Trust Medical Ambulance Services Ltd

Trust Medical Ambulance Services

Quality Report

233 Marine Road Central
Morecambe
Lancashire
LA4 4BQ
Tel: 08700 41 81 41
Website: www.trust-medical.co.uk

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Trust Medical Ambulance Services provides emergency and urgent care and a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 20 and 21 July 2017 along with two unannounced visits to the service on 25 July 2017 and 2 August 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Urgent and emergency services were a small proportion of activity. The main service was patient transport services therefore we have reported findings in the patient transport section.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

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

- There was no clear procedure for reporting incidents. The information collected about accidents, incidents and near misses was not used to identify trends and themes.
- Not all equipment in use for the bariatric ambulances was up to date with testing under the Lifting Operations and Lifting Equipment Regulations (LOLER, 1998).
- Patient records on the patient transport service were not always completed accurately.
- The systems in place to respond to concerns about patients did not ensure all potential risks of abuse or neglect were identified, acted upon and reported in a timely way. Action was taken by the provider during the inspection and improvements to the systems were made.
- Not all staff had been assessed for their competence to complete specific tasks for patients. This included staff that had completed a recognised health professional qualification, but had no ongoing assessment of their competence.
- Staff that provided care and treatment to children were not up to date with their paediatric life support training.
- Staff were not clear how to obtain or record consent to travel from patients especially those who may lack mental capacity to make their own decisions.
- Staff had not received training regarding their role and responsibilities in the assessment and support of patients who lacked mental capacity. There was no general mental health awareness included in the mandatory training.
- The staff were not all up to date with their annual appraisals.

However we found the following areas of good practice:

- The premises we visited and the ambulances we saw were clean, tidy and stocked with the items deemed necessary dependent on their level of response.
- Medicine management systems ensured the safe storage, administration, recording and disposal of medicines.
- Records were managed so as to protect the confidentiality of patients and meet data protection requirements.
- Most staff were up to date with mandatory training.
- There was a comprehensive induction process in place for new staff.
- Ambulance staff had pocket books which provided comprehensive information about how to assess a patient's condition and actions to take.
- There were procedures in place to assess and respond to a patient whose condition deteriorated.

Summary of findings

- Staff were very complimentary about the leadership of the service, including the visibility of managers at the remote sites. There was an open culture with common shared values.
- The provider and managers were responsive to concerns we raised during the inspection and worked to make improvements in a timely way.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with five requirement notices that affected both emergency and urgent care and patient transport services. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We do not currently have a legal duty to rate independent ambulance services. However, we found the following areas of good practice: • All vehicles and ambulance stations were visibly clean and tidy. • All equipment necessary to meet the various needs of patients was available. • There were robust systems in place to ensure vehicles were well maintained. • There was comprehensive patient information documentation which was signed by the discharging health professional prior to transfers home from hospital. • There was a clear medicines management policy which we saw was followed in practice. • The majority of staff were up to date with mandatory training. • Emergency care assistants were appropriately trained. • Systems were in place to identify, assess and manage patients whose condition deteriorated. • There were good systems for remote staff to obtain clinical advice and support. • All staff carried a pocket guide with clinical information which was developed from the latest guidance. • The pocket guides had pictorial communication aids and translations for everyday questions to patients about their comfort. • There were clear systems for the safe transport of patients who received a mental health service. • The policies and procedures were based on best practice guidance. • There was a robust induction procedure. • Patients gave positive feedback about the service they received. • Measures were in place to protect the dignity of the patients. • There were communication aids for patients for whom English was not their first language.

Summary of findings

- The leadership structure of the service was clear and staff could discuss any issues openly with the managers.
- There were systems in place for support for remote working staff outside of normal working hours.
- There were clear governance processes in place which included audits, risk management and improvement planning.
- Staff were positive about their engagement with managers.

However, we found the following issues that the service provider needs to improve:

- There was no clear system for reporting and documenting incidents which was separate to accidents and safeguarding issues.
- Not all the bariatric equipment had been checked to ensure it met the Lifting Operations and Lifting Equipment Regulations (LOLER 1998)
- Staff did not always document that consent to travel had been obtained by the patient, despite this being a mandatory part of the patient records.
- Staff did not have a good understanding of the assessment of mental capacity although they were expected to do this as part of their role.
- The safeguarding processes did not ensure patients were protected from harm. Changes were made during the inspection and improvements were seen.
- Not all staff had completed safeguarding training to the required level.
- No staff had completed paediatric life support training.
- Staff who may need to use equipment such as suction had not been assessed as competent.
- The information required to ensure directors were fit to be in their role was not available.
- In emergency and urgent care there was no assessment of a patient's infection status prior to them travelling in an emergency ambulance.
- There was no training or competence information documented for the qualified paramedics or nurses who worked for the organisation.

Trust Medical Ambulance Services

Detailed findings

Services we looked at
Emergency and urgent care; Patient transport services (PTS)

Detailed findings

Contents

Background to Trust Medical Ambulance Services

Trust Medical Ambulance Services opened in 2011. It is an independent ambulance service with the head office and two ambulance bases in Morecambe Lancashire. There are also ambulance bases in Burton on Trent, Wakefield and Manchester. The service serves the communities of Lancashire, Manchester, West Yorkshire and the Midlands. The urgent and emergency care vehicles were used in Cheshire and Mersey, Cumbria, Greater Manchester and Central Lancashire.

The service provided emergency and urgent care ambulances to support an NHS ambulance trust. This was provided in specific emergency vehicles with staff who had completed emergency care assistant training. These ambulance crews attended calls which had been triaged by the NHS ambulance service call co-ordinators as low risk and requiring a response within four hours. These patients were assessed at the scene and taken to hospital by the emergency ambulances provided. The number of ambulances required to support the trust varied each week and were booked in advance. At times additional support may be required and if the provider had staff and emergency vehicles available they would provide this.

The patient transport service was provided to support two NHS ambulance trusts as well as NHS acute hospital trusts in Lancashire, Yorkshire, Leicester and Greater Manchester. This included transport for patients from hospital to home, between NHS acute hospital sites and to hospitals for appointments.

The provider is registered with the Care Quality Commission (CQC) to provide treatment for disease, disorder and injury and transport services, triage and medical advice provided remotely.

Specialist ambulance services included the areas of mental health, bariatric transfer, repatriation and end of life support as well as medical support for school pupil transfer. They provide an events support service and if requested by the organiser will convey patients to hospital from the event, using appropriately trained staff.

The registered manager for the service had left this post in July 2017. There was a new manager undergoing the process of registration at the time of the inspection. This person had worked in the organisation since September 2015 and in a senior position since January 2016.

The service had been inspected in 2013 and had been compliant with the regulations at that time.

We completed an announced inspection in the head office on 20 July 2017 and in the Manchester and Wakefield ambulance stations on 21 July 2017. We did an unannounced inspection in the head office on 25 July 2017. On 2 August we carried out an unannounced inspection at the head office and Morecambe and Burton on Trent ambulance stations.

Detailed findings

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two other CQC inspectors. The inspection team was overseen by Amanda Stanford, Head of Hospital Inspection (North West).

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The main service provided was patient transport. In the reporting period January 2017 to July 2017 there were 14,742 patient transport journeys. This represented 89% of the total patient journeys for the service. In the same period there were 1,700 urgent and emergency care patient journeys which represented 11%. We have reported both urgent and emergency care and PTS in the patient transport services section of this report. Where there is specific information about urgent and emergency care there will be a section under that heading to highlight this.

During the inspection, we visited the head office and all four of the ambulance stations. We spoke with staff including eleven patient transport ambulance care assistants (ACA) , four urgent and emergency care assistants (EUC), four team leaders, five co-ordinators in the control room, the leads for safeguarding, patient experience, training and clinical compliance. We also received 20 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed 32 sets of patient records. We reviewed other documentation including policies, staff records, training records and call log sheets.

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

There were three registered paramedics, two registered nurses, 46 emergency care assistants and 95 ambulance care assistants working at the service. The emergency care assistants worked on the urgent and emergency ambulances the ambulance care assistants worked on the patient transport ambulances.

Track record on safety

- There had been no never events reported by the organisation. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- Between 1 March, 2017 and the time of our inspection in July 2017 there had been 39 incidents. These were not all clinical incidents. The provider did not categorise their incidents into operational areas or the degree of harm. However from the records we reviewed no incidents had resulted in moderate or severe harm or death.
- There had been two formal complaints between May 2016 and May 2017.

Services accredited by a national body:

- The provider is accredited against ISO 9001 quality management system.
- The organisation has achieved silver accreditation with the Investors in People Standard which is a benchmark of good people management practice.

Patient transport services (PTS)

Summary of findings

Urgent and emergency services were a small proportion of activity. The main service was patient transport services therefore we have reported findings in the patient transport section.

We do not currently have a legal duty to rate independent ambulance services. However, we found the following areas of good practice:

- All vehicles and ambulance stations were visibly clean and tidy.
- All equipment necessary to meet the various needs of patients was available.
- There were robust systems in place to ensure vehicles were well maintained.
- There was comprehensive patient information documentation which was signed by the discharging health professional prior to transfers home from hospital.
- The majority of staff were up to date with mandatory training.
- All staff carried a pocket guide with clinical information which was developed from the latest guidance.
- The pocket guides had pictorial communication aids and translations for everyday questions to patients about their comfort.
- There were clear systems for the safe transport of patients who received a mental health service.
- The policies and procedures were based on best practice guidance.
- There was a robust induction procedure.
- Patients gave positive feedback about the service they received.
- Measures were in place to protect the dignity of the patients.
- There were communication aids for patients for whom English was not their first language.
- The leadership structure of the service was clear and staff could discuss any issues openly with the managers.
- There were systems in place for support for remote working staff outside of normal working hours.
- There were clear governance processes in place which included audits, risk management and improvement planning.
- Staff were positive about their engagement with managers.
- There was a clear medicines management policy which we saw was followed in practice.
- Patient records were comprehensive and mostly fully completed.
- Emergency care assistants were appropriately trained.
- Systems were in place to identify, assess and manage patients whose condition deteriorated.
- There were good systems for remote staff to obtain clinical advice and support.

However, we found the following issues that the service provider needs to improve:

- There was no clear system for reporting and documenting incidents which was separate to accidents and safeguarding issues.
- Not all the bariatric equipment had been checked to ensure it met the Lifting Operations and Lifting Equipment Regulations (LOLER 1998)
- Staff did not always document that consent to travel had been obtained by the patient, despite this being a mandatory part of the patient records.
- Staff did not have a good understanding of the assessment of mental capacity although they were expected to do this as part of their role.
- The safeguarding processes did not ensure patients were protected from harm. Changes were made during the inspection and improvements were seen.
- Not all staff had completed safeguarding training to the required level.
- No staff had completed paediatric life support training.
- Staff who may need to use equipment such as suction had not been assessed as competent.
- The information required to ensure directors were fit to be in their role was not available.
- There was no assessment of a patient's infection status prior to them travelling in the ambulance.
- There was no training or competence information documented for the qualified paramedics or nurses who worked for the organisation.

Patient transport services (PTS)

Are patient transport services safe?

At present we do not rate independent ambulance services. However, during our inspection we noted the following for safe;

- All vehicles and ambulance stations were visibly clean and tidy.
- All equipment necessary to meet the various needs of patients was available.
- There were robust systems in place to ensure vehicles were well maintained.
- In patient transport services there was comprehensive patient information documentation, which was signed by the discharging health professional, prior to transfers home from hospital.
- The majority of staff were up to date with mandatory training.
- There was a clear medicines management policy which we saw was followed in practice.
- Patient transport records were comprehensive and mostly fully completed.
- Emergency care assistants were appropriately trained.
- Systems were in place to identify, assess and manage patients whose condition deteriorated.
- There were good systems for remote staff to obtain clinical advice and support

However

- There was no clear system for reporting and documenting incidents which was separate to accidents and safeguarding issues.
- Not all the bariatric equipment had been checked to ensure it met the Lifting Operations and Lifting Equipment Regulations (LOLER 1998).
- The safeguarding processes did not ensure patients were protected from harm. Changes were made during the inspection and improvements were seen.
- Not all staff had completed safeguarding training to the required level.
- No staff had completed paediatric life support training.
- In emergency and urgent care there was no assessment of a patient's infection status prior to them travelling in the ambulance.

Incidents

- There had been no never events reported by the service. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- There was a current Accident/ Incident/ Near Miss Investigation Policy and Procedure in place. This policy defined an incident as 'an event which falls outside the normal day to day expected outcomes for the delivery of service' and provided examples. It also provided a definition for an accident and a near miss. There was no system for grading incidents.
- All the above were reported on the same accident/ incident/near-miss template form which was provided at the back of the policy. However, there was also another form in use entitled complaint/incident/ near-miss form. This was not referred to in the incident policy.
- The reporting procedure outlined in the policy was that accidents, incidents and near misses should be reported to control (also referred to by staff as co-ordination) immediately or as soon as the situation allowed. Control would then advise either the patient experience coordinator, the quality assurance and health and safety lead, or the safeguarding of vulnerable adults (SOVA) lead dependent on the nature of the incident. They, in turn, would log the details using either the incident template or SOVA investigation form held in compliance.
- An accident book was kept at each station for incidents involving any unplanned event that resulted in personal injury or damage to property or equipment including vehicles. We saw the accident book in situ, but were unable to review the accident forms as they were sent to head office when completed.
- There was no central database of all recorded incidents as they were stored in individual folders dependent on the nature of the event, for example patient injuries were recorded as accident forms, and staff injuries were recorded as 'for information'. Each folder included details of the incident and any follow-up actions.
- Between 1 March, 2017 and the time of our inspection in July 2017 there had been 39 incidents recorded across the different systems. These included issues such as journey delays, vehicle faults and reportable notifications such as patient deaths (not unexpected).

We saw evidence of incidents being followed up on a case by case basis, but there was no record of trends or themes which could mean that recurring issues were not being identified.

- An electronic incident reporting system was in the process of being implemented, but there was no 'go live' date for this at the time of our inspection.
- Incidents that involved a patient of the NHS ambulance trust were reported to that trust's control team, either by the Trust Medical crew, or by their control team. This was a requirement set out in the service specification by the NHS ambulance trust.
- Ambulance crews completed a journey sheet for each patient. These were scanned and sent daily to head office where they were reviewed and any queries or incidents referred to the patient experience coordinator. If an incident was identified for the first time from a journey sheet, and had not been reported at the time, this was followed up with the member of staff concerned.
- Incidents were discussed at weekly meetings attended by the head office team leaders including the chairman and a recently appointed operations manager. Any learning was included in a monthly newsletter which was emailed to all staff, and sent out in paper format to the ambulance stations.
- Where a change to practice was required, Trust Medical head office contacted team leaders to disseminate the information. Emails were sent to all staff but there was only one computer in each ambulance station so paper copies were left in staff members' pigeon holes when necessary. For less formal communication there was a staff social media page and a text messaging system.
- There were no examples of joint investigations or learnings with other organisations including those who commissioned a service from the provider. We saw examples of where this would have been appropriate.
- 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.
- Whilst the Complaints and Investigations policy did not refer to the duty of candour explicitly, it did contain information which followed the principles. In the policy it was stated the complainant would receive an apology, an open and honest explanation of what went wrong and be informed of actions taken to improve services.
- Managers and staff knew about the duty of candour requirement and how this applied to their role.
- There was no system for grading incidents; therefore no clarity of when duty of candour should be implemented.
- Staff were expected to complete on-line training and assessment in duty of candour and 95% of staff had completed this. A reminder to staff of this policy was given in the staff newsletter in May 2017.

Clinical Quality Dashboard or equivalent

- The organisation was part-way through the implementation of an electronic system designed to manage incidents and risks, audits, including the International Standards Organisation (ISO) requirements and other performance monitoring tools such as outcomes dashboards.

Cleanliness, infection control and hygiene

- All of the vehicles we entered were clean and tidy.
- There was a system in place to ensure the vehicles were cleaned and checked prior to the start and at the end of each shift. This included wiping down all surfaces, removing waste and stocking up for the next shift.
- There were occasions when a crew member may have to return a vehicle to base alone at night, for example if they had been working with a crew member from a different base. Staff could place a red card in the front of the vehicle to indicate that it had not been cleaned, which meant that they could just drop the vehicle off without having to stay on the base alone.
- There were daily records for this cleaning regime and those we saw had been completed.
- Each vehicle had a monthly driver and crew check record. This included weekly cleaning schedules for additional cleaning tasks, for example all seatbelts, on certain days each week. On the nine records we reviewed the additional daily rotational cleaning had not been fully completed on three.
- The cleaning records were checked on a monthly basis by the team leader and this check was recorded. We were told if there were omissions in the expected records this would be addressed with the individual staff member.

- There was a system for cleaning the vehicles during the shift which included wiping down the seating between patients if required. Each vehicle had cleaning chemicals and disposable paper towels on board.
- The service was conducting a new way of monitoring checks through a vehicle compliance co-ordinator. The system had been introduced in its Manchester base and we were told it was a success. We saw evidence of a traffic light system which showed when an ambulance was ready to carry out duties and when it was not. The system also allowed ambulance crews to concentrate on delivering patient care.
- Personal protective equipment such as gloves and aprons was available on all the vehicles we saw. There were stocks of this available in each ambulance station and we observed staff to check the stock prior to their shift and replenish it at the end.
- Each vehicle had spillage kits for staff to clean up bodily fluids safely. There was a supply of additional personal protective equipment for this purpose. This included a full body suit, goggles and mask.
- Hand gel was available on the vehicles we saw and this was replenished as part of the vehicle checks.
- Hand hygiene audits were completed for each staff member on a six monthly basis. In July 2017 of the staff audited 73.8% were compliant with the policy and procedures. This did not meet the target of 80%. The team leader in each ambulance base was responsible for making sure improvements were made. This involved one to one discussions or additional training with staff.
- There was cleaning equipment in each ambulance base to complete additional cleaning both inside and the outside of the vehicle. This included hosepipes, brushes and mops.
- Clinical waste bins at the ambulances bases were locked and sharps bins secured. Waste was removed regularly by a waste disposal contractor.
- Arrangements were in place to segregate infected laundry and store this safely prior to it being sent to the local NHS trust for processing.
- There was lockable storage for hazardous chemicals in each ambulance base. We found these to be locked and chemicals to be safely stored.
- All staff we saw were in clean and tidy uniforms.
- The patient journey sheets had an assessment of the patient's status with regard to infections. We saw evidence that where an infection was identified the patient travelled alone in the ambulance.

Urgent and emergency care:

- There was no assessment of a patient's infection status on the patient report forms. There was no reference to infection status in the guidance that accompanied the patient report forms.

Environment and equipment

- We visited all five of the ambulance bases. They were clean and tidy with adequate space to safely store the vehicles and provide office space, facilities for staff, cleaning and storage areas. The head office provided a suitable environment for the control centre, offices, a large training area and staff facilities.
- All bases had secure access arrangements in place.
- There were 59 patient transport service ambulances and 15 emergency and urgent care ambulances. Seven ambulances had been decommissioned over the past 12 months. Vehicles would be decommissioned for various reasons including; the vehicles age had exceeded the contractual requirements for the customer, the repairs were uneconomical or the specification had been made redundant due to newer "multi-purpose" vehicles being in service.
- There were systems in place to monitor the maintenance of the vehicles used by the service. These included centrally held maintenance logs and records of dates for MOTs, vehicle tax and insurance which were overseen by the health and safety coordinator. We saw all vehicles were up to date with MOTs.
- When a vehicle developed a fault the crew on duty completed a vehicle fault report which was reported to control. The fault was logged on a paper record that was attached to the shift summary with the journey sheets. We saw an example of this; details of the fault, who it was reported to and the time it was recorded on the report. It was also documented in the vehicle log book held on each ambulance. Each log book was in use for 28 shifts.
- Health and safety issues reported to control, including vehicle faults, were referred to the quality assurance and health and safety coordinator, who also logged and

managed issues such as product recalls and patient safety alerts. They kept records on an electronic data base, with paper records held as a backup. We saw evidence of this on inspection.

- We saw an example of staff returning to base due to a vehicle developing a fault and that equipment which was reported as faulty was taken out of service immediately.
- The main garage used by the service for suspension faults was located in Morecambe. There had been problems with sending recently repaired vehicles back to their bases, only to find that the fault recurred. On one occasion this had resulted in a vehicle breaking down in Wakefield the same afternoon, with a patient on board. As a result of this, vehicles that had been repaired were used in the local area to the garage for two weeks, prior to returning to their base.
- This protocol was not set out in a policy; however it demonstrated a positive change in practice following an incident and was known to the relevant staff.
- At two of the regional ambulance bases a new role of vehicle compliance coordinator had been introduced. At the other bases this was part of the role of the crew prior to starting their shift. The role was developed so that crews could specifically focus on patient care. The vehicle compliance coordinator role included the replenishment of equipment, including disposable clinical equipment.
- The Lifting Operations and Lifting Equipment Regulations (LOLER, 1998) require that equipment used for lifting people must be inspected at regular intervals. There was an electronic asset log of all equipment held by the organisation with colour coded service dates, including LOLER inspection dates, which flagged up as red when they were due. These records were also held in paper files. We saw the electronic and paper records on inspection.
- The LOLER testing for the specialist equipment for the transport of bariatric patients was not up to date. The hoist should have been inspected in January 2017 and the LOLER test for the mobile ramp expired in July 2016. This equipment was stored in the ambulance station and was accessible to be used by staff. There was no indication that it was out of use and the staff member present was unaware the testing was out of date. This was brought to the attention of the manager at that station. Records provided following the inspection showed the ramp had been tested on 3 August 2017.
- There was various equipment available to meet patient's specific needs including seating and safety belts for children and bariatric patients, scoop stretchers, wheelchairs and carry chairs. Staff said they had access to all the equipment they required.
- The keys for the vehicles were not stored in secure cupboards in all stations. There was secure access to the station building and within that to the offices, in all stations.
- All vehicles were registered with a national breakdown organisation.
- There was an automated external defibrillator on every frontline vehicle and on the bikes that were used for events.

Urgent and emergency care:

- There were 15 urgent care vehicles in service at the time of the inspection. We found these to have the equipment required, be clean and tidy.

Medicines

- There was a medicines management policy in place which included guidance on the safe storage, administration, disposal and recording of medicines. This referenced best practice guidance and relevant legislation for the safe use of medicines. This information was also contained in the individual staff pocket books.
- Staff we spoke with were aware of their responsibilities and restrictions, dependent on their role and training, for the administration of medicines in line with this policy. We saw evidence that ambulance staff had sought advice from the clinical compliance leads regarding the administration of medicines where they thought this was required.
- We saw that any medicines a patient took with them in the ambulance were recorded on the patient journey sheets. This included if a patient needed any medicines en-route or any oxygen administered. This was included on the record which was signed by the medical professional handing over the patient to the ambulance crew.
- Medical gases were stored in accordance with the current guidance. This included oxygen both in the ambulances and at the bases.
- We were told six monthly medicine audits took place. However the date of the last audit provided was 10

October 2016. There was no record of where the audit had taken place and if it included information from more than one ambulance base. The storage, administration, recording and disposal were included and audited against the policy. This audit showed all procedures had been followed.

- Ambulance crews were not trained to manage syringe drivers so were only permitted to transfer patients with syringe drivers when they had lock-box covers or a lock out system controlled by a password. Patients with pumps or syringe drivers controlled by the patient or their relative or carer were also permitted to be transferred, but if these exemptions were not in place the crew would ask the device to be disconnected for the transfer to take place.

Urgent and emergency care:

- On the patient report form (PRF) there was a record of any medicines administered by the ambulance crew. This included the medicine name, route of administration, batch number and expiry date. The record was timed and signed.
- Entonox was provided on all emergency care vehicles. The emergency care assistants had received training in the use of Entonox. Those staff who had completed the First Response Emergency Care (FREC) training to level 3 had not received training in the safe use of Entonox; however they would all be undergoing training for this with the completion of FREC 4. We were told those staff not trained in its use would ring the compliance lead for advice and be told not to administer it.
- Staff who had been trained to FREC 4 could administer additional medicines such as Ibuprofen. However since not all staff on the emergency vehicles were trained to this level it had been agreed not to stock these medicines until all staff had completed the required training for safe administration.
- There was secure storage for the paramedics' medicines including the controlled drugs. Records were kept of stock and any usage or disposal was recorded. The records we checked were accurate. We saw medicines were replaced when they reached their expiry date.
- For example, at the Manchester ambulance base controlled drugs were stored in a locked safe in front of a security camera in the team leader's office which was locked when not in use. The safe code was known only to the team leader, the compliance lead and qualified paramedics when appointed for an event.
- The team leader was familiar with the process to be undertaken for controlled drugs but they had never been used.
- There was a controlled drugs book to be completed when the drugs were removed from the safe by paramedics for events. If any drugs were used a form was completed by the paramedic and countersigned by another paramedic or ECA. These were reviewed and signed off by the team leader when the drugs were securely returned to the base. The forms were then sent to head office.
- There was a controlled drugs check every week by the team leader, countersigned by another member of staff. New drugs were delivered by head office in Morecambe and out of date drugs were returned to Morecambe to be safely destroyed.
- Mobile lockable storage was used by paramedics when they were in ambulances.
- It was the paramedics' responsibility to check they had the required medicines in their emergency kit. There was a system of them checking this prior to each shift and returning medicines to the secure storage on completion.

Records

- Ambulance crews completed a journey sheet for each patient transfer. These records were comprehensive and included demographic details for the patient, their mobility status and basic information about their condition, their needs and details of what happened on the transfer.
- Ambulance crew ensured these records were signed by the nursing professional who was responsible for the care of the patient at the time of the transfer. Those we saw had all been signed by a health professional at the beginning of the journey.
- The quality of the details recorded on the patient journey sheets was variable. We reviewed 28 journey sheets and found some thorough information about journey details, confirmation that infection prevention and control measures were used and summaries of the transfers.
- However, in 18 of the records the patient observations were not documented although it was confirmed in an

email to staff that all hospital admissions, transfers and discharges should have this done. All of these patients were in this category. Information in other sections of the journey sheets was not always consistently completed. Examples of this included patient observations, consent to travel and mental capacity assessments.

- The patient journey sheets were audited by the compliance team. At least one record was audited per shift in every station each day. Results for July showed that overall staff were completing 88% of the records correctly. This almost met the target of 90% of the fields being correctly completed.
- Where a staff member showed repeated non-compliance with the completion of records this would be discussed with them in terms of a training need.
- Patient information was kept confidential at the ambulance bases. There were lockable storage areas within the locked offices where staff posted their records at the end of their shift. These were then collected by the team leader who scanned them to the head office where they were reviewed.
- Every patient journey sheet was reviewed by the administration staff and any anomalies were brought to the attention of the clinical compliance lead, the safeguarding lead or the patient experience manager as appropriate.
- The information on the patient journey sheets included any special instructions such as whether a do not resuscitate order was in place.
- There were additional patient journey sheets specifically for bariatric patients and the transport of deceased patients. These contained specific information pertinent to their circumstances.
- Guidance on the management of records was included in the policies such as information governance.

Urgent and emergency care:

- Ambulance staff completed a patient report form for every patient they transported. This was a record which was required by the commissioning trust and a copy of the form remained with the patient on transfer. This contained patient's details, times of response, medicines administered, mobility, physical observations and mental capacity.
- Daily audits of the patient report forms took place. There were six forms audited for Morecambe, three for Manchester, one for Burton and two for Wakefield. The audit for July 2017 showed overall 93.3% were correctly completed. This exceeded the target of 90%.

Safeguarding

- During the announced inspection we raised concerns regarding the reporting systems within the organisation. We saw evidence that delays in reporting potential and actual safeguarding incidents had occurred, particularly outside of office hours. This was brought to the attention of the provider, immediate action was taken by the provider and systems and processes had been reviewed within four days. These new systems were tested in the first two days of implementation and we saw during our unannounced inspection that these changes had resulted in a timely and appropriate referral to social services.
- At the start of our inspection we saw that a safeguarding incident which had occurred in February 2017 had not resulted in any lessons learnt by staff at the organisation. They had been part of the investigation, but had relied solely on the social services department involved to provide them with an outcome and any actions. This had not been obtained therefore no actions had been taken to prevent a recurrence. The changes made to the safeguarding processes during the inspection included the inclusion of this incident as an example for staff and a catalyst for the changes in processes.
- Crews on the ambulances and in the remote stations had access to safeguarding policies through their mobile phones. Staff we spoke with were aware of how to access these policies. At the unannounced inspection the new policies introduced the previous week had been distributed to staff, via email and hard copy, and those we spoke with were aware of the changes made. We therefore found that the service had positively acted on our concerns.
- The control room co-ordinators were the staff members with the responsibility for making the referrals to social services. At the announced inspection they discussed how the process was not clear; however at the unannounced inspection they stated the new process was simplified. They had the information required to act

in a timely manner, including when they were on call out of normal office hours. This included up to date contact details for the numerous social services departments within their service area.

- There was a review process in place to identify any potential safeguarding concerns which had been missed; however the staff who undertook the review role were not trained to do so. The administration staff who reviewed all the journey sheets completed by the ambulance crews had received no safeguarding training. Therefore it was not clear if they had the knowledge base to identify potential concerns which had been missed and pass them to the relevant manager.
- Following concerns raised at the inspection a system to provide ongoing monitoring of the safeguarding of patients was to be implemented. This included weekly audits of any safeguarding incidents, audits of incidents reported to identify any missed safeguarding concerns and follow up with the staff involved as learning opportunities. This information would be used at a monthly safeguarding meeting to discuss all aspects of this area of work including training, reporting, referrals and feedback.
- All staff, including the control room co-ordinators, had completed safeguarding training for adults and children. This had been delivered in two different formats, some prior to the current training manager being appointed. They had mapped the previous training to ensure it met the current requirements. Following concerns raised during the inspection a review of the training for safeguarding was to be completed.
- The safeguarding lead at the organisation had completed level three training for children and adults. No other person in the organisation had completed training to this level. This did not meet current guidance as paramedic trained staff should have completed training for safeguarding children to level 3. The safeguarding lead for the organisation should complete level 4 training. Care had been provided for 45 children in the past three months; therefore this guidance was not being met.
- Information provided by the provider showed 90% of staff were up to date with this training at the time of the inspection. This met the provider's target.
- There were two other managers who provided advice and support to front line staff, outside of office hours, regarding safeguarding concerns. These staff had completed safeguarding training for adults and children.
- Staff were aware of when it was required to inform the contracting organisation of any safeguarding concerns. Their responsibility in providing information in a timely manner was reviewed with the new processes put in place during the inspection.
- To aid learning for staff, safeguarding concerns and scenarios would be included in the monthly staff newsletter as lessons learnt.

Mandatory training

- In July 2017 there was 87.6% of staff up to date with mandatory training. This exceeded the provider's target of 80%. All areas of mandatory training for all staff were over 85%.
- The areas covered in mandatory training included first aid, basic life support practical, infection prevention and control and moving and handling.
- The training provided was a mix of face to face classroom training and on-line training. Staff stated they found the face to face training more beneficial. They had to do the on-line training in their own time, so they did sometimes find this difficult to complete within the expected timescales.
- Staff received training to use the equipment on board the vehicles. This included moving and handling equipment and clinical equipment such as defibrillators.
- Two team leaders had completed the advanced driving course and they were responsible for assessing the new staff prior to them driving with patients on board. All other staff had an annual assessment of their driving competence.

Urgent and emergency care:

- The provider was unable to provide separate mandatory training figures for the ECA staff. Therefore the information is included in the total numbers for mandatory training compliance in the patient transport section.
- There were plans for all the staff with First response emergency care (FREC) training to level 3 to train to level 4. This would mean all staff who worked on the emergency and urgent care vehicles would then be

trained to the level required to meet the higher scope of practice required by the NHS ambulance service. This would increase the number of patients who could be transferred by the provider for example those with compromised airways.

Assessing and responding to patient risk

- Staff on the patient transport ambulances were expected to use their first aid knowledge to assess if a patient's condition was deteriorating. They were expected to complete an assessment of the oxygen saturation and heart rate for all patients. This was a mandatory field on the patients' journey sheets for in-patient discharges, transfers or admissions to hospital. It did not apply to out-patient visits or clinics.
- The normal limits, for these observations, were in the ambulance care assistant pocket guide. If the observations were outside normal limits or a patient's condition was deteriorating they should call the clinical compliance lead for advice. We saw numerous examples of where this had taken place and advice was given, including where appropriate not to transport the patient or to seek medical help.
- The clinical compliance managers were available 24 hours per day on a rota basis. They provided telephone advice to staff who said they were very helpful and they would ring them about any patient concerns.
- In July 2017 86% of staff were up to date with practical training for basic life support for adults. This was included in the emergency first aid at work (EFAW) one day course which had been introduced as part of the induction training in the past few months. The team leaders at the ambulance bases completed assessments in basic life support as part of their ongoing support and development of staff.
- There were no staff trained in paediatric life support. The basics were included in the EFAW training; however this was not adequate as children were conveyed by the service in both patient transport and emergency and urgent care.
- All children under 16 were required to be transported with a responsible adult. This applied to both patient transport services and urgent care.
- Pressure mattresses were available for patients who may be at risk of developing a pressure ulcer on a long journey.
- A mental health risk assessment had been developed using NICE guidance and best practice to adapt an assessment commonly used on medical admission wards, prisons and urgent care units. This was a tool to assess acute mental health and absconding risk. The Broset Violence Checklist (BVC) and the 'Leave and Absconding Risk Assessment' (LARA) were used for the assessment of patients to be transported. The use of these resulted in an assessment of the need to protect the patient, staff and the public from harm. This then led to the allocation of the most appropriate resource and skill mix.
- Where these assessments indicated a high risk then an additional escort from an appropriately trained professional would be requested.
- There was a mental health policy which detailed the potential risks to patients and staff, how to assess the risks and the actions to take. Guidance on where to obtain further support and advice was included.
- There was a bariatric risk assessment form in place. This included the patient's past medical history, their mobility status, any specialist equipment required and environmental factors to be considered such as steps, obstructions and accessibility. The numbers of staff needed would be determined using this assessment. There was also a bariatric handover sheet which included patient and transfer details, and observations.

Urgent and emergency care:

- Staff on the urgent and emergency care vehicles had completed First response emergency care (FREC) training to level 3 or level 4. This training included the assessment and recognition of a patient who was or was at risk of their condition deteriorating. This included assessment of vital signs, recognition of red flags and use of the National Early Warning Score (NEWS)
- The pocket handbook for the emergency care assistants contained an explanation of the normal vital signs, physiological parameters with corresponding scores and paediatric vital signs. The patient record forms contained a full NEWS assessment and actions to be taken if this assessment showed a patient to be at risk. This included ringing 999 for an emergency ambulance.
- If a NEWS assessment was over five then the staff member with the patient would contact the NHS ambulance trust control centre and raise as a high risk patient. They would receive immediate advice for treatment via the phone and be advised of what actions to take.

Patient transport services (PTS)

- If the crew assessed a patient as requiring more urgent treatment at the scene of the call they would contact their clinical support hub, allocated NHS ambulance control handler or ring 999 for an emergency ambulance as appropriate. If a paramedic attended in a rapid response vehicle (RRV) they could accompany the patient in the service's ambulance. The paramedic's organisation would take the RRV back to the base.

Staffing

- At the time of the inspection 141 staff members were employed. There were five staff members who held paramedic or nursing professional qualifications. Their up to date registration status had been checked and verified. The ambulance crew were either emergency care assistants or ambulance care assistants. This depended on their level of training and they were allocated patient transport or emergency care work accordingly.
- The control team was made up of seven staff including the team leader and assistant team leader. There was a new operations manager in post who was overseeing that department.
- There was one team leader who covered the Wakefield and the Burton ambulance stations. They spent more time in Wakefield as it was busier and there were more staff to manage, however they spent every Thursday as a minimum at Burton and more time if necessary.
- All ambulance staff employed for longer than 12 months were offered a fixed term contract. There was a mixture of fixed term contracts for 20, 30 and 40 hours in addition to those on the bank (zero hours).They used an electronic system to inform the co-ordinators in advance of when they were available for work.
- We saw the co-ordinators used this system to plan staffing in advance and to provide cover for short notice absence or staff additional ambulances. Staff told us the system worked well and co-ordinators said they rarely had to cancel a shift with a commissioner due to lack of staff. The provider did not breakdown unfulfilled shifts into categories and therefore they were unable to provide us with the number of shifts involved.
- In the past 12 months the turnover rate for patient transport service staff was 27.1% which represented 35 leavers. The sickness rate was 6.7% in the same period.
- We were told the main reason for the turnover rate being high was the inability to provide enough contracted hours for some staff. There were a limited number of contracted hours available to cover the contracts with commissioners; however most hours were ad hoc. For some staff they found this did not provide enough hours of work.
- The recruitment procedures met with the requirements to ensure persons employed had the skills, knowledge and were of good character. We reviewed five staff recruitment files and found most of the necessary documentation to be present. In one staff file there was only one reference and not two as required. We were told when two were not provided an alternative referee was not currently sought. We were assured all staff had at least one reference on file.
- We saw an example where disciplinary procedures had been followed and the necessary actions to ensure the safety of patients were taken.
- There was a process to ensure all necessary items were recovered when a staff member left employment. This included the return of identity badges and uniforms. We were told this was not always followed and it was an area managers were aware they needed to improve.
- The working hours of staff were monitored for those hours worked for this provider. There was no process for monitoring the working hours of staff who also worked for another employer. The provider asked staff to provide weekly rotas for their alternative work; however this was not always provided.

Urgent and emergency care:

- There were two crew members on the urgent and emergency care ambulances. These were trained to FREC4 or FREC3. It was never planned for an ambulance care assistant to work on these ambulances; however there may be occasions when they needed to cover at short notice due to sickness.
- Checks of the professional qualifications and registration with a professional body were completed for the paramedics and nurses employed.
- There were three staff members who were trained to drive an emergency vehicle using blue lights. We were told this rarely happened and would usually be with advance notice. There were plans to train further staff as part of the FREC4 training.
- The staff turnover rate, in the past 12 months, for urgent and emergency care ambulance assistants was 16.3% which represented seven staff members. The sickness rate was 1.19% in the past 12 months.

Patient transport services (PTS)

Response to major incidents

- There was a business continuity plan in place which staff were familiar with. This included actions during fuel shortages, loss of electricity and IT failure.
- There was a secondary location identified, should the head office be unavailable, and a designated incident manager with a hierarchy of staff who could drop in to that role.
- A business continuity incident manual set out the actions to be taken should head office be required to relocate to a secondary site, as had happened when a storm in 2015 left head office uninhabitable for a week. The service successfully re-located and carried on with minimal disruption for staff and patients.
- The service tested their business continuity plans by staging annual unannounced scenarios. Staff at head office described an exercise in March 2017 where key members of staff including the control team and senior managers were unavailable (they had rung in 'sick' or were away 'on training'). Staff successfully adapted to the different roles required covering control and providing business continuity and there was some learning for the organisation in terms of the availability of key holders. Similar exercises in previous years had tested different elements of the plans.
- A business impact analysis had been conducted for all departments and key functions critical to business continuity. This was held with the International Standards Organisation (ISO) auditor.
- The ambulance crews or the vehicles were not part of the major incident plan for any other organisation.

Are patient transport services effective?

At present we do not rate independent ambulance services. However, during our inspection we noted the following for effective;

- All staff carried a pocket guide with clinical information which was developed from the latest guidance.
- The policies and procedures were based on best practice guidance.
- There were clear systems in place for the planning of patient journeys and the care they would need during that time.
- The planning process for patient transport services meant if transport was requested for patients whose needs were outside the scope of practice of the staff, alternative safe transport would be arranged.
- There was a robust induction procedure.

However

- Staff in patient transport services did not always document that consent to travel had been obtained by the patient, despite this being a mandatory part of the patient records.
- Staff did not have a good understanding of the assessment of mental capacity although they were expected to do this as part of their role.
- Staff who may need to use equipment such as suction had not been assessed as competent.
- There was no training or competence information documented for the qualified paramedics or nurses who worked for the organisation.
- Performance information, such as response times, was gathered by the organisation; however this was not stored or used to monitor and improve the service.

Evidence-based care and treatment

- There were policies in place to provide guidance to staff with regard to their day to day working. These included the safe conveyance of patients, guidance on supporting patients with specific needs such as people who use mental health services or bariatric patients and human resources procedures such as recruitment and training. Some of these policies had not been reviewed within the timescale documented; however information was provided that the delay had been agreed as the provider was introducing a new computer system in the near future.
- There was reference in the policies and procedures to best practice guidance which included the department of health and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- Pocket books had been developed to aid information for the remote working ambulance crews. This was developed from feedback from the crews which highlighted a need for answers to common queries such as do not attempt cardio pulmonary resuscitation

(DNACPR) validity, paperwork completion, safeguarding and mental capacity. There were two versions of this pocket book, one for Ambulance Care Assistants (ACA), and one for Emergency Care Assistants (ECA).

- Each ambulance crew member carried this pocket book which was based on guidance from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical guidelines for pre-hospital care. Carrying a pocket book was a requirement set out in the uniform policy for the service.

Assessment and planning of care

- The staff did not have any prior information about the patients they would be requested to transport since they were working on a shift to carry out ad hoc work as it occurred. Therefore the crew had to obtain the necessary information once they were on site with the patient. They obtained this information using the patient journey sheet.
- A patient journey sheet had been developed which had to be completed for each patient travelling on an ambulance. The information included medical history, mental capacity and mobility. This information provided an assessment of the fitness of the patient to travel.
- This had first been devised in 2013 and was now on version 15. The information provided a comprehensive picture of the patient. It also contained evidence that the health professional who was discharging the patient into the care of the crew had agreed they were fit to travel. We saw that staff did have a good overall picture of the needs of the patient due to this document. It had also resulted in them seeking advice about the health and welfare of patients in their care.
- As part of the contract for one commissioner the risk assessments for the transport for patients with a known mental health condition were completed by that commissioner at their request. The ambulance personnel carried out their own risk assessment when they arrived on the scene to ensure the patient's behaviour did not present a risk to themselves or staff. Should there be any issues the crew reported these to the commissioners control room and through their own internal processes to the compliance lead.
- Four patient journeys had been declined following the use of the mental health assessment as the needs of the patient were outside the scope of practice of the ambulance staff.
- There had been 19 other patient journeys declined when the information provided showed the patient's needs were outside the scope of practice for the ambulance crews. This included patients with a compromised airway or intravenous medicines in place.
- Should staff be expected to complete very long journeys and have concerns about the comfort of patients they would contact the control centre to seek advice and where possible alternative routes. We saw this occurred where they were asked to take more than one patient and so delaying the end of the journey for some patients.
- Where very long journeys took place, for example to the South of England, the journey would be planned with motorway stops for food and drink. This was to accommodate the needs of both staff and patients.
- There was a pain scale on the patient report form which staff used to assess the severity of a patient's pain. This was included in the emergency care assistant handbook and had a picture version to aid communication.

Urgent and emergency care:

- Crews got basic information about a patient's condition prior to them arriving on the scene. However they were asked to reassess the patient face to face as their condition could have changed since the initial call. They carried out this assessment using the patient report form.

Response times and patient outcomes

- The response times were not kept for the providers own records. All times, including set off, pickup, drop off, on scene and handover were given to the commissioners of the service to include in their own key performance indicators and response time information.
- Information such as the time patients spent on the vehicles, same day bookings and turnaround times were not recorded.

Urgent and emergency care:

- Response times were recorded on the patient report form. This included the time the crew received the call from the control centre, the time they became mobile, time on scene, how long they were with the patient and the time they left the scene. The handover time on arriving at the hospital was also recorded.
- This response time information was sent to the commissioner for their records.; however it was not used

to measure performance by this provider. They did not keep copies of the information they sent to the commissioner and therefore we were unable to access this information.

Competent staff

- There was a comprehensive induction programme. Staff who were new to the organisation completed one week induction training which comprised of completion of the mandatory training, orientation to the policies and procedures and general introduction to working processes. Following this there was a station induction and travelling with other crews on a shift to observe until they felt ready to no longer be supernumerary. This was then confirmed by a team leader conducting a sign off observation.
- There were no competence assessments for any practices or procedures. This included for paramedics or nurses who were qualified and either did or did not work in a similar role elsewhere. There were no ongoing assessments of competence for emergency care assistants or ambulance care assistants once they had completed their induction process. This meant there was no documented evidence that staff had the knowledge and skills to carry out the work they were employed to complete.
- However the team leaders accompanied staff on shifts to carry out observations. This occurred on an ad hoc basis. These observations were recorded and were present in the staff files we saw. Due to the way team leaders worked they were in contact with the crew members and were able to identify to us those who may need extra support or training.
- All the team leaders had completed the "Preparing to Teach in the Lifelong Learning sector" (PTLLS) course. This gave them skills to provide learning opportunities for staff which took place within the ambulance bases.
- Staff told us they could request additional training or updates should they feel this was necessary. These would be provided by one of the compliance managers who was also the training manager. They had a working background in education and training as well as being a qualified paramedic.
- Staff had an annual appraisal with the team leader at the ambulance station they were based. The appraisal rates for staff in the patient transport services were 90% in Manchester, 83% in Burton, 60% in Morecambe. In Wakefield two staff were overdue an appraisal. The remaining staff had not worked for 12 months. These figures included staff that were off work for special leave and this had an effect on the achievement against the target.
- Staff had very limited time within their working day to complete the on-line training as the computers were in the ambulance stations. Managers told us most staff did this in their own time. If they needed to access the organisations computers they would start their shift early.
- Similarly, when staff had one to ones with their team leader, if it was just "a quick catch up" they were asked to come in a few minutes early before their shift. If a more in-depth meeting was required, for example if there was a particular issue that needed discussing, staff would be asked to come in at their convenience, but on their own time.

Urgent and emergency care:

- Staff had a monthly appraisal with the team leader at the ambulance station they were based at. The appraisal rates for urgent and emergency care staff were 100% in Manchester, Burton and Wakefield and 82% at the Morecambe site.
- There was no training or competence documentation for the registered paramedics and nurses. We were told there was an expectation that if they maintained their professional registration they would remain competent in their role.
- There was no documentation for the induction process completed by the qualified paramedics and nurses. We were told the compliance lead completed an orientation which included medicines and records.

Coordination with other providers and multi-disciplinary working

- We saw examples of where care had been co-ordinated with health professionals in other settings. This included care homes, hospitals and health professionals providing patient escorts.
- Concerns were raised, with the commissioners, when ambulance crews were asked to transport patients who had support needs outside their scope of practice. This information was relayed so as to prevent unnecessary aborted journeys for the patients.

Urgent and emergency care:

- Ambulance crews liaised with NHS acute trust paramedics if they had concerns about a patients' condition on arrival at a call. They would discuss the patient and take advice about whether to transport the patient or request an emergency ambulance.
- On arrival at an accident and emergency department the ambulance crew gave the hospitals staff the patient's information as documented on the patient report form.

Access to information

- Information was obtained from hospital staff and entered onto the patient journey forms for any special requirements. This included DNACPR documentation and mental health information. The health professional on the ward then documented that this information had been shared.
- Where patients had an active DNACPR (do not attempt cardio pulmonary resuscitation) order in place the original document was the only version that could be accepted to travel with the patient. Crews received training in this during induction and it was set out in the guidance in the pocket books they carried.
- For journeys commissioned by one of the local NHS acute ambulance trust in the North West, crews were authorised to accept a photocopy. There was a prompt on the patient journey sheet asking whether the patient had a valid DNACPR form and whether the original form had been seen. There was a field for the clinician to sign when this was in place.
- The mobile phones provided by the organisation did not all have access to the applications required for staff to be able to access the policies and procedures of the organisation. Therefore some staff accessed these via their personal phones.
- Paper copies of some policies and access to them via computers was available at each ambulance base.
- We were given conflicting information about the update of satellite navigation systems. One team leader told us there was no system to update the satellite navigation systems used in the vehicles and this could lead to difficulties where new road systems were in place. Another said there was a system and they were updated from head office. This meant there was a lack of clarity around this process.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they had not received training about the mental capacity act and their role in the recognition, assessment and support of patients who lacked capacity. Both ambulance staff and the control room staff told us they did not feel confident in their knowledge around mental capacity. The training manager told us there was some training included in one of the programmes; however they recognised if staff did not recall this or feel competent this had not been sufficient for their role.
- There was no training for staff regarding general mental health awareness. We saw that staff did ring the control room to seek advice if a patient had a mental health diagnosis; however there was some misunderstanding amongst staff regarding how a diagnosis may not have negative effects on a patient's behaviour.
- Those staff allocated to escort patients who used mental health services and whose behaviour may challenge staff had received specific training in restraint and de-escalation.
- There was a lack of clarity amongst the managers we spoke with regarding the transport of patients who are receiving care whilst detained under a section of the mental health act. Information provided by the provider stated instances had occurred where such transport had been provided when required by a commissioner of the service. The provider's staff had completed a 'dynamic risk assessment' and the patient had remained in the custody of the police. However on speaking to senior staff we were told "we do not provide transport to patients who are detained under a section" and "I do not know what section of the mental health act we would agree to transport patients". There were no recorded risk assessments for such patients.
- We reviewed the consent to travel section for 28 patient journey sheets from July 2017. Of these on two records it was documented that consent had been given, despite the documentation showing that the patient had been assessed as not having mental capacity. No notes were documented to explain how consent had been obtained.
- On one journey sheet the consent section was not completed at all and on three others it was documented that consent was not given, but no notes were included

to explain why the transfer had gone ahead without consent from the patient. The concerns we found with regard to consent to travel were brought to the attention of the manager during the inspection.
- We saw one example where a patient did not have capacity but it was noted that staff had given consent for them to travel.

- Managers told us they frequently received transfer requests for patients who used mental health services. They had introduced a mental health risk assessment, with guidance and a transfer form for the call handlers in control to use.
- There were 23 staff members who had completed additional training in the support of patients who used mental health services which could lead to behaviour which could challenge or present a risk of harm. This training included de-escalation and conflict resolution.

Are patient transport services caring?

At present we do not rate independent ambulance services. However, during our inspection we noted the following for caring;

- Patients gave positive feedback about the service they received.
- Measures were in place to protect the dignity of the patients.
- Patients and their carer's wishes were sought and taken into account.
- We saw examples of where staff had demonstrated support and caring for patients.

Compassionate care

- The patient journey sheets had information about a patient's needs which would indicate if they were vulnerable in any way. This included a lack of mental capacity, mobility issues and communication problems.
- As part of the induction training staff were shown how to use blankets as screening to preserve the dignity of patients when they were transferring between stretchers and wheelchairs.
- The ambulances had blinds on the windows which would be closed to provide privacy for patients should this be required.
- Staff we spoke with were aware of the need to protect the privacy of patients. They discussed how they would consider the appropriateness of patients travelling together in ambulances if one of the patients was vulnerable or distressed. We saw evidence that staff had challenged the direction to take more than one patient in their ambulance.
- Staff spoke about the need to communicate with patients and carers during the journey to ensure they were comfortable. Additional pillows and blankets were available for patients' use.
- Managers discussed how part of the assessment of new staff was their ability to communicate with patients as this was a very important part of the job. They gave examples where employment had been terminated as the staff member did not have the appropriate communication skills.
- Patients were given the opportunity to rate the service they received through a feedback form. This should be given to all patients at the end of their journey. 452 feedback forms were received between July 2016 and July 2017. 421 patients rated the service as "excellent" and 30 as "very good". No patients rated the service as "poor".
- We received 20 comments cards back from the public and all had a positive response with none indicating any complaints.
- The responses included general comments about how respectful and caring staff were to patients and their families.
- One respondent said "I cannot fault the service provided. The respect towards the patients and family are second to none". Another person had written "I found the driver and his companion a lovely helpful team, very pleasant" and I cannot fault the service".

Urgent and emergency care:

- The urgent care vehicles had signage on the windows to say treatment may be in progress and no-one should enter.

Understanding and involvement of patients and those close to them

- The "Conveyance of patients' policy" gave guidance for staff on the expected level of communication and interaction, patient welfare, the need for chaperones and specifics such as travel with a guide dog. This policy was used during the induction of new staff.
- Staff explained in what circumstances they would seek advice about transporting a patient, including the

eligibility of a second person to travel. We saw evidence of when this had been done and the needs and comfort of the patient had been paramount in the decision making process.
- Where a potential for declining to transport a patient was identified there was open communication with the patient and everyone else involved in their care. Every possible attempt was made to arrange a safe transfer prior to alternative options being used.
- We saw occasions where a carer accompanied a patient to assist with support which was outside the scope of practice of the crew. This was done with the agreement of all concerned and clinical advice from the compliance leads.

Urgent and emergency care:

- The appropriateness of a carer travelling with a patient would be assessed for each individual journey undertaken by crews. We saw examples of where ambulance crews had sought advice about carers accompanying patients and where possible and safe this had been accommodated.

Emotional support

- All staff completed the "Fundamentals of patient care" training. This provided advice about supporting anxious and distressed patients and carers, including the professional boundaries to observe.
- We saw staff had sought advice and guidance from the control room when a patient had been particularly anxious. The support offered included being accompanied by a familiar person.
- During induction staff were given guidance on the conveyance of patients who were close to the end of their life. This gave them an opportunity to discuss the additional support for carers or families members that may be needed.
- We saw that where a patient had died in an ambulance the crew had acted professionally and stayed with the patient until appropriate staff were present.

Are patient transport services responsive to people's needs?
(for example, to feedback?)

At present we do not rate independent ambulance services. However, during our inspection we noted the following for responsive;

- The pocket guides had pictorial communication aids and translations for everyday questions to patients about their comfort.
- There were communication aids for patients for whom English was not their first language.
- There were clear systems for the safe transport of patients who received a mental health service.
- Written information of how to complain was present on the ambulances we saw. Staff knew how to advise a patient if they wished to complain.

However

- Staff received some training around mental capacity during their induction. However there was no further training regarding mental health awareness, dementia or learning disabilities.

Service planning and delivery to meet the needs of local people

- Service level agreements were in place with two NHS ambulance trusts for non-emergency and non-clinical patient transport. These covered the geographical areas of Yorkshire and Humber and Lancashire.
- Patient transport services were also commissioned by two NHS acute hospital trusts and one local authority. These covered central Lancashire and the East Midlands areas.
- Private bookings were documented so as to ensure the type of ambulance and patient details were clear such as numbers of crew needed, any specific medical information or if oxygen was required.
- We were told there were occasional meetings with the senior managers and some commissioners of the service to ensure the provision remained satisfactory.

Urgent and emergency care:

- The urgent and emergency care service was provided to one NHS acute ambulance trust. This was in the geographical area of Cheshire and Mersey, Cumbria, Greater Manchester and Central Lancashire.
- The service provided emergency and urgent care ambulances to support an ambulance service NHS trust. These ambulance crews attended calls which had been triaged by the NHS ambulance service call

co-ordinators as low risk and requiring a response within four hours. These patients were assessed at the scene and taken to hospital by the emergency ambulances provided. The number of ambulances required to support the trust varied each week and were booked in advance.

- There was an exclusion criterion for the type of patients which was outside the scope of practice for the staff members on the emergency ambulances. This included any blue light response, obstetric patients and those requiring care of a tracheostomy by the crew.
- There were some care requirements which staff with additional training, for example FREC 4, could provide. This included children from 13 years and patients with behavioural disturbances.
- At busy times additional support may be requested by the NHS ambulance service and if the provider had staff and emergency vehicles available they would provide this.
- Staff in the urgent and emergency care vehicles signed on for their shift either with the commissioning acute ambulance trust or acute NHS hospital to which they were attached. The crew were allocated work either via the ambulance control centre or through hospital for calls which had been triaged as non-urgent emergency. This included calls to the 111 service, inter-hospital transfers and calls which required a four hour response time.
- There was no need for a severity level protocol (similar to NHS emergency ambulance services 'Resource Escalation Action Plan - REAP') for delivery of service, as this was dictated by the customer requests and demand. The service attended only to calls which had been triaged by the NHS acute ambulance trust as requiring a non- urgent ambulance required within four hours.

Meeting people's individual needs

- The pocket books which were provided for every crew member contained words and phrases written in various languages. These included questions about drinks, pain and medicines in nine languages including Polish, Chinese, Gujarati and Spanish.
- There was a comprehensive multi-lingual phrase book at one ambulance base which could be used for pre-booked transfers where there was a language barrier, however this had never happened. These were also on some of the ambulances in other areas.
- If required an interpreter service could be booked in advance. The provider had not commissioned an interpreter service such as language line.
- The pocket books also had pictures to assist people with non-verbal communication.
- Staff received some training around mental capacity during their induction. However there was no further training regarding mental health awareness, dementia or learning disabilities.
- Staff we spoke with said they would welcome more training about the support of people with dementia. However they did recognise the basic needs of such patients and the additional support they may require, for example to be re-orientated during their journey.
- There was one specialist bariatric vehicle and bariatric equipment to provide alteration in four vehicles. This included stretchers and wheelchairs that could to go into the convertible vehicles with weight bearing ramps. The fleet moved between the different geographical areas, dependent on need.
- Staff had access to a variety of moving and handling equipment to ensure they could safely help those people with mobility difficulties. These included carry chairs, various sizes of wheelchair, different stretchers and walking aids.
- There was drinking water on board every ambulance we saw with a supply of plastic cups. This was one of the articles to be replenished after every journey.
- Each vehicle had male urinals and bed pans on board so that staff could assist patients if they needed to use the toilet during a journey.

Access and flow

- The commissioner of the patient transport service booked the ambulances from the provider for set shift times for example arrival on site start times. These times varied dependent on the requirements of the service. Some were covered seven days per week and others five. These were recognised to not always be realistic in ensuring the key performance indicators such as patients' arrival times being met. For one commissioner the provider agreed different shift times which resulted in improved performance and the indicators were met.
- When there were increased requests or demand for the service the geographical location of the four ambulance bases meant they could assist other bases with their service. For example Wakefield station assisted Burton

and Manchester, Manchester station assisted Morecambe and Wakefield. This process was actively utilised to assist areas with any peaks in demand or any staff or vehicle shortages.
- The service provided three vehicles a day for a contract with a Midlands hospital, usually two from Burton and one from Wakefield. On the day of the unannounced inspection two of the vehicles were provided by Wakefield and one from Burton. This meant that considerable time was spent travelling to and from the hospital as it was an hour's drive away from the Burton base, and two hours drive from the Wakefield base.
- Records were kept of journeys cancelled on the day. These were cancelled by the commissioner of the service due to last minute changes, for example a patient was not ready to be discharged. The number of cancellations between January 2017 and July 2017 was 1187. The total patient transport journeys for that period was 14,742. These were outside the control of the service provider who had not cancelled any journeys themselves.
- Co-ordination liaised with individuals who wanted to book an ambulance. This might be with the patient themselves or a carer or health professional on their behalf.

Urgent and emergency care:

- The non-urgent ambulance shifts were booked through the co-ordinators a week in advance. Those crews then were on stand-by for the commissioner of the service and sent to the non-urgent calls triaged through their own control room.
- The response time for the non-urgent emergency calls was four hours from the time of the call to arrival on scene. This response time changed on 8 August 2017. This response time is allocated to the commissioning NHS acute ambulance trust. This provider was unable to influence this response time as they had no control over the call allocation.
- The information of performance against response times was sent to the commissioner of the service; however the provider did not maintain a record of their own performance.
- Records were kept of journeys cancelled on the day. These were cancelled by the commissioner of the service due to last minute changes, for example a patient was not ready to be discharged. The number of cancellations between January 2017 and July 2017 was 371. These were outside the control of the service provider.

Learning from complaints and concerns

- There was a complaints and investigation policy which was included for all staff to read and sign that they understood it. This policy documented who was responsible for handling complaints, how they would be investigated and the timescales which should be met.
- Two formal complaints had been received by the provider in the past 12 months. Both of these had been investigated with the commissioner and appropriate actions taken to reduce any identified risks until a resolution was reached.
- The responses to complaints included an apology, the outcome of the investigation and information of the parliamentary ombudsman if the complainant was not satisfied.
- For one complaint lessons learnt had been shared with other staff members to prevent recurrence. The other had not been resolved although the responsibility for this was with the commissioner of the service.
- Written information of how to complain was present on the ambulances we saw. Staff knew how to advise a patient if they wished to complain.

Are patient transport services well-led?

At present we do not rate independent ambulance services. However, during our inspection we noted the following for well-led;

- The leadership structure of the service was clear and staff could discuss any issues openly with the managers.
- There were systems in place for support for remote working staff outside of normal working hours.
- There were clear governance processes in place which included audits, risk management and improvement planning.
- Managers responded quickly and positively to concerns that were raised during the inspection and put measures in place to reduce identified risks.
- Staff of all grades knew the vision and values of the organisation. These were carried through in the positive way staff worked with each other and patients.

- Staff were positive about their engagement with managers.

However

- The information required to ensure directors were fit to be in their role was not available.

Leadership / culture of service

- The service was led by the chairman. They were supported by the lead for each workforce stream which included co-ordination, clinical compliance, training and business development. A new operations manager had been appointed two weeks prior to the inspection.
- The day to day running of the service was shared between the clinical compliance manager and the operations manager, however the chairman had a very active part in the day to day business. Out of hours support was provided by the senior management team and for clinical support the compliance lead and the training lead shared this role. They were available by phone 24 hours per day including weekends.
- There was a clearly documented company structure. This showed clear roles and responsibilities within the senior management team. This included operational and clinical managers. Staff knew which manager would provide them with specific guidance and support.
- The senior management team had been appointed into roles where they could use their previous knowledge and skills. We observed open communication between all senior managers and other staff, including why improvements were needed and how these would be implemented.
- Staff told us they could always speak to a manager to obtain advice and support when they were remote working. They said the response was usually timely and they felt supported by managers. They were given support from their immediate line manager following difficult or challenging situations.
- Staff in the head office and all the ambulance stations said they saw the senior managers of the organisation who visited the ambulance stations regularly. Without exception those we spoke with said the senior managers were approachable and they could have open and honest discussions with them.
- Although staff worked from remote ambulance stations they knew who the managers were their roles and responsibilities and arrangements to contact them if needed.
- There were progression opportunities for staff within the organisation. We spoke to several staff who had been promoted through various roles during their employment. Three staff that started as apprentices had progressed through the organisation.
- All staff we spoke with told us they enjoyed working for this organisation. The reasons for this were mostly that they felt everyone wanted to do a good job and it was a “happy” place to work.

Urgent and emergency care:

- Should ambulance crews need support and advice on a day to day basis they would get this from the commissioning NHS acute ambulance trust. However they told us they also had good support from their internal managers who they could approach anytime with queries regardless of which organisation was commissioning the work.

Vision and strategy for this core service

- The mission and the vision of the organisation were evident in the head office and the ambulance bases. These were incorporated onto a logo which was on the walls, the pocket guides and other documentation.
- The mission was to “put the wellbeing of all our patients, colleagues and business partners as our number one priority.” The vision was that the provider was committed to being the “provider and employer of choice, embracing our ethos of patient care, staff engagement and nurturing our external relationships”.
- The values of the organisation were part of this logo and were ‘respect, teamwork, passion and patient and customer focus’.
- All staff we spoke with knew the companies vision and values. They said these were discussed during induction and other ongoing training.
- Without exception and across all roles within the organisation staff spoke positively about the organisation and the values. They told us everyone had the patient at the heart of what they did.
- There was a company strategy for 2014 to 2018. This outlined the objectives of the organisation, the areas of operation and plans for future growth.

- The organisation wanted to continue to grow and find new business opportunities. They had identified areas of growth which were discussed during the inspection.

Governance, risk management and quality measurement

- The organisation had obtained ISO 9001 certification in 2015. The annual re-assessment had taken place in May 2017 and the outcome was not confirmed at this inspection.
- The governance processes developed to obtain the ISO certification were used to assess the performance of the organisation. This included internal audits, governance meetings and risk assessments.
- A management review meeting took place after each annual ISO inspection. Any non-conformity within the ISO standard was discussed and an action log was created to make the required improvements. This non-conformity and corrective actions log included quality reports, complaints and outcomes from audit processes. This was a recognised document within the ISO process.
- Every Monday morning the team leaders had a meeting followed by the senior management team. The organisational risks were discussed at these meetings.
- We saw minutes of the team leader meetings for March, April and May 2017. Discussions at these meetings included day to day operations, plans for future events, staffing issues and audit outcomes. Actions were attached to each item which included the person responsible for delivery. We saw these actions were followed up at subsequent meetings.
- There was risk register which contained five risks. These were very general risks which were both operational and clinical for example “Patient/staff safety concerns” and “finance”. The impact, risk scoring, actions and review dates were included. This was reviewed as part of the quality assurance system.
- There was a quality policy which documented the expectations of the quality of the service provided, how this would be monitored and who was responsible for it. The quality assurance team had the responsibility for implementation of this policy. This team was made up of the chairman and the quality assurance co-ordinator.
- The quality policy was a standing item on the executive and team meeting agendas. This meant the quality expected in the delivery of the service was discussed at all levels.
- There were quality reports where risks were documented. These included events which could affect the business in terms of being able to provide a quality service. Examples could be an issue with a supplier. These risks could be identified by any member of staff within the office.
- We saw an example of learning from incidents which included changes to the system for the maintenance of vehicles.
- The new IT system will mean ambulance crews will have access to records to make it simpler for staff to raise a risk they identify.
- Internal audits were in place which included clinical practices and audits of systems and processes. There were plans to review the audit programme and processes with the introduction of the new information technology system.
- We saw where these audits showed non-compliance action was taken to make improvements. This included reviewing patient documentation and introducing additional training.
- At the announced inspection there was no information available which would show the director had been appointed in line with the fit and proper person requirements. At the unannounced inspection some of this information had been obtained including a check under the disclosure and barring scheme and verification of identification. The required checks had been completed for all other senior managers prior to employment.
- A risk assessment had been completed in May 2017 for the risks to staff of working alone. Actions to mitigate the risks were identified such as the use of mobile phones, secure access to buildings and informing control of working alone. We saw these actions were in place.

Public and staff engagement

- All staff we spoke with were positive about their engagement by the managers of the service. They said they were involved in decision making around their area of the service, kept informed of changes and could contribute easily by speaking to managers whenever they wished.

- We held an open forum in the head office and nine staff members attended. They talked positively about the leadership of the organisation. All the staff understood the ethos and values of the organisation and its aims. The staff felt proud of the service they delivered and two compared it to other services they had been at positively. Staff told us the organisation listened to them and invested in staff positively.
- The investors in people staff survey was completed for 2017. There were nine overall indicators and all areas had a positive outcome of between 60% and 70%". All staff members agreed that the organisation lived by its values and behaviours.
- The area where most people disagreed were staff receiving higher levels of reward and recognition for high performance and being able to experiment without feeling worried about making mistakes.
- The managers we asked about how this information had been used to improve staff satisfaction were unaware of any action taken.
- There were patient feedback forms in the ambulances and crew were expected to actively give these to patients whenever it was suitable. A freepost envelope was provided and large print versions of the form were available. We saw the number of feedback forms received for each ambulance base was part of their monthly quality monitoring. The feedback from patients was positive in terms of the service received.
- There were also posters in the ambulances telling patients of the five ways they could provide feedback. These included e-mail and telephone.
- Patient's comments were fed back to individual staff members and a selection was printed in the staff newsletter.
- We were told where there were negative comments these were reviewed as part of the Monday management meeting and acted upon by the relevant team leader in the ambulance base. Positive comments were also discussed as part of the management review.

Innovation, improvement and sustainability

- The provider developed a comprehensive patient journey sheet in order to improve patient care and treatment.
- There were examples of changes to the service to ensure improvements were made which would allow for innovation within the service. This included the introduction of a new information technology system which would provide a platform for the collection of data which could be used in various ways to improve the service.
- There had been a successful trial in vehicle turn around in one of the Manchester ambulance base. This improved the efficiency for vehicles being cleaned, restocked and rechecked for the crews prior to starting their shift. One of the primary advantages of this system was a reduction to the risk of vehicles being utilised without sufficient stock, checked out of date stock and reduced any delays at the start of the shift by identifying vehicle or equipment problems before the shift takes place.
- Following the successful trial at Manchester, two full time staff were employed at Morecambe to adopt the same process. The Manchester station improved this system further, with the implementation of 'tagging' equipment. This will in effect, barcode and tag each ambulance bag, cupboard and drawer to ensure they are fully stocked, checked and ready for use. This will be implemented in all stations by the end of 2017.
- The strategy for vehicle replacement included the expansion of the multi-purpose fleet. These ambulances could be converted into either those for patients who used a mental health service, had behaviour which challenged the crew or bariatric patient. This would mean there would be fewer delays whilst the crew returned to base to change vehicles to that which could meet the patients' needs.

Outstanding practice and areas for improvement

Outstanding practice

- The pocket books carried by the ambulance care assistants provided comprehensive information about how to assess patients in their care. These pocket books were not widely used in private ambulance services especially the patient transport service.
- The patient journey sheets were signed by the health professional on the ward prior to ambulance staff accepting the patient for transfer. This meant staff ensured they had all the pertinent details; they were up to date and had been provided by a relevant person. We had not seen this in other services we inspected.
- Ambulance staff knew the scope of practice for their level of patient transport and we saw evidence that they requested advice if they were asked to take patients with additional needs. The criteria for declining to transport a patient was clear and there were many examples when this had been applied so that alternative safe transport was identified.

Areas for improvement

Action the hospital MUST take to improve

- All equipment in use must have an up to date testing under the Lifting Operations and Lifting Equipment Regulations (LOLER, 1998).
- The systems in place to respond to concerns about patients did not ensure all potential risks of abuse or neglect were identified, acted upon and reported in a timely way. Action was taken by the provider during the inspection and some improvements to the systems were made.
- Staff who provides care and treatment to children must be competent in paediatric life support.
- Staff must be competent to perform the tasks they are employed to complete. This includes staff that are a registered health professional.
- Staff must receive the necessary training to assist them to support patients who lack mental capacity, including those with dementia.
- The consent of patients to travel must be obtained prior to a journey. The mental capacity of a patient to consent must be assessed and documented.
- All the information required to ensure any directors are fit to perform their function must be obtained prior to them taking up their post.

Action the hospital SHOULD take to improve

- The provider should develop a clear procedure for reporting incidents. The information collected about accidents, incidents and near misses should be used to identify trends and themes.
- Where incidents occur the provider should consider ways to work with others to investigate and learn from these incidents.
- All cleaning on the weekly rotas should be completed and recorded as required on the relevant documentation.
- Patient journey sheets on the patient transport service should be completed accurately.
- All staff members who provide care to patients should have two references obtained.
- Annual appraisals should be completed for all staff.
- The provider should be clear if patients who were detained under a section of the Mental Health Act could be transported in their ambulances.
- The provider should consider ways to use the information collected for their commissioners to monitor and improve their own service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Equipment must be properly maintained. The registered provider must ensure all equipment stored for the use in bariatric ambulances has been tested in line with the Lifting Operations and Lifting Equipment Regulations (LOLER, 1998) Regulation 15 (1)(e)

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent skilled and experienced persons must be deployed. Staff must be competent to carry out the tasks they are expected to perform. Staff who provide care and treatment to children must be up to date with paediatric life support training. Staff must understand their role and responsibility for patients who lack mental capacity to make their own decisions. Regulation 18(1)(2)(a)

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

Systems and processes must be established and operated effectively to prevent abuse of service users.

Systems and processes must be operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse.

Regulation 13(1)(2)(3)

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person. Regulation 11(1)(2)(3)(4)

Regulated activity	Regulation
	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors A person should not be appointed as a director of the service unless they satisfy the requirements in paragraph (3) of this regulation. Regulation 5 (1)(2)(3)(4)(5)