UK Specialist Ambulance Service Ltd - Headquarters

Quality Report

UK Specialist Ambulance Service Ltd
Corporate Headquarters
A1 Thames View Business Centre
Barlow Way
Rainham
Essex, RM13 8BT
Tel: 03332 407 111
Website: www.uksas.org

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

Summary of findings

Letter from the Chief Inspector of Hospitals

UK Specialist Ambulance Services Limited (UKSAS) is an independent medical transport provider based in Rainham, Essex. The provider is registered at this location, with additional, separately registered sites in Fareham in Hampshire and Beaconsfield in Buckinghamshire. UKSAS provides emergency and urgent care services which are commissioned by NHS ambulance trusts and other organisations. Services are staffed by trained paramedics, ambulance technicians and emergency care assistants.

We carried out a comprehensive 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:

- There was evidence of learning from incidents and changes to practice as a result. There were appropriate risk assessment systems in place to ensure crews had the capacity and competency to care for different types of patients.
- There was good completion of staff mandatory training.
- Staff adhered to relevant national and local guidelines and had access to appropriate evidence-based policies and guidance. Staff received appropriate training and practiced within the limits of their competency but did not receive regular appraisals.
- Infection prevention and control was mostly well managed. There were isolated incidents where hygiene processes could be improved.
- There were no direct reporting lines to safeguarding authorities for crew members to report safeguarding concerns.
- There was no evidence of a cohesive, managed process for ensuring clinical products were in date.
- The service did not routinely collect or monitor information on patient outcomes, such as the number of patients seen, response times or performance on clinical quality measures.
- Staff interactions with patients were respectful, friendly, kind and compassionate. Patients were kept informed of what was happening and where they were going. Staff checked patients' wellbeing, in terms of physical pain and discomfort, and emotional wellbeing. However, staff did not have access to literature which they could share with patients to direct them towards other services or sources of help.
- There was no coordinated training for staff in dementia awareness, mental health or learning disabilities. This meant services delivered might not take account of some patient' specific needs.
- The service did not have a robust system for handling, managing and monitoring complaints and learning from complaints was not shared with all staff to improve services.
- Senior managers understood their main priorities and risks. Staff told us managers were visible and approachable. However, governance arrangements were not sufficiently robust. The organisation did not have access to performance information to identify areas where performance could be improved.

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

Action the provider MUST take to improve:

- Ensure there are robust systems to collect, assess and monitor performance data and information on patient outcomes to improve the quality and safety of the services provided.

Summary of findings

- Ensure there are formalised lines of escalation for reporting safeguarding concerns and appoint an organisational lead for adult and child safeguarding to provide oversight of all safeguarding matters.
- Ensure there are robust internal governance and risk management systems in place which are understood by all staff.
- Fully implement the system for recording and monitoring the expiry date of clinical products across all vehicles and areas where clinical products are stored to ensure all clinical products are within date and safe for patient use.
- Ensure all staff are trained in duty of candour and are aware of their responsibilities.
- Ensure staff administer medicines in line with the Human Medicines Regulations 2012 and that lines of accountability in medicines management are clear.
- Ensure all staff are supported in their roles by effective appraisal systems.

Action the location SHOULD take to improve:

- 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.
- Take steps to proactively engage and involve staff and patients to ensure adequate opportunities are available for individuals to share concerns, receive information and inform service development.
- All staff should have adequate training in mental health and learning disability awareness, which is updated at regular intervals to ensure they can meet the individual needs of all patients.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services		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.

Summary of findings

Contents

UK Specialist Ambulance Service Ltd Headquarters

Services we looked at
Urgent and emergency services

Summary of this inspection

Background to UK Specialist Ambulance Service Ltd - Headquarters

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

We conducted an unannounced inspection of UKSAS Headquarters 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 two inspectors, a pharmacy inspector and one specialist advisor who had extensive experience and knowledge of emergency ambulance services and non-emergency patient transport services.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting UKSAS Headquarters we reviewed a range of information we held about the provider and asked other organisations to share what they knew. We carried out an unannounced inspection on 1 September 2016.

During the inspection we looked at ambulance vehicles and the working environment of the site. We reviewed patient records of people who use services. We spoke with 12 staff including emergency care assistants, ambulance technicians, paramedics, administration staff, and service 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 reviewed local and national policies. We checked servicing records for a sample of ambulance vehicles and equipment. We inspected six vehicles where we looked at cleanliness, infection control practices, stock levels for equipment, medicines and other supplies.

Information about UK Specialist Ambulance Service Ltd - Headquarters

UK Specialist Ambulance Services Limited is an independent medical transport provider with headquarters based in Rainham, Essex. There are additional locations at Fareham in Hampshire and Beaconsfield in Buckinghamshire which are registered separately. The service is registered to provide transport services, remote triage and medical advice, and the treatment of disease, disorder and injury required by patients who use their services.

UKSAS provides 999 emergency services which are commissioned by regional NHS ambulance trusts..

Summary of this inspection

Emergency transport services are staffed by trained paramedics, ambulance technicians and emergency care assistants. It also provides medical transport support for events and other private commissions

The service provides cover seven days a week for its contract work. UKSAS Headquarters has 20 whole time equivalent permanently employed staff and over 40 self-employed staff.

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

UKSAS Headquarters is an independent ambulance service which provides an emergency and urgent care service to patients across East and South East England through contract arrangements with local NHS ambulance trusts. All management functions for the service are managed from the Rainham head office.

Emergency and urgent care services are operated from the Rainham headquarters. Vehicles used for contract work are kept at Rainham, Fareham and Beaconsfield. The service has a fleet of 100 vehicles used for emergency and urgent care, including ambulances, four wheel drive vehicles and vehicles for patient transport services.

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:

There was evidence of learning from incidents and changes to practice as a result.

There were appropriate risk assessment systems in place to ensure crews had the capacity and competency to care for different types of patients. There were good completion rates for mandatory training. Staff received appropriate training and practiced within the limits of their competency but they did not receive regular appraisals

Infection prevention and control was mostly well managed, but there were isolated incidents where hygiene processes could be improved.

However, there were no direct reporting lines to safeguarding authorities for crew members to report safeguarding concerns.

There was no evidence of a process for ensuring clinical products were in date.

Staff adhered to relevant national and local guidelines and had access to appropriate evidence-based policies and guidance.

The service did not routinely collect or monitor information on patient outcomes, such as the number of patients seen, response times or performance on clinical quality measures.

Urgent and emergency services

Staff interactions with patients were respectful, friendly, kind and compassionate. Patients were kept informed of what was happening and where they were going.

Staff checked patients' wellbeing, including pain, discomfort, and emotional wellbeing. However, staff did not have access to literature which they could share with patients to direct them towards other services or sources of help.

There was no coordinated training for staff in dementia awareness, mental health or learning disabilities. This meant services delivered might not take account of some patients' individual needs.

The service did not have a robust system for handling, managing and monitoring complaints and learning from complaints was not shared with all staff to improve services.

Senior managers understood their main priorities and risks. Staff told us managers were visible and approachable. However, governance arrangements were not sufficiently robust. The organisation did not have access to performance information to identify areas where performance could be improved.

Are urgent and emergency services safe?

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

- There was evidence of learning from incidents and changes to practice as a result.
- There were good completion rates for mandatory training.
- There were appropriate risk assessment systems in place to ensure crews had the capacity and competency to care for different types of patients.
- There were appropriate business continuity plans and major incident arrangements to ensure continuation of service in the event of significant disruption.

However:

- Infection prevention and control was mostly well managed, but there were isolated incidents where hygiene processes could be improved.
- UKSAS did not have its own medicine protocols or patient group directions (PGDs). Staffed used the PGDs of the contracted provider but their competence to use the PGDs was not assessed and they did not have signed authorisation to use them.
- Staff did not have training in duty of candour and were unable to describe the principles or give examples of when they had put it into practice.
- There were no direct reporting lines to safeguarding authorities for crew members to report concerns.
- There was no evidence of a cohesive, managed process for ensuring that clinical products for patient use were in date and safe to use.

Incidents

- There were two reporting pathways when an incident occurred. The first was UKSAS's own reporting system and the second was through the organisation to which they were contracted, such as an NHS trust).
- The chief executive and director of corporate strategy told us that incident reporting largely depended on the process of the organisation to which they were contracted. This also applied to learning from incidents as each contract provider used their own process which

UKSAS was contractually obliged to use. Crews used the incident reporting system which was reported to the relevant contracted organisation's pathway, for example using electronic reporting systems.

- With UKSAS's incident reporting protocols, an incident reporting form captured the incident details which were then categorised as either clinical or non-clinical. If the incident was clinical, it was investigated by the clinical director and if it was non clinical, it was investigated by the customer services manager.
- We were given examples where UKSAS had investigated reported incidents and demonstrated learning points. There was evidence of action taken in response to incidents. For example, during our inspection, three members of staff were attending a training session on staff attitudes. Another example was given where staff practices had been revised after incidents. In early 2016 training took place for crews on ensuring orthopaedic scoop stretchers were assembled correctly following a reported incident.
- We asked an emergency care assistant (ECA) what action they would take if a minor incident occurred. They told us that they would contact the NHS trust's single point of contact (SPOC) and report it as an adverse incident. They told us they had used this system in the past and gave an example of the incident they reported. This showed that they understood how to report incidents appropriately.
- 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 the staff we spoke with 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.

Mandatory training

- The recruitment and staffing department demonstrated a software package which was a rota system that documented all mandatory training completion. The system was only used for staff working as part of the South Central Ambulance Service contract (SCAS). We sampled the record of employees and could see that they had completed training covering the following areas: conflict resolution; dementia awareness; equality and diversity, safeguarding; fire safety; health and safety; infection prevention and control; information governance; and manual handling.
- Other staff mandatory training was recorded and maintained on a separate system by the training department.
- 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 which training 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. Drivers were required to demonstrate they had completed this training as part of their employment checks.

Safeguarding

- The service had provisions in place for the conveyance of adults and children. There were 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.
- There were two safeguarding reporting pathways. The first was UKSAS's and the second was through the organisation to which they were contracted, such as an NHS trust. Crew members could report safeguarding concerns using the UKSAS instant reporting system which was reported to the control room.
- UKSAS did not report safeguarding concerns directly to NHS trust safeguarding teams or local safeguarding authorities. We were told that crews would pass on the issue of concern to a responsible person at the site where they were transporting a patient to or from, such as an outpatients unit, day centre or care home.

- There were no direct reporting lines to safeguarding authorities. The chief executive and director of education acknowledged that reporting processes needed to be established and that it would be easy for the control centre to be aware of safeguarding protocols in order to report concerns to the relevant authorities when advised by crews.
- An ECA gave us an example where they had concerns for a patient on entering their home. They had contacted the single point of contact (SPOC) and reported the issue and received an e-mail which acknowledged this concern and thanked them for raising it.
- Safeguarding vulnerable adults and child protection was part of mandatory training. All staff had completed this training between August 2015 and June 2016.

Cleanliness, infection control and hygiene

- We were shown a large garage at the site. During our inspection around 20 vehicles were parked in the garage. We noted the garage area was very clean, tidy and well organised. The floor was sealed with an appropriate product and a floor cleaning machine was available. No extractor system was visible, however a large door was open and provided good ventilation.
- To the rear of the smaller garage there were toilet facilities. In this room the wash basin did not have a functioning hot water supply so effective handwashing was compromised. The toilet basin was placed upon a plinth, the plinth appeared to be constructed of a rough concrete like material. It would not be possible to clean the plinth to an acceptable standard to ensure appropriate infection prevention and control.
- We saw a kitchen area adjacent to the garage area. This was clean and tidy and we could smell it had been cleaned using a bleach or chlorine releasing product.
- We saw toilet facilities in the main building which were clean and fit for purpose.
- We saw an ambulance being checked by its crew. The vehicle was visibly clean inside and out. Both the cab and the patient compartment appeared to be clean and hygienic.
- A vehicle cleaning operative showed us the deep cleaning schedule that listed all vehicles on the fleet (around 100 including the managers' cars). The schedule showed the date of the last clean and the date when the next clean was due. The standard was for each vehicle to be deep cleaned every six weeks. The first page of the cleaning schedule listed 27 vehicles, of these 10 were overdue. The next three pages of the list showed a similar compliance rate. It was explained to us that some of the vehicles listed were managers' cars which did not carry patients and were not deep cleaned. However, this meant we could not be assured that all vehicles had been cleaned within the set timeframe.
- We were told that some vehicles were kept at the UKSAS depot in in Ashford, Kent and another employee was due to commence work there to provide extra cleaning capacity.
- In the vehicles we checked there were spill kits available and a full range of personal protective equipment (PPE) such as gloves and aprons. In one of the vehicles we checked there was no sanitising hand gel available.

Environment and equipment

- During our inspection the equipment stores were being re-shelved to allow a logical distribution. Our unannounced inspection took place on a very busy delivery day, with six deliveries together with a return of medical devices. At the beginning of the day, the stores appeared to be chaotic with unopened boxes on the floor, but by the end of the day the boxes had been opened, the stores booked in and stores were shelved. The stores were clean, the products were appropriately stored.
- Overall, we found the vehicles to be well maintained and well stocked. All equipment was stored in its original packaging which was intact. However, products were not always organised in a way that enabled the user to quickly find the required product in an emergency which had a potential to delay treatment.
- Clinical engineering servicing was provided for UKSAS by an external provider. This supported the maintenance of defibrillators and monitors, together with any advisory defibrillator and the suction units. Each item of equipment was serviced and provided with a sticker that showed the date of the service and the date of the next service. A register of work was available from the clinical engineering servicing provider which provided a copy to UKSAS. This process reflected best practice. All ambulances we checked had defibrillators that were in date.
- Retrospective analysis and action took place as a result of issues such as equipment failure. We saw evidence that Medicines & Healthcare Products Regulatory Agency notices and medical device alert field safety notices were acted upon. Contracted organisations also

communicated directives for UKSAS to enact. If a medical devices alert came in, information was sent directly to crews who had to acknowledge the message before being able to accept their next job.

- We sampled the equipment available on one ambulance. There were four cylinders of oxygen on the vehicle and one medical nitrous oxide and oxygen mixture set. All were well within their stated expiry dates. The scoop stretcher was within date of its next service.
- We looked at a further two vehicles, in each of these vehicles superglotic airways were out of date. Using out of date airway adjuncts could increase the risk of a healthcare acquired infection. We reported all identified out of date medicines and equipment to staff and they were removed and replaced immediately.
- We were shown a system where the expiry dates for certain products was recorded. We were told that this system was new and did not cover all vehicles. There was no evidence of a cohesive, managed process for ensuring that clinical products for patient use were in date.
- We saw that there was a practice of carrying additional oxygen and medical gas cylinders in the vehicle cupboards, surplus to identified requirements. The cupboards were fitted with burst proof catches so this would be unlikely to have a potential to cause patient harm, but best practice is to store medical gases in the designated storage locker.
- There were two storage cupboards accessible on the offside of the A&E vehicles, one was the medical gas cupboard, and the other contained the fuse board and circuitry for the ancillary electrics and emergency lighting systems. These cupboards were fitted with lockable doors, however those we checked were not locked. A failure to secure the medical gases does increase the risk of theft or misuse. Medical nitrous oxide and oxygen mixture can be misused and consequently should be secured appropriately. Unauthorised interference of the vehicle circuitry could render the vehicle defective.
- We saw a medical gas store within the garage area immediately adjacent to the entrance door. The cabinets were secure and complied with the requirements of the medical gas supplier. However, the location was not temperature monitored and the area did not have the required safety signage. On the day of the inspection, we highlighted this to the provider and they put up appropriate signs.
- During our inspection we saw one vehicle being cleaned in a dedicated cleaning bay. There were three 4x4 vehicles which were in a second, smaller garage and a number of vehicles were parked outside. The vehicles in the garage were attached to 'shoreline' chargers. The vehicle cabs were locked. The keys were available from the control room and this ensured that secure access to the vehicles was maintained while there were on site.
- The fleet manager told us that vehicles were serviced if the engine management light indicated a service requirement, but they were also inspected and serviced on a mileage and interval basis. For example, a vehicle would receive a safety check at a mileage interval; time interval or on demand, (e.g. 5000 miles, 6 months, or when the warning light came on, whichever was soonest).
- Staff submitted vehicle defect forms which were transposed into a duplicate book which enabled a single job list to be generated for repair. The defect sheets were then closed with a completed date. We were unable to determine if defects were addressed in a timely manner. This was because the defect sheets only provided the date the job was completed and not when the defect was identified.
- We asked the fleet manager to provide assurance that vehicles were within their maximum gross vehicle laden weight (GVLW). Some assurance was given, however when we asked about the weight of a 'cell vehicle' which may carry as many as eight individuals (including escorts, driver, attendant and patient) together with a Home Office approved cell, there was no immediate assurance available. Immediate steps were taken to get a vehicle weighed to determine if the weight would remain within the maximum GVLW of 3500 Kg. This was confirmed as within agreed limits in documents submitted following our inspection.

Medicines

- Medicines were stored in locked, secure cupboards in areas monitored by CCTV. Staff at the Rainham site packed medicines in to paramedic and ambulance technician packs and distributed the packs to other UKSAS locations. The packs contained a medicine list that detailed medicines which could be administered by

paramedics or and those by ambulance technicians. Staff used a system to tag packs green or red to identify packs ready for use and those that needed replenishing. All medicines seen were in date and suitable for use. The staff used a manual stock recording system and recorded stock levels and the details of medicines issued to packs or individuals.

- While there were some forms that documented monitoring the temperatures of the medicine fridge and areas that stored medicines, these forms only recorded the immediate temperature of the fridge or area when it was taken, and did not record maximum and minimum temperatures. There was no evidence of historic temperature records.
- In two vehicles we saw that the glucose 10% for infusion was out of date by four months. There is a potential that an out of date prescription only medicine could cause harm if given to a patient.
- Staff recorded medicine administration on a medicine administration record which was kept with the medicine pack, and also on the patient record form (PRF) which was sent to the NHS trust. The administration records identified the medicines the paramedics and technicians had administered and who was accountable for the administration.
- While UKSAS had medicine management and controlled drug policies they did not have any medicine protocols or patient group directions (PGD's). Medicine protocols and PGDs provide a framework to support staff to administer medicines safely. Managers told us that UKSAS staff worked to the PGD's and protocols of the NHS trusts that contracted UKSAS services. This meant that UKSAS had not legally taken on the NHS trust's PGD's and had not assessed competence or signed authorisation for staff to work to the PGD's.
- Medicines that require extra controls because of the potential for abuse (controlled drugs) were stored securely at the site and on the ambulances. The UKSAS headquarters held the appropriate Home Office license to enable the supply of controlled drugs to self-employed paramedics. 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.
- During our inspection we found gaps in the recording of controlled drugs register. There were 18 entries in the controlled drugs register relating to the issue of morphine, but an absence of signed orders. We also found some ampoules of out of date morphine in an envelope, and written on the envelope indicating that these had been placed in a controlled drug destruction jar (doop jar), however the ampoules were still inside. We required UKSAS to conduct an in-depth investigation into both of these errors. The report of the provider's investigation explained that four signed orders were found in another folder on the shelf, and the remaining 14 entries required evidence of receipt by paramedics. All relevant paramedic staff were contacted and supplied with the date and quantity of drugs issued and required to photograph their own registers showing receipt of the morphine to tally with the date the medicine was booked out to them. Sample proof was provided to us. The out of date morphine was disposed of, which was witnessed by another paramedic.

Records

- There were two pathways of record management, with systems belonging to the contracted organisations and separately UKSAS's own record system. The NHS trusts to whom UKSAS was contracted was responsible for, stored and maintained all records of patients completed by UKSAS staff while on duty for that particular provider. We were told that only the contracted NHS provider had ownership of the patient record forms.
- Vehicles had secure storage areas for patient records. We saw that these were locked to ensure only authorised individuals could access the documentation.
- We saw patient information kept within locked metal cupboards at the headquarters until they were transported to the ambulance contract provider.

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.
- 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.

- Situation dynamic risk assessments were carried out. Sometimes risk pre-assessments were carried out prior to the patient journey. For instance, for bariatric or secure patients. We reviewed a bariatric pre risk assessment which was comprehensive.
- UKSAS policy stipulated that if a patient's health needs were greater than the crew were qualified or equipped to manage, the crew were expected to report it back to the control centre, who then reassessed the risk factors based on information given. Options available included sending a different vehicle to manage health needs, or dispatching more qualified or extra crew.
- UKSAS worked with mental health patient transfer services to transfer patients from one unit to another. Such patients may be detained under a section of the Mental Health Act, voluntarily or formally. The control room manager was able to explain the process for taking a booking which would ensure that all relevant details were collected in such cases, to include the needs of the patient, any associated risk assessment, the number of escorts with the patient, pick up time and location and destination. We were told that in some cases there may be a patient transported in a cell together with the driver, attendant and up to four escorts. The individual risk assessment would identify if the patient should be transferred in a cell or if it was more appropriate for the patient to travel seated in a chair, or on a trolley.

Staffing

- Ambulances were staffed by emergency care assistants, ambulance technicians and paramedics. Ambulance technicians and paramedics staffed rapid response cars.
- There was an agreed number of ambulances provided on each day of the week for NHS ambulance providers. 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.
- Each organisation requested crews and specified the required skill mix. Senior managers told us this could vary on a daily and weekly basis. 90% of staff were self-employed bank staff to provide flexibility for each contract. Staff were asked to commit to around 12 shifts per month.
- 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.
- An annual audit was conducted to ensure that paramedics were registered with the Health and Care Professions Council (HCPC). Audits took place in September each year and were timed to reflect the HCPC re-registration cycle which required re registration every two years. We were shown a list of 42 Paramedics contracted by UKSAS as self-employed staff. The recruitment officer was able to input their registration numbers into the HCPC multiple registrant search and we reviewed the status of the employees. It appeared that all were registered and that appropriate annual processes were in place to provide appropriate assurance.
- The organisation ensured that staff had a valid and in date Disclosure and Barring Service (DBS) check. This was through a software package that supported DBS management. We were also shown the home page for a personnel information system which used a traffic light system to show any potential or actual problems. If an applicant's criminal records check showed disclosures the name would be shown in red to highlight a concern which would then lead to an individual risk assessment.
- We met two ambulance care assistants (ACAs) employed to service the 'secure' contract. Their rota was a two week rota, week one was a 10:00-20:00 Monday to Friday week, week two was a 08:00-18:00 week. The 10:00-20:00 week was an 'on-call week' which encompassed two 24 hour periods of on-call on Saturday and Sunday. We were told it was common to be required to work during a period of on-call and that a minimum period of eight hours was provided before returning to work.
- We looked at timesheets for August 2016 which included one day where 21.5 hours were worked. The Working Time Directive sets out how working time should be managed to ensure the health and safety of workers, this legislation requires weekly and daily rest periods. It was possible that the on-call arrangements and associated pattern of work which was significantly extending the hours worked done in a single day breached the daily rest period requirements.

Anticipated resource and capacity risks

- UKSAS had business continuity plans for contract work which enabled the service to plan for, manage and operate in the event of significant disruption to services.
- Senior managers told us the service had no anticipated resource or 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.
- UKSAS formed part of the major incident plan with the NHS trusts to which they were contracted and would be involved with ward movements of patients to make space for casualties during a crisis.
- Technician crews told us they had major incident training. We were told there was no chemical, biological, radiological, nuclear (CBRN) component to it at the time of our inspection.
- The provider had a secondary base at a nearby location in case of an incident at their permanent premises, where there could carry on operations.

Are urgent and emergency 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.

- Staff adhered to relevant national and local guidance for their roles. All staff had access to appropriate evidence-based policies and guidance materials.
- Staff received appropriate training and practiced within the limits of their competency.
- Information systems were in place to share patient information with operatives to support care.

However,

- Staff did not receive dedicated formal training on consent or mental capacity.
- 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.

Evidence-based care and treatment

- UKSAS disseminated clinical and procedure updates to staff via the shift booking computer system. Staff were required to acknowledge they had read the updates or 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 the shift booking computer system.
- Ambulance staff were able to access policies and procedures to support working with the NHS ambulance contract providers.
- 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 paramedics, technicians and emergency care assistants 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 centres of the NHS ambulance contract provider.
- Ambulance crews told us they treated 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'. Staff adhered to the appropriate NHS

ambulance contract provider's non-transfer and referral policy to identify which patients could be considered as '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.

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 had access to the external data of one contracted NHS trust to corroborate the provider's performance. We were told that performance against key performance indicators had been on an exception basis up until the time of our inspection.
- The NHS trust provided a summary report of UKSAS performance times. This showed UKSAS performance in the three months prior to our inspection was generally in line with the NHS trust's own ambulance response times.

Pain relief

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

Competent staff

- All UKSAS ambulance crew members were required to complete an accredited ambulance emergency driving course. Up to December 2015 individuals were required to complete the Institute of Health and Care Development (IHCD) three week Emergency Driving Course. After this date, the programme changed to the four-week FutureQual Level 3 Regulated Qualifications Framework (RQF) Emergency Driving Course.
- Ambulance care assistants (ACAs) told us about their training. They underwent a two week emergency care assistant training course and a three or four week accredited blue light driving course. UKSAS offered the blue light driving course to all students during their initial ECA training, which staff were required to pay for in arrears.
- Ambulance crews and ACAs were required to complete a one day course on the policy and processes for not for resuscitation instructions (DNACPR).
- Staff felt their training had been sufficient to meet their needs and they were confident to perform all the tasks of their roles.
- The crew members we spoke with told us they had not received an appraisal in the year preceding our inspection. Managers told us they did not undertake appraisals with self-employed staff. An appraisal is an opportunity for staff to discuss areas of improvement and development within their role in a formal manner.
- Some staff told us they had been able to transfer into different roles within UKSAS, for example, ACAs had moved from patient transport services to secure teams. To support their development in each role, they worked with and 'shadowed' experienced colleagues who they felt provided effective mentoring.
- Vehicles carried a range of equipment which some crew members were not authorised to use. For example there was a full cannulation kit available as was a suction unit and trauma dressings, which were outside of the emergency care assistants' (ECA) training or scope of practice. The ECAs we spoke with were aware of the limits to their practice. We asked an A&E crew to show us how they checked the suction unit, the crew explained that they were not trained to use it and its use was outside of their scope of practice.
- Emergency care assistants (ECAs) told us they had been trained in the use of medical gas sets on board vehicles. We asked ECAs about their understanding of contraindications for the use of medical nitrous oxide and oxygen mixture and they explained that it should not be given to patients with head injuries, with a reduced conscious level or to children unable to understand how to self-administer the gas. They felt that it should be withheld from patients with abdominal pains, but some ECAs were unable to recall the contraindications relating to flying, diving or chest injuries unprompted. All ECAs told us they would seek appropriate advice before administering medicines in situations where they were uncertain and they were keen to fill any gaps in their knowledge.

- Crew members working on the East of England Ambulance NHS Trust (EEAST) contract providing support to emergency services identified that if they could contact a 24 hour clinical advice line (provided by EEAST) and were able to give examples where they had contacted the advice line and been supported. They did not have direct access to reference materials in their vehicles. Best practice would be for the crews to be provided with some reference material to support them.
- The service worked with education providers to deliver accredited training courses and was entering into a partnership with a local university to provide paramedic training.

Coordination with other providers

- Ambulance staff worked to agreed care pathways under the agreement with NHS ambulance contract providers to ensure standardisation of care for patients.
- UKSAS was contracted to provide support to NHS ambulance contract provider's 999 services. Crews were allocated to specific geographical areas on a daily basis based on the needs of the 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 patient's presenting complaints, to avoid an admission to hospital.

Multidisciplinary working

- UKSAS was contracted to several organisations to provide both emergency and patient transport services work and engaged with professionals at a variety of different levels staff interacted with nurses, physiotherapists, police forces and shared information with doctors and nurses.

Access to information

- Staff had access to 'special notes' about patients such as pre-existing conditions, safety risks or advanced care decisions. This information was provided by the emergency operations centre who dispatched the crew to the call. Staff told us they would check for care plans in patients' homes 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.
- Staff told us they could seek information from the control room while they were away from the base.
- Staff told us that if multiple services were involved in the care of a patient, one set of paperwork was completed and this stayed with the patient, to ensure safe care and treatment at all stages of their care. We saw a blank form booklet. Forms were carbon-copied so individual services could keep a copy for their own records and audit purposes.
- Crews had additional information available prior to any patient contact as was deemed necessary to enable better care and account for risk. This included whether an infection control risk was present, whether the patient was hard of hearing (so the operative knew to knock loudly), if the person had dementia, if there were access to address issues and whether an escort was needed.

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, and unable to consent.
- UKSAS did not provide dedicated formal training on consent or mental capacity, but staff told us basic principles and responsibilities in this area were included as part of their induction.
- Verbal consent to treatment was recorded on patient record forms. Staff told us that for children, consent was sought from the parent, carer or guardian.
- There was a 'Capacity to Consent Policy' (2014) available for all staff on the company's intranet and the staff we spoke to were aware of it and how to access it.
- Staff used relevant forms from the NHS ambulance contract providers in order to guide them in the assessment of a patient's mental capacity.
- With regard to DNACPR, we were told UKSAS would 'piggy back' on to the policy of the organisation they were contracted to, and follow what the contract provider stipulated. Local induction of crews took place depending on contracted organisation's patch they were to work in and included guidelines on DNACPR.

Urgent and emergency services

Are urgent and emergency services caring?

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

- Staff interactions with patients were respectful, friendly, kind and compassionate.
- Patients were kept informed of what was happening and where they were going.
- Staff checked patients' wellbeing, in terms of physical pain and discomfort, and emotional wellbeing.

Compassionate care

- We observed staff interactions with patients and witnessed respectful, friendly, kind and compassionate care by ambulance staff providing treatment to patients. They spoke with patients in a gentle manner and offered reassurance, particularly if the patient was distressed or in pain.
- We observed one instance of a very anxious patient and the crew were sensitive to the patient's needs. They provided constant reassurance, answered questions clearly and with appropriate openness. For example, the patient asked if the journey was long, and the crew said, 'not too long, it's about 15 minutes, I don't want to rush because I want to give you a nice smooth ride'.
- 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 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.
- 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 in vulnerable 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 them

- 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.
- 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.
- 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.
- There were messages of thanks and appreciation from patients on the station notice board with comments which recognised the caring approach of staff.

Supporting people to manage their own health

- 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 and offered options for care that suited the patient's individual situation and circumstances.

Are urgent and emergency 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.

- There was no coordinated training for staff in dementia awareness, mental health or learning disabilities. This meant services delivered might not take account of some patient' individual needs.
- There were systems in place to analyse trends and patterns arising from complaints, however feedback and learning from complaints was not shared with all staff to improve services.
- The service did not have a robust system for handling, managing and monitoring complaints and concerns.
- Staff did not have access to literature which they could share with patients to point them towards other services or sources of help.

However,

- There were appropriate risk assessments and information sharing processes in place to support the needs of patients requiring secure transport.

Service planning and delivery to meet the needs of local people

- UKSAS provided emergency and patient transport services in partnership with contracted providers to support capacity with additional vehicles and staff. As a contracted provider, UKSAS provided capacity as required by the contracted provider's control room and was able to dispatch vehicles and crew to locations as requested of the provider. UKSAS crews worked across a wide geographical area.
- UKSAS held three main NHS A&E contracts, with East of England Ambulance Service, South East Coast Ambulance Service and South Central Ambulance Service. There were in excess of 90 vehicles used per day across these three trusts.
- Organ transplant journeys were made on behalf of two NHS trusts, a large private hospital and other acute hospitals on an ad hoc basis.
- Secure patient transport was provided to mental health patients requiring transfer between hospitals as well as conveying patients to hospital who were newly sectioned under the Mental Health Act 1983.
- UKSAS was also sub-contracted to an international company specialising in repatriating patients back to the UK.
- Contracted hours totalled approximately 3,500 hours per month. Demand and capacity was planned and calculated two weeks in advance of the projected activity.

Meeting people's individual needs

- Ambulance care assistants (ACAs) employed to service's the mental health contract told us that UKSAS transported patients with a range of mental health conditions which may range from dementia to patients who are detained under section of the Mental Health Act. We observed staff undertaking this task. The crew provided appropriate care across a range of indicators; this included having sufficient information prior to the journey to meet patient need, an appropriate crew being sent and the taking of sufficient information to ensure appropriate care while in transport.
- During our inspection, one crew was sent out to collect an elderly patient for transport to a mental health facility. Initial information provided before the journey stated that the patient would require a stretcher and a female crew. A female crew was provided. The handover that took place covered the patient's needs in comprehensive detail. It was identified that the patient had severe osteoporosis and it was decided that the most comfortable way to transport the patient was lying on the ambulance trolley.
- 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 training to staff to raise awareness and education for patients with a learning disability. Staff we spoke with were unable to give any examples of meeting the needs of people with a learning or physical disability.
- Staff had access to interpreting services through an external provider, which was commissioned by the NHS ambulance contract provider.
- The service had vehicles equipped with specialist equipment for moving and handling bariatric patients. Bariatric patients are those with excessive body weight which is dangerous to health.
- We did not find any literature or guidance materials for staff to guide patients towards other sources of support or help them manage their own health.

Access and flow

Urgent and emergency services

- NHS ambulance contract providers monitored all response, on scene and turnaround times. Response times for emergency transport were measured by 'time on scene' and 'time at hospital'. Summary data provided by one NHS trust demonstrated that response times were in line with the NHS ambulances. Senior managers told us that performance statistics were reviewed in performance meetings with the contracted provider.
- The service provided 'queue' support when the local NHS emergency department was under severe capacity pressure.
- UKSAS worked to key performance indicators, which mainly concerned the number of hours that had been committed to and whether they had met the commitment. There was a target to provide 95% of requested crews. We did not have access to the external data of the contracted providers to corroborate this. Contract review meetings were the forum where standards and quality measurements were reported and reviewed.
- The control room manager explained that on the day of our unannounced visit, the service was busier than it would normally be. There were ten mental health transfers, four stretcher transfers and two A&E journeys. We discussed one of the A&E journeys which related to a patient who was being transferred from an airport as part of repatriation from an accident abroad. The information we saw illustrated that a structured process was in place to ensure that relevant information was collected and made available to crews in advance.
- All vehicles were fitted with emergency ambulance/A&E software on mobile data terminals and connected to the NHS Patient Administration System (PAS). For continuity and consistency the service used the same software system as the contracted NHS trust.
- Vehicles had been fitted with the NHS Airwave radio system to ensure effective communication with the ambulance contract provider.

Learning from complaints and concerns

- The service did not have a robust system for handling, managing and monitoring complaints and concerns. For example patients were provided with information about how to complain about the NHS ambulance trust but not about the UKSAS. There were very few examples of patient literature or guidance on how to make a complaint in any areas or within any of the vehicles. We found one 'how to complain' form in the glovebox of one vehicle, but this was for the contracted NHS ambulance trust, rather than for UKSAS. Frontline crews that we spoke with were unsure of the complaints process for patients who wanted to complain about the service.
- There were systems to analyse trends and patterns from complaints, however feedback and learning from complaints was not shared with all staff to improve services.
- Across all registered locations, UKSAS received 56 complaints overall between July 2015 and July 2016.
- Senior managers informed us that any complaints would be directly sent to the NHS ambulance contract provider. They told us they operated on a 'no news is good news' scenario, whereby UKSAS only heard about things where they were not performing to standard.

Are urgent and emergency 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.

- UKSAS had a clear mission statement and organisational philosophy.
- Senior managers understood their main priorities and risks.
- Staff told us managers were visible and approachable and they felt able to talk to them about difficulties and issues.

However,

- Governance arrangements were not sufficiently robust, for example, some meetings were not minuted and actions were not logged.
- The organisation did not have access to performance information to identify areas where performance could be improved.

Leadership of service

- Key senior staff were identified as the chief executive, the director of education and the clinical director, who were supported by the managing director, director of corporate strategy, medical director, fleet director,

finance officer, operational manager and head of patient transport services. We were told that all of these roles were expected to attend clinical governance meetings.

- Senior leaders of UKSAS were based at the Rainham site and were responsible for overseeing the day to day management at Rainham. The staff we spoke with told us their managers were visible and approachable and felt able to talk to them about difficulties and issues.
- The chief executive of UKSAS was also the director of the Independent Ambulance Association and attended regular meetings which provided UKSAS with an inter-organisational perspective to multidisciplinary working.

Vision and strategy for this service

- Senior leaders in UKSAS were able to explain the main priorities and risks for the organisation which were financial sustainability, vehicle and equipment management and staffing.
- UKSAS displayed the organisation mission statement and philosophy on a plaque in the main reception area. The mission statement was to provide a quality service in accordance with, and adhering to, the codes and practices of the British Ambulance Association and the Patient's Charter. The organisation's philosophy comprised six statements around recognising that patients have the right to be transported with dignity in a safe, secure environment; providing the best possible patient care; staff respect individual needs of patients; patients are encouraged to provide feedback, and staff engagement and development. The staff we spoke with were able to explain the principles of the organisation's vision and values.

Governance, risk management and quality measurement

- Governance systems were in place, however they were not sufficiently robust or established to ensure effective oversight and challenge of performance and risk management.
- There was an organisational chart which showed the leadership and divisional structure. However, there was not a governance structure in place to show how meetings, lines of governance and organisational accountability worked. We discussed this with senior management who acknowledged there needed to be a clearer understanding of the purpose and function of each meeting and how assurance was reported through the structure. Senior managers told us the size of the service had increased in recent years but the governance structure had not grown with it. UKSAS agreed the need to review this structure with the director of education taking the lead due to their governance background.
- A clinical governance group met on a monthly basis. We reviewed minutes for the May, June and July 2016 meetings. The minutes showed attendance by senior managers. Agendas showed topics discussed included: servicing defibrillators, drug boxes, equipment, training and a review of incidents. Different topics were discussed in other months including vehicle cleanliness, vehicle defects and drug boxes. The clinical governance meeting had become a regular meeting in May 2016. There was no agreed set agenda that would ensure that essential items were covered. Staff told us topics were decided on by what attendees stated they wanted to discuss beforehand and what was brought up at the meeting, based on any issues at the time. We were told there were items that tended to be discussed most months although this could not be assured.
- The chief executive told us that the clinical governance meeting was the forum where leadership decisions were ratified and operational issues discussed. We discussed the governance and organisational structure with the senior leadership team. Along with the clinical governance meetings there were also contract decision meetings, contract review meetings and board meetings which were stated as integral to the running of the service.
- We reviewed minutes of review meetings that covered issues such as training, safeguarding and clinical issues that had arisen. Minutes showed that updates on issues were given and actions committed to such as improvement to deep cleaning of vehicles, working to the trust's photography policy and welfare breaks for crews. The chief executive logged all review meetings and RAG rated (red, amber, green) the outcomes. The log showed positive changes that had come out of the meetings, where explanations and feedback were required and where action needed to be taken within a timeframe.
- Board meetings were not minuted. Actions arising from the board meetings were not documented. NHS trusts that UKSAS worked with issued a computer-aided dispatch pin number for each individual UKSAS staff

member (CAD, a method of dispatching vehicles by computer). Pin numbers were issued on the satisfaction of meeting training and qualification checks. Checklists included DBS checks, disciplinary checks, identification checks, medical declaration and training in a number of topics such as use of airwave radio, infection prevention and manual handling, conveyance, mental capacity advanced life support and end of life protocols. Verification of meeting these requirements was assured by UKSAS.

- The chief executive told us the organisation was keen to know more about the quality of their performance. However, senior leaders explained that it was not easy to get information from the providers they were contracted to other than when things were not up to standard. Contracted providers presented outcomes data to UKSAS in performance meetings but the information was not shared outside of these meetings so UKSAS had no way of understanding the data any further than what was presented by the provider organisations.

Culture within the service

- We were told that the provider believed in providing a safe transportation service to patients and believed in appropriately supporting staff to work competently and progress their careers. Examples were given to demonstrate this in that the service had taken on staff and progressed them to paramedics. There were a cohort of 19 staff who were due to start university in September for the same reason.
- Staff we spoke with told us that UKSAS was a good place to work. They told us they generally felt supported and valued. One ambulance crew said that they had worked at UKSAS for a number of years and "loved the job". Others told us it was a "great place to work" and "staff are really friendly and helpful".

Public and staff engagement

- The chief executive told us they believed in doing work in the wider community. Examples were given regarding involvement with community organisations and offering training, advice and ambulance support on a voluntary basis.
- The managing director did regular frontline shifts and was visible in different parts of the country where UKSAS was active. They carried out clinical assessments and did 'ride-outs' with crews. We were told that an integral part of this was to speak to staff and understand the issues and challenges they faced.
- There were no staff meetings. Information was communicated to and between staff by group emails and group text messages.
- We were told by the chief executive that they attempted to get patient feedback at events attended by ambulances but were not able to do so. We were told that UKSAS was not permitted to gather feedback from patients while delivering NHS contracts. There was no recorded patient feedback from patient transport services. Managers told us they worked on the principle of "no news was good news".

Innovation, improvement and sustainability

- The service had achieved accreditation to deliver the IHCD Ambulance Technician Course and was entering into a partnership with a local university to provide paramedic development training.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure there are robust systems to collect, assess and monitor performance data and information on patient outcomes to improve the quality and safety of the services provided.
- Ensure there are robust internal governance and risk management systems in place which are understood by all staff.
- Ensure there are formalised lines of escalation for reporting safeguarding concerns and appoint an organisational lead for adult and child safeguarding to provide oversight of all safeguarding matters.
- Fully implement the system for recording and monitoring the expiry date of clinical products across all vehicles and areas where clinical products are stored to ensure all clinical products are within date and safe for patient use.
- Ensure all staff are trained in duty of candour and are aware of their responsibilities.
- Ensure staff administer medicines in line with the Human Medicines Regulations 2012 and that lines of accountability in medicines management are clear.
- Ensure all staff are supported in their roles by effective appraisal systems.

Action the provider SHOULD take to improve

- 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.
- Take steps to proactively engage and involve staff and patients to ensure adequate opportunities are available for individuals to share concerns, receive information and inform service development.
- All staff should have adequate training in mental health and learning disability awareness, which is updated at regular intervals to ensure they can meet the individual needs of all patients.

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (e) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulated Activities Regulations 2014). Safe care and treatment How the regulation was not being met: • Medicines were not always managed properly and safely and in line with current regulation and best practice guidance. In particular patients and staff were at risk because staff were not assessed as competent, nor authorised to use patient group directives. • There was no evidence of a cohesive, managed process for ensuring that clinical products for patient use were in date. We found some out of date medicines and consumables.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulated Activities Regulations 2014). Safeguarding service users from abuse and improper treatment How the regulation was not being met: • The service did not have an appointed safeguarding lead for vulnerable adults and children as required by intercollegiate guidance.

This section is primarily information for the provider

Requirement notices

• There were no direct reporting lines to relevant safeguarding authorities.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulated Activities Regulations 2014). Receiving and acting on complaints How the regulation was not being met: • Suitable arrangements were not in place in relation to identifying, receiving, recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (a) (b) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulated Activities Regulations 2014). Good Governance How the regulation was not being met: • Adequate audit, risk management and control systems were not in place. • There were no internal quality and monitoring processes in place to review performance information or patient outcomes. • There were no processes in place to seek and act on feedback from patients or staff to evaluate and improve services.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulated Activities Regulations 2014). Staffing How the regulation was not being met: • There was no clear appraisal system in place.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulated Activities Regulations 2014). Duty of Candour: How the regulation was not being met: • The service did not have procedures in place to ensure that all staff were aware of duty of candour.