Hatzola Ambulance Service Ltd

Hatzola Ambulance Service Ltd

Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We inspected Hatzola Ambulance Service Ltd using our focused inspection methodology after obtaining information which gave us some concerns about the safe use of medicines, standard of policies and governance processes within the service.

We carried out an unannounced inspection (the provider did not know that we were coming) on 31 March 2021, with further interviews and evidence requests continuing until 21 April 2021. To get to the heart of patients' experiences of care and treatment, we normally ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? During this focused inspection we focused on the domains of safe, effective and well led.

As this was a focused inspection we did not rate the service.

We found:

- The pathways within the provider's 'Call and Dispatch Policy' did not clearly prioritise the identification of people at highest risk to life, or the referral to NHS emergency services to ensure the appropriate level of trained response was sought, other than to ask the caller to make the NHS emergency services call. This may put service users at risk of harm where the caller does not follow the advice to call 999, thus causing a delay in the attendance of an NHS suitably qualified emergency care practitioner. Hatzola Ambulance Service have since advised, however, that in the case of category one patients their call handlers will also contact local emergency services to request their attendance. Recommendations have been made that their policy is amended to reflect these actions.
- The Call and Dispatch Policy did not provide enough detail to define a category one call priority to ensure that safe care and treatment is offered to the service user. However, call response times by the service were found to be consistently rapid, which reduced the risk to patients.
- The Call and Dispatch Policy did not clearly identify the calls that would be categorised as Cat One (purple) calls, which are referenced in the procedure, ie. those where a service user's condition may be life threatening. Although, it did list those calls that would be considered as priority calls (red).
- Whilst the service had enough first response staff with the right qualifications, skills, training and experience, there could be a lack of certainty around the availability of suitable staff for calls; the on-call system relied purely on the members' availability to respond at any given time.
- The service did not have sufficient numbers of senior medical officers (SMO) to provide a rota system which ensured access to clinical advice at all times. Following the inspection we were advised that the provider had since employed further clinical staff as SMOs, which allowed the introduction of a rota system.
- There was no risk assessment for temperature variations for medicines stored in vehicles to ensure they were stored within the safe storage temperature range required.
- Some Hatzola Ambulance Service response staff were included in treating patients with prescription only medicines (POMs) that would normally need either a patient specific direction or a patient group direction (PGD). Although this practice is not supported by current legislation, we were assured that an appropriate governance process was in place to assess and manage ongoing risk.
- The provider's 'Critical Care Pathway', 'Urgent Care and Discharge Pathway' and 'Paediatric Care Policy and Procedure' did not always accurately reflect the protocols or pathways followed by its first response staff. These policies did not always give clear, definitive guidance to staff and instead provided them with a choice of options.

Summary of findings

Although the provider advised that staff would always request attendance of NHS emergency services in the first instance, the lack of clarity in the policy could potentially put patients at risk should staff follow the policy and delay a request being made for NHS emergency services ie. where staff call a SMO for advice initially. Hatzola Ambulance Service has agreed to make these changes to their policies.

However:

- The service provided mandatory training in key skills to all response staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service used electronic systems and standardised processes to record and audit the use of medicines and to securely store medicines.
- The service used electronic systems to monitor and audit business and staff performance and used this to make improvements.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations.
- The service provided care and treatment based on national guidance and evidence-based practice.
- The service monitored response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.
- Managers appraised work performance and held supervision meetings with staff to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff always had access to up-to-date and accurate information relating to the patient's care and treatment. All staff had access to an electronic records system that they could all update.
- People could access the service when they needed it and received care in a timely way.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for staff. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated most risks and issues and identified actions to reduce their impact.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Inspected but not rated	Please refer to the overall summary above.

Summary of findings

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Summary of this inspection

Background to Hatzola Ambulance Service Ltd

Hatzola Ambulance Service Ltd was registered in November 2020 and has actively provided a service from January 2021. It is a registered ambulance service delivering emergency first response and medical care to the community. The service is staffed by volunteers from within the community they serve and the operations manager for the service is the registered manager.

The service is provided 24 hours a day, seven days a week and primarily covers the Prestwich, Broughton Park and Whitefield communities in Manchester.

Regulated activity

The provider is registered to provide:

• Transport services, triage and medical advice provided remotely

• Treatment of disease, disorder or injury

Activity (January 2021- February 2021)

In January 2021 the service attended 352 calls and 425 in February 2021. On reviewing the data provided we noted that the provider had attended a high volume of calls relating to children. In January 2021 the provider attended 172 calls for children up to 18 years of age (49% of all calls). In February 2021 they attended 219 calls to children (52% of all calls).

Inspection history

As the service is newly registered it had not been inspected prior to this inspection.

How we carried out this inspection

The inspection team consisted of a lead CQC inspector, another CQC inspector and a medicines specialist. The team had oversight from an off-site inspection manager and overall oversight from the Head of Hospitals Inspection, Karen Knapton.

During the inspection we visited the registered location. The inspection team reviewed provider policies, medicines storage facilities, medicines audits, electronic Patient Report Forms (ePRF), training records, electronic systems and performance audits.

The team spoke with the registered manager, the nominated individual, the clinical lead, the office administrator and three members of the volunteer responder team.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services. The provider agreed to make these changes following the inspection, minimising any potential risk to patient safety.

Action the service MUST take to improve:

- The service must ensure that all existing policies are reviewed to ensure they contain an accurate reflection of their service provision, pathways and processes. (Regulation 17- Good governance)
- The service must reduce the risk resulting from lack of provision of information for safe triage of calls, to ensure that the provider can safely respond to all emergency category one calls. (Regulation 17- Good governance)
- The service must reduce the risk resulting from a lack of an effective system to ensure the provision of senior support at all times. (Regulation 17- Good governance)
- The service must ensure that they have sufficient numbers of senior medical staff to enable access to clinical advice at all times. (Regulation 18- staffing)

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The service should risk assess the storage of medication in environments subject to temperature variation.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Emergency and urgent care

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

Are Emergency and urgent care safe?

Inspected but not rated

Mandatory Training

The service provided mandatory training in key skills including the highest level of life support training to response staff and made sure everyone completed it.

The inspection team reviewed the provider's training log which identified what training staff had undertaken and when this was due to be renewed. Most staff were up to date with the core competency and statutory/mandatory training requirements. However, recently recruited staff members had been unable to undertake their face to face safeguarding training due to COVID-19 restrictions. One member of staff had been unable to complete their First Response Emergency Care (FREC) refresher training for the same reason. Management assured us that none of these staff would attend as the first responder and would only be on site with a member of staff who had the relevant and up to date training.

We were told that should any incident evaluation, training or clinical audit identify any gaps in training then ad hoc training would be arranged for all relevant staff members.

Staff were required to undertake a training programme prior to commencing active duty which included completion of a mandatory training programme. All staff had received mandatory training in the Mental Health Act and the Mental Capacity Act.

We were told that there had been additional training sessions provided, including group advanced life support (ALS) sessions and scenarios, utilising electronic equipment. (The electronic equipment can act like a person who is symptomatic e.g. is bleeding, vomiting or has chest pain). Weekly ALS training was also being provided on a rotational basis.

The service had purchased a machine to support resuscitation in transit. This was not yet in use but there were plans to organise training for the staff in order that this could be used.

The provider's electronic systems were all linked and had been purpose built to capture all data required for monitoring and audit purposes. Training records would 'flag' when a module was due for renewal. The nominated individual was keen for staff to complete training and competencies to progress in the service. We were told that the registered manager for another Hatzola ambulance service was supporting the service with staff appraisals.

Assessing and responding to patient risk

Inspected but not rated

Emergency and urgent care

Staff completed and updated risk assessments, whilst on scene, for each patient and removed or minimised risks. However, no clinical risk assessment was undertaken by call handling staff at the time of the call.

The registered manager told us that the call handlers followed a set 'script' when contacted on the dedicated phone line. It was confirmed that call handlers do not triage calls. If the dispatcher is told that the patient is not breathing or is unconscious, however, they would advise the caller to hang up and call 999.

We were further told that on a few occasions staff had arrived on scene and a call had not been made to the emergency service as advised. Following the inspection, the registered manager informed us that if a call involved a category one situation the call handler would also ring 999 to ensure that an NHS emergency ambulance was dispatched immediately. This was not made clear in the 'Call and Dispatch Policy'.

Management and staff explained that if response staff arrived on scene and a patient had deteriorated, or if they deteriorated once on scene, the responders would radio the call handlers to request NHS emergency services and senior medical officer support, as well as additional member support if required. This process was not clearly reflected in the providers policies.

The clinical lead explained that the service had arranged for Pathfinder and Manchester Triage training to be provided by an external company, to support with on-scene and call handling standardisation.

Multiple calls to the same address and calls for the same issue, which could identify a risk, were monitored and assessed for any trends in behaviours. These were flagged on patients' electronic records.

Staff and management told us that dynamic risk assessments were undertaken by responders on arrival at scene. There was no written record of risk assessments identified in the patient records reviewed by the team. The call handlers would undertake an assessment with regards to infection control issues so that responders could wear the most appropriate personal protective equipment on arrival.

Safeguarding

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

Senior management told us that all staff received face to face level three adult and children safeguarding training and that the service had four safeguarding leads with level four safeguarding training. The completion of safeguarding training was documented on the provider's training log.

The service appropriately reported safeguarding concerns. CQC had received two statutory notifications between January and March 2021, from the provider's safeguarding lead, identifying possible safeguarding concerns. These had also been reported to the local safeguarding authority.

Staff told us that if they had any concerns about the welfare or safety of a patient, they would either ring 999 or contact the patient's GP and would report the concerns as per policy to their safeguarding lead.

Records

Emergency and urgent care

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

The inspection team were shown the provider's own secure electronic record system and viewed 12 electronic patient records. The records were clearly completed and contained all the relevant and up to date information expected. We were told that staff could access historic records via the secure system for relevant history.

All staff had access to an electronic records system that they could all update.

Staff and management confirmed that they had an electronic record system which the provider had developed (CAD system) which could be accessed remotely via their mobile devices.

Staffing

The service mainly had enough response staff with the right qualifications, skills, training and experience , however, due to the reliance on the availability of volunteers to attend a call this could potentially result in those staff initially attending not having the adequate level of skills, dependent on the nature of the call.

There were only two SMOs employed and no rota for senior medical officer cover. Following the inspection the provider told us that they had since recruited three more SMOs with another two officers due to be employed in the next two months. This had allowed a rota to be introduced ensuring adequate senior medical cover at all times.

The provider had access to clinical and medical professionals for clinical advice, including a medical director (GP) and an advanced paramedic. They were also plans to add a paediatric specialist, a pharmacist, a nurse and another paramedic to the team.

All response staff had undertaken the appropriate level of training for the roles that they were undertaking. Staff we spoke with told us that they did not undertake procedures that were outside of their capability or level of training. We were told that the service had now employed two full time members of office staff.

Response staff were all volunteers and carried a radio/bleep in order that they could be contacted when there was a call. Those staff that were available to attend would make this known to the call handler.

A number of staff had also undertaken blue light training, via the local ambulance service, in order that they could use blue lights in an emergency situation. This consisted of a five-day initial training course, annual refresher day and three yearly repeats of the five-day training course.

The clinical lead was also employed by the local NHS ambulance service.

The level of training provided to response staff, on the assessment of children in emergency situations, was not clear on the provider's training log, however, we were given verbal assurances that all staff had received this training. FREC4 training included assessment of children in emergency situations and we were told that all FREC3 trained staff received additional training in the emergency assessment of children, however, we did not see evidence of this during the inspection.

A GP (the medical director) was available to provide advice and support to staff and there were plans to introduce a paediatrician for clinical support and a pharmacist for medicines management.

The provider had eight volunteer call handlers.

Medicines

Systems and processes to store, administer and record medicines were not always clearly described in the policies and procedures.

A medicines management procedure (dated April 2020) was available and described the process for the ordering, receipt, storage, administration and disposal of medicines. However, some of the arrangements described in the policy were not always clear particularly regarding the individual members authorisation and scope of practice.

Medicines were stored safely and securely at the provider location and on emergency vehicles, with access only by authorised members of staff. There were two types of medicine bags, or kits, one for 'volunteer responders (kept in their own vehicles) and one kept in the ambulance Medicines available on the ambulances varied from those carried in the responders' own vehicles.

All medicine bags were secured with security tags which included an expiry date to indicate medicines were safe and ready for use. We observed that the numbers on the tags corresponded to the responder's identification number which was used on the electronic patient report forms. We were unable to check inside the medicine bags due to the security tags as no one was available to replace the tags. A checklist of medicines was included on each bag.

The medicine bags were stored with members emergency equipment packs in their cars and although there were no medicines carried which required refrigeration there was no risk assessment for temperature variations for medicines stored in vehicles, to ensure they were stored within the safe storage temperature range required. The service acknowledged that it would be useful to undertake an overall risk assessment for the safe and secure storage of medicines on vehicles.

The clinical lead told us that standard operating procedures (SOP's) had been developed according to Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance and were replicated in a booklet which was available to all staff. Patient Group Directions (PGD's) were not yet available which would give the required authorisation for paramedics and nurses to administer additional prescription only medicines (POM) not listed in Schedule 17 or Schedule 19 exemptions of The Human Medicines Regulations. However, the service was in the process of developing and authorising PGDs which would need to be signed by the medical director, a pharmacist and a paramedic.

Ambulance technicians were also included in treating patients with POMs that would need either a patient specific direction or a PGD. Ambulance technicians are not listed as a named, authorised, registered health professional and therefore are unable to use a PGD. We were shown evidence that technician staff had undertaken appropriate training and had been assessed as competent to administer the listed POMs. Although this practice is not supported by current legislation, we were assured that an appropriate governance process was in place to assess and manage ongoing risk.

Electronic systems were in place to track and audit medicines from receipt to administration. Any medicines used were recorded and tracked against the electronic Patient Report Form (ePRF). The medicine bag number, batch numbers of each medicine including their expiry date were electronically recorded. This ensured that medicine stock levels were monitored, the reason for administration could be audited and any medicine recalls could be actioned immediately. A sign in and sign out register was also kept ensuring that each medicine bag could be tracked. Stock rotation was undertaken to ensure medicines did not go out of date. Any medicines that required to be removed and destroyed were recorded and two staff witnessed the destruction.

Inspected but not rated

Emergency and urgent care

The service had taken advice from the local fire safety officer for safe storage of medical gases. Medical gas cylinders were stored safely and securely in a dedicated secure area that was clean, dry and well ventilated. Appropriate hazard warning stickers prohibiting smoking and naked lights were visible on the outside of the storage area. Cylinders were stored on racks which ensured segregation between empty and full cylinders.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. The service used monitoring results well to improve safety.

Staff members knew what incidents required reporting and explained the process to do so. They told us that they always got feedback regarding the incidents that had been reported.

We were told by the operations manager that the time taken to investigate incidents depended on the incident itself.

Following any serious incident, a 'hot debrief' was held and was followed by discussion at the next all staff meeting, allowing staff discussion and learning.

The service manager told us that the organisation had its own incident report forms (IRF) which were completed for everything from minor to major incidents. A recent example was described, where a form had been submitted to advise that an open channel had not been used on the radio when there was a major incident. The learning from this was that closed channels should not be used as this prevented all staff being updated at the same time.

The team was told that all IRFs were audited and feedback given to relevant the staff member/s. Incidents could be reported via the admin team or anonymously through the Freedom to Speak up Guardian.

Are Emergency and urgent care effective?

Inspected but not rated

Competent staff

Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff told us that they had weekly tutor meetings, as well as monthly training sessions and discussions around recent calls. They told us that management listened to requests for additional training where a development need was identified.

Management confirmed that all staff had regular appraisals and performance was audited regularly, which allowed any specific performance issues to be addressed as required.

The operations manager told us that all staff had access to online performance data.

Emergency and urgent care

The inspection team viewed the provider's training record, for FREC 3 and FREC 4, training which verified that all responders had received appropriate training, with only one member of the response team awaiting their refresher training (as mentioned above).

In the staff training information provided on 21 April 2021, it was noted that there were 22 response staff trained to FREC 4 level and 11 trained to FREC 3 level. All but one of those with FREC 4 level training had also undertaken the safe administration of lifesaving medicine (SALM) training.

Evidence based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

The clinical lead told us that clinical pathways and medicines administration followed the JRCALC guidance and local standard operating procedures and clinical pathways had been developed in line with these guidelines.

On reviewing the Hatzola Ambulance Service pathways/ policies it was also noted that the provider stipulates that they follow National Institute for Health and Care Excellence (NICE) and JRCALC guidelines, and for the paediatric care pathway the Resus Council guidance.

Multi-disciplinary team working

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

On reviewing electronic patient records the team identified two instances where the Hatzola crew had worked alongside the local NHS ambulance service to provide care to a patient. They also identified instances where additional assistance on scene had been requested from the clinical or medical leads, where the patient's condition was critical and required urgent lifesaving medication that the responders could not administer.

We were told by the operations manager that the call handlers would use radio communication with the crew to allow them to update NHS emergency services on route to the patient's address, or to stand down NHS emergency services where they are no longer required.

Patient Outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The operations manager told the inspection team that the service now had a second paramedic working within the service, whose responsibility it was to audit the ePRFs. They audited performance in relation to the completion of the forms and the actions undertaken. Where issues were identified they were discussed with the individual staff members concerned and any global lessons learned were shared with the wider team, either at staff meetings or via their newsletter.

The service monitored response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

Inspected but not rated

Emergency and urgent care

Call response times were recorded electronically via the CAD system and were regularly audited. Any delays in response were investigated and actions taken to prevent recurrence, if appropriate. A review of response times in January and February 2021 identified that for category one calls the average response time was two minutes and 26 seconds. For urgent calls the average response time, over the two months, was eight minutes and 45 seconds.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The inspection team reviewed 12 patient records and confirmed that in all consent had been documented (although details were redacted in line with data protection principles). Staff told us that should the patient lack capacity, determined following their assessment, or be unable to provide consent to treatment, they would request this from their next of kin, if they are a child, or held power of attorney for health decisions. In cases where consent was not given, for example, where the patient refused transfer to hospital, the crew would request attendance of the local NHS ambulance service or discuss the issue with the patient's GP.

The operations manager told the inspection team that all staff undertook mental health act and mental capacity act training, via an external organisation.

Staff told us that at every stage in the patient's care the crew would explain what was happening and ensure that consent was given to the procedure or treatment being undertaken.

Are Emergency and urgent care well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for staff. They supported staff to develop their skills and take on more senior roles. Staff felt respected, supported and valued.

We were told that the clinical lead had been with the service approximately eight months and had been involved with reviewing governance processes, including reviewing policies and audits. The lead was part time and continued to work for the NHS to help maintain their skills and competencies.

The registered manager/operations manager had experience of working for other independent ambulance services prior to Hatzola Ambulance Service

Staff told us that the management team were approachable and open to ideas from staff. An example was provided where staff had suggested that a wound closure course may help improve their clinical care. The management team arranged for an external training course to be provided to all staff and this was positively received by staff.

Additionally, management told us that they were fully supportive and encouraging of progression within the organisation and in skills development. The service was funding masters training for the organisation's registered nurse and had provided an opportunity for one of the responders to take responsibility for managing 'feedback'. Following this the responder's completion of ePRFs had also improved and they had received an outstanding performance review.

Governance

Leaders mostly operated good governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The inspection team reviewed the provider's Medicines Management procedure, which clearly demonstrated the level of training required in order to administer specific medications, however, it was unclear in the policy what level of staff were classed as a senior medical officer (SMO).

The clinical lead acknowledged that although the administration of medication was limited to those with the appropriate level of training, the policy did not reflect what happened in practice. They agreed that this would be reviewed and amended appropriately.

The clinical lead explained that the service had received support on their policies from other a compliance officer who also supported other Hatzola ambulance services. They had employed an independent organisation to assist with drafting policies and preparing the service for registration. In addition, the clinical lead had reviewed and/or drafted many of the policies.

The inspection team noted that there were sections of these policies which were not clear in relation to when emergency services would be contacted, or their response to the deterioration of patients, particularly children. We were told that if there were concerns about the condition of a patient, including any deterioration, then NHS emergency services would be called in preference to seeking advice from the clinical lead (or other SMO).

Regular audits of performance data were undertaken along with use of medicines and clinical audits. Learning from these audits was shared with staff and lessons learned identified to help improve the service provided.

Management of risk, issues and performance

Leaders and teams had systems to manage performance. They did not always identify potential risks and issues. However, where these were identified actions were taken to reduce their impact.

The operations manager told us that the organisation had a live risk register which was updated regularly and identified operational risks and actions required to reduce or remove the risks.

Following the inspection, it was identified that risks relating to inaccurate policies and pathways and lack of SMO cover had not been identified as risks by the provider.

The provider told us that they had three levels of meetings where corporate, performance and operational issues could be discussed. Any important information discussed at the monthly senior management level meeting could be disseminated, as appropriate, to all staff at the weekly staff meeting.

This section is primarily information for the provider

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems to ensure that the service consistently had enough access to suitably qualified staff with the skills and training to meet the needs of service users, as there were not enough senior medical officers available to allow a rota system to be provided.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective policies and procedures to ensure that staff safely respond to emergency calls or directly escalate calls, when needed, to NHS emergency services. This may put service users at risk of harm as the provider has not ensured that dispatchers have sufficient guidance to respond safely to the level of seriousness of a service user's condition.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have an effective policy or procedure for staff to follow in situations when a service user's condition is deteriorating and needs escalating to NHS emergency services. A lack of definitive pathways may put service users at risk of harm especially where treatment is time critical.