SSG UK Specialist Ambulance Service Ltd

SSG UK Specialist Ambulance Service - Corporate HQ

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the location on 6 November 2018. We previously inspected the service in September 2016 when it was registered under a different company name.

The service had a combination of emergency response ambulances, patient transport and secure transport vehicles. Secure vehicles were used for the transport of mental health patients and 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:

- Incident reporting and investigation was not effectively managed. There was no evidence of learning from incidents to improve practice. The service did not discharge its Duty of Candour responsibilities.
- Staff training records did not contain accurate information so there was limited assurance that all staff had completed mandatory training and safety checks relevant to their roles. The mandatory training programme did not reflect current good practice.
- The service did not have sufficiently accurate records to provide assurance that there were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- We were not assured all staff had completed relevant safeguarding training. However, most staff were clear about the actions they needed to take if they suspected or witnessed any type of abuse.
- There were insufficient processes to review patient records and the service's information sharing policy was out of date.
- Medicines were not safely managed. There was a need for more formalised and robust accountability and audit of individual paramedics' usage, storage and return of Controlled Drugs (CDs). There was no clear and formal policy or process for managing medicine safety alerts and it was not clear how staff competence for safe medicine administration was assessed. Drug fridge temperatures were not routinely recorded.
- There was limited evidence of clinical audit activity and the service did not have a planned annual audit programme. The service did not routinely collect or monitor information on patient outcomes to improve practice.
- There were limited in-house policies and guidance documents based on national guidance and evidence-based practice. The service was required to follow commissioning NHS trust protocols for the treatment and care of patients. The sample of organisational policies we reviewed showed most clinical policies were out of date.
- Self-employed staff did not receive an annual appraisal or participate in supervision. There was no clear process for identifying individual training and development needs, and training processes were applied inconsistently.

Summary of findings

- Staff had variable knowledge of their roles and responsibilities under the Mental Capacity Act. The service capacity to consent policy was out of date.
- There were no specific tools available to support patients whose first language was not English or those with communication support needs. Staff sought translation support from the respective commissioning NHS trust.
- The service did not have a robust system for handling, managing and monitoring complaints and concerns. The service did not directly investigate individual complaints so learning was not identified. There was no evidence of information available on vehicles to help patients raise a concern or complaint.
- Local leaders did not all have the necessary range of skills, knowledge, experience or capacity to lead and develop the service. Some directors did not have appropriate training, development or resources to support them in their role.
- There were concerns with the organisational culture within the service, including a perceived disconnect between senior leaders and frontline staff. Senior leaders told us there was still a need to build trust with frontline staff. We received feedback from staff about perceived bullying and unprofessional behaviours by named individuals in the service leadership team and individual crew members.
- We were not assured of the integrity or validity of information presented to the board. This meant the board did not have a complete corporate understanding of the risks and challenges to service quality and sustainability.
- Minutes of governance meetings were insufficiently detailed and did not provide a clear record of discussions or actions. Management information was not routinely shared with staff.
- Risks, issues and performance was not managed effectively. There were limited systems in place to monitor the quality or safety of the service provided. This was because performance and quality data were not routinely collected or formally monitored.
- There was no evidence that the service actively sought patients' views to improve the service provision.
- A new vision and values statement had been developed in April 2018 and was being communicated to staff through a series of workshops. However, the service's published vision and values were from the previously registered organisation and had not been updated since it was taken over by SSG.
- The service commissioned an external review in June 2018 which highlighted serious concerns regarding patient safety, quality and organisational sustainability. We found these serious concerns had not been addressed since the review and they continued to impact on the safety of patients using the service.

However, we found the following areas of good practice:

- The service controlled infection risks. Staff used control measures to prevent the spread of infection and keep equipment and vehicles clean.
- The service had suitable premises and equipment. There was appropriate equipment on board ambulance vehicles to provide monitoring and assessment of patients.
- All vehicles we inspected were visibly clean and tidy. Vehicles were well maintained and well stocked. There were suitable processes to ensure vehicles were roadworthy.
- The service had policies and processes for safeguarding children and adults which reflected current national guidelines and good practice.
- Pain scoring and pain relief administration took place routinely and in a timely manner.

Summary of findings

- The service responded to calls in a timely way that met national standards. Performance standards were in line with NHS ambulance trusts.
- Crews had good working relationships with staff in commissioning NHS ambulance trusts and in the hospitals they relayed patients to. They felt supported and could contact them for support and advice.
- Crews spoke sensitively about meeting the needs of different patient groups. They made adjustments to better support patients, and demonstrated principles of patient-centred care and respecting individual needs and wishes.
- Vehicles were equipped to meet the needs of differing patient groups. For example, adaptations and specialist equipment.
- Leaders of the service had taken steps to support managers with a new training and development programme.
- Leaders of the service had taken steps to improve engagement with staff working for the service, including surveys, newsletters and workshops with service leaders.
- There was good support for crew members who had experienced difficult clinical situations that impacted on their well-being.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We issued the provider with a Warning Notice for breaches of regulations. Details are at the end of the report.

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.

Nigel Acheson

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Inadequate 	We have rated safe, effective and well-led as inadequate. Responsive is rated as requires improvement. We did not rate caring as we did not inspect it.

SSG UK Specialist Ambulance Service - Corporate HQ

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

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Background to SSG UK Specialist Ambulance Service - Corporate HQ

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

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

The organisation is registered with the CQC to provide:

• Transport services, triage and medical advice provided remotely

• Treatment of disease, disorder or injury

The provider was previously registered with CQC as U.K. Specialist Ambulance Services Ltd (ID 1-238150426), which deregistered on 3 August 2017 when the organisation was taken over by Servicios Socio Sanitarios Generales (SSG), a company based in Spain. The company is the second largest cross-border provider of health transport services in Europe, operating in Spain, Sweden, Portugal, the UK and Peru.

The Rainham headquarters location was inspected in September 2016 before the take over and deregistration. The CQC set requirement notices and 'should do' actions following the inspection.

We carried out a comprehensive inspection of the Rainham Headquarters location on 6 November 2018 as it was two years since the previous inspection (albeit under a different registration). The CQC South Central team also conducted parallel inspections of the provider's Fareham Location in response to specific concerns.

During the inspection, we spoke with 20 staff including; registered paramedics, emergency care assistants (ECAs), ambulance care assistants (ACA), technicians, managers and service leadership. During our inspection, we reviewed a sample of staff and patient records and looked at organisation policies, documents and management information.

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

Activity:

Provider data for the period December 2017 to July 2018 showed there were approximately 40,000 transfers across the three main commissioning NHS ambulance trusts the provider worked with. The data did not highlight the age group of patients or the number of children transferred.

Detailed findings

The provider did not have accurate and contemporary records of the number of employed staff or those working as self-employed bank staff. Records showed there were around 650 paramedics, emergency care assistants (ECAs) and technicians recruited, with 300 of these working on a regular basis for the provider, of which almost 30 were paramedics. However, these figures were not confirmed.

A paramedic is a qualified healthcare professional. Paramedics respond to emergency calls and deal with complex and non–emergency hospital admissions, discharges and transfers. They work as part of a rapid response unit, usually with support from an ambulance technician or an ECA. The ECAs drive ambulances under emergency conditions and support the work of qualified ambulance technicians and paramedics.

Our inspection team

The team that inspected the service comprised two CQC inspectors, a medicines specialist inspector and two specialist advisors with expertise in urgent and emergency care. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

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
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

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

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

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

Summary of findings

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

- Incident reporting and investigation was not effectively managed. There was no evidence of learning from incidents to improve practice. The service did not discharge its Duty of Candour (Doc) responsibilities.
- Staff training records did not contain accurate information so there was limited assurance that all staff had completed mandatory training and safety checks relevant to their roles. The mandatory training programme did not reflect current good practice.
- The service did not have sufficiently accurate records to provide assurance that there were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- We were not assured all staff had completed relevant safeguarding training. However, most staff were clear about the actions they needed to take if they suspected or witnessed any type of abuse.
- There were insufficient processes to review patient records and the service's information sharing policy was out of date.

Emergency and urgent care services

- Medicines were not safety managed. There was a need for more formalised and robust accountability and audit of individual paramedics' usage, storage and return of Controlled Drugs (CDs). There was no clear and formal policy or process for managing medicine safety alerts and it was not clear how staff competence for safe medicine administration was assessed. Drug fridge temperatures were not routinely recorded.
- There was limited evidence of clinical audit activity and the service did not have a planned annual audit programme. The service did not routinely collect or monitor information on patient outcomes to improve practice.
- There were limited in-house policies and guidance documents based on national guidance and evidence-based practice. The service was required to follow commissioning NHS trust protocols for the treatment and care of patients.
- The sample of organisational policies we reviewed showed most clinical policies were out of date. Processes for reviewing policies were ineffective.
- Staff records showed self-employed staff did not receive an annual appraisal or participate in supervision. There was no clear process for identifying individual training and development needs, and training processes were applied inconsistently.
- Staff had variable knowledge of their roles and responsibilities under the Mental Capacity Act. The service capacity to consent policy was out of date. There was no coordinated training for staff in learning disabilities or mental health support.
- There were no specific tools available to support patients whose first language was not English or those with communication support needs. Staff sought translation support from the respective commissioning NHS trust.
- The service did not have a robust system for handling, managing and monitoring complaints and concerns. The service did not directly investigate individual complaints so learning was not identified. There was no evidence of information available on vehicles to help patients raise a concern or complaint.
- Local leaders did not all have the necessary range of skills, knowledge, experience or capacity to lead and develop the service. Some directors did not have appropriate training, development or resources to support them in their role.
- We identified concerns with the organisational culture within the service, including a perceived disconnect between senior leaders and frontline staff. Senior leaders told us there was still a need to build trust with frontline staff. We received feedback from staff about perceived bullying and unprofessional behaviours by named individuals in the service leadership team and individual crew members.
- We were not assured of the integrity or validity of information presented to the board. This meant the board did not have a complete corporate understanding of the risks and challenges to service quality and sustainability.
- Minutes of governance meetings were insufficiently detailed and did not provide a clear record of discussions or actions. Management information was not routinely shared with staff.
- Risks, issues and performance was not effectively managed. There were limited systems in place to monitor the quality or safety of the service provided. This was because performance and quality data were not routinely collected or formally monitored.
- There was limited evidence that the service actively sought patients' views to improve the service provision.
- A new vision and values statement had been developed in April 2018 and was being communicated to staff through a series of workshops. However, the published organisational vision and values were from the previously registered organisation and had not been updated since it was taken over by SSG.

Emergency and urgent care services

- The service commissioned an external review in June 2018 which highlighted serious concerns regarding patient safety, quality and organisational sustainability. We found these serious concerns had not been addressed since the review and they continued to impact on the safety of patients using the service.

However, we found the following areas of good practice:

- The service controlled infection risks. Staff used control measures to prevent the spread of infection and keep equipment and vehicles clean.
- The service had suitable premises and equipment. There was appropriate equipment on board ambulance vehicles to provide monitoring and assessment of patients.
- All vehicles we inspected were visibly clean and tidy. Vehicles were well maintained and well stocked. There were suitable processes to ensure vehicles were roadworthy.
- The service had policies and processes for safeguarding children and adults which reflected current national guidelines and good practice.
- Pain scoring and pain relief administration took place routinely and in a timely manner.
- The service responded to calls in a timely way that met national standards. Performance standards were in line with NHS ambulance trusts.
- Crews had good working relationships with staff in commissioning NHS ambulance trusts and in the hospitals they relayed patients to. They felt supported and could contact them for support and advice.
- Crews spoke sensitively about meeting the needs of different patient groups. They made adjustments to better support patients, and demonstrated principles of patient-centred care and respecting individual needs and wishes.
- Vehicles were equipped to meet the needs of differing patient groups. For example, adaptations and specialist equipment.
- Leaders of the service had taken steps to support managers with a new training and development programme.
- Leaders of the service had taken steps to improve engagement with staff working for the service, including surveys, newsletters and workshops with service leaders.
- There was good support for crew members who had experienced difficult clinical situations that impacted on their well-being.

Emergency and urgent care services

Are emergency and urgent care services safe?

Inadequate

We rated safe as inadequate because:

- Incident reporting and investigation was not effectively managed. There was no evidence of learning from incidents to improve practice.
- The service did not discharge its Duty of Candour (DoC) responsibilities. The service did not communicate with patients and their relatives when things went wrong.
- Staff training records did not contain accurate information so there was limited assurance that all staff had completed mandatory training and safety checks relevant to their roles. The mandatory training programme did not reflect current good practice.
- The service did not have sufficiently accurate records to provide assurance that there were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- There were insufficient processes to review patient records and the service's information sharing policy was out of date.
- There was a need for more formalised and robust accountability and audit of individual paramedics' usage, storage and return of Controlled Drugs (CDs).
- There was no clear and formal policy or process for managing medicine safety alerts and it was not clear how staff competence for safe medicine administration was assessed. Drug fridge temperatures were not routinely recorded.

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- The service had policies and processes for safeguarding children and adults which reflected current national guidelines and good practice. Most staff were clear about the actions they needed to take if they suspected or witnessed any type of abuse. However, we were not assured all staff had completed relevant safeguarding training.
- The service controlled infection risks. Staff used control measures to prevent the spread of infection and keep equipment and vehicles clean.
- The service had suitable premises and equipment. There was appropriate equipment on board ambulance vehicles to provide monitoring and assessment of patients.
- All vehicles we inspected were visibly clean and tidy. Vehicles were well maintained and well stocked. There were suitable processes to ensure vehicles were roadworthy.

Incidents

There was not an effective incident reporting process in place and learning from incidents was not captured or shared with staff in a formalised way. The service did not discharge its responsibilities under Duty of Candour.

There were two incident reporting pathways. The first was the service's own reporting system and the second was through the organisation to which they were contracted, such as an NHS ambulance trust. The service had documented policies and procedures for incident and serious incident reporting, which stated that staff were encouraged to report any incidents so that reoccurrence could be prevented and lessons learnt. However, we found no evidence that the internal process was being used effectively.

During our inspection we saw data which showed there were 171 reported incidents between July 2017 and October 2018. Senior leaders told us incident reporting largely depended on the process of the organisation to which they were contracted. This also applied to learning from incidents as each contract provider used their own process which the service was contractually obliged to use. Crews used the incident reporting system according to the relevant provider's pathway, for example using an electronic reporting system.

Staff told us they could report incidents to their line managers and these were escalated to the registered person. They told us they usually did not receive feedback on incidents they had reported. The service's customer liaison officer undertook initial assessments of reported incidents to determine if they required clinical or non-clinical investigation. Non-clinical incidents were

investigated by the customer liaison officer and clinical incidents were submitted to the clinical team. We did not see evidence that learning or outcomes from incidents was shared with staff.

Incidents were reported to the relevant commissioning NHS ambulance trust using a paper reporting template, which were scanned for 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 did not receive feedback from the respective trust about the incident they had reported so changes to practice and learning did not occur.

There was an escalation process for staff to alert senior managers to serious incidents, which were initially reported back to the service by the commissioning NHS trust the staff worked for at the time of the incident. The head of operations reported incidents to a director. There was no formal on call team leader or director rota system. This meant that there may be a delay if they could not attend due to other commitments. A formal on call rota was being developed but there was no set timeframe for its implementation.

The service did not have a learning review group or equivalent to identify learning from incidents and means of disseminating learning to change practices, for example updates to mandatory training or information bulletins. There was also no formalised review of incident data to identify trends or themes.

Staff we spoke with understood the principles of being open and honest when things go wrong. 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 not meeting its duty to discharge DoC responsibilities. We saw evidence of a serious incident where a patient was involved in a road traffic collision which met the criteria for DoC. However, there was no evidence that the service communicated with the patient and their family after the incident. Instead the commissioning trust did so. This meant that whilst the family were contacted, the registered manager was unaware of the discussions that had taken place.

Mandatory training

The service did not have a suitable mandatory training programme and there were risks that some staff may not have completed training to give them the necessary skills and knowledge for their roles.

Staff working for the service were required to complete mandatory training. The service had a programme of mandatory training for staff provided by a range of trainers, which included manual handling, health and safety, first aid, infection control and restraint. However, the mandatory training programme did not reflect current good practice and was not consistently completed by all staff. For example, we reviewed a sample of training materials which included some out of date national guidance. Some contained information which was not relevant to the service provided or referenced services the provider did not deliver. Medicines management was not included in mandatory training. Therefore, there were risks that some staff may not have received appropriate training to give them the necessary skills and knowledge for their roles. Senior leaders of the service told us they were introducing 'Skills for Health' online modules for mandatory training to provide more suitable training materials.

We reviewed a sample of staff training records and found they did not contain accurate or current information so we were not assured all staff had completed all mandatory training. There was also 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 to demonstrate their fitness to work. Work had commenced on merging training records into individual personnel files, but a number of records still did not contain up to date evidence of completed training. This meant staff could be deployed even if they did not complete the required checks and updates to undertake their role.

All crew members used a shift booking system, which required them to electronically sign a form when they start a shift to confirm they were up to date with all required checks, mandatory training and requirements set by the commissioning NHS ambulance trust. This was designed to prevent staff from booking onto a shift if they had not completed the required mandatory training. However, some staff told us that there were examples of individual

staff who had not completed their mandatory training but were still able to book shifts. There was no assurance that all staff booking shifts were up to date with their mandatory training.

The service's recruitment team was responsible for ensuring new staff completed a 'compliance list' which included mandatory training and professional registration expiry dates. The process involved shared information with the Director of Governance and Associate Director of HR to inform them when staff needed to complete training. Managers and staff were alerted when training, updates and disclosure and barring services (DBS) checks were due for renewal. Staff were given 70 days to complete these checks and training from when they were recruited. Failure to do so meant they could not book onto shifts.

However, we were not assured the compliance list process was managed properly. For example, all new staff were expected to complete a 'third person shift' as part of their induction, which is when a crew member accompanies a crew to observe but not deliver care. This induction was unpaid so there was a potential risk that a new staff may not attend it. We were provided with examples of staff who had not completed the mandatory third person shifts. Although this was documented in organisational policy, we saw no evidence to provide assurance that the requirement for third person shifts were complied with and any non-attendance followed up.

Safeguarding

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

Most crew members had a good understanding of their safeguarding responsibilities. However, there were isolated examples of staff who were not aware of the term 'safeguarding' and told us they had never had to make a safeguarding referral.

The service had policies for safeguarding children and adults which had been reviewed in 2017, these reflected current national guidelines and good practice. Most staff we spoke with were aware of the policies and were clear about the actions they needed to take if they suspected or witnessed any type of abuse, and how to escalate concerns.

The service had up to date guidance on safeguarding children and adults and a list of local authorities across the geographical footprint of the service for staff to report safeguarding concerns and incidents.

There was a named senior individual for safeguarding within the organisation, which was the Director of Governance. The director had completed level 4 safeguarding training.

Crew members told us there was a single point of contact for safeguarding referrals and vulnerable patients at each of the commission NHS ambulance trusts they worked with. They could contact the relevant individual via the control room or directly with the trust.

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

The Safeguarding Children and Young People roles and competencies for health care staff intercollegiate document (2014) sets out the following training guideline: all clinical and non-clinical staff who have some degree of contact with children and young people must have Level 2 safeguarding children training, which is the minimum level required. At the time of our inspection the service was not able to demonstrate it was compliant with this national guideline.

Cleanliness, infection control and hygiene

The service controlled infection risks. Staff used control measures to prevent the spread of infection and keep equipment and vehicles clean.

The service had an infection prevention and control policy, which referenced appropriate national guidelines. However, the policy was expired and had not been updated since July 2017.

Staff were required to complete the infection control training as part of their mandatory training. However, the available data was incomplete and did not provide assurance that all relevant staff were compliant with this training.

There was a large vehicle garage at the site. During our inspection around 15 vehicles were parked in the garage. The area was clean, tidy and well organised. The floor was sealed with an appropriate product and a floor cleaning machine was available. No extractor system was visible, however a large door was open which provided good ventilation.

All the vehicles we inspected were visibly clean and tidy. Crew members were required to check vehicles were clean at the start of each shift. There was a team of 'make ready' operatives responsible for ensuring vehicles were ready for use. 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 showed that deep cleans were undertaken every six weeks.

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

Crews had access to personal protective equipment on vehicles including gloves and aprons to reduce the risk of the spread of infection between staff and patients. Vehicles carried spills kits for crews to manage small spillages to reduce the infection and hygiene risks to other patients.

There were no hand gels on the vehicles we checked and staff told us they carried dispensers on their persons. Staff stated they used hand gel to prevent and control the spread of infection.

All crew members we spoke with wore visibly clean and neat uniforms. Staff were responsible for washing their own uniforms but washing facilities were available on site.

In August 2018 the service commenced infection control audits which included hand washing and vehicle cleanliness. However, there was no evidence that the data captured by the audits were used beyond addressing any immediate concerns, for example to inform practice or share learning with the wider team.

Environment and equipment

The service had suitable premises and equipment, which was safety checked and well maintained.

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

Overall, we found the vehicles to be well maintained and well stocked. All equipment was stored in its original packaging which was intact. However, products were not always organised in a way that enabled the user to quickly find the required product in an emergency which had a potential to delay treatment.

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

We checked the equipment available on a sample of ambulances. All ambulances we checked had defibrillators that were in date. Oxygen cylinders on each vehicle were secured and within their stated expiry dates. Scoop stretchers were within date of their next service.

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

Vehicle keys were stored in the control room, which ensured secure access to vehicles was maintained while they were on site.

The fleet manager told us vehicles were serviced if the engine management light indicated a service requirement, but they were also inspected and serviced on a mileage and interval basis. For example, a vehicle would receive a safety check at a mileage interval; time interval or on demand, (at 5000 miles, six months, when the warning light came, on whichever was soonest).

The service had a process to ensure that vehicles had in-date certificates for motor insurance. We checked a sample of vehicle records and saw all were within date. This ensured the vehicles were roadworthy.

Each vehicle carried a grab bag which included clinical supplies such as bandages, wound dressings and oxygen masks. We checked a sample and found all consumables were within date. Emergency vehicles also had emergency life support equipment for adults and children.

The service had a mechanic and support mechanic on site to repair vehicle defects.

Staff used their own mobile phones to communicate with commissioning trust control centres. 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 inactive for a period. These alarms enabled the control centre to track the location of the crew and provide immediate assistance if necessary.

Assessing and responding to patient risk

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

There was appropriate equipment on board ambulance vehicles to provide monitoring and assessment of patients. For example, patients could have an electrocardiogram, oxygen saturations, non-invasive blood pressure, temperature and blood sugar recorded on the scene. This allowed the crew to supply the clinical support desk with detailed clinical observations to assist in getting the right urgent treatment for the patient. It also allowed the clinical support desk to pass this information to the emergency department the patient was being conveyed to.

Situation dynamic risk assessments were carried out. Sometimes risk pre-assessments were carried out prior to the patient journey. For instance, for bariatric or secure patients.

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.

Staff told us that the commissioning NHS ambulance trust emergency control centre allocating the job alerted crews of patients' specific needs, risks or concerns. These risks included patients with challenging or aggressive behaviour. This meant staff could prepare and consider how they would approach each patient and deliver care accordingly. However, some crew members told us they were often dispatched to calls without sufficient information.

There was a documented health and safety policy and handbook for staff. The documents were comprehensive and clear, but at the time of our inspection they were in draft form and had not been approved for use.

There was a documented policy for the use of handcuffs within secure and forensic services. This was within date and referenced appropriate guidelines, legislation and good practice, and included a record sheet for staff to complete when they were required to use restraint.

Staffing

The service did not have sufficiently accurate records to provide assurance that there were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The provider records did not give a completely accurate account of the total number of staff who were employed or self-employed. A number of individuals on the staff record were considered 'inactive' but remained on the system even though they had not completed shifts in the previous 12 months. Of approximately 650 staff on record, we were told 300 or so worked on a regular basis. The lack of an accurate and contemporaneous record meant the provider could not be assured that all staff were compliant with mandatory training, held current disclosure barring service (DBS) checks and active professional registrations.

Commissioning NHS trusts could request crews and specify the required skill mix. Senior managers told us this could vary on a daily and weekly basis. Most crew members were self-employed staff which provided flexibility for each contract. Staff were usually asked to commit to around 12 shifts per month. Few staff held permanent contracts, although the organisations was seeking to redress the imbalance by recruiting more permanent staff. At the time of our inspection approximately 70% of crews (210) were self-employed and 30% (70) employed. This was recorded as one of the organisation's highest rated risks. 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 there was no recorded and agreed timescale for when this would occur and if fixed term contracts would be offered to all staff groups.

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

An electronic rostering system was used to plan shifts. Shortfalls in cover were shown on this system and staff could request to work additional shifts. Shift patterns were dependent on the needs of the commissioning NHS ambulance trust and regularised shift patterns were not always possible. Crew members showed us the electronic shift booking system they used on their smartphones, which allowed staff to book shifts and receive confirmation of the date, hours and location of allocated shifts.

There was evidence that some staff worked excessive shifts, which could impact on their ability to deliver safe and effective care and potentially place themselves and patients at risk of harm. The organisation did not have a system in place to check staff working hours and alert managers when staff were undertaking excessive shifts. There were no checks of individuals working for other providers. We spoke with some staff who told us they regularly worked 60 hours each week for the service, and some also had other jobs. Some staff told us they worked five or six 12- hour night shifts in a row on a regular basis. Managers told us that as most staff were self-employed it was difficult to monitor or control staff working for other providers as it was individuals' responsibility to declare if they were working for other providers.

All new recruits were required to complete a 44 point recruitment checklist, which included proof of qualifications, registrations, and criminal record checks.

Checks were conducted to ensure all paramedics working for the service were registered with the Health and Care Professions Council (HCPC). Initial checks were conduct on employment, with annual checks subsequently. An annual audit was conducted to ensure all paramedics were registered with the HCPC. Audits took place in September each year and were timed to reflect the HCPC re-registration cycle which required re registration every two years. Identified sanctions or conditions on practice were escalated to directors for consideration and action as appropriate.

There were processes to ensure staff had a valid and in date Disclosure and Barring Service (DBS) check. This was through a software package that supported DBS management. We were also shown the home page for a personnel information system which used a 'traffic light' system to show any potential or actual problems. If an applicant's criminal records check showed disclosures the name would be shown in red to highlight a concern which would then lead to an individual risk assessment.

We reviewed the risk assessment process for an 'adverse' DBS check of an applicant with a previous conviction. We found that the process was robust and included full completion of risk assessment documentation and assessment by multiple senior staff.

The service had recruited a workforce manager to improve recruitment and retention of staff. Senior leaders told us there was presently high demand for staff across a number of providers in the region. In response the service had introduced some enhanced benefits, and was promoting the organisation at recruitment open days, links with partner training providers and radio adverts.

Records

Patient information was stored securely, but there were insufficient processes to ensure patient information was recorded and shared appropriately.

The service used a paper patient care record system. The patient care records (PCRs) were returned to a secure box on site at the end of each shift. Completed PCRs were scanned and sent to the commissioning NHS ambulance trust daily. Since April 2018 the service had conducted monthly dip sample audits of 10 PCRs to check they were completed properly. We were told that any gaps and non-compliance was fed back to the individual staff member. However, there were no records to demonstrate that all staff had or would have their PCRs audited on a regular basis and there was no evidence of plans to ensure all staff participated in this audit. There was no evidence of wider dissemination of learning from the records audit.

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

For some commissioning contracts crew members had NHS email accounts so the commissioning NHS trust could share information with staff by email.

The personnel files we reviewed during the inspection all included a copy of individual staff current driving licence and evidence they were qualified for the correct category and weight of the vehicles they drove.

The Director of Governance was the lead staff member responsible for information governance within the organisation. However, they had not completed training or approved qualifications to effectively discharge this responsibility, for example in understanding the organisation's responsibilities under general data protection regulations (GDPR).

We checked the service's information sharing policy and found that the policy had expired and was out of date.

Medicines

Medicines were not safely managed. Policies and processes for the storage and administration of medicines including Controlled Drugs (CDs) were not sufficiently robust to ensure patients were kept safe.

Medicines were stored in locked, secure cupboards in areas monitored by CCTV. This included secure storage for stock medicines, grab bags and medical gases. Crew members did not have access to the medicines store. The service had a current licence from the Home Office to handle Controlled Drugs (CDs).

We checked the medicine drug fridge temperature and found it was within acceptable range on the day of our inspection. However, fridge temperatures had not been recorded since January 2018. There was a paper log on the fridge door which showed temperatures were recorded nine times on sporadic days between November 2017 and January 2018, with no subsequent records. Staff told a visual check was completed each day, but there was no record of this. The service's medicines management policy also did not include provision for monitoring storage temperatures. The room where the fridge was located had rubbish bags and old equipment on the floor which had to be climbed over to reach the fridge.

The main CD stock for the organisation was held in a safe. We were told two members of staff had access to the safe code and the safe code was changed each month. The service had introduced this system shortly before our inspection, however, there was no register of who had the door codes to the CD store and there was no process to inform relevant staff when the code had been changed.

We reviewed the balance of a sample of CDs against the stock record. We found that available stocks tallied with the register. However, at the time of our inspection there was no written guidance for staff on frequency of stock checks including CDs, and no evidence of overview.

At the time of our inspection crew members were not using medicines other than exemptions, for example medications requiring patient group directions (PGDs) had been withdrawn pending reissue of an approved PGD (the provider removed the use of PGD medications for all paramedics working from the Rainham headquarters locations following a Warning Notice issued to the SSG UKSAS Fareham location by CQC in September 2018).

We found paramedics and other relevant crew members were working within their legal authority as independent practitioners. However, the managers we spoke with were unclear of current legislation and good practice regarding PGDs. The organisation was required to follow commissioning NHS ambulance trusts, which each had different PGD requirements.

At the time of our inspection organisational policies on medicines management were being redeveloped and the published policies we reviewed were past their review data and did not reflect the updated processes. In October 2018 the service had set up a new medicines management working group to discuss legal matters and review PGDs. However, the group had not met formally so there were no recorded terms of reference or minutes for us to review.

Standard Operating Procedures for medicines management were also in development. In the meantime, staff responsible for day to day management of medicines were not aware of any procedure or written guidance they could refer to for consistent working.

There was no clear and formal policy or process for managing medicine safety alerts. Alerts were accessible

only because a staff member knew the previous medicines coordinator's passwords. We found different staff members each had a different understanding of who was responsible.

It was not clear how staff competence for safe medicine administration was assessed. We saw two examples of clinical audits which covered record keeping and hand hygiene, but there were no formal audits on medicines use or administration techniques.

Paramedics working for the service held personal issue CDs, but there was a need for more formalised and robust accountability and audit of individual paramedics' usage, storage and return of Controlled Drugs (CDs). The organisation was in the process of changing to central stock of CDs and for all stocks to be signed in and out each shift. We received documentary evidence of the service's audit of paramedics' home storage of CDs which took place in October 2018. The audit included photographs of the safe, log book with current stock of morphine for each paramedic, but in some instances the audit information was incomplete. For example, one paramedic's audit documentation did not record the home address, which was left blank. Also, the photographs of the medicine safes at home locations did not provide sufficient assurance that the photographs were indeed taken at the specified location. The photocopies we received were not of sufficient quality to demonstrate that medicines were stored securely and according to relevant regulations and guidelines.

The audit highlighted some areas of concern, for example the photo of the log for one individual paramedic showed that they were not recording the current balance, so there is no way to check whether the number of ampoules shown was correct. On one page there was a record of a broken vial, which had not been witnessed. The Director of Governance told us both matters were under investigation.

Some grab bags and CDs were not returned at the end of each shift as there were staff who worked and lived a long distance from the headquarters who could not come in each day. Spot checks were conducted but there were some bags which had not been checked in the five months before our inspection.

Are emergency and urgent care services effective?

Inadequate

We rated effective as inadequate because:

- There was limited evidence of clinical audit activity and the service did not have a planned annual audit programme.
- The service did not routinely collect or monitor information on patient outcomes to improve practice.
- There were limited in-house policies and guidance documents based on national guidance and evidence-based practice. The service was required to follow commissioning NHS trust protocols for the treatment and care of patients.
- The sample of organisational policies we reviewed showed most clinical policies were out of date. Processes for reviewing policies were ineffective.
- Staff did not have remote access to the service's own guidelines and clinical protocols, which were held in paper form at stations.
- There was an inconsistent approach to driving re-assessment.
- Staff records showed self-employed staff did not receive an annual appraisal or participate in supervision. There was no clear process for identifying individual training and development needs.
- Staff had variable knowledge of their roles and responsibilities under the Mental Capacity Act. The service capacity to consent policy was out of date.

However:

- Crew members followed the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines.
- Pain scoring and pain relief administration took place routinely and in a timely manner.
- The service responded to calls in a timely way that met national standards. Performance standards were in line with NHS ambulance trusts.

- The service had recruited a new role of Head of Clinical Operations to support crew compliance and practise development.
- Crews had good working relationships with staff in commissioning NHS ambulance trusts and in the hospitals they relayed patients to. They felt supported and could contact them for support and advice.

Evidence-based care and treatment

The service did not have suitable policies and processes to ensure staff were providing up to date evidence-based care and treatment.

There were limited in-house policies and guidance documents based on national guidance and evidence-based practice for staff to refer to. Instead we found the service was required to follow commissioning NHS trust protocols for the treatment and care of patients, for example management of different presentations, illnesses and conditions.

Crew members could access policies and procedures to support working with the NHS ambulance trusts. For example, they could access policy documents via a 'cloud-based' online storage system on their smartphones. This meant they could access policies while on the road. However, staff did not have remote access to the service's own guidelines and clinical protocols, which were held in paper form at stations. Crews were required to seek telephone advice from the commissioning trust's emergency operating centre.

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

At the time of our inspection the service was developing a staff handbook containing all organisational policies. We were told this would be printed with copies available in each station. We reviewed a sample of organisational policies and found that many were out of date. All policies relating to staffing and human resources were current, however policies relating to clinical practice were all out of date. This included policies on capacity to consent, blue light policy, resuscitation protocols, Duty of Candour and infection prevention and control. Each of these policies expired in July 2018 having been last updated in July 2017. The process for reviewing policies was reliant on manual checks by the Director of Governance and there was no reminder or alert system in place.

The policies we looked at included scope, principles and instructions, with some reference to further guidance, but this was inconsistent and not present in all policy documents.

Self-employed staff did not have access to the service computer network, so they could not access electronic versions of policy documents. This group of staff was required to contact the control room to access remote guidance and information. Senior leaders told us the service was investing in handheld devices to enable crews to access policies, patient records and incident reporting remotely. However, it was not clear when they would be introduced.

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

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

Staff who undertook secure transfers of mental health patients followed the commissioning NHS trust's guidelines for transferring patients who were under section.

Pain relief

Patients' pain relief needs were assessed and addressed appropriately.

Pain scoring and pain relief administration took place routinely and in a timely manner. Staff told us they asked patients to rate their pain on a numerical basis, ranging from zero to ten. This was scored and recorded on the Patient Record Forms (PRF).

Response times

The service responded to calls in a timely way.

Emergency and urgent care services

During our inspection we reviewed a sample of service performance reports collated by commissioning NHS ambulance trusts. The data in the reports showed that the service responded to calls in a timely way that met national standards. Performance standards were in line with those expected of NHS ambulance trusts. Senior leaders and managers of the service met with commissioning NHS trusts on a routine basis to review performance. The reports identified named individual crew members if they were performance outliers and this was used to identify areas for improvement.

The national Ambulance Response Programme (ARP) was used by commissioning NHS 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 service did not routinely collect or monitor information on patient outcomes to inform service development.

The service did not routinely collect or monitor information such as the number of patients seen, response times or performance against clinical quality measures. There was a reliance on commissioning NHS ambulance trusts to monitor response times for work undertaken as part of their contract management. Performance data were shared with the service at regular meetings. We had access to the external data of one commissioning NHS trust to corroborate the provider's performance. The data in the report showed the service performance in the three months prior to our inspection was generally in line with the NHS trust's own ambulance performance, for example in response times.

It was not clear if the service contributed to the ambulance quality indicators (AQI) of the commissioning NHS ambulance trusts and staff were not able to provide evidence that learning from quality performance was identified and shared.

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 NHS ambulance trust and could not confirm if the data were included in the commissioning trusts national return. No feedback was provided to staff to improve patient outcomes.

Competent staff

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

Most staff training was undertaken at the service headquarters. Self-employed staff told us they were not paid for attending training and they were required to complete training in their own time. The service training records did not contain accurate or current information so we were not assured all staff had completed all necessary training.

Crew members were required to attend commissioning NHS ambulance trusts' induction before they could book onto shifts.

The records of appraisals showed that self-employed staff did not receive an annual appraisal or participate in supervision. All the crew members we spoke with told us they had not received an appraisal in the previous year. There was therefore no clear process for identifying individual training and development needs. Staff told us they identified their own learning needs.

Some staff were supported to undertake a paramedic training qualification, but in most cases training was self-funded.

The provider checked all staff against the Driver and Vehicle Licensing Agency database for driving offences on an annual basis to ensure they were fit and qualified to drive. If checks identified any issues such as driver disqualification, the individual would be removed from driving responsibilities.

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

Emergency and urgent care services

All new staff who did not hold a blue light qualification undertook a four week 'blue light' training course, which they were expected to self- fund. If new staff already held a blue light driving qualification their driving was only assessed as part of the recruitment process if the recruiting manager requested it. There were no criteria to inform the recruiting manager which individuals would be required to complete the assessment.

The service had recruited to a new role of Head of Clinical Operations to implement the governance policy in operations. At the time of our inspection the new head of clinical operations was awaiting a start date. The Clinical Governance Lead was responsible for the direct management of the six clinical governance supervisors. This clinical role was intended to support crew compliance and practise development in line with organisational policy and current good practice.

We saw some examples of learning resources available to staff, for example there was a learning 'cascade' case study learning document dated June 2018, which detailed a hypothetical clinical situation with learning and reflection points for crews to develop their knowledge and skills on specific subject matters.

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

Multi-disciplinary working

Staff working for the service worked with other healthcare professionals appropriately.

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

The management team had regular contract monitoring meetings with 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.

Ambulance crews communicated with the NHS ambulance trusts, emergency operations centre and other NHS providers by mobile phone to support urgent and emergency services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service did not have suitable policies or processes to ensure staff could effectively care for patients who lacked capacity to make decisions about their care.

Amongst the staff we spoke there was variable knowledge and understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Some staff did not know how to support patients those who lacked the capacity to make decisions about their care.

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

The service had a policy on capacity to consent policy which included the key principles of the Mental Capacity Act (MCA) 2005. The policy outlined the responsibilities of staff when transferring patients who lacked capacity to make informed decisions for consent. This included reference to Deprivation of Liberty Safeguards (DoLS). These safeguards were introduced to ensure that people receive treatment without infringing on their liberty. However, the policy was out of date. It expired July 2018 having been last updated in 2017. We saw updated Mental Capacity Act and Informal Consent guidelines for the organisation, but these did not follow good practice. It comprised of dense copied text from legislative documents and NHS trust policies but it was not written in a clear and accessible way for staff to easily understand their responsibilities.

Are emergency and urgent care services caring?

Emergency and urgent care services

Not sufficient evidence to rate

We have not rated Caring because we did not inspect it, but we spoke with staff about the principles and practice of caring for patients.

Compassionate care

During our inspection we were unable to observe any care being delivered to patients, however the frontline staff we spoke with described their passion for providing care in a compassionate way and meeting the needs of patients.

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 they were involved in decision making and were kept informed.

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

Understanding and involvement of patients and those close to them

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

We did not find any literature or guidance materials for staff to guide patients towards other sources of support or help them manage their own health.

The provider did not carry out patient surveys so feedback from patients was not available.

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

Requires improvement

We rated responsive as requires improvement because:

- There was no coordinated training for staff in learning disabilities or mental health support.
- There were no specific tools available to support patients whose first language was not English or those with communication support needs. Staff sought translation support from the respective commissioning NHS trust.
- The service did not have a robust system for handling, managing and monitoring complaints and concerns. The service did not directly investigate individual complaints so learning was not identified. There was no evidence of information available on vehicles to help patients raise a concern or complaint.

However,

- The service operated 24 hours a day, seven days a week to provide additional capacity and support to help meet local demand for urgent and emergency care.
- There were routine contract monitoring meetings with commissioning NHS ambulance trusts, with different levels of oversight to review quality and performance.
- Data showed the service was performing in line with agreed targets.
- Crews spoke sensitively about meeting the needs of different patient groups. They made adjustments to better support patients, and demonstrated principles of patient-centred care and respecting individual needs and wishes.
- Vehicles were equipped to meet the needs of differing patient groups. For example, adaptations and specialist equipment.
- Vehicles were fitted with the NHS Airwave radio system to ensure effective communication with the NHS ambulance provider.

Service delivery to meet the needs of local people

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

The service was commissioned by in the main by three NHS ambulance trusts to provide additional capacity and support to help meet local demand for urgent and emergency care. There were more than 90 vehicles used

per day across these three trusts. Senior leaders told us work was evenly balanced across the three main providers, with approximately 90 per cent urgent and emergency care and 10 per cent patient transport services.

The service received referrals from commissioning trusts and jobs were planned and prioritised accordingly. These were recorded on booking forms and details included the date and time of the journey. Patients details, arrival, time of pick up and discharge were also recorded.

As a contracted provider, the service provided capacity as required by the contracted provider's control room and dispatched vehicles and crews to locations as requested by the provider. Crews worked across a wide geographical area which were allocated on a daily basis based on the needs of the contract provider.

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

Organ transplant journeys were made on behalf of two NHS trusts, a large private hospital and other acute hospitals on an ad hoc basis.

Secure patient transport was provided to mental health patients requiring transfer between hospitals as well as conveying patients to hospital who were newly sectioned under the Mental Health Act 1983. Service leaders told us this was mostly ad hoc work rather than planned shifts so there were no service level agreements in place for monitoring by the commissioning provider. This meant there were no contract monitoring reports or data to assure that the service was delivering care in line with agreed performance standards.

There were routine contract monitoring meetings with commissioning NHS ambulance trusts, with different levels of oversight. For example, monthly operational reviews were attended by the relevant station manager to review performance and quality data such as mobilisation, discharge, time at hospitals, complaints and booking on times. There were quarterly middle manager reviews attended by the operations manager which covered utilisation, compliance and penalties. There were also senior manager reviews every six months attended by heads of and directors which covered performance and risks around staffing, core shifts, short shift fulfilment, staff sickness, non-conveyance rates and vehicle matters. There were action plans to address risks and concerns identified at the contract monitoring meetings. We reviewed the data reports for the contract monitoring meetings and found the service was performing in line with agreed targets.

The service was part of a 'dynamic purchasing system' (DPS) which was an NHS ambulance trust initiative to group providers together on one platform so they can bid for tenders. Senior leaders of the service told us that the commissioning environment was presently uncertain with limited continuity of contracts. This resulted in risks to the planning and sustainability of the organisation as commissioning demands for flexibility and changing specifications meant the service was required to respond to changes at short notice to win or maintain contracts. There was a bank of core staff for the service to utilise to respond to fluctuations in demand.

Meeting people's individual needs

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

Frontline staff we met spoke sensitively about meeting the needs of different patient groups. For example, staff frequently cared for vulnerable patients and those experiencing crises. Staff could describe situations where they made adjustments during the course of their work to better support patients, as well as the principles of patient-centred care and respecting individual needs and wishes. For example, staff encouraged carers or family members of patients with learning disabilities and those living with dementia to accompany them in the ambulance.

However, there was no coordinated training for staff in learning disabilities or mental health support. This meant services delivered might not take account of the needs of patients and callers living with dementia or mental health support needs, although the staff we spoke with gave us examples of how they would communicate with such patients.

Staff followed internal processes and provided vehicles for the transfer of patients with mental health support needs. Vehicle cells 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 safe and effective transfer of the patient.

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

There were no specific in-house tools available to support patients whose first language was not English or those with communication support needs. Staff told us they sought support from the respective commissioning NHS trust to access advocacy and translation support when 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 NHS trust if additional support was required.

Vehicles were equipped to meet the needs of differing patient groups. For example, adaptations such as vehicles equipped with specialist equipment for moving and handling bariatric patients. Bariatric patients are those with excessive body weight which is dangerous to health.

Access and flow

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

Commissioning NHS ambulance trusts monitored all response, on scene and turnaround times. Response times for emergency transport were measured by 'time on scene' and 'time at hospital' and summary data collated by one NHS trust demonstrated that response times were in line with agreed targets.

The service worked to key performance indicators, which mainly concerned the number of hours that had been committed to and whether they had met the commitment. There was a target to provide 95% of requested crews. Mobilisation time averages were consistent year round, below the target standard of 30 seconds. Outliers for crew mobilisation were addressed in one to one meetings with staff to improve performance. We saw that 'clear up' times were slightly below standard. Senior leaders told us this was because crews were frequently caught up in a queue of ambulances at a hospital so were stuck in the system and could not leave the patient. The service was penalised for these delays despite it being outside of their control.

The service provided 'queue' support when the local NHS emergency department was under severe capacity pressure.

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

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

Learning from complaints and concerns

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

There was a complaints procedure which staff said they followed to report any complaints verbally to their line manager. There was a designated member of staff responsible for dealing with complaints relating to the service. However, the service did not directly investigate individual complaints, which were referred to the commissioning NHS ambulance trusts to investigate and respond to the complainant. We were told that the service did not always receive feedback on the outcome of complaints so opportunities for learning were not available.

The service did not collect data about the number or types of complaints received in the 12 months before our inspection. We did not see evidence of trend or theme analysis of complaints This was not sufficient as it meant useful patient feedback was not used to inform learning or changes to practice.

On the sample of vehicles we checked there was no information available to patients on how to raise a concern or complaint.

Emergency and urgent care services

Are emergency and urgent care services well-led?

Inadequate

We rated well-led as inadequate because:

- Some local leaders did not have the necessary range of skills, knowledge, experience or capacity to lead and develop the service. Some directors did not have appropriate training, development or resources to support them in their role.
- We identified concerns with the organisational culture within the service, including a perceived disconnect between senior leaders and frontline staff. Senior leaders told us there was still a need to build trust with frontline staff.
- We received feedback from staff about perceived bullying and unprofessional behaviours by named individuals in the service leadership team and individual crew members.
- We were not assured of the integrity or validity of information presented to the board. This meant the board did not have a complete corporate understanding of the risks and challenges to service quality and sustainability.
- The minutes of governance meetings were insufficiently detailed and did not provide a clear record of discussions or actions. Management information was not routinely shared with staff.
- The provider did not routinely carry out audits on areas such as documentation, infection control or staff competency and performance of their roles.
- There was limited formal governance around staff roles and scope of practice.
- Risks, issues and performance was not effectively managed. There were limited systems in place to monitor the quality or safety of the service provided. This was because performance and quality data were not routinely collected or formally monitored.
- There was limited evidence that the service actively sought patients' views to improve the service provision.
- A new vision and values statement had been developed in April 2018 and was being communicated to staff through a series of workshops. However, the published organisational vision and values were from the previously registered organisation and had not been updated since it was taken over by SSG.
- The service commissioned an external review in June 2018 which highlighted serious concerns regarding patient safety, quality and organisational sustainability. We found these serious concerns had not been addressed since the review and they continued to impact on the safety of patients using the service.

However,

- Most frontline staff told us they enjoyed their jobs and there was strong camaraderie and support amongst crew members and their immediate line managers.
- The service had redeveloped its governance structures with new processes introduced in October 2018 shortly before our inspection. Although the new structures were documented, many of the committees and working groups had not yet met, so terms of reference and recorded minutes were not available for us to review their effectiveness. However, the plans we saw demonstrated a more comprehensive structure.
- The service had invested in leadership capacity to support business development with a focus on staff retention, engagement and development.
- Senior leaders were able to explain the main priorities and risks for the organisation.
- Leaders of the service had taken steps to support managers with a new training and development programme.
- Leaders of the service had taken steps to improve engagement with staff working for the service, including surveys, newsletters and workshops with service leaders.
- There was good support for crew members who had experienced difficult clinical situations that impacted on their well-being.

Leadership of service

Emergency and urgent care services

Some local leaders did not have the necessary capacity or capability to lead and develop the service. This meant the board did not have a complete corporate understanding of the risks and challenges to service quality and sustainability.

The company 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 for two days each month for board meetings and to monitor UK operations. There was a senior local 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.

The finance director and director of operations met with the CEO and a non-executive director one day each month. This was where direction was given, with actions to carry out. This was also where previous actions were reported on. Examples of current actions and topics were given such as procurement, personnel and general business.

The director of finance was the Nominated Individual of the service. The Nominated Individual is the main point of contact with the Care Quality Commission (CQC) and has overall responsibility for supervising the management of the regulated activity and ensuring the quality of the services provided. The directors of finance and human resources did not have previous experience of leading ambulance services. However, following the inspection we were told that they did have NHS experience during which they had worked in acute settings and therefore had worked alongside ambulance providers. There were no plans to identify and provide development opportunities to ensure all directors had the necessary skills to lead and develop the service.

The Director of Governance held a number of important organisation-wide responsibilities, such as health and safety, Controlled Drugs Accountable Officer, training and development, safeguarding, Caldicott Guardian and anti-money laundering. The Director of Governance had not received appropriate training, development or resources to support them in their role. In other organisations such roles may be more distributed amongst the leadership team or delegated to managers.

Directors of the service had identified an organisational priority to develop middle managers of the service, in recognition that some managers did not have the required management skills and there was inconsistency in the application of organisational policies and processes. The service had invested in a tailored leadership development programme. The training was delivered over six months and included workbook based learning on subjects such as the role of the manager, corporate governance, managing difficult conversations, performance management, developing staff, and effective communications and culture. Middle managers had given positive feedback and the training was mandatory. There was no equivalent training for director level staff.

The service had invested in leadership capacity by introducing a new role of Associate Director of Human Resources to support business development with a focus on staff retention, engagement and development. Previously this function was not in place, so priorities for the role had included establishing more consistent processes, such as a new competency-based recruitment assessment process.

Vision and strategy for this service

The organisational vision and strategy had been redeveloped to reflect new priorities for the service.

A new vision and values statement had been developed at the time of our inspection, with new values focused on quality, care and growth. The service leadership had held an executive away day to develop the new vision or values and review the organisational culture. Senior leaders described a vision that aspired to be a people focused service which strives for excellence and innovation. This had been promoted to staff in the staff newsletter and new staff handbook and was included in job descriptions for new recruits. The service had arranged four values workshops for frontline staff to ask them what quality, care and growth means them and to cascade the new values.

During our inspection, the organisation mission statement and philosophy were displayed on a plaque in the main reception area and in service literature. The published mission statement was to provide a quality service in accordance with, and adhering to, the codes and practices of the British Ambulance Association and the Patient's Charter. The organisation’s philosophy comprised six statements around recognising that patients have the right to be transported with dignity in a safe, secure environment; providing the best possible patient care; staff

respect individual needs of patients; patients are encouraged to provide feedback, and staff engagement and development. However, the principles displayed were from the previously registered organisation and had not been updated since it was taken over by SSG.

Culture within the service

We identified a number of concerns with the organisational culture within the service including reports of entrenched unprofessional behaviours.

Senior leaders told us there were legacy issues from the previous leadership of the service and they described a previous culture of a hierarchical management style and an abrasive and aggressive management which still resonated in some parts of the service. There was a perception that these behaviours were entrenched and difficult to change. There was ongoing organisational development work to address it, but senior staff noted some resistance from particular staff members.

Most frontline staff told us they enjoyed their jobs and there was strong camaraderie and support amongst crew members and their immediate line managers. However, there was some feedback about isolated unprofessional behaviours from individual crew members, including examples of discriminatory comments. The staff we spoke with dismissed these comments as "banter" and told us they did not apply for shifts if certain individuals were also working. This highlighted an organisational culture that did not reflect or promote a truly safe and supportive working environment for all staff. There was a sense that some staff endured such behaviours and were reluctant to challenge it despite knowing it was unacceptable.

During our inspection we received written feedback from staff about perceived bullying and unprofessional behaviours by named individuals in the service leadership team. This included some serious allegations of perceived intimidation and aggression. We were unable to corroborate this feedback as we could not do so without identifying particular staff members. However, a number of individuals directly reported a disconnect between leadership and frontline staff, which they felt impacted on relationships and trust within the organisation. Some staff had escalated their concerns to senior leaders but told us they had not received feedback or seen action taken.

The frontline staff we spoke with told us they understood the reasons for organisational changes, and that elements of the organisation had improved since the takeover by SSG, but some staff felt this had resulted in some challenges before things got better.

Senior leaders identified some concerns around the workforce model in terms of promoting a positive organisational culture. This related particularly to the ratio of self-employed to permanent staff, which made it difficult to embed a quality agenda. Current initiatives to address this included a target of 60:40 ratio of permanent to bank staff, and the development a new staff handbook to promote quality and improved adherence to organisational processes and ways of working.

Governance

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

The service had redeveloped its governance structures with new processes introduced in October 2018 shortly before our inspection. Although the new structures were documented, many of the committees and working groups had not yet met, so terms of reference and recorded minutes were not available for us to review their effectiveness. However, the plans we saw demonstrated a more comprehensive structure with new committees for finance and performance, operations and procurement, risk management and clinical governance. There were also new working groups for specific subject areas such as vehicles and equipment, estates and facilities and medicines management, all with representation from managers and operational staff.

There were monthly board meetings attended by executive and non-executive directors. A formal board report was prepared by the Director of Operations each month. We reviewed the report for September 2018 and found it presented comprehensive assessment of performance and risks. However, we were not assured of the integrity or validity of data included in the pack. For example, the service could not provide us with accurate numbers of the staff they employed. Therefore, we were not assured about the accuracy of this training compliance data.

We reviewed the minutes of two governance meetings: a special meeting of the Executive Management Committee

(board) and the Risk Management and Clinical Governance Committee, both held on 19 October 2018. The minutes were recorded on the meeting agenda document. However, the notes for each meeting were insufficiently detailed and did not provide a clear record of what was discussed and what actions were taken.

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.

There was limited formal governance around staff roles and scope of practice.

Management of risk, issues and performance

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

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

Senior leaders were able to explain the main risks for the organisation. Following a separate CQC inspection of the provider's Fareham location there was a new focus on regulatory compliance and quality assurance. However, the service had commissioned an external review in June 2018, which highlighted serious concerns relating to patient safety, quality and organisational sustainability. During this inspection we found these serious concerns were still present, such as the management of medicines, information governance and compliance with mandatory training. The reported concerns had not been addressed since the review and they continued to impact on the safety of patients using the service. There was no evidence the provider had developed action plans to mitigate these risks or take immediate action within the 30-day period the external review had recommended.

The service risk register was presented to and reviewed by the board each month. The service used a RAG rating model to categorise risks according to severity and impact. The most serious risks (rated red) were escalated to the board. Some board members did not speak English as a first language. Senior leaders told us there were sometimes issues with the informal translation provided to the board in accurately presenting risks. This meant that the full extent of some stated risks were not clearly explained in full. There were plans to use an independent interpreter.

We reviewed the service risk register and saw that recorded risks aligned with the risks senior leaders told us about and the concerns we identified during inspection. Top risks included incomplete training records, risk of death of a staff member due to road traffic incidents, lack of emergency communication facilities, staffing, and internal political issues between staff and management. There were named leads for each risk, however, the accountable senior leader for most risks was the Director of Governance, which meant one individual was responsible for addressing a number of organisation-wide risks, which in some instances was not appropriate. Although mitigations were listed for each risk, the risk register did not provide a space for responsible staff to record updates on previous and current actions taken or the current risk status.

The service held appropriate insurance to safeguard against business and clinical risks. This included current insurance for employer liability, medical malpractice, and public liability.

Information Management

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

During our inspection senior leaders explained that new governance structures and processes had been introduced, supported by more effective information management. However, the new processes were only introduced in October 2018, a few weeks before our inspection, so there were no records or minutes available and in some cases, the new meetings or groups had not yet met. The executive team monthly meetings did not have recorded minutes of actions.

Monthly reports were presented to the company board on performance, training compliance and incidents. However, we were not assured the information contained in the report was accurate given that some organisational data

such as staffing and mandatory training records were not current. The board reports were not shared with local teams or frontline staff to keep them informed about what was happening in the organisation.

There was an identified Caldicott Guardian, this is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. The 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, the named individual, or how to access support.

Public and staff engagement

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

The service had introduced a new staff newsletter in August 2018 called 'Blues n Twos' to provide staff with organisational news and updates. It included thank you notices from directors, training courses, shift availability, contract news, recruitment updates and messages relating to social matters like staff birthdays and family news.

The new Director of Human Resources had commenced a programme of consultations, surveys and change management to engage staff in organisational changes, for example in the restructuring of the service's A&E hub from seven roles to four. The changes had received some negative feedback from staff impacted by the changes and leaders recognised the need for more face to face communication with staff.

Senior leaders told us there was still a need to build trust between leaders and frontline staff, and particularly with self-employed crew members. For example, the organisational culture workshops were for contracted staff only. Senior leaders told us they had received a lot of feedback around equitable pay and working conditions for self-employed staff. We were told there were some staff complaints and grievances about inconsistent application of internal processes, pay issues and discrepancies in sick pay. There was a collective grievance about pay inconsistencies for self-employed workers. The service used an external national conciliation service to address workplace problems. The service had also published pay guidance for crews to standardise pay rates so individuals did not feel aggrieved. There were investigating officers to provide externality with grievances.

The Director of Human Resources had conducted temporary workforce questionnaires to identify this staff group's concerns and areas for improvements. There were also some one-to-one interviews with staff to gauge their thoughts about the organisation. This resulted in feedback around vehicles, uniforms and communication. Out of this, improvements to SSG were made, such as introducing 'walk ons' and 'ride outs' by clinical supervisors to provide direct guidance, support and leadership to crews while they were on the road.

Staff could raise concerns in a number of ways. There was a whistleblowing policy and process in place. Staff could report concerns directly to their line manager or to a director of the organisation. If a complaint or concern related to another staff member the service would investigate. We reviewed a sample of the responses following concerns raised. However, each complaint was managed in isolation which meant opportunities to offer support or training to staff to prevent reoccurrence were not identified. Senior staff did not receive training in addressing verbal and written complaints. This resulted in an inconsistent approach to how staff complaints were investigated and reported, and some staff felt this resulted in inconsistent actions being taken.

Innovation, improvement and sustainability

There were some example of innovative practice within the service to improve staff engagement, support and management capability.

Leaders of the service had recognised the need for improved management capability and had taken steps to support managers with a new training and development programme.

Leaders of the service had taken steps to improve engagement with staff working for the service, including surveys, newsletters and workshops with service leaders.

The service had a team of Trauma Risk Management (TRiM) practitioners. These were staff who had received additional training to support staff who had experienced 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 after the incident to support them. This was a positive intervention to improve support to staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Establish effective formalised processes for incident reporting, investigation and learning dissemination.
- Establish effective formalised processes to discharge Duty of Candour responsibilities, including policies, processes and staff training.
- Ensure staffing records contain only accurate and current information, including staff numbers, completed mandatory training and safety checks relevant for all staff.
- Ensure the mandatory training programme meets national standards and is relevant to the service being provided.
- Establish effective formalised processes to routinely audit and review patient records.
- Review and update all out of date policies and establish effective formalised processes for routine and planned policy management.
- Ensure all policies, processes and guidance documents are based on national guidelines and evidence-based practice.
- Establish a policy and process for managing medicine safety alerts.
- Establish effective formalised processes to ensure the accountability and audit of individual paramedics' usage, storage and return of Controlled Drugs (CDs) (see enforcement actions section for more detailed information).
- Establish a policy and process to routinely assess staff competence for safe medicine administration.
- Ensure drug fridge temperatures are routinely monitored, recorded and audited.
- Establish a planned clinical audit programme, including the routine collection and monitoring of patient outcome data.
- Ensure there are suitable processes for self-employed staff to complete annual appraisals and participate in supervision.
- Ensure consistent staff understanding of the Mental Capacity Act.
- Establish training for staff in dementia awareness, learning disabilities and mental health support.
- Establish an effective, formalised system for receiving, managing and monitoring complaints and concerns. This must include routine liaison with commissioning partners to ensure all complaints about the service are identified and learning is shared to improve practice.
- Ensure information for patients on the process for raising concerns or complaints is visible and available on all vehicles.
- Identify learning and development needs of local leaders, including directors, to ensure all leaders have the necessary skills, knowledge, experience, capacity and support to lead and develop the service.
- Investigate and address staff concerns relating to organisational culture and professional behaviours within the service.
- Ensure all management information presented to the board is accurate, validated and presented in a way that enables the clear identification of risks and concerns.
- Ensure records of all governance meetings are sufficiently detailed and provide a clear record of discussions and actions.
- Establish policies and process to ensure performance, risk and quality data are routinely collected, analysed, monitored, escalated and addressed.
- Establish policies and processes to actively and routinely obtain, analyse and act on patient feedback to improve service provision.

Outstanding practice and areas for improvement

Action the hospital SHOULD take to improve

- Review provision of translation, interpretation and advocacy support to ensure there is sufficient communications support for staff and patients.
- Ensure the updated organisational vision and values are communicated appropriately to staff and stakeholders.
- Address the findings of the external review in June 2018 which highlighted concerns regarding patient safety, quality and organisational sustainability, to improve the service.
- Share relevant management and governance information, such as meeting records and performance reports with staff.

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. During our inspection of the location on 6 November we found evidence that medicines were not managed safely and this posed risks to patient safety. The audit and control processes for individual paramedics' usage, storage and return of Controlled Drugs (CDs) did not provide sufficient assurance that CDs were being managed according to current legislation and national guidelines. 2. There was no clear and formal policy or process for managing medicine safety alerts. 3. Staff competence for safe medicine administration was not routinely and formally assessed. 4. Drug fridge temperatures were not routinely recorded so there was no assurance that fridge temperatures were maintained within an acceptable range. 5. There was no evidence of learning from incidents to improve practice. 6. Staff training records did not contain accurate information so we were not assured that all staff had completed mandatory training and safety checks relevant to their roles. 7. The service did not have sufficiently accurate records to provide assurance that there were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. 8. There were insufficient processes to review patient records and the service's information sharing policy was out of date. 9. The sample of organisational policies we reviewed showed most clinical policies were out of date.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints 1. During our inspection of the location on 6 November we found there was not a suitable system for handling, managing and monitoring complaints and concerns. 2. The service did not directly investigate individual complaints, which were referred to the commissioning NHS ambulance trusts to investigate and respond to the complainant. 3. Staff told us the service did not always receive feedback on the outcome of complaints so opportunities for learning were not available. 4. The service did not collect data about the number or types of complaints received. We did not see evidence of trend or theme analysis of complaints. This was not sufficient as it meant useful patient feedback was not used to inform learning or changes to practice. 5. On the sample of vehicles we checked there was no information available to patients on how to raise a concern or complaint.
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. During our inspection of the location on 6 November we found the service did not have sufficiently accurate records to provide assurance that there were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. 2. We were not assured of the integrity or validity of information presented to the board as some data held by the service were not accurate. 3. There were sometimes issues with the informal translation provided to the board in accurately presenting risks. This meant that the full extent of

This section is primarily information for the provider

Enforcement actions

some stated risks were not clearly explained in full. This meant the board did not have a complete corporate understanding of the risks and challenges to service quality and sustainability.

4. The minutes of governance meetings were insufficiently detailed and did not provide a clear record of discussions or actions.
5. The provider did not routinely carry out audits on areas such as documentation, infection control or staff competency and performance of their roles.
6. There was limited formal governance around staff roles and scope of practice.
7. There were limited systems in place to monitor the quality or safety of the service provided. This was because quality data were not routinely collected or formally monitored.
8. There was limited evidence that the service actively sought patients' views to improve the service provision.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 1. Staff training records did not contain accurate information so there was limited assurance that all staff had completed mandatory training and safety checks relevant to their roles. 2. The service did not have sufficiently accurate records to provide assurance that there were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. 3. Staff records showed self-employed staff did not receive an annual appraisal or participate in supervision. 4. There was no clear process for identifying individual training and development needs. 5. There was no coordinated training for staff in dementia awareness, learning disabilities or mental health support.

This section is primarily information for the provider

Enforcement actions

6. The Director of Governance had not received appropriate training, development or resources to support them in their role.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour 1. The service did not discharge its Duty of Candour responsibilities. 2. Staff did not receive training in Duty of Candour.