

U.K. Specialist Ambulance Services Limited

UKSAS Regional Headquarters Hampshire

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

UKSAS Regional Headquarters Hampshire is part of U.K. Specialist Ambulance Services Limited. It is an independent medical transport provider based in Fareham, Hampshire and has a satellite site at Beaconsfield in Buckinghamshire. UKSAS Regional Headquarters Hampshire provides emergency and urgent care which is commissioned by a regional NHS ambulance trust. The service had one vehicle for occasional patient transport services but there was not a sufficient service to inspect at the time. Services are staffed by trained paramedics, ambulance technicians and emergency care assistants.

We carried out a scheduled comprehensive inspection on 23 August 2016 and unannounced inspection on 1 September 2016.

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Our key findings were as follows:

- The service had a system in place for reporting and recording incidents. However, learning and action points from incidents were not disseminated to staff.
- Systems and processes were not in place to implement the statutory obligations of Duty of Candour.
- The service did not have a Patient Group Directions (PGDs) policy and did not monitor staff competency to administer authorised medicines.
- Infection control practices needed to improve.
- Staff needed a better understanding of the Mental Capacity Act (2005) and Mental Health Act to be able to support patients.
- The ambulance service response times were similar to those of the local NHS ambulance contract provider and were in line with their contract expectations. However, overall national target times were not being met.
- The service could not demonstrate they were learning from complaints.
- The service needed to improve its governance arrangements to assess and monitor quality and risk issues and to improve service delivery.
- A vision and strategy had not been developed. The service did not always proactively engage all staff, to ensure that the views of all staff were noted and acted on.

However,

- All staff had completed their statutory and mandatory training and ambulance drivers were appropriately trained.
- Equipment was available and appropriately serviced and maintained and vehicles had appropriate checks.
- Medicines were stored safely and were in date.
- Patients were appropriately assessed and monitored and patient records were held securely and included appropriate information.
- Staffing levels were as planned based on activity.
- The service used evidence based practice guidelines and ambulance transport arrangements were managed in line with the current standards and legislation.
- Staff had the skills to carry out their roles effectively, and in line with best practice. Staff worked effectively in multi-disciplinary teams.
- Staff had a strong focus on providing caring and compassionate care. We observed staff acting in professional and respectful ways when engaging with patients and their families. Staff enjoyed and felt proud to work for the service.
- Staff felt valued and supported by their peers and the local management team. They were given appropriate training and were completing mandatory training.

Summary of findings

- The service was accredited to deliver training to ambulance technicians and was developing links with the local university to mentor paramedic students.

There were areas of poor practice where the location needs to make improvements.

Importantly, the location must ensure:

- There are effective systems to assess, monitor and improve the quality and safety of the services provided.
- Internal governance and risk management systems are in place and understood by all staff
- There is learning from incidents and the learning and changes to practices are shared across all staff.
- A vision and strategy for the service is developed and is embedded across the organisation
- The Care Quality Commission of both safeguarding incidents and incidents affecting the running of the service.
- Staff understand and implement the statutory obligations of the duty of candour.
- Staff administer medicines in line with the Human Medicines Regulations 2012 and that lines of accountability are clear.
- Staff are supported in their roles by effective supervision and appraisal systems.
- Policies and procedures for disposal of clinical waste are followed.

In addition the provider should ensure:

- The service should establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by patients. Any complaints received must be investigated and necessary and proportionate action taken. The service should ensure complaints are recorded locally.
- To proactively engage and involve all staff to ensure voices are heard and acted on.
- The service should risk assess the storage location for medical gas cylinders and ensure the temperature is monitored.
- All staff should have adequate training in mental health and learning disability awareness, which is updated at regular intervals to ensure that mental health knowledge is current.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

**Emergency
and urgent
care services**

Rating

Why have we given this rating?

We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

UKSAS Regional Headquarters Hampshire

Detailed findings

Services we looked at

Emergency and urgent care

Detailed findings

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Background to UKSAS Regional Headquarters Hampshire

UKSAS Regional Headquarters Hampshire is part of U.K. Specialist Ambulance Services Limited and was registered on 9 July 2012. It is an independent medical transport provider based in Fareham, Hampshire and has a satellite location at Beaconsfield in Buckinghamshire. UKSAS Regional Headquarters Hampshire provides 999 emergency services which are commissioned by a regional NHS ambulance trust. Services are staffed by trained paramedics, ambulance technicians and emergency care assistants.

The service was last inspected in April 2013 and was found to be compliant with the five outcomes inspected at that time.

The service provides cover seven days a week, for its contract work. UKSAS Regional Headquarters Hampshire has five whole time equivalent permanently employed staff plus self-employed staff.

We visited two sites, Fareham and Beaconsfield and accompanied staff on ambulance vehicles to observe care given to patients.

We inspected UKSAS Regional Headquarters Hampshire on 23 August 2016 and unannounced on 1 September 2016. This was a comprehensive inspection. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Our inspection team

Our inspection team comprised of three inspectors, a pharmacist and two specialist advisors, who had extensive experience and knowledge of emergency ambulance services and non-emergency patient transport services.

How we carried out this inspection

We carried out an announced inspection on 23 August 2016 and an unannounced inspection on 1 September 2016. We visited two locations; Fareham and a satellite location at Beaconsfield and accompanied staff on ambulances to observe care given to patients. Before

visiting UKSAS Regional Headquarters Hampshire, we reviewed a range of information we held about the location and asked other organisations to share what they knew.

Detailed findings

During the inspection, we observed how people were being cared for and reviewed patient records of people who use services. We spoke with 17 staff members including emergency care assistants, ambulance technicians, paramedics, team leaders including the senior service manager and chief executive officer. We also spoke with the director of education and training, a mechanic and a service engineer. We observed three interactions of care, by accompanying staff on an ambulance when they responded to a call. This included the interactions between the ambulance crew and

hospital staff or other emergency crews. We reviewed four patient records. We also looked at local and national policies which staff worked to and checked servicing records for a sample of ambulance vehicles and equipment on these vehicles. Random spot checks were carried out on 11 vehicles and we looked at cleanliness, infection control practices and stock levels for equipment and supplies. Following the inspection we also contacted and spoke with the main contractor of the services, the local NHS ambulance trust.

Facts and data about UKSAS Regional Headquarters Hampshire

UKSAS Regional Headquarters Hampshire is an independent ambulance service registered to provide transport services, remote triage and medical advice, and treatment of disease, disorder and injury required by the patients who use their services.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

UKSAS Regional Headquarters Hampshire is an independent ambulance service which provides an emergency and urgent care service to patients across the Thames Valley and Hampshire area. This is through a contract with the local NHS ambulance trust. All management functions for this service are managed from the Rainham head office location in Essex.

Emergency and urgent care services were operated from the main office at Fareham, with a further satellite location based at a hotel in Beaconsfield. Vehicles used for contract work were kept at Fareham and Beaconsfield. The service has a fleet of 27 vehicles used for emergency and urgent care, 16 four wheel drive vehicles and one vehicle for patient transport services which was kept at Fareham on day hire. The service had five employed staff and self-employed staff for contract work.

During the inspection, we visited both locations. We spoke with 17 staff including emergency care assistants, team leaders and service managers, including the senior service manager. We also spoke with the director of education and training, mechanic and service engineer. We observed three interactions of care, by accompanying ambulance crews, when they responded to a call and reviewed four patient records. We also analysed data provided by the service both before and after the inspection.

Summary of findings

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

We found that:

- The service had a system in place for reporting and recording incidents. However, learning and action points from incidents were not disseminated to staff.
- Systems and processes were not in place to implement the statutory obligations of Duty of Candour.
- The service did not have a Patient Group Directions (PGDs) policy and did not monitor staff competency to administer authorised medicines.
- Infection control practices needed to improve.
- Staff needed a better understanding of the Mental Capacity Act (2005) and Mental Health Act to be able to support patients.
- The ambulance service response times were similar to those of the local NHS ambulance contract provider and were line with their contract expectations. However, overall national target times were not being met.
- The service could not demonstrate they were learning from complaints.
- The service needed to improve its governance arrangements to assess and monitor quality and risk issues and to improve service delivery.

Emergency and urgent care services

- A vision and strategy had not been developed. The service did not always proactively engage all staff, to ensure that the views of all staff were noted and acted on.

However,

- All staff had completed their statutory and mandatory training and ambulance drivers were appropriately trained.
- Equipment was available and appropriately serviced and maintained and vehicles had appropriate checks.
- Medicines were stored safely and were in date.
- Patients were appropriately assessed and monitored and patient records were held securely and included appropriate information.
- Staffing levels were as planned based on activity.
- The service used evidence based practice guidelines and was being ambulance transport arrangements were managed in line with the current standards and legislation.
- Staff had the skills to carry out their roles effectively, and in line with best practice. Staff worked effectively in multi-disciplinary teams.
- Staff had a strong focus on providing caring and compassionate care. We observed staff acting in professional and respectful ways when engaging with patients and their families. Staff enjoyed and felt proud to work for the service.
- Staff felt valued and supported by their peers and the local management team. They were given appropriate training and were completing mandatory training.
- The service was accredited to deliver training to ambulance technicians and was developing links with the local university to mentor paramedic students.

Are emergency and urgent care services safe?

By safe, we mean people are protected from abuse and avoidable harm.

- The service had a system in place for reporting and recording incidents via the commissioning NHS ambulance contract provider. However, learning and action points from incidents and complaints were not disseminated to staff and robust records were not kept.
- The service did not have appropriate facilities to support best practice or infection control policies. The station was visibly dirty, not all ambulances had cleaning wipes or hand sanitizers available and some vehicles had ripped mattresses.
- There were no infection prevention control audits conducted to ensure good standards of cleanliness were present. Clinical waste was not always managed safely.
- Systems and processes were not in place to implement the statutory obligations of Duty of Candour.

However,

- Policies and procedures were in place for cleaning and deep cleaning ambulances. Ambulances were visibly clean and staff were using personal protective equipment.
- All staff had completed their statutory and mandatory training.
- All ambulance drivers were appropriately trained
- Staff had received training and had a good knowledge of safeguarding procedures. Referrals were made following safeguarding concerns. Although the service had not appointed safeguarding leads.
- Equipment was available and appropriately serviced and maintained and vehicles had appropriate checks,
- Medicines were stored safely and were in date.
- Patient records were held securely and included appropriate information and the local NHS ambulance contract providers regularly audited these.
- Patients were appropriately assessed and monitored.
- Staffing levels were as planned based on activity.

Emergency and urgent care services

Incidents

- The service had a paper-based system in place for staff to report accidents, incidents and near misses. The system was provided by the NHS ambulance contract provider who had a contract with the service.
- The NHS contract provider confirmed that there was a requirement for the service to forward incident forms to them, and an expectation that the service would contribute to any investigation and to forward learning points to their staff in a timely way.
- Ambulance crews and senior management told us they would complete incident forms when they returned to the office and these were reported to the NHS ambulance contract provider
- Incidents would be discussed as part of the contract monitoring meetings which were held monthly. However, the data was not collated internally which meant the service did not identify specific number or types of incidents, monitor trends or share learning to improve the service. The NHS trust had been working with UKSAS to provide a more robust IT based monitoring system. This was still in its development when we inspected. We understand that since the inspection it has been operational although not yet completed by UKSAS due to staff sickness.
- The service at Fareham did not keep a formal log of incidents recorded; we were told this was because it would take too much time and resources to do this. At the satellite location at Beaconsfield we were informed that the paper based system had only been in place a month and there had been no incident forms completed.
- We saw that safety alerts were emailed to team leads from the NHS ambulance contract provider; these were then shared with staff via their computer system. Ambulance staff were required to sign to say they had read any safety alerts, to show they were aware of changes they needed to make to their practice.
- We found no evidence of any learning from reported incidents to avoid reoccurrence. The staff we spoke with told us learning from incidents was not shared. We reviewed three sets of minutes from clinical governance meetings, and found there was no record of discussions about learning from recent incidents.
- The 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 had a Duty of Candour Policy (2015), however most staff were unable to describe the principles of the Duty of Candour, and were unable to give examples of when they had put it into practice.

- At the time of the inspection, training for staff in duty of candour had not been implemented. We were not provided with a timescale of when this training would be provided. The service could not demonstrate the implementation of the Duty of Candour.

Mandatory training

- Staff within the service had attended appropriate mandatory training for their role. We saw evidence of training modules attended and when they were due to complete further training.
- Mandatory training was delivered by a combination of e-learning and face to face sessions. All staff were required to complete and record mandatory training and used a computer system to provide records of their training. Staff were not permitted to book shifts without having a complete record of up-to-date training. Data provided by the service showed 100% of staff had completed their mandatory training, at the time of the inspection.
- Team leaders were able to review records to see the training staff had completed and training, which was due for renewal.
- All drivers were appropriately trained to 'drive under blue lights' as part of the requirement of the NHS ambulance contract provider.

Safeguarding

- The service had safeguarding children and adult policies and procedures in place to protect vulnerable patients. However, the service did not have an appointed safeguarding lead for vulnerable adults and children.
- All staff we spoke with had a good understanding of safeguarding and when they would report an incident. We observed staff completing a safeguarding referral, when a crew attended a patient where there were obvious safeguarding concerns. One technician described how they had responded to a patient with mental health needs and involved social services and police to safeguard the family and 15 year old child.

Emergency and urgent care services

- Safeguarding vulnerable adults and child protection was part of mandatory training. All staff had completed this training between August 2015 and June 2016.
- The service had a procedure to use the NHS ambulance contract provider safeguarding paperwork for recording and raising safeguarding concerns. This would be faxed to a 24 hour single point of access that would pass it to the relevant local authority. However, the service did not log or record any safeguarding referrals made.

Cleanliness, infection control and hygiene

- Clinical waste management was a concern as maintenance staff were reopening, checking inside closed clinical bags in clinical waste bins, tagging them and placing them back in clinical waste bins. This could result in a possible risk of cross infection.
- Three out of 11 mattresses on stretchers in the vehicles were visibly ripped. There was at risk of it becoming contaminated if the mattress covers became worn or damaged from small holes or rips in the fabric and patients would be at risk for infection if they come into contact with blood and body fluids from other patients. We raised this at the time of the unannounced inspection.
- The Control of Substances Hazardous to Health (COSHH) folder at Fareham had not been updated since 2014 and at the satellite location at Beaconsfield did not have a COSHH folder so there was no clear direction to staff for dilution rates of cleaning products or their side effects.
- Different coloured mops and buckets were available for different areas; advice as to which mop should be used in which area was prominently displayed. However we observed that a 'dirty' toilet mop and bucket was being stored incorrectly in a clean area.
- Ambulance staff used universal sanitising wipes and detergent for routine cleaning. There were separate processes and disinfectant for body fluid spillages and known infection. We observed that eight out of eleven ambulances we inspected did not have decontamination wipes or hand cleansing gel available.
- The station at Fareham was visibly dirty and carpets were stained. We observed poor hand washing facilities in the station. There was no hand sanitizer gel or soap in the ladies toilets or lights in one of the ladies toilets. On our unannounced visit this had not improved and the light was still not working. There were no records to show that the station, toilet and shower facilities were cleaned daily; visible contaminants were present in one of the toilets on both visits. There were no records to show that water sources had been run or tested at least every week. Outlets on hot and cold water systems should be tested regularly to maintain water supplies at safe temperatures and to minimise the risk of Legionella bacteria colonisation.
- We saw no evidence of infection, prevention and control audits or hand hygiene audits within the service. This meant the service was not assessing compliance.
- At the satellite location at Beaconsfield clinical waste was brought back to the location store room and was removed weekly and taken to the headquarters at Rainham for disposal.
- The 'make ready' team had recently been employed by the service within the last two months. The make ready teams cleaned, prepared and replenished stock in ambulance vehicles. There was a check list in place to ensure each vehicle and its equipment was checked appropriately. They stated they took pride in their job and stated they prepared vehicles to the standard they would want their family to be transported in. All the vehicles we looked at were uncluttered and visibly clean.
- Ambulance crews completed and signed daily vehicle running sheets to confirm the vehicle was clean at the end of the shift. We checked 10 running sheets; eight did not show the cleaning tasks had been performed at the end of the shift. There was no log kept on the vehicle to show when it was last used to cross-reference this with the cleaning record. On our unannounced inspection we found that the service was in the process of introducing a folder for each vehicle to be kept on the vehicle.
- Ambulance vehicles were deep cleaned on a six week programme by the make ready teams. Vehicles displayed a sticker that showed when the vehicle had been deep cleaned. We found that the deep clean date for some vehicles had expired. The service was aware that the deep clean schedules had not been maintained and were actively taking steps to address this.
- The station at Fareham had a designated area for vehicle and equipment cleaning, drying areas and storage of clean items. We saw that cleaning chemicals and equipment were stored safely at each location and locked away when not in use. Staff told us that when a vehicle became heavily contaminated, or had transported a patient with an infectious disease or condition, the staff would return the vehicle to Fareham

Emergency and urgent care services

to be deep cleaned. We were informed the satellite location at Beaconsfield staff would take vehicles home or to the local petrol station to wash and clean them at end of their shift cycle.

- There were arrangements with the local hospitals for disposing of used linen and restocking with clean.
- We saw personal protective equipment (PPE) was provided on ambulance vehicles in the form of latex gloves, aprons and sleeve protectors. We observed staff using aprons and gloves appropriately.
- We observed most ambulance staff adhering to the principles of 'bare below the elbow' as a way of minimising the spread of infection. However, we observed one ambulance crew wearing a long sleeved jumper and another wearing a watch that could not be easily cleaned. This was escalated to senior management during the inspection.
- All staff wore visibly clean uniforms and most staff carried alcohol gel on their person. However staff informed us they bought their own alcohol gel as the service did not have any. This was escalated to senior management during the inspection.
- The ambulances we inspected were fully equipped, with disposable single use equipment stored appropriately and in-date.

Environment and equipment

- Most of the vehicles had identical layouts and equipment storage. This meant that crews could easily access equipment without delay. Equipment including blood pressure cuffs, thermometers and blood glucose monitoring kits were standardised across vehicles which ensured staff knew how to use the equipment during patient treatment.
- Equipment was cleaned and replenished by the make ready teams. This included all disposable equipment and medical supplies.
- When the make ready team was not on duty, ambulance staff were responsible for restocking their own vehicles from the top-up store.
- The make ready team were responsible for ensuring that all medical devices had been appropriately tested within the specified time frame to ensure suitability and safety.

- Staff we spoke with knew how to report faulty equipment and provided examples of when they had done so. For example, we saw a stretcher that was faulty that had been red tagged, paperwork completed and waiting to be taken to the headquarters at Rainham.
- At the satellite location at Beaconsfield we spoke with staff about how they prepared the ambulance prior to their shift. Most ambulances were parked overnight at the hotel site and this was where the vehicles were checked and prepared prior to shift starting. A vehicle came from the service's headquarters in Rainham to top up supplies as required.
- Vehicles were taken off the road for repair when needed, and labelled to ensure that staff were aware.
- There was provision for the conveyance of children. The service was in the process of rolling out on all ambulances a paediatric safety strap system which adapts any ambulance stretcher for the safe transport of children.
- Conveyance in vehicles were safe and secure, we observed staff using the seatbelt in the back of ambulance vehicles to keep patients secure through their journey.
- There were satisfactory records of vehicle and equipment checks. For example, there were appropriate procedures to ensure that ambulance vehicles were serviced and had Ministry of Transport (MOT) test certificates. Mechanical equipment was serviced and labelled to show the date of the last service and when the next service was due. The electronic fleet management system was updated with records of repairs and maintenance; there was also a paper copy file for each vehicle. The service kept maintenance and service logs in line with legislation. For example, there were records kept at resource centres that showed that ambulance vehicle tail lifts were checked every 6 months under the lifting operations and lifting equipment regulations.
- Staff told us that if there were any issues with a vehicle the ambulance crew would complete a vehicle defect form. Vehicle defect forms were kept at the station.
- Stock cupboards were well organised and secure. We observed stock cupboards were locked.

Medicines

- The service had medicine management and controlled drug policies although they did not have any local medicine protocols or patient group directions (PGDs).

Emergency and urgent care services

Medicine protocols and PGDs provide a framework to support staff to administer medicines safely. Managers told us that staff worked to the PGDs and protocols of the NHS ambulance trust that they were contracted to. This meant that the service had not legally taken on the NHS trust's PGDs and had not assessed competence or signed authorisation for staff to work to PGDs.

- Medication was stored on the station in a locked secure cupboard in an office monitored by CCTV; however, it had an outside window in the room without locks. On our unannounced inspection we found locks had been installed.
- Paramedics and ambulance technicians recorded administration of medicines on a medicine administration record (kept with the medicine pack) and Patient Record Forms. The administration records identified the medicines the paramedics and technicians had administered and who was accountable for the administration. However, when we checked inside five medication packs, four of them did not contain a medicine list. Hence there was no record of what medicines had been used.
- The Fareham station and the satellite location at Beaconsfield received medicine packs directly from the UKSAS headquarters at Rainham. There was tagging system in use for ambulance medicines packs. Packs were tagged green or red to identify packs ready for use and those that needed replenishing. All medicines seen were in date and suitable for use. However, we found eight out of 11 packs that had not been tagged according to procedure.
- The service did not keep controlled drugs on site. Controlled drugs are a group of medicines that require special storage and recording arrangements due to their potential for misuse. The paramedics received controlled drugs directly from the UKSAS headquarters at Rainham. Once in their possession, the paramedic was responsible for the correct storage and management of the controlled drugs. Each vehicle had a fixed safe to store controlled drugs. The keys for the controlled drug cupboard were held separate to the vehicle keys. These arrangements ensured that controlled drugs were stored securely.
- Medical gases were carried on each ambulance vehicle. Oxygen cylinders were appropriately secured in the ambulance and checked during each vehicle inspection. We found that they were in date.

- The service kept medical gas cylinders in locked cages in a sheltered location at both Fareham and Beaconsfield. Storage of medical gases was secure and appropriate with segregation between full and empty cylinders and there were signs to alert staff and visitors to the flammable nature of the gases. However the service had not risk assessed either locations and the temperatures were not monitored for safety.

Records

- All Patient Record Forms (PRF) were completed appropriately on carbonated forms. The original form was passed to staff at the receiving hospital, to ensure all staff delivering care for the patient could access the information. The second copy was given to the NHS ambulance contract provider to ensure they had a record of care and were also used for auditing the standard of record keeping. The organisation did not keep any patient records.
- We saw patient information and PRFs kept within locked metal cupboards at Fareham and Beaconsfield until they were transported to the NHS ambulance contract provider.
- The NHS ambulance contract provider ensured that up-to-date 'do not attempt cardio pulmonary resuscitation' (DNACPR) orders and end of life care planning was appropriately recorded and communicated when patients were being transported.
- The NHS ambulance contract provider undertook a monthly external review of a random selection of ten PRFs. This information was shared with senior staff, who discussed any concerns with the member of staff.
- The service audited PRF's every month informally, the results were not documented. Feedback was given to staff on both the content of the PRF and the care they provided to patients. We saw emails where this had occurred which enabled learning and improvement.

Assessing and responding to patient risk

- Staff completed clinical observations on patients, as part of their care and treatment, to assess for early signs of deterioration. We saw staff checked patients vital signs such as respiration and pulse rates, blood pressure, heart rate monitoring and these plus notes on the patient's condition was recorded on the PRF.
- Ambulance crews were able to access specialist clinical advice from the NHS ambulance contract provider, when on scene or in transit.

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- There was appropriate equipment on board ambulance vehicles to provide monitoring and assessment of patients. For example, patients could have a 12 lead 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.
- During our observations of direct care we saw appropriate manual handling techniques used for the transfer of all patients. This ensured that staff and patient safety was maintained and injuries avoided.
- The NHS ambulance contract provider had a flagging system for addresses for patients who had a number of issues, for example, where there were risks of violence to ambulance staff, where drugs were misused, or where specialist equipment had been used in the past. This information was passed onto ambulance crews.

Staffing

- Team leaders and senior staff, regularly reviewed staffing levels and the appropriate skill mix of staff to cover shifts through the contract with the NHS ambulance contract provider.
- Ambulances were staffed by emergency care assistants, ambulance technicians and paramedics and ambulance technicians and paramedics staffed rapid response cars.
- There was an agreed number of ambulances provided on each day of the week for the NHS ambulance contract provider. 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.
- The agreement with the NHS ambulance contract provider was for 95% of shifts allocated to the service per week would be covered. The provider was able to staff 92-94% of the shifts requested. They did not cover shifts if they were unable to provide staff.
- All ambulance crews had appropriate recruitment checks including valid enhanced Disclosure and Barring Service (DBS) checks as part of the contract agreement with NHS ambulance contract provider. The service had a Recruitment Policy (2013)
- Staff did not raise any concerns about their access to time for rest and meal breaks.

Anticipated resource and capacity risks

- Business continuity plans were in place for contract work, to enable the service to plan for, manage and operate in the event of significant disruption to services. As part of their contract with the local NHS ambulance trust, UKSAS were required to check their business continuity on a regular basis.
- The service had no anticipated resources and capacity risks as all ambulance crews were self-employed. We were informed that the service would only accept jobs if they had the staffing capacity to cover them.

Response to major incidents

- A major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services and would generally include the involvement, either directly or indirectly, of large numbers of people.
- As an independent ambulance service, the provider was not part of the NHS major incident planning. However, we were informed that they had been utilised as part of the NHS ambulance contract providers' major incident plan when a local incident had occurred.

Are emergency and urgent care services effective?

(for example, treatment is effective)

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- The service used national and best practice clinical guidelines to assess and plan patient's care.
- Staff were provided with patient information via the NHS ambulance contract providers control room, this provided them with all the key information they would need to know for the job.
- Staff accessed policies and guidance to support working with NHS provider. The organisation worked effectively with the NHS to coordinate services with other providers.
- We saw good multidisciplinary team working between ambulance crews and other emergency teams. Information shared during patient handover was relevant and enabled continuing care of the patient.

Emergency and urgent care services

- Staff had the relevant competencies to carry out their role effectively, and in line with best practice.

However,

- The ambulance service response times to red calls were comparable with the local NHS ambulance contract providers but targets were not being met.
- Staff understanding of the Mental Capacity Act (2005) was varied and staff understanding of the Mental Health Act was limited. At the time of the inspection staff had received no formal training on these topics.
- Staff had not received any formal appraisals.

Evidence-based care and treatment

- Ambulance staff were able to access policies and procedures for the service to support working with the NHS ambulance contract provider.
- Clinical and procedure updates were sent to staff via the shift booking computer system. If staff did not acknowledge they had read the updates they would be inactivated and were not able to book shifts with the NHS ambulance contract provider. Team leaders and managers had access to the names of staff that had been inactivated from shift booking computer system.
- The ambulance service followed the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. We observed that staff on ambulance vehicles carried the JRCALC guidance and referred to it in their assessment and documentation of patient care.
- Guidance documents with pathway advice and contact details were available to paramedic, technician and emergency care assistant staff working with the NHS ambulance contract provider.
- Staff used guidance and protocols of the NHS ambulance contract provider for patients detained by the police under section 136 of the Mental Health Act and needed transport to hospital.

Assessment and planning of care

- Staff adhered to relevant national and local guidance for their role. Patients were assessed and their care planned against national guidance, including the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) which provides clinical specialty advice to ambulance services. Staff had a copy of the JRCALC assessment and triage guidance available to refer to.

- If staff needed clinical advice, they contacted the clinical support desk, based in the emergency operations centre for the NHS ambulance contract provider. Staff told us the advice enabled them to support the patient further.
- Ambulance crews were treating a number of patients at home or on scene without the need to convey them to hospital for further care. This was known as 'see and treat'. The NHS ambulance contract provider had a non-transfer and referral policy to support staff to see and treat without transporting them to an acute hospital.
- Ambulance crews took patients to the nearest appropriate hospital for their treatment, as advised by the health care professional who had requested the hospital admission or transfer.
- All ambulance crews and staff we spoke with had a limited understanding of the Mental Health Act (2005) and the associated code of practice. We were not assured therefore that patients with a mental health problem would be identified correctly and supported appropriately.

Response times and patient outcomes

- The service did not routinely collect or monitor information on patient outcomes, such as the number of patients seen, its own response times or performance on clinical quality measures.
- The NHS ambulance contract provider monitored response times for work undertaken as part of the contract and reported these to the service at monthly meetings. We saw that there had been recent work by the contractor on providing more robust monitoring of UKSAS's achievements against their key performance indicators. We were told that there would be exception reporting and explanation of any underachievement's in the future.
- We were shown a recently developed summary where performance times were displayed in a colour rated chart, to show UKSAS current performance was generally in line with the local NHS ambulance trust response times. The local NHS ambulance trust told us they were satisfied with UKSAS's performance overall.
- The service, however, was not achieving target times to conveyance category Red calls (that is the most urgent calls). The service achieved 70% of its contract response times to for category A calls (Red 1 and Red 2). This target is to have a vehicle capable of transporting a patient at the scene for 95% of patients within 19 minutes. The target was not met overall.

Emergency and urgent care services

Pain relief

- Pain scoring and pain relief administration took place routinely and in a timely manner. Staff asked patients to rate their pain on a numerical scale, ranging from zero to ten. We observed staff asking patient's about their level of pain. This was scored and recorded on the Patient Record Forms (PRF).

Competent staff

- Paramedics are required to re-register with the Health and Care Professional Council (HCPC) every two years. They are required to undertake continuous professional development (CPD) and receive clinical supervision. We were told that the service did not provide formal or clinical supervision for staff.
- Senior management informed us, they did not undertake appraisals with self-employed staff and the small team of employed staff had not yet had appraisals. An appraisal is an opportunity for staff to discuss areas of improvement and development within their role in a formal manner.
- The service's Induction and Familiarisation Policy and Procedures for ambulance service staff included First Person on Scene course level 2.
- There was an in-house training program for Emergency Care Assistants (ECAs) to study towards becoming an Institute of Health Care Development (IHDC) Ambulance Technician an industry standard Edexcel BTEC IHCD qualification. We spoke with one ECA who had recently completed this training route and they reported that it had worked well with good support from the service.
- The service had recently entered into a relationship with a local university to support and mentor 19 people through the paramedic course. Paramedics and trainers within the service had completed courses to enable them to observe and sign off staff competencies as a clinical team mentor (CTM).
- All ambulance crews completed an Ambulance Emergency Driving course, Regulated Qualifications Framework (RQF) IHCD an accredited approved national training programme for ambulance crews responding to incidents under emergency conditions utilising audible and visual warnings.

Coordination with other providers

- Ambulance staff worked to agreed care pathways under the agreement with the NHS ambulance contract provider, to ensure standardisation of care for patients.
- We received positive feedback from the NHS ambulance contract provider and a NHS hospital trust informed us they found the crews to be helpful and efficient with their practices.
- The organisation was contracted to provide support to the NHS ambulance contract providers 999 service. The crews were allocated to specific geographical areas on a daily basis based on the needs of the NHS ambulance contract provider.
- Ambulance crews communicated with the NHS ambulance contract providers, emergency operations centre and other NHS providers by mobile phone to support urgent and emergency services.
- We observed one patient where the crew telephoned the patient's GP to discuss the patients presenting complaints, to avoid an admission to hospital.

Multidisciplinary working

- We observed good multi-disciplinary team working between ambulance crews and other emergency staff when responding jointly to a call. The teams worked well together to coordinate the care for the patient and agree onward transfer arrangements to hospital.
- We also observed handovers between ambulance crew and hospital staff, for patients who were transferred to hospital. Staff gave handover information clearly and brought any urgent concerns to the attention of staff, such as a patient being the main carer for their relative.
- Staff reported good working relationships with the NHS ambulance contract providers. We observed good communication between the call centre and ambulance crews. Ambulance crews could contact the clinical support desk if they had any queries about a patient's condition or treatment and needed advice or support.
- Staff completed a falls referral form from the NHS ambulance contract providers when a patient aged 65 years or over had fallen but was not conveyed to hospital. This was sent to the patient's own GP.

Access to information

- Staff told us and we observed that if multiple services were involved in the care of a patient, one set of paperwork was completed and this stayed with the

Emergency and urgent care services

patient, to ensure safe care and treatment at all stages of their care. Forms were carbon-copied so individual services could keep a copy for their own records and audit purposes.

- Staff had access to 'special notes' about a patient such as pre-existing conditions, safety risks or advanced care decisions, as information was provided by the emergency operations centre who dispatched the crew to the call. Staff told us they would check for a care plan in a patients' home or if they collected a patient from a nursing home. Staff provided this information during the handover.
- Staff did not raise any concerns around access to information on patient location and the reason for the calls they responded to.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ambulance staff had an understanding of the need to gain full consent prior to any treatment or interventions. Staff told us they acted in the 'best interest' of patients who were critically unwell or unconscious, being unable to consent.
- We observed staff, in non-emergency situations, explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment. Verbal consent to treatment was recorded on patient record forms. For children, consent was sought from the parent or guardian.
- Staff we spoke with had a limited understanding of the Mental Capacity Act (MCA) (2005) particularly around the assessment of capacity and completing a best interest assessment. There was a Capacity to Consent Policy (2014) available for all staff via the intranet.
- Managers informed us that they did not offer training on the MCA or the Mental Health Act (MHA) Code of Practice (1983). However, this was discussed as part of the induction.
- Staff used a form from the NHS ambulance contract providers in order to guide them in the assessment of a patient's mental capacity.

Are emergency and urgent care services caring?

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

- Staff were kind and showed empathy to patients' they were caring for, particularly when upset or in pain. We observed patients were treated with privacy and dignity at all times.
- Staff explained the care and treatment they needed to provide appropriately for each patient so they understood.
- When appropriate, patients were supported to manage their own health by using non-emergency services such as their GP or local urgent care centres.
- Patients and their relatives/carers received emotional and practical support from ambulance crews.

Compassionate care

- Staff were respectful, friendly, kind and compassionate when providing treatment or care to patients. They spoke with patients in a gentle manner and offered reassurance, particularly if the patient was distressed or in pain. One patient told us that an ambulance staff member was 'a diamond'.
- We saw staff introduced themselves to patients and made sure that they were thoroughly informed of the treatment that was needed, and what was going to happen next.
- When a patient became distressed, staff responded in a timely and sensitive way. Staff gave time for the patient to explain the reasons for their distress. Staff treated these reasons respectfully, actively listening and asking further questions where appropriate in order to provide emotional support. We observed staff telling the patient "they were there for them".
- Staff took the necessary time to engage with patients. They communicated in a respectful and caring way, taking into account the wishes of the patient at all times. Staff asked personal questions in a consistently professional manner.
- Staff maintained patients' privacy and dignity. Patients conveyed to hospital were covered in a blanket to maintain their modesty and keep them warm whilst on a stretcher or in a wheelchair.

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- Ambulance doors were shut after loading patients to ensure they were kept warm or cool and their privacy and dignity maintained. Ambulance crews maintained the dignity of patients when transferring them from a stretcher to a hospital trolley or bed.
- The interactions we observed demonstrated that staff respected patients and relatives as individuals, including those invulnerable circumstances such as the elderly and those with mental ill health. We observed staff making patients hot drinks and toast ensuring their comfort before leaving their address.

Understanding and involvement of patients and those close to

- We observed written and verbal information given to patients to support discussions that had taken place. An emergency care assistant (ECA), was observed talking to a very distressed patient giving clear explanations to the patients about the care and treatment they could provide.
- Crews asked permission to enter the patients' home, when they collected a patient from their home to take them to hospital.
- We observed patients being involved in decisions about their care and treatment. Ambulance crews gave clear explanation of what they were going to do with patients and the reasons for it. Staff checked with patients to ensure they understood and agreed to the treatment offered.
- We observed staff adjusting the way they communicated with different patients in order to explain treatment and gain their consent. They listened to the patient's wishes and offered options for care that suited the patient's individual situation and circumstances.
- Where a patient did not require hospital treatment, we observed ambulance staff discussing this with the patient to ensure they were happy to remain at home or be referred to another care provider, for example their GP.
- Staff showed respect towards relatives and carers of patients and were aware of their needs; explaining in a way they could understand to enable them to support their relative.

Emotional support

- We saw staff checked patients' wellbeing, in terms of physical pain and discomfort, and emotional wellbeing.

- We saw staff provide emotional support to relatives of a patient who had become very distressed, demonstrating a kind and empathic response and listening to concerns.
- There were messages of thanks and appreciation from patients on the station notice board.

Supporting people to manage their own health

- The operation centre staff identified frequent and high volume callers and ambulance crews would be informed before they attended the address. Staff told us they always relied on clinical assessment when they attended that ensured patients received appropriate care.
- We saw staff promoting patient health and wellbeing verbally during interactions, including advice for appropriate alcohol intake levels. Staff also advised patients on how to access information about health advice.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

By responsive, we mean that services are organised so that they meet people's needs.

- The service worked effectively with the NHS ambulance contract provider and the contract provider monitored response times for ambulance crews and discussed performance at monthly meetings with the service. The response times of the service were in line with expectations of the contract provider.
- Specially adapted ambulances were available to accommodate bariatric patients.

However,

- The service could not demonstrate they were learning from complaints.
- Staff did not have training to support patients in vulnerable circumstances.

Service planning and delivery to meet the needs of local people

- The service worked with the local NHS ambulance trust, as part of the contract, to support them to meet patient demand for their service across the area they covered.

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- The agreement with the NHS ambulance contract provider was for 95% of shifts allocated to the service per week would be covered, we were informed that they were achieving 92-94%.
- Rapid Response Vehicles (RRVs) were utilised by the NHS ambulance contract provider which allowed solo staff to respond and provide rapid patient care prior to a double crewed ambulance arriving.
- Ambulances and RRVs were all equipped with two tracking devices, one by the NHS ambulance contract provider and one by the organisation. The service had the ability to monitor the locations of its vehicles and to identify where they were.
- We saw staff promoting patient health and wellbeing verbally. The NHS ambulance contract provider had patient information leaflets to provide ongoing support or advice following discharge at scene; these were given to the organisation to give to patients.

Meeting people's individual needs

- We were informed for patients with communication difficulties or who do not speak English, staff had access to interpreting services through language line provided by the NHS ambulance contract provider. Staff told us some colleagues could speak other languages which helped at times. Otherwise, staff would rely on the patient's relatives or use hand gestures.
- There was no coordinated training for staff in dementia awareness or mental health. This meant services delivered might not take account of the needs of patients and callers living with dementia or mental health although some staff gave us examples of how they would communicate with patients living with dementia or mental health.
- The service did not provide any training to staff to raise awareness and education for patients with a learning disability. Staff were unable to give any examples of meeting the needs of people with a learning or physical disability.
- The service had vehicles equipped with specialist equipment for moving and handling bariatric patients, and ambulances equipped to transport patients. Bariatric patients are those with excessive body weight which is dangerous to health.

Access and flow

- Ambulance crews had travelling time built into their shift, if they were due to start their shift some distance from their base location. This ensured an efficient response could be provided to patients, when a call was received from the emergency operations centre.
- The NHS ambulance contract provider monitored all response, on scene and turnaround times. We saw that the response times were in line with the NHS ambulances. The service provided 'queue' support when the local NHS emergency department was under severe capacity pressure; this had in the past included supplying a 'jumbalance' to provide additional capacity.

Learning from complaints and concerns

- Senior management informed us that any complaints would be directly sent to the NHS ambulance contract provider. Patients were provided with information about how to complain about the NHS ambulance trust, which had systems in place to analyse trends and patterns for the services provided by UKSAS.
- We did not see any information about how to make a complaint in any areas or within any of the vehicles. Frontline crews that we spoke with were unsure of the complaints process for patients who wanted to complain about the service.
- The UKSAS company overall received 56 complaints between July 2015 and July 2016. However, the service was unable to quantify how many complaints related specifically to service provided by UKSAS Regional Headquarters Hampshire.
- The NHS ambulance contract stated that the service was expected to investigate any complaints, and learning shared with the service concerned. However, feedback and learning from complaints was not shared with all staff to improve services.

Are emergency and urgent care services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high- quality person-centred care, supports learning and innovation and promotes an open and fair culture.

Emergency and urgent care services

- There service did not have its own arrangements to deliver effective internal governance arrangements to monitor risks and quality within the service.
- There was no formal risk register in place which limited the services ability to identify, monitor and mitigate risks quickly.
- A vision and strategy had not been developed and embedded across the service.
- The service did not always proactively engage all staff, to ensure that the voices of all staff were heard and acted on.

However:

- The service received information about risk and quality from the NHS ambulance contract provider and there was evidence of improvements to service.
- All staff felt supported by senior management and said they were very accessible and present should they require any advice.
- All staff were very passionate and dedicated to their work, and a number of staff said they worked well as a team.
- The service was accredited to deliver training to ambulance technicians and was developing mentoring for paramedic students.

Vision and strategy for this service

- We spoke with the chief executive officer of the service who told us they did not have a documented vision or strategy for the organisation. The strategy was to continue providing a service.
- The chief executive office was clear of three top risks for the organisation which were finance, vehicles and equipment and staff.
- Staff understood the instability of the work through the contract with the local ambulance trust and the desire of the service to work with the NHS ambulance contract provider to develop a more long-term plan.

Governance, risk management and quality measurement

- A senior manager told us they worked towards the NHS ambulance contract provider's performance indicators, Senior managers told us they knew they were doing a good job through their meetings with the NHS ambulance contract provider. The NHS ambulance contract provider who showed us the performance information that had been shared and discussed with

the UKSAS. The NHS ambulance trust acknowledged that they needed to assist UKSAS in monitoring quality of services, through the provision of clearer information that could be used to improve services.

- We reviewed a set of three meeting records from April to June 2016 between the NHS ambulance contract provider and the service, where clinical governance, clinical and operational issues were discussed and monitored. It was evident from these meetings, that the service was making improvement in ensuring they met the contractual requirements of the contract. For example, the introduction of electronic patient records.
- Clinical governance meetings within the service were held monthly. We reviewed the minutes from May 2016 to July 2016 and clinical governance, training and equipment was discussed. However, record of the discussion that took place were minimal and only two people out of six attended the meetings for June and July. There was no agenda item on learning from incidents and complaints.
- There service did not have a local or corporate risk register to record risks identified regarding patients, staff or the business. This meant there was no formal process for identifying and prioritising risks and recording measures implemented to mitigate the identified risks within the organisation. Senior managers and directors confirmed to us that there was no formal risk register in place.
- The service did not undertake its own monitoring to provide easy access to key performance information on quality, including feedback from patients, number of complaints and incidents. It was not possible to see the performance of the service on a monthly basis or over the last year.
- There was no system in place to disseminate learning from incidents, safeguarding and complaint outcomes.
- The service did not carry out or participate in audits such as infection, prevention and control and hand hygiene. Patient records were audited and information and learning was shared with senior staff but not frontline staff.
- There was a lack of risk assessment of the environment for example; the placing of the cylinder stores in Fareham and in Beaconsfield without any thought for temperature controls and which contributed to the lack of monitoring the quality of the service and risks that may be present.

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Leadership of service

- There were lead individuals identified within the organisation who were responsible for different operational aspects of the business including training, operations, site, fleet manager and equipment manager.
- There was one manager overseeing the day to day management at Fareham. The manager looked after the welfare of the staff and was responsible for the planning of the day to day work.
- The chief executive officer was a director of the independent ambulance association (IAA).
- Ambulance crews spoke very positively about the management team and felt able to approach them with any difficulties and issues. They described seeing the manager every time they came to the office and told us they could discuss anything with them during this time.

Culture within the service

- Staff told us and we observed a positive culture within the service. Staff commented they were happy working for the service. They wanted to make a difference to patients and were passionate about performing their role to a high standard. Staff clearly cared for and supported each other and were comfortable in raising concerns.
- Staff said they were well supported and had access to welfare support through trauma and risk management team (TRiM) provided by the NHS ambulance contract provider.

Public and staff engagement

- The service did not proactively engage staff, to ensure that the views of all staff were heard and acted on. The management team acknowledged more was required with all staff to engage them and ensure their voices were heard.
- The service did not monitor patient satisfaction but relied on the NHS ambulance contract provider to carry this out.

Innovation, improvement and sustainability

- The service had achieved accreditation to deliver IHCD Ambulance Technician Course and is currently entering into a relationship with a local university to provide Paramedic development.
- The NHS ambulance contract holder acknowledged the need to assist UKSAS in recognising where their quality and performance was below requirements and had developed visual charts the use of colour ratings: red, amber and green. We were told of future formal monthly exception reporting by UKSAS, to highlight and explain any deterioration in quality or performance.
- The provider had plans to expand their Patient Transport Services.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

The provider must ensure

- There are effective systems to assess, monitor and improve the quality and safety of the services provided.
- Internal governance and risk management systems are in place and understood by all staff
- There is learning from incidents and the learning and changes to practices are shared across all staff.
- A vision and strategy for the service is developed and is embedded across the organisation
- The Care Quality Commission of both safeguarding incidents and incidents affecting the running of the service.
- Staff understand and implement the statutory obligations of the duty of candour.
- Staff administer medicines in line with the Human Medicines Regulations 2012 and that lines of accountability are clear.
- Staff are supported in their roles by effective supervision and appraisal systems.

- Policies and procedures for disposal of clinical waste are followed.

Action the hospital **SHOULD** take to improve

The provider should ensure

- The service should establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by patients. Any complaints received must be investigated and necessary and proportionate action taken. The service should ensure complaints are recorded locally.
- To proactively engage and involve all staff to ensure voices are heard and acted on.
- The service should risk assess the storage location for medical gas cylinders and ensure the temperature is monitored.
- All staff should have adequate training in mental health and learning disability awareness, which is updated at regular intervals to ensure that mental health knowledge is current.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• Medicines were not always managed properly and safely and in line with current regulation and best practice guidance for patient group directives.• Infection control procedures were not adequate. Staff did not always follow infection control policies and there were no systems in place to identify and monitor infection control risks. <p>Regulation 12 (1) (2) (g) (h)</p>
Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• Adequate audit, risk management and control systems were not in place.• Lack of environmental assessments meant there were risks to staff and other users of the business site. ?• There were no internal quality and monitoring processes in place to review systems and procedures and to take learning to make improvements.• There were no processes in place to seek and act on feedback from patients or staff to evaluate and improve services. <p>Regulation 17 (2) (a) (b) (e) (f)</p>

This section is primarily information for the provider

Requirement notices

Regulated activity

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

- There was no clear appraisal and clinical supervision system in place.

Regulation 18 (2)

Regulated activity

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

How the regulation was not being met:

The service did not have training or processes in place to ensure that all staff were implementing the Duty of Candour

Regulation 20