North East Community Health Limited

NECHS

Quality Report

Unit 11, Bellway Industrial Estate,
Newcastle Upon Tyne
NE12 9SW
Tel: 0191 2381610
Website: www.responseservicesgroupuk.co.uk

Date of inspection visit: 10 May 2018
Date of publication: 30/07/2018

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

Ratings

Overall rating for this ambulance location

Emergency and urgent care services	**Not sufficient evidence to rate**

Summary of findings

Letter from the Chief Inspector of Hospitals

North East Community Health Services (NECHS) is operated by the provider, which is also called North East Community Health Services. The company provides emergency and urgent care and a patient transport service. They also provide medical cover at public and private events. We did not inspect this part of the service as it is not currently a regulated activity.

The main service provided was emergency and urgent services and a small proportion of activity attributed to patient transport services; therefore, we have reported our findings in relation to the patient transport services section, in the emergency and urgent care section.

We inspected this service using our comprehensive inspection methodology. We carri ed out the announced inspection on 10 May 2018.

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 stated and how the provider understood and complied with the Mental Capacity Act 2005.

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 provider needs to improve:

· The provider's policy and procedures for the management and investigation of incidents was not robust.

· There was no mandatory training framework in place for staff and no process to ensure care and treatment provided was in line with national guidance and best practice.

· Safeguard policies and processes were not service specific and were not in line with Adult Safeguarding Levels and Competencies for healthcare, Intercollegiate guidance (2016).

· Risk assessments were not reflective of the current concerns and the provider did not have processes in place to regularly review and mitigate risk.

· Patient care records were not completed in a consistent manner and audit processes were not established to identify gaps.

· We did not see clear treatment guidelines to ensure staff worked within their professional boundaries and provided safe care and treatment.

· Crew did not receive mandatory rest breaks in line with Working Time Regulations 1998.

· We reviewed 40 of the 60 provider's policies and saw they were not service specific and contained references to other providers.

· Response times were not formally monitored and processes were not in place to drive improvement for the service.

· Staff supervision was not provided in accordance with the provider's policy and we did not see evidence of any recorded clinical supervision.

· Essential employment checks, including disclosure and barring service checks were not clearly recorded in the staff files we checked.

Summary of findings

However, we also found the following areas of good practice:

· The environment was clean and well organised and there were clear infection control protocols in place.

· Staffing levels were sufficient to support on-going services and future expansion.

· Staff stated they were committed to providing the best care and treatment for their patients and strongly believed in the first response vision.

· The provider had developed networking relationships with local universities and professional providers.

· The provider had business continuity plans in place and the ability to relocate, in the event of a major incident.

Following this inspection, we issued the provider with a warning notice. Details of this notice can be found at the end of the report. We also issued the provider with six requirement notices that affected the patient transport and urgent and emergency services. Details are at the end of the report.

Ellen Armistead

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Not sufficient evidence to rate	We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The main service was urgent and emergency services. Where arrangements for patient transport services were the same, we have reported findings in the urgent and emergency services section.

NECHS

Detailed findings

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

Detailed findings

Contents

Background to NECHS

North East Community Health Services is operated by North East Community Health Services (NECHS). The company was established in May 2017 and is an independent ambulance service in Long Benton, near Newcastle upon Tyne in the North East of England. The service primarily serves the North Northumberland area but does operate throughout the North East.

At the time of the inspection, NECHS did not have any long-term contracts in place to provide services. However, it had an on-going service level agreement in place with a local NHS trust to provide first response to 70 care homes and users of specific emergency alarms in their own homes. The aim of the service is to provide clinical assistance to patients in their normal place of residence, avoiding the need to attend hospital and possible admission. These arrangements commenced as a pilot in July 2017 and were reviewed on a month to month basis. The provider also deployed a patient transport vehicle at the local NHS hospital to support the main ambulance provider with discharge transportation services.

The service has had a registered manager in post since May 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in urgent and emergency and patient transport services.

Facts and data about NECHS

North East Community Health Services has an ambulance base in Long Benton in the North

East of England. There are four vehicles available to provide services at the base.

At the time of the inspection, the service directly employed 13 people: a managing director, a deputy manager, an operations director, an operations manager, three ambulance technicians, three urgent care staff, and three ambulance control staff.

The service is registered with the CQC to provide the following regulated activities:

Detailed findings

· Transport services, triage and medical advice provided remotely, and

· Treatment of disease, disorder or injury.

The service's track record on safety for the current year, from October 2017 to April 2018 showed:

· No never events

· No incidents

· One complaint

Since the start of January 2018, approximately 3,000 (average of 56 per week) patient journeys had been undertaken. The service was working with adults.

During the inspection on 10 May 2018, we visited the Long Benton site. We spoke with seven staff including frontline ambulance crews and members of the management team. We observed care and treatment provided for one patient and reviewed four comment cards. During our inspection, we reviewed a sample of patient records. We checked three of the vehicles at the Long Benton site.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This service had not been inspected before.

We inspected this service using our comprehensive inspection methodology.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	**Not sufficient evidence to rate**

Information about the service

Patient transport services were a small proportion of activity. The main service was emergency and urgent care and we have reported findings in the urgent and emergency services section.

Summary of findings

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

- The provider's policy and procedures for the management and investigation of incidents as not robust.
- There was no mandatory training framework in place for staff and no process to ensure care and treatment provided was in line with national guidance and best practice.
- Safeguard policies and processes were not service specific and were not in line with Adult Safeguarding Levels and Competencies for healthcare, Intercollegiate guidance (2016).
- Risk assessments were not reflective of the current concerns and the provider did not have processes in place to regularly review and mitigate risk.
- Patient care records were not completed in a consistent manner and audit processes were not established to identify gaps.
- We did not see clear treatment guidelines to ensure staff worked within their professional boundaries and provided safe care and treatment.
- Crew did not receive mandatory rest breaks in line with Working Time Regulations 1998.
- We reviewed 20% of the provider's policies and saw that they were not service specific and contained references to other providers.
- Response times were not formally monitored and processes were not in place to drive improvement for the service.

Emergency and urgent care services

- Staff supervision was not provided in accordance with the provider's policy and we did not see evidence of any clinical supervision.
- Essential employment checks, including disclosure and barring checks were not clearly recorded in the staff files we checked.
- We saw that governance processes were not in place to monitor and improve services for patients and there was no evidence of lessons learnt following incidents.

However, we also found the following areas of good practice:

- The environment was clean and well organised and there were clear infection control protocols in place.
- Staff stated they followed the Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines 2016 and received clinical support from the senior management.
- Staffing levels were sufficient to support on-going services and future expansion.
- Staff stated they were committed to providing the best care and treatment for their patients and strongly believed in the first response vision.
- The provider had developed networking relationships with local universities and professional providers.
- The provider had business continuity plans in place and the ability to relocate, in the event of a major incident.

Are emergency and urgent care services safe?

Incidents

· The provider had an incident reporting policy which was reviewed. The document was not service specific and appeared to have been copied from another provider, as it included references to staff and management structures that did not exist within North East Community Health Services.

· A senior manager stated that any lessons learned following a review of an incident report would be shared during the staff meetings which were held monthly. Any individual learning would be recorded in staff appraisals with a development plan, where appropriate.

· The service reported no never events or serious incidents in the past year. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

· Staff we spoke with were able describe what never events were. We were told the provider had not recorded any never events.

· Senior management could describe what the application of duty of candour was, and gave examples of when it should be used. We were told the provider had never had to apply duty of candour.

· The provider's duty of candour policy was reviewed. It contained all relevant information staff would need to understand and apply duty of candour.

Mandatory training

· The provider did not have a training policy or mandatory training framework in place to ensure staff were appropriately trained to meet standards in relation to their roles.

· Managers said that they had not determined what training was mandatory as staff had received training previously through different employers.

· There were no processes in place for monitoring that training was consistent with relevant clinical guidance and best practice. For example, Adult Safeguarding Levels and Competencies for healthcare, Intercollegiate guidance (2016).

· A senior manager stated they had been appointed specifically to build training and development for staff but these arrangements were not in place at the time of inspection and it was unclear if plans were being developed to implement this.

Safeguarding

· The provider had a safeguarding policy but it was not specific to the service and did not include local safeguarding contacts or relevant local safeguarding protocols. The policy did not specify what level of safeguarding training staff were required to undertake, as defined within Adult Safeguarding Levels and Competencies for healthcare, Intercollegiate guidance (2016) and Safeguarding Children and Young people: Roles and Competencies for Health Care Staff Intercollegiate guidance (2014).

· Managers stated there was no designated safeguarding lead within the service and the provider did not have an internal system for making safeguarding referrals. Safeguarding concerns would be shared with the call centre the provider used.

· We were told the safeguarding referrals would be reviewed by the senior management. There was no evidence of any referrals documented or reviewed.

· There was evidence of safeguarding training in some of the staff files; however, there was no evidence of the level of training completed.

· Following inspection, a senior manager stated there were plans to undertake adult safeguard training level four and the role of safeguarding lead.

Cleanliness, infection control and hygiene

· The service had an infection, prevention and control policy but it was not specific to the service. However, staff we spoke with were aware of their responsibilities relating to infection, prevention and control.

· Files showed that some staff had completed training in infection control and ambulance deep cleaning in March 2018.

· Three ambulances were inspected. Both were classed as dual purpose and could be used for patient transport service and urgent and emergency care if required. Both vehicles, and the equipment carried inside them, were clean. There was evidence the vehicles were deep cleaned every six weeks. This information was held on a computer data base.

· All equipment on the vehicles was in date and, where applicable, had been tested in accordance with portable appliance testing. Both vehicles contained had gel, wipes and personal protective equipment.

· A senior manager stated vehicle cleaning was carried out by an external contractor. They would swab cleaned areas and prepare reports for each vehicle. If the results were below acceptable levels the area would be re-cleaned and re-swabbed until the results were acceptable. The contractor had trained NECHS staff in the appropriate methods of cleaning the vehicles and they were observed doing this. If there were any concerns staff would be retrained.

· There was evidence in the vehicle records that they had been cleaned daily.

· There was evidence that a hand hygiene audit had been carried out every month since August 2017 to April 2018. A total of 31 staff had been observed hand washing. No issues or concerns had been identified.

· There were notices displayed above sinks in the station which showed good hand washing techniques. Uniforms appeared clean and in good condition.

· The sluice appeared visibly clean. Disposable mop heads were used. We observed new mop heads and handles, which were clean and ready for use. There was a shower for staff to use if they became contaminated with vomit or excrement.

· There was information available to determine which cleaning agents needed to be used, as required by standards for control of substances hazardous to health and manufacturer guidance available for staff.

· The ambulance crews were made aware of specific infection and hygiene risks of individual patients by information gathered at the time of the booking. The information recorded included an assessment of the patient's status in relation to infections. Crew staff

confirmed they were made aware of patients who had infections so they could wear appropriate personal protective equipment and could ensure that adequate cleaning of the vehicle was completed after use.

· The provider had arrangements in place to deal with clinical waste which was collected by a sub contracted company once a month. Some vehicles had clinical waste cupboards leading to a secure bin.

Environment and equipment

· The station had security, which included key coded doors, and security lights. There was limited parking outside of the premises due to its location within a busy industrial estate.

· The ambulances were kept in a large ground floor garage with sufficient room to park the vehicles. The garage contained several equipment store cupboards and medical gas storage. There was an emergency exit door at the rear of the garage, which was clearly indicated.

· Access to the first floor was via stairs from the garage area. The first floor consisted of a store room a sub-let office and a crew room which was large and had welfare facilities.

· We found the ambulance station, including the garages and equipment storage areas, were clean and well laid out. They were well lit, organised and fit for purpose.

· Hazardous substances were stored securely. There was an appropriate control of substances hazardous to health assessment in place.

· We found that vehicle checklists were on a phone app which crews had access to. The information immediately updated a master sheet. Any concerns were picked up immediately by the dispatcher who reviewed the information to ensure the any faults were dealt with.

· All electrical equipment on the three ambulances and in the station had, where required, been tested in accordance with portable appliance testing. All were in date.

· During inspection we observed that vehicle MoT testing and vehicle servicing scheduling dates were recorded on a spreadsheet which flagged when they were due. The information was also displayed on a white board in the senior management's office.

· A senior manager stated that the provider had a stand by vehicle to use if one of the PTS vehicles was off the road.

· We observed that relevant equipment was available for adults, for example moving and handling equipment.

· All vehicles had a tracking system to enable the provider to monitor their location and driver performance.

· Fire exits were clearly marked. However, there was no fire evacuation plan displayed and the fire safety record book was checked. No tests had been recorded of alarms, evacuations or fire equipment testing. We saw evidence of a health and safety station inspection in February 2018.

Medicines

· The provider had a medicines management policy and procedure. A senior manager stated that approval to supply medicines has only been in place for two weeks prior to inspection and there were a limited number of medicines that the advanced technician could administer.

· A senior manager stated that staff gave medicines in line with Joint Royal Colleges Ambulances Liaison Committee (JRCALC) guidelines.

· Oxygen was available for staff to administer prior to the above approval, but we did not see evidence of any training provided to staff to ensure oxygen was administered safety.

· The provider contracted a third-party provider to oversee governance arrangements for the provision of specialist clinical governance and medical advisory services. The senior management told us medicines advice and guidance was readily available and shared with staff.

· The provider kept supplies of medicines in a locked cabinet. No controlled drugs were stored at the station.

· The provider also kept supplies of medical gases. Medical gases were stored in accordance with the British Compressed Gases Association Code of Practice 44: the storage of gas cylinders in the ground floor garage. The cylinders were in a cage with a combination lock which was secure. The area is dry and well ventilated.

· When the level of drugs stocks was low, the technician returning the bag at the end of the shift would apply a red tag. The drugs were replenished by the senior management and a green tag would replace the red indicating the drugs bag was full.

· The management and stock control of medicines was also overseen by the third-party provider. Any request for additional drugs was approved by the lead.

· Medicines stock log book used by technicians to sign drugs in and out was up to date and in order.

· A senior manager stated that staff were recently asked to complete a multiple-choice questions and answer test to ensure medicines knowledge was appropriate.

Records

· Staff in the control room completed an electronic record when they received a call about a patient. This was stored on a password protected computer system. The ambulance crew could access this information directly on mobile handsets.

· Paper patient record forms were completed by staff responding to call outs. At the end of each shift paper notes completed by crews were typed up on the computer system and then linked to the existing electronic notes with a reference number.

· A senior manager stated that the service had made changes to the patient record form in response to staff feedback and findings from audit. They described how structured text boxes had been added to capture clearer information about patients' ethnicity and to record chest assessments in a more structured way.

· We reviewed the design and use of the recording forms. They were fit for purpose and recorded all relevant information about the patient, including relevant details of their medical and social history and any allergies. A record of observations, any medicines administered and discussions at handover were also kept.

· Paper notes were stored off site. There was a secure process to transport and deliver the confidential records.

· We reviewed 23 patient record forms and found only two were completed fully.

· A senior manager stated that patient records forms were audited monthly. We reviewed these audits which had been completed and saw that it provided totals for each section completed but did not raise any actions or learning to share with staff.

· Managers stated crew awareness of special notes were achieved through their clinical training and was included as part of the induction training. If a patient had a do not attempt cardio pulmonary resuscitation (DNACPR) order in place this was recorded on the patient report form.

Assessing and responding to patient risk

· A senior manager stated crews would carry out a risk assessment on what they observed if they felt a patient was deteriorating. Staff would carry out a clinical assessment before deciding to take the patient to hospital themselves after pre-alerting the nearest accident and emergency department, or to ring 999 and request a NHS ambulance.

· Managers stated any patients that were violent or potentially violent would be identified through their emergency care plan. He advised that staff act in accordance with their clinical training as to how to deal with disturbed or violent patients.

· The provider had a restraint policy which was reviewed. The document was not service specific and appeared to have been copied from another provided as it included references to management structures that did not exist within NECHS.

· The ambulance staff we spoke with had a clear understanding about what to do if a patient deteriorated during a journey. They stated they would pull over their ambulance and dial 999 for emergency assistance.

· The ambulances were each equipped with an automatic external defibrillator (AED) and oxygen that could be used in the event of an emergency. This equipment was checked daily by staff and we observed that they were in good working order on the day of the inspection.

· We reviewed three staff files. All files indicated that staff had undertaken training in risk assessment and first aid, as part of the induction.

· A senior manager stated that crew could called out to 'red alerts' which indicate those calls that are deemed immediately life threatening. In these situations, a second NHS vehicle would also be requested as the 999 call response would result in the local ambulance provider response.

· We did not see evidence of clear written pathways in determining the treatment and care that NECHS staff were expected to provide in these situations. However, all staff we spoke with understood their roles and responsibilities.

· The operations director was the only registered paramedic within the organisation. All other crew were advanced technicians. The number of staff required for each journey was assessed at the time of booking against the risk information provided. For example, bariatric patients.

· The provider had developed a 'Safe and well form' which was an environmental assessment form which was left at the patient's home following a visit. The form identified utilities, fire safety, hazards and risks to staff.

· Four members of staff were trained to assess for equipment in the home and refer the equipment request as an 'emergency assessment'.

Staffing

· Staff consisted of one enhanced care paramedic, three ambulance technicians, three urgent care staff, and three ambulance control staff. All staff were directly employed by the provider.

· Each day the provider deployed two cars, one ambulance and one car at a local NHS hospital discharge lounge.

· Crew members worked 12-hour shifts. There was a system for monitoring whether or not staff took their breaks at appropriate times. Staff in the control room stated they would monitor if ambulance crews had taken breaks and provide reminders to staff to take breaks in accordance with Working Time Regulations 1998.

· We reviewed staffing data between 6 and 9 May 2018. On 6 May 2018 none of the staff took breaks in accordance with guidelines. On 7 May staff on one vehicle out of four in use took breaks in accordance with guidelines. On 8 and 9 May staff in two out of four vehicles on shift took breaks in accordance with guidelines.

· At the time of the inspection, the service provided occasional private patient transfer services to patients travelling to hospitals outside of the area. These journeys were planned and staffing was planned in accordance with the needs of the patient.

· We discussed staffing levels with the senior management who were satisfied that they had enough members of trained staff available to fulfil the current demand and expansion of their services.

Anticipated resource and capacity risks

· We saw evidence of generic risk assessments but these were not reflective of the concerns and issues that were live at the time of inspection to anticipate and mitigate risk. There was no risk register for the service.

· A senior manager told us there were sufficient staff to meet surges in the demand for services.

Response to major incidents

· The provider was not part of any NHS trust major incident plan therefore the staff were not trained in respect of major incidents

· The provider had a business continuity plan. The plan had recently been practically tested when the building flooded. The provider could relocate to another office owned by them located near to station. The senior management stated business had not been affected.

Are emergency and urgent care services effective?

Evidence-based care and treatment

· Staff said they followed the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) guidelines when assessing patients for care and treatment.

· We asked the senior management if staff carried or had access to JRCALC guidance when responding to call outs. We were told that not all staff carried the guidelines and no formal checks were carried out to confirm this.

· Staff stated that the senior management provided information about any changes or developments to clinical and professional guidelines and they could obtain additional clinical advice whenever needed. The senior management told us there were no formal service policies in place to provide information and guidance about clinical assessment and intervention and staff would refer to JRCALC.

· A senior manager stated that a pain assessment would be conducted and documented for every patient. They also reported that an assessment of nutrition and hydration would be conducted for each patient. This would involve an assessment of physical wellbeing, as well as an

assessment of other factors that may support or limit the patient's ability to receive nutrition and hydration. We reviewed 23 patient records and did not see evidence of nutrition and hydration assessments.

· Staff told us they had access to information about the facilities available at local hospitals. They described how this knowledge was used to ensure that patients were transported to the most appropriate destination for their healthcare needs. The senior management described how staff had received frailty training from a local hospital to increase their knowledge of eligibility for the service.

· During the inspection, 40 of the 60 provider's policies were reviewed. Ten of 40 policies were not specific to the provider and appeared to have been copied from the internet or other providers because the documents referred to management positions and staff that did not exist within the NECHS management structure.

· Staff we spoke with confirmed the policies had been copied and they were undergoing review to make them provider specific.

Assessment and planning of care

· The provider stated that 90% of all journeys undertaken were first response visits to care homes and to patients using a specific emergency call pendent. These visits were unplanned and all calls came through a third-party control room before coming through to the NECHS control room.

· A small number of non-emergency transport journeys for patients who required transferring between hospitals, transfers home or to another place of care, were also provided. Staff told us they would receive a handover from hospital staff. They also said they would request any further information required relating to support required, clinical needs, and risks.

· Staff had prior information about the first response patients through the control room. Details were logged electronically and accessed by crew when they came through the system.

· Staff showed us that they completed a 'non-conveyance and discharge checklist' when deciding to assess and treat the patient at home and not to take the patient to hospital. This included information about conducting relevant assessments, recording appropriate information, obtaining further advice if needed, providing advice to patients and carer s, informing other relevant services, and arranging follow up.

· A senior manager stated that they would convey patients to hospital if they were not suitable for treatment at home. Decisions were based on the nature of the health difficulty, the nature of the home environment and competencies of staff working in the home, and the competencies of the attending ambulance crew.

· Staff stated the service did not transport patients under the mental health act but described occasions where they had been called to assist patients demonstrating behaviour that was challenging. Dynamic risk assessments were conducted in such situations to balance the risk of conveying the patient to hospital compared to the risk of not conveying the patient.

· Staff described taking measures to reduce risks, such as using de-escalation techniques, assistance from carers, requesting another crew member, and requesting assistance from the police.

· A senior manager described one occasion where they transported a patient from hospital to the ambulance wrapped tightly in a blanket strapped into a carry chair with a strap. They said that minimum restraint was used with patients and that physical support was used as a last resort.

· We were told where restraint was used, this would be documented on the patient record form and staff would liaise with the GP to ensure the ongoing physical wellbeing of the patient. However, there was no formal process for documenting any risk assessments for restraint or ensuring staff training was up to date.

· Staff stated that telephone calls and visits were made to some patients to monitor wellbeing after assistance had been provided. The decision of whether or not to do this was based on the clinical judgement of the staff member. Follow up appointments were logged on the computer system. This ensured that if the staff member was called away, another staff member could provide follow up.

Response times and patient outcomes

· A senior manager stated that ten patient record forms were audited each month and feedback would be provided directly to relevant staff members and a plan developed to

improve practice, if appropriate. Any general learning points would be shared at staff meetings. We reviewed the audits which had been completed and saw that it provided totals for each section completed, but did not raise any actions or learning.

· One member of staff however, gave an example of an occasion where they had not completed a twelve-lead electro cardio graph (ECG). This was identified on the patient record form and then investigated by the senior management and the reasons identified. For example, the patient found it difficult to sit still.

· The provider aimed to attend to all calls within 45 minutes but we did not see any data to formally monitor this. We did not see evidence of any other form of review or audit of response times or patient outcomes.

· Staff monitored patient outcomes following call out in relation to the nature of support provided by the service. This showed that 52% of patients were treated at home, 20% were admitted to hospital, on 5% of occasions staff were stood down, and for the rest of the calls referrals were made to other sources of health and social care support.

Competent staff

· Managers stated that all staff received induction training. There was a two-day, face to face, internal induction training programme for all new staff. Training comprised of equality and diversity, adult safeguarding, health and safety, risk management, fire safety, moving and handling, first aid, and information governance.

· We reviewed three staff files and saw there were records in all files which showed staff had undertaken induction. Documentation stated that induction consisted of training in equality and diversity, adult safeguarding, health and safety, risk management, fire safety, moving and handling, first aid, and information governance.

· The induction training was an internal arrangement and it was not clear what detail or level of training had been provided and what level of understanding staff were expected to achieve.

Detailed findings

· Two staff stated that they received a further two days supported by a more senior member of staff who observed them in their role.

· Staff started work upon completion of the induction programme and staff we spoke with, had completed the induction process in line with the policy.

· A senior manager stated that staff received clinical supervision but details were not recorded.

· We saw there was a policy on clinical supervision. This referred to the HPC (Health Professions Council), rather than the HCPC (Health and Care Professions Council). The HPC changed its name to the HCPC in 2012. The HCPC is the professional regulatory body for paramedics.

· The policy distinguished between clinical supervision of trainees and qualified staff and identified reasons and procedures for clinical supervision. It stated that trainees would be supervised in simulated environments. Then when competent in this setting, would be supervised in real life environments by an appropriately qualified person until they were assessed as fully competent.

· We did not see any records of staff supervision in simulated environments.

· Managers stated that staff had not yet undertaken annual appraisals as the staff had not been in post for longer than a year. The service had a policy for staff appraisals which was dated November 2017. This included information about the responsibilities of different staff members in the appraisal process and in developing and reviewing goals, and personal development plans.

· We saw driving licence checks within the staff files but the provider did not have a policy to re check them.

· The operations director was an enhanced care paramedic was also an associated senior lecturer at two local universities.

Coordination with other providers

· The senior management felt that they had good working relationships with the local care homes, ambulance services and commissioners.

· The service was currently reviewed on a month to month basis by local commissioners and the provider felt they could work flexibly with other providers as required in the future.

Multi-disciplinary working

· The provider had developed links with the local university to develop opal accreditation to transport critically ill patients.

· A senior manager stated that links had been established with a local hospital to support frailty assessments in the elderly.

Access to information

· Staff had access to policies at the ambulance station. Staff stated the senior management provided them with updates regarding clinical practice and risks.

· Ambulance crews were provided with key information and special notes though the booking process. For example, mobility issues.

· Staff were aware of the importance of do not attempt cardiopulmonary resuscitation orders, but noted that these were not regularly in use for the category of patients that they were currently working with.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

· The patient record form included a section for staff to complete regarding mental capacity.

· There was a form available for staff to record patients' capacity to consent to transportation or treatment but we did not see these had been completed.

· There was a policy providing guidance on informed consent and mental capacity. This contained information about how to assess capacity to consent and the decision-making process if the person was unable to consent.

· We spoke with one member of the ambulance crew staff who confirmed that they had been trained in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards during a previous employment. They were aware of need to act in a person's best interests when working with patients who lacked capacity.

· There was a policy on requesting consent for photographs to be taken. This stated that written informed consent should be sought from patients or carers. There was no information in this policy relating to provisions if the patient was unable to consent.

· Staff understood that voluntary patients could only be moved with their consent. Staff commented that if someone refused care or treatment they would respect that decision and seek advice.

Are emergency and urgent care services caring?

Compassionate care

· Senior managers we spoke with during the inspection stated that staff had a commitment to providing the best possible care.

· We reviewed four patient comments cards which were completed by users of the service.

- All comments were positive and one card stated, 'Great care given'. Staff were described as 'friendly'.

· We observed care being provided by staff during a call out to a patient's home. The crew carrying out the visit did not consider the privacy and dignity of the patient whilst moving and handling. The patient wore only night wear whilst assistance was provided and staff did not offer a blanket or sheet during the transfer.

Understanding and involvement of patients and those close to them

· Whilst observing the above visit, we saw that staff did not seek additional information regarding the patient. Basic information had been provided when the call out was booked but crew did not seek any further clinical information regarding the patient or demonstrate any professional curiosity.

· We saw that staff did not bring any equipment with them as they entered the patient's home. This included moving and handling equipment, which was needed for this visit. Staff subsequently returned to the ambulance to collect a transfer chair.

· Staff stated that they had extensive experience working within the ambulance sector but had not received any formal training with the provider.

Emotional support

· We observed an instance where the ambulance crew offered regular verbal reassurance during patient transfers.

Emergency and urgent care services

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

Service planning and delivery to meet the needs of local people

· A service level agreement was in place with local commissioners, to provide first response to 70 care homes in Northumberland and to patients living at home with a specific emergency pendant fitted. This service level agreement was reviewed on a month to month basis.

· In addition, the provider deployed a vehicle to the local hospital discharge lounge to support the main ambulance provider with discharge work. These were usually long-distance journeys.

· The provider outlined many additional services that they could offer in the future which included Qualsafe registered training, equipment sales, critical care transfers and clinical assessments for third parties such as wardens at sheltered accommodation venues. Qualsafe is an authorised company providing first aid training. None of these services were in operation at the time of inspection but discussed as part of future service planning.

· The senior management shared minutes of meetings with the local health trust, which showed the number of calls provided, response times, complaints and compliments and geographical areas the service provided.

Meeting people's individual needs

· The service had vehicles, which could accommodate wheelchair users.

· Information that had been received as part of the booking process were shared with staff prior to transporting a patient. Staff also carried their own observations and collected information from other providers at handover points.

· Staff described measures to support and communicate with patients with difficulties seeing or hearing. For example, writing information down, using a magnetic board, using gesture and appropriate touch, varying the language used, the level of detail provided, and the speed of conversations. Staff said they had access to a telephone translation service (language line) to enable communication with patients and carers whose preferred language was not English.

· There was an equal opportunities policy which provided guidance to prevent discrimination against patients and staff which was based on legally protected characteristics. We reviewed three staff files and in all cases staff had undertaken equality and diversity training.

Access and flow

· A senior manager stated they had the capacity to deal with between 20 and 25 calls per day. A senior manager stated if there was a surge in demand, the service had sufficient numbers of staff and vehicles to cope as they were operating at 60% capacity at the time of inspection.

· We saw a fleet of four vehicles with a new vehicle currently on order.

· Bookings were managed by a small team of control room staff and crew and vehicles were deployed according to the nature of the calls that came in. Crew who accepted the job were provided with all relevant information.

· The provider had developed an electronic log to record the details of each patient journey, and the nature of support provided by the service. This showed that 52% of patients were treated at home, 20% were admitted to hospital, on 5% of occasions staff were stood down, and for the rest of the calls referrals were made to other sources of health and social care support.

Learning from complaints and concerns

· There was a complaints policy dated November 2017. This provided information about procedures for receiving, recording, and investigating complaints. The policy stated that complaints should be acknowledged within three days and a formal written response provided within 25 working days.

· A senior manager stated that patients could make a complaint directly to the service. The complaint would then be directed to the senior management who undertook the investigation and developed an action plan. The senior management said a joint investigation would take place if a complaint related to the service and another linked organisation.

· The service had received one complaint in the past year. We reviewed the complaint report which described that a thorough investigation had taken place and an action plan developed. The report did not always include relevant information such as dates that key actions in the investigation process took place. However, there was clear designation of ownership for actions.

· We reviewed the investigation, which outlined four clear actions included staff disciplinary action, a formal written apology, a written academic reflection piece and equality and diversity staff training. None of these actions were evident in the relevant staff file and the provider was unable to locate them at the time of inspection. Following inspection, the provider submitted all documentation.

· We asked staff how learning from complaints was shared to prevent a recurrence of the concerns raised. They stated that they were kept up to date by the senior management and through face to face meetings.

Are emergency and urgent care services well-led?

Leadership of service

· The service was led by the managing director, who was also the registered manager. They were supported by a part-time deputy manager and full-time senior management.

· We were not assured that the management team were clear regarding their roles and responsibilities. None of the managers could answer all the questions specific to governance and accountability and finance issues were solely managed by the managing director.

· The deputy manager had been in post for six weeks prior to inspection and was working through policies. The deputy manager recognised that they 'were not very good'. The deputy manager stated there were plans to create a management board and the deputy manager would chair this.

· A senior manager had been in post since August 2017 and was responsible for the clinical education of the staff and oversight of the clinical care and treatment provided. The training programme was in development at the time of inspection.

· Both managers stated the managing director visited the station twice weekly and could contacted by telephone if required.

Vision and strategy for this this core service

· The provider's mission statement was 'Care with Compassion'. The provider stated the service had been developed to provide independent specialist patient centred care which aimed to treat all individuals with dignity and respect.

· We reviewed the provider's vision which stated, 'We aim to provide a specialist falls and bariatric service across the North East of England which works in close collaboration with the NHS'.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

· A senior manager stated that quality was discussed and shared with colleagues from the local NHS body and key performance indicators were monitored.

· We reviewed minutes from these meetings and saw that nature of calls were discussed, compliments and complaints, response times and care home feedback.

· The provider did not have a system to review policies and procedures and no recorded process to observe clinical practice.

· We were not assured that managers understood the risks within the organisation and there was no risk register to provide any assurance.

· Roles and responsibilities were not clearly defined across the organisation and there was no clear accountability framework.

· Records were not managed effectively and staff were unclear where to find certain documents.

· There was recognition from the provider, however, that there was work to be undertaken to ensure governance processes were strengthened and there was a commitment by the senior management to make these improvements.

· The service had started to monitor patient journeys in terms of the care provided. We reviewed data and graphs that showed the nature of the calls made by the provider.

· We reviewed three staff files. These all showed evidence of application forms, driving licenses, and statements of terms of employment. One person's file had two completed references, but one file had a reference which was partially complete, and the other file had only one reference. Two files contained evidence of DBS checks, but one file did not. No files contained information about employment interviews. Following inspection, the provider submitted disclosure and barring application numbers for each member of staff but these did not show dates that these checks were carried out.

· A senior manager stated that they had registered with a system whereby DBS checks could be reviewed online and planned to review DBS checks annually. However, as the service had been in operation less than a year the annual review had not yet taken place. They advised that a date had not yet been set for DBS checks to be reviewed and that there was no reminder system in place to monitor that DBS updates were reviewed in a timely fashion.

· Managers stated that if staff were employed before DBS checks had been completed they would undertake limited duties. The manager said that staff would always be with another staff member and never left alone with a patient. The manager informed us that in such situations risk assessments and plans were developed and communicated to staff verbally, but that these were not written down.

· We saw the service had a conduct and performance policy dated August 2016. This described underperformance due to lack of skill or to lack of effort. Where lack of skill was the reason then managers would identify the problem, develop a plan to remedy this, and then review. Where underperformance was due to lack of effort disciplinary proceedings would follow. No staff were being managed under this policy at the time of inspection.

Culture within the service

· The management team stated that they worked towards maintaining an open culture where all staff could discuss ideas and concerns with the management team.

· Staff we spoke with commented that the management team were approachable and responsive to their concerns and requests. For example, requests for new equipment had been promptly reviewed and acted on.

· The management team had demonstrated a commitment to improving quality and safety through the action taken to improve and strengthen governance structures and systems since the previous inspection in August 2017.

Public and staff engagement (local and service level if this is the main core service)

· The provider stated that feedback was actively sought from patients using the service, in terms of customer experience. All patient feedback in relation to customer service was positive.

· A senior manager stated that a staff survey had not been carried out but there were plans to complete this in the near future.

· Feedback cards we reviewed regarding the service were positive.

Innovation, improvement and sustainability (local and service level if this is the main core service)

· During inspection we saw evidence of a phone app staff used to carry out the daily vehicle checks. Any defects would be highlighted immediately and rectified. This system reduced the amount of paper documents required to be stored.

· A senior manager stated that there were plans for staff to teach first aid training in the future.

· The provider had also developed links with the local university to develop opal accreditation to transport critically ill patients.

· A senior manager stated that links had been established with a local hospital to support frailty assessments in the elderly`

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

· The provider must ensure staff receive such appropriate support, training, professional development, and supervision as is necessary to enable them to carry out the duties.

· The provider must ensure safeguarding systems and processes must be established and operated effectively to prevent abuse of service users.

· The provider must assess, monitor and improve services through regular clinical audit and review against national guidance.

· The provider must maintain records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity and the management of the regulated activity.

· The provider must assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks.

· The provider must seek and act on feedback from relevant persons following incidents and complaints, for the purposes of continually evaluating and improving services.

Action the hospital SHOULD take to improve

· The provider should improve processes to enable staff to receive appropriate rest breaks.

· The provider should develop processes to formally record and monitor response times.

· The provider should develop processes to ensure staff driving ambulance vehicles, were appropriate to do so.

· The provider should ensure staff receives training in relation to maintaining privacy and dignity.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; **How the regulation was not being met** - We saw crew did not seek any further clinical information regarding the patient or demonstrate any professional curiosity during care and treatment delivery.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and processes must be established and operated effectively to prevent abuse of service users.

This section is primarily information for the provider

Requirement notices

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

How the regulation was not being met

- There was no evidence the safeguarding vulnerable adults training was in line with Adult Safeguarding Levels and Competencies for healthcare, Intercollegiate guidance

(2016).

- The provider did not record when what level of safeguarding training staff had completed or when refresher training was required.

- There was no evidence the safeguarding vulnerable adults training was in line with Adult Safeguarding Levels and Competencies for healthcare, Intercollegiate guidance

(2016).

- The provider did not have an internal system for making safeguarding referrals.

- There was no evidence of protocols for safeguarding referrals in the event of work that is sub-contracted to or from other providers.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Treatment of disease, disorder or injury **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 (1) (2): Staffing** 18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

This section is primarily information for the provider

Requirement notices

(2) Persons employed by the service provider in the provision of a regulated activity must—

(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the

duties they are employed to perform,

(b) be enabled where appropriate to obtain further qualifications**.**

How the regulation was not being met

- There was no training matrix or other method of monitoring and documenting that all relevant training had been undertaken and updated in a timely fashion.

- We asked the Operations manager if any clinical guidance / pathways had been developed for staff, as they treat a wide range of issues. We were told us that staff would refer to GR Calc.

- We asked the Operations manager if any checks were undertaken to check that staff referred to this. We were told no, but he knew that not all staff carried the GR Calc

- We asked the Operations manager how they could be assured that staff had all training / guidance that they required in order to carry out their role safely. We were told he could not be assured.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Treatment of disease, disorder or injury **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17, (1) (2), (a) (b) (d): Good governance.** 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; (d) maintain securely such other records as are necessary to be kept in relation to— (i) persons employed in the carrying on of the regulated activity, and

This section is primarily information for the provider

Enforcement actions

(ii) the management of the regulated activity; (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

How the regulation was not being met

- Risk assessments were generic and not service specific. During inspection we read 18 risk assessments which were not signed and there was no evidence that they had been read by anyone.

- Governance processes were not in place to monitor and improve services for patients.

- Policies and procedures had been copied from other providers and were not service specific or therefore fit for purpose.

- We did not see any evidence of clinical review against national guidance and senior managers were not assured that care and treatment was carried out in accordance with best practice.

- Staffing records were incomplete and we were not assured that all staff had received a DBS checks since first employed with the service.

- We saw that processes in place to manage complaints were not robust as actions following a complaint could not be evidenced at the time of inspection.

- Senior managers were not provided with all necessary information to manage the service fully. For example, financial information.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
You are failing to comply with Regulation 17, (1) (2), (a) (b) (d) Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	**17. Good Governance** (1) systems and processes must be established and operated effectively to ensure compliance with the requirements in this part. (2) without limiting to paragraph (1), such systems or processes must enable the registered person, in particular, to- (a) assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity; (b) assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (d) maintain securely such other records as are necessary to be kept in relation to- (i)Persons employed in the carrying on of the regulated activity, and(ii)the management of the regulated activity;(f)evaluate and improve their practice in respect of the processing of information referred to in sub-paragraphs (a) to (d). **Why you are failing to comply with this regulation:** 1. As the provider for the regulated activity of an ambulance service, you have a legal duty to ensure that good governance methods are in place, and facilitate effective operating systems and processes to comply with these regulated activities. You are therefore in this case failing to comply with this regulatory requirement. 2. Risk assessments were generic and not service specific. During inspection we read 18 risk assessments which were not signed and there was no evidence that they had been read by anyone. All risk assessments were created on the 07/05/18 (3 days prior to inspection). We found that some risk assessments were repeated for no apparent reason.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

3. We saw that governance processes were not in place to monitor and improve services for patients.
4. During the inspection we saw that policies and procedures had been copied from other providers and were not service specific or therefore fit for purpose.
5. The provider had an incident reporting policy which was reviewed. The document was not service specific and appeared to have been copied from another provided as it included references to management structures that did not exist within NECHS.
6. The provider had a restraint policy which was reviewed. The document was not service specific and appeared to have been copied from another provider as it included references to management structures that did not exist within NECHS.
7. We did not see any evidence of clinical review against national guidance.
8. We were not assured that all staff had received a DBS check since first employed with the service. We were told that the service had registered with a system whereby DBS checks could be reviewed online and that the service planned to review DBS checks annually. However, as the service had been in operation less than a year the annual review had not yet taken place. We were informed that a date had not yet been set for DBS checks to be reviewed and that there was no reminder system in place to monitor that DBS updates were reviewed in a timely fashion.
9. We reviewed three staff files. These all showed evidence of application forms, driving licenses, and statements of terms of employment. One person's file had two completed references, but one file had a reference which was partially complete, and the other file had only one reference. Two files contained evidence of DBS checks, but one file did not. No files contained information about employment interviews.
10. We saw that processes in place to manage complaints was not robust. The provider reported one complaint during the last 12 months. We saw this related to a crew member who allegedly used abusive and racial language whilst attending to a

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

patient in a care home. This compliant was reported by a care home manager in Dec 2017. The outcome of the compliant investigation showed four recommendations; we did not see evidence of lessons learned or training as an action, and the operations director stated they did not know if this had been done.