safeguarding children and adults which staff were confident in using.

Are emergency and urgent care services safe?

Inadequate

We rated safe as inadequate, this was because;

- The process for the storage, administration, recording and overall management of medicines was not safe and in line with legislation
- Controlled drugs (CDs) were not managed safely. As no CD audits were undertaken, the provider could not be assured that CDs were effectively managed and in line with the Dangerous Drug Act (1971), NICE guidelines (2016) and their own policies and procedures.
- The records of medicines that were destroyed were incomplete and the provider could not provide any assurance that this was undertaken in line with legal requirement and the service's guidance.
- Technicians were administrating medicines via patient group directions, this was not within the scope of their role, competence and skills.
- Incidents were not reported in a consistent way and senior management did not understand their responsibilities in reporting incidents. Outcomes were not shared to facilitate learning and improve practice.
- The provider did not follow the duty of candour process when things went wrong to provide support to patients and their family.
- There was no overall data at the service to provide assurance that all staff had completed the necessary mandatory training and updates as required for their roles.
- There was no assurance staff had completed the required levels of safeguarding training for adults and children.
- There were no specific policies and processes to support staff on how to identify or manage a deteriorating patient. This could impact on the care people would receive.
- There were out of date consumables and intravenous (IV) fluids being used for training which were stored in an

unlocked room at the provider's headquarters. This posed a risk that out- of -date consumables and IV fluids may be accidentally removed and placed back into circulation.

- The recruitment process was not effective as evidence of all necessary checks being completed was not available in staff records. Therefore, there was a lack of assurance that only suitable individuals were employed by the service.
- Staff records were not maintained or stored safely and securely.

However;

- The service had staff who were working towards or had achieved the First Response Emergency Care (FREC) qualification at levels 3 and 4.
- Staff had access to personal protective equipment such as gloves, including latex free gloves and aprons to reduce the risk of the spread of infection.

Incidents

- There was not an effective incident reporting process in place and lessons were not learnt.
- The provider's incident reporting policy stated staff were encouraged to report any incidents so that reoccurrence could be prevented and lessons learnt. There was no evidence that they were following their own policy.
- The provider did not always follow processes for reporting all incidents which affected the health and welfare of people using the service to the Care Quality Commission (CQC) as required. We found there was confusion among the senior staff about incident reporting and the service's responsibility to report specific incidents to CQC. We received a report of serious concerns relating to a road traffic accident (RTC). The registered manager told us they had not reported this incident to CQC, despite it being an incident that should have been reported, as they thought the commissioning NHS trust would report this to the CQC. Following a request for a report of this incident to be sent to the CQC, the provider reported the incident. Staff told us they reported incidents to their line managers and these were escalated to the registered person. They usually did not receive feedback on incidents and investigations to influence learning.
- Incidents were reported to the relevant commissioning NHS trust, via a paper reporting template, managers told us these were scanned to the trust to review and investigate. Internally these were logged on an excel spreadsheet, but no trend analysis took place to identify learning. We were told staff and the service did not receive feedback from the trust about the incident they had reported and therefore changes to practice and learning did not occur.
- There was an escalation process for alerting senior managers to serious incidents such as RTCs, these were initially reported to the station team leader by the trust the crews were working for. The station team leader would report to the head of operations and if necessary to a director. There was no formal on call team leader or director rota. This meant that while they did respond there may be a delay if they could not attend due to other commitments. A formal on call rota was being developed but managers did not know when this would be implemented.
- Staff had not received training in the Duty of Candour (DoC), although they said it was about being honest with the patients.
- Duty of Candour 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.
- The service was failing in its duty to invoke DoC. We had evidence of a recent incident where a patient was involved in an RTC which met the criteria for the invoking of DoC. However, the provider did not follow this through and failed in their responsibilities towards the patient and their family, the registered manager left it to the commissioning trust to do so. The registered manager confirmed to us the commissioning NHS trust had contacted the patient's family. This meant that whilst the family were contacted, the registered manager was unaware of the discussions that had taken place.

Emergency and urgent care services

Mandatory training

- The mandatory training programme did not reflect best practice and most recent guidance and was not consistently completed by all staff.
- The service had a programme of mandatory training for staff provided by a range of trainers. This included manual handling, health and safety, first aid, infection control, restraint, mental capacity. A review of the training slides showed that they included out of date national guidance, some contained information which was not relevant to the service provided or referenced services the provider did not deliver. Therefore; staff may not have the necessary skills and knowledge required for their role.
- There was no overall data at the service to provide assurance that all staff had completed the necessary mandatory training and updates required for their roles. We requested this information from the provider. this was not provided during r following our inspection.
- The manager told us that the shift booking system would not allow staff to book a shift if they had not completed the required mandatory training. However, some staff stated that not all staff completed their mandatory training as they had to do this in their own time but were still able to book shifts. There was no assurance that all staff booking shifts were up to date with their mandatory training.
- All new staff were expected to complete the mandatory training followed by third person shifts as part of their corporate induction process. A third person shift is a period when an individual accompanies a crew on an ambulance but does not deliver care and they observe other staff delivering the care. As this induction was unpaid there was a risk not all new staff would attend. We were provided with examples of staff working for the provider who had not completed the mandatory third person shifts. We were not provided with any evidence that attendance at corporate induction or mandatory third person shifts were monitored and non-attendance followed up.
- Information we received as part of this inspection was that not all new staff competed the required third person shifts or the station team leader would sign to state these third person shifts had been completed even when they had not been. We saw no documented evidence to provide assurance that the requirement for third person or mentoring shifts were complied with in line with the provider's policy
- 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 the emergency ambulance services. This provided staff with the skills to deal with pre- hospital emergencies such as life support, maintaining safe airway and recognising sepsis. Staff were expected to self-fund this course, which we were told was due to these individuals being self- employed. This meant that on completion of the course the individual may choose to leave the service and work for another provider, impacting on retention of staff.

Safeguarding

- Most staff understood how to protect patients from the risk of abuse. Not all staff had completed training on how to recognise and report abuse.
- The service had policies for safeguarding children and adult which had been reviewed in 2017, these reflected the current national guidance. Staff were aware of these policies and were clear about the actions they needed to take if they suspected or witnessed any type of abuse.
- Not all staff had completed safeguarding children training appropriate to their role. It was unclear from the data we received what percentage of staff and which staff groups had completed safeguarding children level 1, 2 and 3 training. For example, the staff who undertook the secure transfer of mental health patients told us they transported children and young people, some as young as eight years old therefore it would be expected these staff members would have completed this training. We requested data from the provider about the number of children they had transported, the provider did not provide this information during or following our inspection.
- The Safeguarding Children and Young People: roles and competencies for health care staff intercollegiate document (2014) sets out the following training guideline. Staff must have Level 2, which was the

minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people. The service was not compliant with this national guidance.

- The service had up to date guidance on safeguarding children and adults and a list of local authorities in their area for reporting safeguarding incidents.

Cleanliness, infection control and hygiene

- The service controlled infection risks. Staff kept themselves and equipment and most vehicles clean. They used control measures to prevent the spread of infection.
- The service had an infection control policy dated July 2017 and developed in line with national guidance.
- Staff were required to complete the infection control course as part of their mandatory training. There was no data available and assurance of staff compliance with this training.
- The grab bags on vehicles were not wipeable and therefore posed an infection control risk.
- Most of the vehicle we inspected were visibly clean and tidy. However; we observed that the secure and some other vehicles were not all clean. This included dirt and mud, cigarette butts on the floor and hair on a patient's trolley.
- Staff told us they cleaned the vehicles at the start of each day and that not all staff left their ambulances clean at the end of their shift. For example, they did not empty clinical waste bins, this posed a risk of cross infection
- One of the five secure vehicles where patients were transported in the cell was rusty which posed infection control risks as these could not be effectively clean.
- 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 a deep cleaning schedule with all ambulances being cleaned every six weeks. The make ready team maintained a schedule for these deep cleans. Records of these deep cleans were kept by the make ready staff who reported the majority of these took place. A review of the records showed that deep cleans were undertaken every six weeks.
- There were two staff members who were responsible for ensuring the ambulances were ready for use. These staff said they completed cleaning audits and sent these to the head office but received no feedback or learning from these. The service had a mechanic and support mechanic on site Monday to Friday.
- Staff had access to personal protective equipment such as gloves, including latex free gloves and aprons to reduce the risk of the spread of infection between staff and patients. Crews carried a spills kit on their vehicles to manage any small spillages to reduce the infection and hygiene risks to other patients.
- There were no hand gels on the ambulances as staff told us they carried these on their persons. Staff stated they used hand gel to prevent and control the spread of infection.
- We observed staffs' uniforms were visibly clean. They told us they were responsible for washing their own uniforms and washing facilities were available at the local ambulance station.
- The provider had in August 2018 started carrying out infection control audits which included hand washing and vehicle cleanliness. Three of these records showed that if the vehicles failed the audit, actions were taken and re audited. However, there was no process for capturing this data to inform practice and share learning with the wider team.

Environment and equipment

- The service had suitable premises and equipment, but these were not always effectively managed.
- The station was situated on the edge of an industrial estate near a main road. Access to the crew room and office was via an unlocked door. This may pose risk of unauthorised access to the station.
- All staff attended the office at the start of their shift and logged on duty before collecting and checking their ambulance. Once booked on they then may be requested to travel to another station or stand by point to commence their shift. Staff were not paid for the

travel time between booking on and arriving at another station or stand by point, they did this in their own time. Therefore, they booked on duty as late as possible which could result in vehicle checks being rushed as crews were not given any allocated time to undertake this task.

- The vehicles carried a grab bag which included clinical supplies such as bandages, wound dressings and oxygen masks which were in date. The emergency vehicles also had emergency life support equipment for adults and children. However, in the vehicles used for transporting secure mental health, they had emergency life support equipment for adults only. We raised this with the staff as they told us they also transported children as young as eight years old. There was uncertainty among the staff regarding paediatric emergency equipment and how this would be accessed if required. The lack of paediatric equipment on these vehicles could impact on children's safety in the event of an emergency. A senior staff member told us they would be taking this forward with management and revise their policy and procedure.
- Some paramedics had their own response bags, these were personal issue and should be exchanged at least monthly, to ensure all their contents were in date. We were told these were audited but despite asking to these audits during and post inspection, this information was not provided. Therefore, we were not assured that all personal issue bags contained in date consumables and medicines.
- We were told that staff exchanged out of date stock equipment from their response bags with stock from ambulances that had been 'made ready' for use. Examples of this practice included an intravenous (IV) needle dated 2012 which was left on an ambulance and an in- date one removed. This meant there was a risk that not all stock may be in date and fit for use despite the ambulance being prepared and labelled as ready for use.
- A review of service stickers on electrical and mechanical equipment showed these were checked, and serviced annually. However, we noted that some equipment was past its review date and therefore may not be fit for purpose. We highlighted this at the time of our inspection and this was escalated to the management team.
- Staff used their own mobile phones to communicate with the trust's control centre. There were plans to introduce a new alarm system device which would alert the control centre when activated or if a member of staff was down for a period. These alarms enabled the control centre to track the location of the crew and provide immediate assistance if necessary.
- The planned implementation date for this alarm system was stated to be by September 2018. As all staff were to be issued with an alarm; we requested to see the implementation plan including the training that would be provided to staff to ensure they were aware of how to use these devices appropriately. The plans were not provided to us during or following the inspection.
- The staff followed their internal process for reporting any faulty equipment. They would inform the shift leader who would escalate this to head office and the faulty piece of equipment would be removed from the vehicle. There was an equipment store at head office and staff reported replacement equipment was available without delay.
- During the inspection, we observed out of date consumables and intravenous (IV) fluids were used for training and stored in an unlocked room at the service's headquarters. These were located in a training room and separate from stock items. This may pose a risk of out- of -date consumables and IV fluids may be accidentally removed and placed back into circulation. This was raised with the registered manager during our inspection, who stated he would remove these and ensure they were disposed of.
- Sufficient ambulances may not be available to meet the service's demands. The team leader told us that they had adequate number of vehicles to assure business continuity. However, staff reported the fleet was ageing with many ambulances having high mileage and an increased number of vehicles off the road for repairs on a frequent basis. All the staff we spoke with were aware of the vehicle defect sheet and had experience of completing it. The mechanic made an assessment and recommendations to the provider if a vehicle was not repairable and needed to be taken off the road. Staff confirmed that the provider was responsive and any

faulty vehicles would not be used to protect patients and staff. The ambulances we checked as part of this inspection were in good state of repair and fit for purpose.

- There was no formal replacement plan for vehicles. A senior member of staff stated they were currently collecting evidence to demonstrate the need for replacement ambulances as at the present time there were no plans or identified funds for replacement fleet.
- The service used a local garage that provided them with breakdown cover. For example, there was a service level agreement with a garage with a 90 minutes turnaround for replacement of tyres. This meant that vehicles were not taken out of action for long periods and caused minimal disruptions. Staff did not know if there was a service level agreement which applied to other types of breakdown where the ambulance would be recovered in a timely manner.
- The service had a process to ensure that vehicles had in-date certificates for motor insurance which covered the vehicles. A random check of 10 vehicle records showed these were in date. This ensured the vehicles were road worthy and protected staff and patients if these vehicles were involved in an accident.
- The keys to each ambulance were stored with the grab bag in a secure locker, keys were stored in a key safe, the combination code for the safe was issued to all staff. This ensured that access to vehicles was restricted to the appropriate staff. However, the combination code to the key safe was not changed regularly which may pose security risks. We raised this with the registered manager during the inspection. Following the inspection, the provider confirmed that a procedure had been introduced regarding frequency of changing security codes and staff had been informed.

Assessing and responding to risks

- Patients risks were not always assessed or responded to mitigate the known risks when providing care.
- Staff told us that the NHS emergency control centre allocating the job alerted the crews of any "special notes" for individual patients that were available to ensure that they were aware of risks. These risks included patients with behaviour that may be a challenge. This allowed staff to prepare and consider how they would approach the patient and deliver care.
- Staff told us that the NHS emergency control centre allocating the job alerted the crews of any "special notes" for individual patients that were available to ensure that they were aware of risks. These risks included patients with behaviour that may be a challenge. This allowed staff to prepare and consider how they would approach the patient and deliver care.

Staffing

- Due to the lack of accurate data it was not possible to assess if the service had 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
- We were provided with a recruitment policy version 1, that had been issued in July 2017 and reported to be reviewed in July 2018 but retained the same version number. The policy was detailed and included safe recruitment processes including disclosure and barring checks and references. Staff we spoke with could not confirm if any changes had been made to the policy and which was the correct date for version 1. This meant that we were not assured the provider had a recruitment policy that met the needs of the service.
- Most staff at the service were employed as bank or self-employed staff with very few holding fixed or permanent contracts. This we were told was provider's highest risk. To address this the provider was planning to employ more staff on fixed term contracts to provide stability and assist in ensuring staff had the skills and competencies requested by commissioning trusts. At the time of our inspection the service had not started to employ staff on fixed term contracts and we were not provided with a timescale when this would occur and if fixed term contracts would be offered to all staff groups.
- The provider could not provide us with accurate numbers of staff who were employed or worked as bank staff, but thought there were around 650 staff recruited with 300 of these working on a regular basis. Therefore,

we were not assured that all staff working for the provider were compliant with mandatory training, held a current disclosure barring service (DBS) check and active professional registration.

- Recruitment process was stated to be the responsibility of the internal Human Resource (HR) team. During our inspection we reviewed 10 staff files that we were told included recruitment documents, qualifications and training records. It was reported the provider was in the process of merging staff members personal and training files. All files we reviewed were disorganised, while most had a recruitment check list completed, the relevant paperwork was not always filed. We were not assured that all necessary pre-employment checks had been completed.
- The majority of staff files did not include evidence of compliance with statutory and mandatory training, evidence of a driving assessment being undertaken when the staff member was recruited. Only one file included evidence of a clinical assessment of the staff member's competency being undertaken. This meant that staff were being deployed without being assessed as competent for the role they were undertaking.
- Most of the staff files we reviewed had in date disclosure barring service (DBS) checks, however, some of these checks included information of concern. The provider could not demonstrate how decisions were taken and risk assessed when staff did not have a clear DBS. This meant that there was no assurance that not only suitable staff were employed.
- The commissioning NHS trust disclosure and barring service (DBS) form that staff were required to complete did not always reflect the individual's DBS information accurately. Therefore, we were not assured that commissioning trusts had been provided with accurate information to enable them to manage any known risks.
- The recruitment process was not always effectively implemented, we found not all staff files included a signed contract and the majority were not for the current provider. Of the 10 staff files we reviewed, three files included two references, two files had one reference and the other five had no references. Only 50% of the staff files seen included interview notes, CV or prior employment history. The provider was not following their own policy and procedure when recruiting staff and could not be assured of staff fitness.
- The registered manager told us there were between 28-30 staff on the secure team, it was unclear how these staffing numbers had been determined to ensure they all undertook sufficient transfers to maintain their skills. Therefore, we were not assured that staff were completing sufficient transfers to maintain their skills and competencies.
- Staff stated their shift patterns were very dependent on the work the trusts commissioned and therefore regular shift patterns were not always possible. They showed us their skill stream app on their mobile phone, this allowed the individual to book shifts and receive confirmation of the shift allocated. This approach ensured staff were aware of shifts they were expected to work and the location of this shift.
- Staff may be working excessive shifts, which could impact on their ability to deliver safe and effective care and place themselves and patients at risk of harm. There was no evidence of triggers for alerting managers of staff undertaking excessive shifts and if the individual worked for several providers. The manager told us some staff worked five or six 12- hour night shifts in a row on a regular basis. Therefore, some staff were working 60-72 hours per week on a regular basis. We were told that as most of staff were bank it was difficult to monitor the number of shifts they were working as some of them worked for other providers.
- We saw evidence that staff had opted out of the working time directive and the registered manager told us it was the individual's responsibility to declare other providers they were working for. None of the personal files we reviewed included evidence that staff had declared that they worked for other providers. Therefore, we were not assured that the current system of recording individual's other employers was effective.
- The service had a team of Trauma Risk Management (TRiM) practitioners. These were staff who had received additional training to support staff who had experience

work situations that had affected their wellbeing. For example, during the May bank holiday staff attended a traumatic road traffic collision. The TRiM practitioners debriefed staff.

Records

- Staff records were disorganised, loose in files and not stored securely. We found personal information in the wrong files which we shared with the registered manager during the inspection. We observed there were a large quantity of staff records which were left on desks and on the floor in the offices. This posed risk of unauthorised access to staff Records and in breach of general data protection regulation(GDPR).
- The service used a paper record system. The patient care records (PCRs) were returned to a secure box at the end of each shift. These were scanned to the commissioning trust daily. We were informed since April 2018; 10 PCRs were audited each month and non-compliance was fed back to the individual but we were not provided with evidence of these audits during or following the inspection. There were no records to demonstrate that all staff had or would have their PCRs audited on a regular basis. This meant that while the person auditing stated they made a mental note of whose PCR they had audited there was no evidence to demonstrate there were plans to ensure all staff participated in this audit. Staff we spoke with had not received any feedback following this audit and there had been no learning from these audits shared with staff.
- All staff members had an NHS email accounts which the provider used to share information with staff.
- The personal files we reviewed during the inspection all included a copy of the staff member's current driving licence and evidence they had the correct category for the weight of the vehicles they drove.

Medicines

- The service did not prescribe, administer, record and store medicines in line with national guidance and legislation.
- During our inspection we were informed the three paramedics based at the station used patient group directions (PGDs) to administer medicines. The PGDs had not been drafted by the service and approved by the commissioning NHS trust, therefore they were working without a company approved document which gave them the legal authority to administer these medicines.
- We requested to see the PGDs that were in use, these were not provided. Following our inspection, we received five PGDs all version one, issued in August 2018. These did not cover the range of medicines administered via PGDs by staff at the service. Therefore, we were not assured the service had PGDs in place that covered all medicines being administered via PGDs by trained, competent staff.
- Managers told us medicines were administered by technicians some of which were administered via PGDs. The Human Medicines Regulations state medicines can only be administered via PGDs by specified registered healthcare professionals for example paramedics and registered nurses. Therefore, technicians were working outside of the human medicines regulations by administering medicines via PGDs.
- The registered manager confirmed that technicians administered medicines such as activated charcoal, dexamethasone, clopidogrel and tranexamic acid via the PGDs in specific circumstances. However; the service had no PGDs to allow technicians to undertake this role and this task is outside their scope of practice and legislation.
- There was no training and assessment that staff completed before they were considered competent to administer medicines via PGDs. We requested evidence that all staff using PGDs had signed to state they had been assessed as competent to undertake this role. The list of signatures provided included only 13 staff, we were informed that more than 13 staff used PGDs but no explanation was provided why they had not signed to state they were competent and understood the PGD before using it. This may pose significant risks to patients' safety as medicines were administered by staff without the proper safeguards in place such as training and competency in medicines management.
- We raised our concerns with the registered manager about medicines including controlled drugs (CDs) which were not managed safely and securely. The process for the transport, storage and destruction of controlled medicines were not safe. A senior staff member told us

that they were aware that CDs management did not meet with national guidelines and legislation and that there was some work that needed to be done to become compliant. At the time of our inspection no mitigation was in place to manage this risk.

- Following our inspection, we requested copies of a sample of three paramedics individual controlled drug registers. The evidence provided demonstrated that some paramedics were using large amounts of morphine. The majority of the CD registers we reviewed were incomplete and did not routinely include information such as a running balance, there were missing pages which made tracking difficult and it was not possible to confirm this large amount used was accounted for. Most records included a job reference number but not always the patient's name or initials, if the job involved more than one patient it was therefore not possible to identify which patient had received the medicine. There was no evidence these CD registers had been audited and no assurance that usage of CDs could be accurately tracked.
- The data provided from the service relating to paramedics who held CDs was inaccurate. All paramedics were issued with personal issues of CDs, however the data provided did not cover all paramedics. There were only 13 paramedics included in the data. We were therefore not assured that all CDs held by paramedics were traceable.
- Paramedics were issued with personal issue CDs that they transported between their home and the service as these were stored off the premises in a safe provided either by the individual or the service. There was no assurance regarding these practices and the registered manager confirmed that they did not carry out any checks on if the safe had been installed correctly, if it was used and if the CD balance was correct. The provider could not be assured that CDs were effectively managed and in line with the Dangerous Drug Act and their own policies and procedures. There was no audit process to ensure that CDs were not mismanaged and were accounted for at all times.
- The sample of personal CD registers held by paramedics we reviewed demonstrated that when the individual requested CDs from head office these were issued by the controlled drug accountable lead for the service (CDAL) for the service. This arrangement of the CDAL issuing CDs was not compliant with the Misuse of Drugs Regulations 2001.
- We reviewed the storage and destruction of CDs at the provider's headquarters in Rainham. The registered manager confirmed they were the CDAL for the service. The registered manager undertook the destruction of CDs with another staff member as evidenced in the records we reviewed during the inspection. This contravened the Misuse of Drugs Regulations 2001 and the service's CD destruction policy that we received from the provider. This stated that the "Accountable Officer for controlled drugs cannot undertake this role and in line with the Health Act 2006 and subsequent Controlled Drugs (Supervision of Management and Use) Regulations 2006. This stated that the Accountable Officer should be independent of day-to-day management of controlled drugs."
- The provider's policy also stated the Accountable Officer could authorise people or groups of people to witness the destruction of controlled drugs in compliance with regulations. The person undertaking this role should have the necessary training to ensure they undertake this role in line with legislation and best practice. There was no evidence and the registered manager told us the nominated staff member witnessing destruction had not completed any training for this role. This meant staff were not adhering to the service's own policy and procedures.
- The central controlled drugs supply was held at head office, in the server room which was accessed with a swipe and had CCTV monitoring both outside and internally. However, the manager stated the room was not compliant with legal requirements and there were plans to relocate this room. Issues with the room included the safe not being secured to the floor, the door having a window. There was no process for monitoring the temperature to ensure that medicines in the room was managed safely. The issue of non-compliance was identified a week prior to our inspection, this risk was not on the risk register and no mitigation had been implemented to reduce the risk

whilst work was underway to prepare the identified room for use and no timescale for the completion of the work was provided. Therefore, the known risk was not being mitigated.

- Prescription only medicines (POMs) were not managed effectively. The stock levels were not aligned to usage resulting in high wastage. While the check list that was included in the POMs pack had been revised, it was not possible to track and trace these drugs. The current process for checking POM in and out was not effective and could result in errors This lack of an effective system not only resulted in wastage it meant that in the event of a medicines recall it would not be possible to be assured all affected medicines had been removed from frontline ambulances.
- The records of medicines that were destroyed were not managed safely and the provider could not provide any assurance that this was undertaken in line with guidance. We looked at the records for the months of July and August 2018. This showed that on approximately 25 occasions the dates that the medicines were destroyed was not recorded and not signed by the individual destroying the medicines. We reviewed the records at the service's headquarters and found the staff member responsible for destroying medicines was entering dates and signatures against the medicines which had been destroyed retrospectively.
- We saw that destruction records were maintained, in an adapted drug register book that was not fit for purpose. All medicines for destruction were placed in a designated bin, however when the bin which included CDs and other medicines was removed from site by the contractor responsible for the disposal of medicines waste, no records of their contents were sent with the bin.
- We looked at a sample of 10 patients' record forms (PRFs), which staff used to record administration of medicines. There were no audits of these PRFs which meant discrepancies or errors in medicines management could not be identified for actions to be taken.
- The service stored medical gases in line with best practice and national guidance.
- They had secure storage for medical gases which included pain relieving gases and oxygen. These were stored on the ground floor in an upright position and in locked cages with good natural ventilation and signage. This was in line with guidance for storage of Medical gases. Staff told us they followed their internal procedure for ordering medical gases and their minimum stock list. A team leader told us the fire service
- We issued the provider with a letter of intent following the serious concerns regarding medicines' management. The provider confirmed on 20 September 2018 they had taken actions such as withdrawal of all CDs which paramedics held and stored off site. These were returned to head office, and the provider withdrew the use of medicines which were administered via PGDs. No risk assessment had been completed to assess the impact on patient care prior to these actions being taken.

Are emergency and urgent care services effective?

Inadequate

We rated effective as inadequate, this was because;

- Policies and procedures were out of date and did not reflect current guidance. This may impact on care to patients.
- There were patient group directions in use which had not been drafted in line with National Institute for Health and Care Excellence (NICE) guidelines and not approved by the commissioning NHS trusts.
- There were no effective audits processes in place. Patient outcome data was not audited to improve practice and learning.
- The provider undertook some driving assessments; however, this was not consistently applied for all staff.
- There was limited assurance that all staff completed updates for their roles.

However,

- 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 to drive the vehicles.
- Staff planned secure transfers in advance to ensure patients received food and fluids and breaks when undertaking long journeys.

Evidence-based care and treatment

- We were provided with five patient group directions (PGDs) that had been drafted by the service these had not been developed in line with NICE guidance and managers we spoke with were unclear of the correct process for developing, authorising and implementing PGDs. None of these PGDs had been approved by the commissioning NHS trusts.
- Staff told us they followed the commissioning NHS trusts protocols for the management of strokes and heart attacks. We were not provided with copies of these or evidence of their use during or following the inspection despite requesting these.
- There was limited evidence that the service provided care and treatment based on national guidance and evidence of its effectiveness.
- We found limited evidence of the service using National Institute for Health and Care Excellence (NICE) guidelines to ensure patients experienced co-ordinated care with clear and accurate information exchange between relevant health and social care professionals.
- Staff had access to the clinical bulletins and policies from one of the NHS trust who commissioned services from the provider. These were held in paper form in a folder at the station. However, we noted that many of the policies and bulletins were out of date, some dating back to 2013. This meant staff may not be providing care in line with the most up to date guidance or in line with the commissioning trust's current policies.
- Staff did not have remote access to the service guidelines and protocols, we were told these were held at the station and if staff required advice they would contact the commissioning trust's emergency operating centre for advice.
- Staff told us they followed the commissioning NHS trusts protocols for the management of strokes and heart attacks. We were not provided with copies of these or evidence of their use during or following the inspection despite requesting these.
- Front line staff told us they followed the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). Staff who undertook secure transfers of mental health patients said they followed the commissioning NHS trust's guidelines for transferring patients who were under sections.

Response times

- The service responded to calls in a timely way that met national standards. The registered manager met. with the commissioning trusts monthly to review performance. Staff at a local level reported that they did not receive any feedback on their performance or areas for improvement. Performance standards were the same as those expected of NHS ambulance trusts.
- However, during and following our inspection we were not provided with any performance data.
- The national Ambulance Response Programme (ARP) was used by the commissioning trusts to monitor the provider's response times. The results were discussed at regular contract meetings but these were not displayed or shared with staff.

Patient outcomes

- The managers we spoke with were unsure if they contributed to the ambulance quality indicators (AQI) of the commissioning trusts. They stated that for all cardiac arrests they photocopied the electrocardiogram (ECG) onto a cover sheet labelled with the patient's name and dispatch number before submitting with the paperwork to the trusts. However, they did not receive any feedback from the commissioning trust following the submission of ECGs, this meant that learning was not identified.
- Patients care and treatment outcomes such as ST-elevation myocardial infarction (STEMI) and outcomes 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 trust. A defibrillator is a machine that delivers treatment for life

threatening cardiac incidents such as cardiac arrests or cardiac dysrhythmias to re-establish a patient's normal cardiac rhythm. Managers we spoke with could not confirm if their data was included in the commissioning trusts national return. No feedback was provided to the staff to improve patients' outcomes.

- The provider had no agreed annual audit programme and we were told that ad hoc audits took place such as the recent patient care record (PCR) audits. There was limited evidence of learning or changes to practice from audits that were carried out.

Competent staff

- Managers did not ensure all staff were competent for their roles.
- The records we reviewed at the service highlighted the mandatory third person shifts were not recorded on the duty roster or in the individual's personal file to evidence that the individual member of staff had complied with this requirement. A third person shift is a period when an individual accompanies a crew on an ambulance but does not deliver care they observe other staff delivering the care. We noted that in the last month, station managers had started to return reports on third person shifts completed to head office There was no audit to demonstrate the accuracy of the data as these shifts were not consistently recorded.
- 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 to drive the vehicles. If these checks identified any issues such as an individual had been disqualified, the operational team would be informed via email and the individual would be removed from driving responsibilities. We were not provided with evidence to demonstrate the effectiveness of this process and that emails were acted on in a timely manner.
- 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 a road traffic incident. The driving re-assessment we saw was not detailed and therefore we could not comment on the quality of this assessment.
- Staff told us that there had been an increase in road traffic collisions (RTCs), contributing factors were reported to be that staff completed their blue light training in a car not an ambulance and only drove the ambulance at the end of the course when they were being assessed, therefore lacked experience of driving an ambulance. Most of these accidents were stated to have occurred at low speed and involved new emergency care assistants (ECAs). ECAs drive ambulances under emergency conditions and support the work of qualified ambulance paramedics and technicians. The service could not provide us with data that showed how the station compared to the two other provider's locations. Lessons were not learnt and shared across all locations following accidents.
- To obtain their personal identification number (PIN) to book shifts for commissioning NHS trusts; all staff were required to attend the trust's induction, which we were told they did as failure to complete this meant they would not be issued with their PIN.
- We were not assured all staff were competent and had the necessary skills appropriate for their roles. There was a matrix by staff group and the mandatory training they should complete. We found not all courses were relevant to the service provided.
- Managers and staff were alerted when training, updates and disclosure and barring services (DBS) checks were due for renewal. The individual was given 70 days to complete these checks and training. We were told failure to do would not allow the staff to book any shifts. However, there was currently no effective system to link the completion of training with the staff file to ensure there was one record held for each member of staff that demonstrated their fitness to work. While work had commenced on the merging of training records into the individual's personal file, those records that we reviewed which we were told had been merged did not include evidence of training. This meant that staff could be deployed who may not have the required updates to undertake their role.
- Most of the staff training was undertaken at the service's head office in Rainham which some staff said was difficult to attend due to the distances they had to travel. We were told if staff were self-employed they

were not paid for attending the training and completed training in their own time. As there was lack of accurate training records held we were not assured all staff had completed the necessary training.

- The records of appraisals showed that most of the staff were employed as bank and did not complete their annual appraisals or participate in supervision. Currently appraisals were not offered to the bank staff and there were no clear processed for identifying individual's training or development needs. Staff stated that they identified their own learning needs, we were told some staff were supported via access to learning material to undertake their paramedic course. The majority of the first year of this course was on line and competed in their own time. However, the commissioning NHS trusts they worked for did not allow them to develop clinical skills as part of their training as there was no trust member of staff available to supervise their practice. Therefore, it was unclear how the individuals would achieve the required skills to progress to year two of the course as the individuals had not secured clinical placements for their course.
- The provider 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 this. There were no criteria to inform the recruiting manager which individuals would be required to complete this assessment. There was consistent approach to driving re-assessment, some staff told us they did not receive blue light training updates while other staff stated that they were reassessed every three years which included a day at the training school in Rainham. On checking personnel files, we saw no evidence that routine driving re-assessments had taken place.

Multi-disciplinary working

- The staff told us they had good relationship with the commissioning trusts, they felt supported and could contact them for support and advice.
- The management team had regular contract monitoring meeting with the commissioning trusts. The manager said they referred complaints and incidents for the commissioning trusts to investigate. However; they were not involved in these investigations and did not always receive feedback from these investigations. Therefore, opportunities for learning were missed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Not all staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They did not all know how to support patients those who lacked the capacity to make decisions about their care.
- The service had a policy which included the key principles of the Mental Capacity Act (MCA) 2005). It outlined the responsibilities of staff when transferring patients who lacked capacity. This included reference to the Deprivation of Liberty Safeguards (DoLS). These safeguards were introduced to ensure that people receive treatment without infringing on their liberty.
- Mental Capacity Act (MCA) training was not part of the staff mandatory training. Staff we spoke with had limited knowledge of the MCA or deprivation of liberty. This meant that patient's individual needs may not be met and the fundamentals of best interest principles and decisions may not be understood and applied.

Access to information

- Staff we spoke with told us they would be informed by the emergency call centre staff, assigning them a job, if patients had a do not attempt resuscitation order. They also confirmed this information with the service they were collecting the patient from, such as a care home, to ensure the patient's wishes were respected in the event they deteriorated before arriving at the planned destination.
- Information provided by the commissioning trusts was the only information available to staff to inform their assessment and management of their patient's care.
- The ambulances were equipped with up-to-date satellite navigation systems which staff said were reliable and all ambulances had a map if the satellite navigation system failed.

Emergency and urgent care services

Are emergency and urgent care services caring?

Not sufficient evidence to rate

We have not rated Caring, as we do not have adequate information to rate this section

Compassionate care

- We were unable to observe any care being delivered to patients or speak with them as there was no one receiving care during our visit.
- Staff spoke about their passion for providing care in a compassionate way.

Emotional support

- Staff spoke about how they would provide emotional support to people and their relatives using the service.
- They said they always considered the well- being of the carer and relatives so that they were not forgotten.
- 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 means of involving the family and carers and giving them clear explanation of their actions.

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

Requires improvement

We rated responsive as requires improvement, this was because;

- There were no specific tools available to support people whose first language was not English or those with communication problems.
- There were no processes for reviewing concerns or complaints at station level to identify themes, address issues and share learnings and improve the quality of care.
- Complaints were sent to the commissioning trusts and the provider did not seek or receive feedback enabling action to be taken to minimise their reoccurrence

However;

- Vehicles were equipped to meet the needs of differing patient groups.Adaptations such as bariatric patient stretchers and chairs were available when required.
- Staff encouraged a relative or carer to accompany the patient if possible to reduce the patient's anxiety.

Service delivery to meet the needs of local people

- The service was commissioned by two NHS trusts to support them to meet the local demand for ambulance services. They received their referrals from the commissioning trusts and jobs were planned and prioritised accordingly. These were recorded on booking forms and details included the date, time of the journey. The patients' details, arrival time of pick up and discharge were also recorded.
- The service attended regular contract monitoring meetings with the commissioning NHS trusts to review their service provision, including response times. However, there was no evidence that areas for improvement were identified to ensure people's needs were constantly met.

Meeting people's individual needs

- Staff spoke sensitively about meeting the needs of different patient groups and adjustments they may need to make during the course of their work. Staff told us they encouraged a family member or carer to accompany the patient if possible as this reduced the patient's anxiety. For example, carers or family members of patients living with dementia were encouraged to accompany them in the ambulance.
- Staff followed internal processes and provided vehicles for the transfer of mental health patients. While the cell on the vehicle was not fit for purpose, these had limited

ligature points to reduce the risk of self-harm. All mental health patient bookings were discussed with the duty manager prior to staff undertaking them to ensure the effective transfer of the patient.

- There were no specific tools available to support people whose first language was not English or those with communication and vision problems. Staff told us they were able to seek support from the trusts to access interpreters if required.
- The service did not have a member of staff responsible for supporting staff to deal with people experiencing a mental health crisis. Staff said they would contact the commissioning trusts if additional support was required.
- Vehicles were equipped to meet the needs of differing patient groups. Adaptations such as bariatric patient stretchers and chairs were available when required.

Access and flow

- The service operated 24 hours a day, seven days a week, and the duty roster was developed in advance to ensure they had adequate 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.
- Some of the service's work was planned such as transporting patients who required additional support such as those under the care of the mental health team or transporting patients to hospital appointments. Staff told us they were on standby at other times and picked up other work as allocated by the commissioning trusts.

Learning from complaints and concerns

- There was a complaint procedure in place which staff said they followed and would report any complaints verbally to their line manager. The registered manager told us that they no longer investigated patients' complaints as these were referred to the commissioning NHS trusts to investigate and responded to the complainant. We were told that the service did not always receive feedback on the outcome of the complaints and therefore opportunities for learning were missed.
- If the complaint or concern related to another staff member the service would investigate. We reviewed a sample of the responses following concerns raised and saw appropriate action had been taken to resolve these complaints in a timely way. However, each complaint was managed in isolation which meant opportunities to offer support or training to staff to prevent a reoccurrence were not identified and implemented.
- There was a designated person based at head office who was responsible for dealing with complaints relating to the service. Complaints and concerns information was not used to identify trends and themes at station or provider level to inform learning or changes to practice.
- The service could not provide information regarding the number or type of complaints received in the last 12 months.
- Senior staff had not received training in handling verbal and written complaints. Therefore, there was no consistent approach to how complaints were investigated or findings reported.
- There was no information available to patients on the vehicles on how to raise a concern or complaint.

Are emergency and urgent care services well-led?

Inadequate

We rated well led as inadequate this was because;

- There was limited evidence of a governance structure or a clear vision and strategy to develop the service.
- Managers did not demonstrate they had the necessary skills, knowledge or experience to effectively manage and develop the service.
- There were no plans to identify and provide development opportunities to ensure managers had the necessary skills to lead and develop the service
- The meeting and committee structure was not fully developed. While the board met monthly the minutes of these meetings were not recorded and information was not effectively shared with staff.

- The process for managing risks was not effective, risks were not identified and actions developed to mitigate these. The management team were not aware of the serious risks we identified during the inspection.
- The risk register did not reflect the local risks to the business and the risks identified following an external review completed in June 2018.
- There was an absence of audits and there were no processes for the provider to gain assurance of the delivery of high quality, person -centred care.

However**;**

- Staff told us they felt well supported by their immediate line managers and they were supportive to each other.

Leadership of service

- The board consisted of a chief executive officer (CEO) and five directors. The CEO and two of the directors were based overseas but were registered as directors in the UK. The CEO and overseas directors visited the service on a monthly basis for board meetings. There was a senior leadership team which included the finance director and director of operations who reported to the board and managed the service on a day to day basis.
- At the time of the inspection, staff were unable to describe the structure and areas of responsibilities and one of the directors told us there was an urgent need to refresh the structure of the board.
- Local managers did not all have the necessary range of skills, knowledge and experience to lead and develop the service. There was limited evidence they understood the challenges to service quality and overall sustainability of the service.
- The governance director had not received the appropriate training to support them in their role and the human resources and finance directors did not have any experience of ambulance services. There were no plans to identify and provide development opportunities to ensure directors and managers had the necessary skills to lead and develop the service.
- There was a lack of a clear meeting and committee structure to ensure identified risks were fed up to director level, discussed with actions agreed and disseminated to staff. While the board met monthly there was a lack of structure below board level. We were told that there were plans to introduce a structure of working groups who would report to sub committees. These sub committees would report to the board through the senior leadership team. However, this had been newly developed and was due to be presented to the board in September 2018. We were not provided with a timescale for the implementation of this structure if approved by the board.
- Following a service review commissioned by the provider in June 2018, serious concerns were highlighted relating to medicines management. During this inspection we found these serious concerns had not been addressed and these continued to impact on the safety of patients using the service.

Vision and strategy for this service

- There was no clear documented vision or strategy for the service. The registered manager told us their vision was to develop the service but could not state how this would be achieved.
- We did not see a strategy which was aligned to local plans and documented how change would be managed within the organisation. There were also no strategies to address issues which could affect the service such as recruitment and retention or communication.
- Some teams within the service had a localised vision for their team. The staff who undertook the transfers of mental health patients told us they were planning to submit another bid to a local mental health trust. This would enable them to transfer patients who were sectioned under the Mental Health Act. However, we were not provided with evidence of when this would be submitted or what support the team would be provided with to develop this bid.
- Staff told us they were not always involved in developments or discussions about the strategy for the service and were only involved in developments discussions if actions affected their local site.

Culture within the service

- Staff told us that there was 'lots of pressure from above to get the job done and care could get forgotten.' This impacted on staff morale and they felt that they were not listened to and the quality of patient's care came second to productivity.

- There was a disconnect between the local station and the headquarters where the senior managers were based. Staff told us they 'got on with their jobs' and sometimes attended the office in Rainham for training. Meetings were held at local stations and this was facilitated by team leaders as senior managers were not present.
- The provider had a whistle- blowing policy in place and managers reported they had an open door, if staff wished to raise any issue with them. We were not provided with evidence or examples of this being used when we requested to see this.
- Staff told us they felt well supported by their immediate line managers and were supportive of each other. They felt their team worked well together and had a good rapport.
- Staff who undertook the secure transfer of mental health patients told us they were a small team and the team leaders had an open- door policy. Staff were passionate about delivering good quality care and they told us they were proud to be working for the service.

Governance

- There was no effective governance structure in place. The service was in the process of developing a governance structure which was due to be presented to the board in September 2018.
- The provider commissioned an external clinical review in June 2018 which raised serious issues including with the overall management of medicines, information governance and compliance with mandatory training. This review highlighted the same serious concerns we identified during this inspection. There was no evidence that the provider had developed action plans to mitigate these risks and had taken the immediate action within the 30-day period the external team had recommended or developed an effective action plan to address all issues identified during this review.
- The provider did not routinely carry out audits on areas such as documentation, infection control or staff competency and performance of their roles. The provider had recently introduced processes for reviewing specific standards such as the cleanliness of vehicles and handwashing observations. However; the outcomes were not used to develop actions plans to mitigate any risks to patients in a consistent way.
- The governance processes around the drafting and use of patient group directions (PGDs) was not effective. There was confusion amongst staff around which PGDs were to be used and the copies presented during inspection had not been drafted by the service in line with (NICE) guidance. The approval of these documents by the service's medical director and pharmacist was unclear and not in line with best practice. The registered manager stated that two of the commissioning NHS trusts had given them permission to use their PGDs. There was no documented evidence that this permission had been provided and two of the documents stated to be used were dated 2013.
- There was limited governance around staff roles and scope of practice. For example, we were informed that technicians were administering medicines via patient group directions (PGDs) which was outside their scope of practice and was not complaint with medicines legislation.
- Staff told they undertook remote prescribing. Remote prescribing is when medicines are prescribed over the phone to treat certain conditions. However, there was no governance in place to support this practice. There was no assurance staff had been trained and assessed as competent to undertake this role and the provider did not have a policy or procedure in place for staff to follow when requesting or taking remote prescribing orders. There was no evidence of the patient assessments that had had taken place to inform the remote prescription. This meant the assessment and remote prescribing practice was not supported by effective governance arrangements to mitigate risk and ensure patient safety.

Management of risk, issues and performance

- Risks, issues and performance was not effectively managed. There were limited systems in place to monitor the quality or safety of the service provided.
- Performance data relating to compliance with policies and procedures were not fully developed. Key performance data for these areas was not collected or formally monitored,

- The registered manager told us information regarding completion of staff mandatory training was held on the training database and compliance with mandatory training was reported to the board monthly. We requested access to this data, the provider could not provide us with accurate numbers of staff they employed. Therefore, we were not assured about the accuracy of this training compliance data.
- We received a number of concerns prior to and following our inspection. These concerns were in relation to specific practices, risks and the ineffective processes to manage these. We reviewed these concerns as part of this inspection and found practices were not monitored and risks were not effectively managed.
- We observed some staff had two trusts' ID badges as well as an SSG badge. We were told they had requested these from the trusts to provide them with easy access to the trust's emergency department (ED) including the children's ED. There was no central record at the provider's head office relating to staff who had been issued with these trust badges. This may pose a safety risk if the staff member was dismissed or left the service, they would still have access to trust's premises. The NHS trusts who had issued these ID badges were contacted and stated they were investigating this matter immediately.

Information Management

- There were limited processes in place for managing information. The executive team told us they held monthly meetings, however there were no minutes of these recorded.
- We were told monthly reports were presented to the board on performance, training compliance and incidents. However, these were not shared with local teams to inform their work. It was unclear if these reports were accurate as the data used to inform the content had not been validated. During and following our inspection we were not provided with copies of these monthly reports.
- There was an identified Caldicott Guardian, this is individual who held this role had not yet completed training to prepare them for this role and the responsibilities they had assumed. None of the staff we spoke with were aware of this role or how to access the individual.

. **Public and staff engagement**

- There was limited evidence that the service actively sought patients' views to improve the service provision.
- There were no staff surveys currently at the service and the manager was not aware if this was being developed.
- We saw evidence of local staff meetings which were held monthly. A staff member told us the management took actions following feedback from staff. These included meal breaks and other work-related adjustments had been made.

Innovation, improvement and sustainability

- There was no information about innovation at the service when we sought feedback from the staff or any planned improvement at the time of the inspection.

Patient transport services (PTS)

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

Information about the service

Patient transport services were not the main service provided by this ambulance service. The service provided patient transport and the secure transfer of mental health patients for adults and children. These services were commissioned by NHS ambulance trusts.

Summary of findings

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

- Infection control management was not effective, particularly in the secure vehicles which posed risks of cross infection to patients.
- The use of restraint was not audited to ensure that any type of restraint used was legal and proportionate, to facilitate learning, improve practices and safeguard people from the risks of receiving inappropriate care.
- The provider undertook some driving assessments; however, this was not consistently applied for all staff.
- There were no specific tools available to support people whose first language was not English or those with communication problems.
- Managers did not demonstrate they had the necessary skills, knowledge or experience to effectively manage the service.
- There was limited evidence that the local leaders understood the challenges to quality and sustainability of the service.
- Incidents were not effectively managed, there was no evidence of learning from incidents and improvement in practice.

Patient transport services (PTS)

- There were no specific management or user groups at the time of inspection which enabled discussion of operational and strategic issues by staff.
- Minutes of meetings were not recorded and information was not consistently shared with staff.

However, we also found:

- Staff planned secure transfers in advance to ensure patients received food and fluids and breaks when undertaking long journeys.

Are patient transport services safe?

Inadequate

We rated safe as inadequate, this was because;

- Incidents were not reported in a consistent way and senior management did not understand their responsibilities in reporting incidents. Outcomes were not shared to facilitate learning and improve practice.
- The provider did not follow the duty of candour process when things went wrong to provide support to patients and their family.
- There was no overall data at the service to provide assurance that all staff had completed the necessary mandatory training and updates as required for their roles.
- There was no assurance staff had completed the required levels of safeguarding training for adults and children.
- The cells on the secure vehicles in which patients were transported, were rusty which posed infection control risks as these could not be effectively cleaned.
- There were out of date consumables and intravenous (IV) fluids being used for training which were stored in an unlocked room at the provider's headquarters. This posed a risk that out- of -date consumables and IV fluids may be accidentally removed and placed back into circulation.
- There was limited evidence of how the registered person gained assurance that staff followed mechanical restraint policy and procedures to safeguard patients from the risks of harm.
- The recruitment process was not effective as evidence of all necessary checks being completed was not available in staff records. Therefore, there was a lack of assurance that only suitable individuals were employed by the service.
- Staff records were not maintained or stored safely and securely.

However;

- The service had staff who were working towards or had achieved the First Response Emergency Care (FREC) qualification at levels 3 and 4.
- Staff had access to personal protective equipment such as gloves, including latex free gloves and aprons to reduce the risk of the spread of infection.

Incidents

Please see the Safe section of urgent and emergency care services report for details on incidents.

Mandatory training

Please see the Safe section of urgent and emergency care services report for details about mandatory training.

Safeguarding

- The service had a restrictive intervention policy dated February 2018 policy for the use of mechanical restraints. This did not include a clear criterion for situations that mechanical restraint could be used or instructions to staff that a risk assessment must be carried out when mechanical restraint was used. This meant the service had not formally identified clear criteria for restraint and safeguards which needed to be in place before using mechanical restraint. This posed a risk that restraint could be used inappropriately or without adequate safeguards.
- The mechanical restraint policy states 'As a minimum, all secure staff and operational team leaders will be trained in the use of handcuffs'. The policy states that when the use of restrictive intervention was taking place during transfer of the service user, staff needed to provide a full explanation of the behaviour and de-escalation techniques used in response to behavioural disturbances. We asked to see completed records when restrictive intervention had occurred during and post- inspection however, these were not provided by the service. Therefore, we could not assess if the correct procedures and documentation was being carried out.
- The provider's policy on the use of restraint and category A transfers stated that a patient was not to be placed in cell seclusion for longer than five hours. There was no data available relating to length of time patients were placed in cell seclusion. Although staff told us they would arrange for breaks in advance of the journey.

Please see the Safe section of the urgent and emergency care services report for details about safeguarding.

Cleanliness infection control and hygiene

- The service controlled infection risks. Staff kept themselves and equipment and most vehicles clean. They used control measures to prevent the spread of infection.
- One of the five secure vehicles where patients were transported in the cell was rusty which posed infection control risks as these could not be effectively clean.

Please see the Safe section of the urgent and emergency care services report for further details about cleanliness and infection control.

Environment and equipment

- We observed one of the secure vehicles used for the transport of mental health patients was not fit for purpose. The cell area that was used to transport patients, had a metal bench with no padding on the seat, this was rusty and patients had to sit directly on the metal.

Please see the Safe section of the urgent and emergency care services report for further details about environment and equipment.

Assessing and responding to patient risk

- There was limited evidence on how the registered person gained assurance that staff followed restraint policy and procedures and safeguarded patients from the risks of harm. The nine records for secure patients where restraint had been used showed that staff did not follow the process for the use of handcuffs. There were no risks assessments completed and staff did not record a clear and consistent rationale for the use of mechanical restraint.
- The service did not complete records, such as body maps and observations following restraint, together with incident forms. Therefore, there was no assurance that patients' risks had been appropriately managed.
- Staff told us any form of restraint they used was the minimum amount necessary for the shortest possible time, and as a last resort. However; this was not clearly reflected in the records seen as the reasons for the use for restraint was not clearly recorded.

Patient transport services (PTS)

- The current risks and rationale for the use of mechanical restraints were not identified. Reasons provided for the use of restrain were reported to be the patient had previously absconded. However, this may not be a current risk as the patient may be compliant and staff had not considered the least restrictive interventions. The staff practices did not comply with guidance by the Department of Health (DoH) 'Positive and Proactive Care: reducing the need for restrictive interventions' (2014) and NICE Guideline 25.

Staffing

- The registered manager told us there were between 28-30 staff on the secure team, it was unclear how these staffing numbers had been determined to ensure they all undertook sufficient transfers to maintain their skills. Therefore, we were not assured that staff were completing sufficient transfers to maintain their skills and competencies.

Please see the Safe section of the urgent and emergency care services report for further details about staffing.

Records

- The secure transfer team told us they received records of transfer from the discharging service which were in sealed envelopes as part of patients' transfers. These were handed over to the team receiving the patient.
- The records of care for patients transported in the secure transports were inadequate as these did not contain consistent assessments and how risks were assessed when using handcuffs and cells.

Please see the Safe section of the urgent and emergency care services report for further details about records.

Medicines

- The service stored medical gases in line with best practice and national guidance.
- They had secure storage for medical gases which included pain relieving gases and oxygen. These were stored on the ground floor in an upright position and in locked cages with good natural ventilation and signage. This was in line with guidance for storage of Medical gases. Staff told us they followed their internal procedure for ordering medical gases and their minimum stock list. A team leader told us the fire service had visited the service and were satisfied with the management of medical gases.

Please see the Safe section of the urgent and emergency care services report for further details about medicines.

Are patient transport services effective?

Inadequate

We rated effective as inadequate, this was because;

- Policies and procedures were out of date and did not reflect current guidance. This may impact on care to patients.
- There were no effective audits processes in place. Patient outcome data was not audited to improve practice and learning.
- The provider undertook some driving assessments; however, this was not consistently applied for all staff.
- There was limited assurance that all staff completed updates for their roles.

However,

- Staff followed the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance and guidelines were available for transfers of mental health patients.
- 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 to drive the vehicles.
- Staff planned secure transfers in advance to ensure patients received food and fluids and breaks when undertaking long journeys.

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Evidence-based care and treatment

Please see the Effective section of the urgent and emergency care services report for further details about evidence-based care and treatment

Nutrition and hydration

- The service did not usually provide food and fluids to patients. However; staff told us for the transfer of secure patients which may incur longer journeys, they arranged with other authorities such as the police, in advance of the journey to use their facilities to support the patients with food and fluids. There was no evidence that this was a formal arrangement and that staff were provided with guidance.

Response times

Please see the Effective section of the urgent and emergency care services report for further details about response times.

Patient outcomes

Please see the Effective section of the urgent and emergency care services report for further details about response times and patient outcomes

Competent staff

Please see the Effective section of urgent and emergency care services report for details about competent staff

- The staff who transported secure patients told us they worked well with the police and local authorities and commissioning trusts which was facilitated effective care to patients who had complex needs.

Please see the Effective section of urgent and emergency care services report for details about competent staff.

Multi-disciplinary working

Please see the Effective section of urgent and emergency care services report for details about multi-disciplinary working.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff who undertook secure mental health patients' transfers we spoke with understood their responsibilities under MCA and the action that they would take to protect patients.
- It was unclear which category of sectioned patients the service was commissioned to transport. Staff working on the secure ambulance told us they transported people under Section 135. However; the registered manager told us that the service only transported patients under Section 4. Therefore we were not assured that effective safeguards were in place to protect patients from harm or that the crew were always aware of their patient's condition and Section status at the onset of their journey.
- The secure staff had completed training in both restraint and challenging behaviour. They told us they always tried to calm situations verbally before resorting to any form of restraint and that mechanical restraint was always a last option. There was no data to support this approach or the effectiveness of interventions.

Please see the Effective section of urgent and emergency care services report for details about consent and mental capacity and deprivation of liberty safeguards.

Access to information

- Please see the Effective section of urgent and emergency care services report for details about access to information

Are patient transport services caring?

Not sufficient evidence to rate

We have not rated Caring, as we do not have adequate information to rate this section

Compassionate care

- We were unable to observe any care being delivered to patients or speak with them as there was no one receiving care during our visit.
- Staff spoke about their passion for providing care in a compassionate way.

Emotional support

- Staff spoke about how they would provide emotional support to people and their relatives using the service.
- They said they always considered the well- being of the carer and relatives so that they were not forgotten.
- 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

Patient transport services (PTS)

- Staff described various means of involving the family and carers and giving them clear explanation of their actions.

Are patient transport services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement, this was because;

- There were no specific tools available to support people whose first language was not English or those with communication problems.
- There were no processes for reviewing concerns or complaints at station level to identify themes, address issues and share learnings and improve the quality of care.
- Complaints were sent to the commissioning trusts and the provider did not seek or receive feedback enabling action to be taken to minimise their reoccurrence

However;

- Vehicles were equipped to meet the needs of differing patient groups.Adaptations such as bariatric patient stretchers and chairs were available when required.
- Staff encouraged a relative or carer to accompany the patient if possible to reduce the patient's anxiety.

Service delivery to meet the needs of local people

Please see the Responsive section of the urgent and emergency care services report for details about service delivery to meet the needs of local people

Meeting people's individual needs

Please see the Responsive section of the urgent and emergency care services report for details about meeting individual needs

Access and flow

Please see the Responsive section of the urgent and emergency care services report for details about access and flow.

Learning from complaints and concerns

Please see the Responsive section of the urgent and emergency care services report for details about learning from complaints and concerns.

Are patient transport services well-led?

Inadequate

We rated well- led as inadequate this was because;

- There was limited evidence of a governance structure or a clear vision and strategy to develop the service.
- Managers did not demonstrate they had the necessary skills, knowledge or experience to effectively manage and develop the service.
- There were no plans to identify and provide development opportunities to ensure managers had the necessary skills to lead and develop the service
- The meeting and committee structure was not fully developed. While the board met monthly the minutes of these meetings were not recorded and information was not effectively shared with staff.
- The process for managing risks was not effective, risks were not identified and actions developed to mitigate these. The management team were not aware of the serious risks we identified during the inspection.
- The risk register did not reflect the local risks to the business and the risks identified following an external review completed in June 2018.
- There was an absence of audits and there were no processes for the provider to gain assurance of the delivery of high quality, person -centred care.

However**;**

- Staff told us they felt well supported by their immediate line managers and they were supportive to each other.

Leadership of service

Please see the well- led section of the urgent and emergency care services report for details about leadership of the service.

Vision and strategy for this service

Patient transport services (PTS)

Please see the well- led section of the urgent and emergency care services report for details about vision and strategy for the service.

Culture within the service

- Staff told us they felt well supported by their immediate line managers and were supportive of each other. They felt their team worked well together and had a good rapport.
- Staff who undertook the secure transfer of mental health patients told us they were a small team and the team leaders had an open- door policy. Staff were passionate about delivering good quality care and they told us they were proud to be working for the service.

Please see the well- led section of the urgent and emergency care services report for details about culture within the service.

Governance

- The use of restraint was not audited to ensure that any type of restraint used was legal and proportionate. There was no process to review incidents to facilitate learning, improve practices and safeguard people from the risks of receiving inappropriate care and treatment which could breach their human rights.
- The provider's mechanical restraint policy states, 'the use of mechanical restraint must be recorded on an Incident Report Form' and 'should include details of why the use of handcuffs was deemed necessary and justified'. The inspection team reviewed nine incidents forms where the provider had confirmed restraint was used within the last twelve months and found the information recorded was inconsistent. Therefore, we were not assured policies were always implemented to safeguard patients.

Please see the well- led section of the urgent and emergency care services report for details about governance.

Management of risk, issues and performance

- Performance data relating to compliance with policies and procedures were not fully developed. Key performance data for these areas was not collected or formally monitored, for example the duration patients were handcuffed and transported in the cells. This was not in line with current restraint guidance which states internal data must be gathered, aggregated and published by providers including progress against restrictive intervention reduction programmes. Guidance and details of training and development in annual quality accounts or equivalent must be documented which the provider was failing to do so.

Please see the well- led section of the urgent and emergency care services report for details about management of risks and performance.

Information Management

Please see the well- led section of the urgent and emergency care services report for details about information management.

Public and staff engagement

Please see the well- led section of the urgent and emergency care services report for details about public and staff engagement.

Innovation, improvement and sustainability

- There was no information about innovation at the service when we sought feedback from the staff or any planned improvement at the time of the inspection.

Please see the well- led section of the urgent and emergency care services report for details about innovation, improvement and sustainability.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the provider MUST take to meet the regulations:

- Ensure that all medicines including controlled drugs (CDs) are managed safely, securely including transport and destruction of medicines and CDs.
- Ensure that there are clear processes and lines of accountability for the management of patient group directives (PGDs).
- Ensure a review of prescription only medicines (POMs) is completed and sufficient stock is available and track and trace of medicines is improved.
- Ensure that all incidents that affect the health and welfare of people are reported to CQC without delay.
- Develop clear procedures for the use of any type of restraints; including mechanical restraints to safeguard the safety and rights of people using the service.
- Maintain records of care including risk assessments and be able to clearly demonstrate how risks are managed.
- Have an effective recruitment process to ensure all necessary checks are completed prior to people starting work.
- Ensure systems are in place to support staff training, development, supervision which is appropriate to their roles.
- Ensure that there are effective audits systems which are developed to support the delivery of care.
- Ensure compliance with mandatory training and attendance at induction.
- Ensure all mandatory training reflects up to date guidance and legislation.
- Ensure Duty of Candour responsibilities are met.
- Ensure all those members of staff who hold management or leadership positions have the necessary skills, experience and knowledge to undertake their roles.
- Develop a governance process to assess risks and develop action plans to mitigate those risks.

Action the hospital SHOULD take to improve

- Develop systems to evaluate feedback from staff and people using the service to drive improvements.
- Policies and procedures should be regularly updated to reflect current guidance and support staff practices.
- Develop clear process for sharing access codes securely.
- Review processes for monitoring personal issue response bags to reduce the risk of out of date consumables and medicines entering the system.
- Review the suitability of grab bags which are currently not wipeable.
- Consider the introduction of triggers to alert manager when staff are working an excessive number of shifts.
- Review how those patients/relatives whose first language is not English or who have communication issues are communicated with.
- Consider developing a vision and strategy for the service.

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 managed safely and securely at all times. This must include safe controlled drug management. Technicians were administering medicines via PGDs which was out of their scope of practice. Controlled drugs were not managed safely and securely.

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 the regulated activity. There was limited management oversight risk management and its impact on the service provided. There was ineffective governance processes and policies, procedures were not always developed and kept under reviews. This did not reflect the latest best practice and national guidance. This meant that treatment provided may not be in line with the latest national guidance The governance process was immature and was not fully developed.

This section is primarily information for the provider

Requirement notices

Risks were not fully assessed and understood for mitigating actions to be developed and managed effectively.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure staff receive appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out their duties safely. Staff did receive appropriate ongoing or periodic supervision in their role to make sure competence was maintained. Staff were undertaking medicines management and remote prescribing without the appropriate training. This may pose patients' safety risks.

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. There was no effective recruitment process to ensure all necessary checks were completed and records available prior to staff staring work.

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure the safe management of medicines. There was no evidence that checks were carried out on CDS that they stored off the premises. Staff were administering medicines under PGDs and there was no evidence of training and competency. The provider was unable to provide evidence that they held an appropriate Home Office for the management of CDs. Therefore, the Commission was not assured that controlled drugs were always stored in line with national guidance and controlled drugs legislation. Medicines cabinet was unlocked and located in an unlocked office. Therefore, medicines were not stored securely and posed risks of unauthorised access to medicines. Medicines were administered by technicians via patient group directions (PGDs). The Human Medicines Regulations states medicines can only be administered via PGDs by specific registered healthcare professionals for example paramedics. Therefore, the service was not working in line with the human medicines regulations by instructing technicians to administer medicines via PGDs.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Providers must ensure that their audit and governance systems remain effective. There was no evidence of audits being carried out to confirm the effectiveness of medicines management or that procedures and practices were safe.

There was no assurance that medicines were stored, administered and disposed of in line with national guidance and best practice.

There was no records or audit trail of staff who had used patient group directions (PGDs) when providing care and treatment. There was no assurance that only trained, competent staff administered medicines via PGDs.

There was no governance to support remote prescribing to ensure the safety of patients.

The provider could not provide assurance that the service's standard operating procedures and medicines management policy, including the disposal of controlled drugs were up- to- date, implemented and used in practice. This meant medicines were not effectively managed and in line with guidance and legislation.

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...