Falck Medical Services Ltd

Falck Medical Services Ltd (Bow)

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Falck Medical Services Ltd (Bow) is operated by Falck Medical Services Ltd. The organisation provides emergency and urgent care, including the transportation of high dependency patients, and non-emergency patient transport services, together with a call centre and control room. It provides transport services for adults and children. The service has been registered to provide transport services, triage and medical advice provided remotely since 2011.

Emergency and urgent care covers the assessment, treatment and care of patients at the scene by ambulance crews with transport to hospital. It includes high dependency and intensive care transport between hospitals or other care settings. Patient transport services (PTS) are the non-urgent and non-specialist services that transport patients between hospitals, home and other places such as care homes.

The main service provided by this independent ambulance provider was emergency and urgent care, but non-emergency patient transport represented a similar proportion of work. We have prepared reports for each service. However, where our findings on emergency and urgent care also apply to patient transport services, for example, management arrangements, we do not repeat the information but cross refer to the emergency and urgent care section of the report.

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 areas of good practice across urgent and emergency care (First Response) and patient transport services (PTS):

- There was a good overall safety performance and good compliance with cleanliness, infection control and hygiene standards and vehicle and equipment maintenance.
- There were effective safeguarding processes and 100% of staff were up to date in safeguarding training. There was a dedicated safeguarding 'hotline' for staff to seek advice and guidance.
- There was good completion of mandatory training amongst all staff groups.
- The organisation had a detailed business continuity plan and clear processes to respond to emergency incidents.
- Ambulance crews kept up to date with national guidelines and good practice and staff demonstrated this in the application of evidence-based practice.
- First Response performance was generally good and targets were being met.
- Staff told us the organisation supported them in their development and progression.
- Staff demonstrated a caring and compassionate approach. They communicated in a polite and professional manner and maintained patient dignity.
- Ambulance staff received training in the care and transportation of patients with specific individual needs, including those living with dementia or learning disabilities.
- There were examples of very good involvement of patients to develop services that met their needs.
- There was a dedicated patient experience team which responded to complaints and concerns.
- Senior leaders understood their challenges and vulnerabilities but also recognised their organisational strengths. Managers and the senior leadership team were visible and accessible. Staff told us there was a good team spirit.

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

- No staff had received a formal documented appraisal since August 2016.
- Some staff did not understand the term Duty of Candour.
- There were challenges with the recruitment and retention of staff and this resulted in high levels of vacancies in First Response and PTS services.

Summary of findings

- Feedback from partner NHS trusts was that the PTS service generally delivered an effective service, but there were concerns about frequent delays with arrivals and pickups.
- Some staff were unclear when to request a patient chaperone or escort.
- The organisation did not have robust systems to collect and use patient feedback.
- Governance processes did not always facilitate the timely mitigation of some long-standing concerns, risks and issues.
- There were some concerns around staff engagement and ensuring that all staff felt respected and recognised for their work.

Following this inspection, we told the provider that it must take action 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 issued the provider with one requirement notice that affected both core services. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (London and South East), 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		• There was a good overall safety performance and good compliance with cleanliness, infection control and hygiene standards, safeguarding, medicines management, maintaining patient records and very good completion of mandatory training. There were detailed business continuity plans. However, there were challenges with the recruitment and retention of staff and this resulted in high levels of vacancies. • Ambulance crews demonstrated evidence-based practice in line with guidelines. Response time performance and shift completion rates were generally good. There were high levels of compliance with clinical performance indicators. There was good multi-disciplinary interaction and handovers between staff. Staff were supported in their development. Ambulance crews had good access to information using their handheld electronic devices. There were systems in place to ensure appropriate application of consent, Mental Capacity Act and Deprivation of Liberty Safeguards processes, but some staff did not know when to request a patient chaperone. • Staff demonstrated a caring and compassionate approach. They communicated in a polite and professional manner and maintained patient dignity. Staff engaged well with patients' carers and relatives. • Ambulance staff received training in the care and transportation of patients with specific individual needs. They had timely access to interpretation support. Feedback from partner NHS trusts showed that performance targets were being met. Complaints processes were effectively managed, including joint investigations and shared learning with partner NHS trusts. However, the organisation did not effectively collect and use patient feedback such as patient surveys. • Senior leaders understood their challenges and vulnerabilities but also recognised their organisational strengths. Managers and the senior leadership team were visible and accessible. Staff told us there was a good team spirit. Staff told us that the company had

Summary of findings

become more professionalised and structured. There were governance processes in place to ensure performance and risk information was reviewed and addressed by senior managers. However, these processes did not always facilitate the timely mitigation of some long standing concerns, risks and issues. There were some concerns around staff engagement and ensuring that all staff felt respected and recognised for their work.

Patient transport services (PTS)

In addition to the findings in urgent and emergency services:

• There were appropriate processes for the reporting of incidents in PTS services. All patient records were stored securely. There were effective risk management processes. Control room staff conducted routine telephone calls called 'call aheads' the day before scheduled PTS journeys to confirm patients' specific needs. However, there were challenges with PTS staff recruitment and retention and concerns about ambulance care assistants' work intensity. There were insufficient numbers of telephone call handlers to effectively respond to the volume of calls, but 99% of telephone calls were answered within agreed times.

The organisation had introduced new roles of senior ACAs to help provide guidance and support to more junior staff. Feedback from partner NHS trusts was that the PTS service generally delivered an effective service. However, there were concerns about frequent delays with arrivals and pickups; service delays were experienced on a daily basis.

There were opportunities for development for senior PTS drivers. There were examples of good involvement of patients to develop services that met their needs. For example, the planned provision of computer tablets at departure lounges of hospitals for patients to track their transport arrival times.

There was positive, collegiate and professional dialogue between staff, which demonstrated mutual respect.

Falck Medical Services Ltd (Bow)

Detailed findings

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

Detailed findings

Contents

Background to Falck Medical Services Ltd (Bow)

Falck Medical Services Ltd (Bow) is an independent ambulance service operated by Falck Medical Services Ltd based in Bow in East London. The Bow station opened in 2011. It is the location of the organisation's national head office and is the national operations centre for all of the provider's registered transport services at weekends. Falck Medical Services Ltd (Bow) operated 24 hours a day 365 days a year.

Falck Medical Services Ltd (Bow) worked under contract with partner NHS hospital and ambulance trusts across Greater London and South East England, providing both PTS and First Response services. As a result it served a diverse patient demographic across an extensive geographical area. It was not sub contracted to other independent ambulance service providers. First Response contracts involved supplementing the services provided by ambulance trusts through the supply of a set number of vehicles, or filling a set number of shifts.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector, and two specialist advisors with expertise in emergency transport, emergency operations centre management and frontline paramedic experience. The inspection team was overseen by Nicola Wise, Head of Hospital Inspections.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology and carried out an unannounced visit to the provider's premises on 20 September 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?

During our inspection we spoke with 20 staff including; registered paramedics, patient transport drivers, administrators and management. We spoke with one patient and one carer. During our inspection, we reviewed eight sets of patient records. Before the inspection we reviewed information the public had shared with us through the CQC's National Customer Service Centre.

Detailed findings

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

Facts and data about Falck Medical Services Ltd (Bow)

Falck Medical Services Ltd (Bow) is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely, and
- Treatment of disease, disorder or injury.

The registered manager of Falck Medical Services Ltd (Bow) had been in post since November 2011.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The Bow location has been inspected twice previously. The most recent inspection took place in October 2013 and found that the service was meeting all standards of quality and safety it was inspected against. Two other separately registered Falck Medical Services locations were inspected separately in early 2017.

Activity (October 2016 to September 2017):

- In this reporting period there were over 2000 emergency and urgent care patient journeys undertaken, and
- There were 4237 patient transport journeys undertaken.

19 registered paramedics, 25 paramedic technicians, and 140 patient transport drivers worked at the service, which also had a bank of temporary staff that it could use. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety:

- No never events
- 240 incidents of which 222 were record as no harm, 12 low harm, four moderate harm, and two as severe harm.
- 14 formally reported complaints.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Emergency and urgent care covers the assessment, treatment and care of patients at the scene by ambulance crews with transport to hospital. It includes high dependency and intensive care transport between hospitals or other care settings.

Summary of findings

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve. For each of the five domains we found:

Safe

- There was a good overall safety performance, with no reported Serious Incidents or Never Events. Staff felt supported and were encouraged to report incidents. There were appropriate processes for the reporting and investigating incidents with good dissemination of learning.
- There was good compliance with cleanliness, infection control and hygiene standards. Staff followed infection control procedures and vehicles and equipment were clean, in good working order and well maintained.
- There were appropriate systems in place to ensure the safe storage and administration of medicines, including controlled drugs.
- Patient records were accessed, updated and secured appropriately. All of the records we checked were completed in full, legible and signed.
- There were effective safeguarding processes. 100% of staff were up to date in safeguarding training. There was a dedicated safeguarding 'hotline' for staff to seek advice and guidance.
- There was very good completion of mandatory training amongst all staff groups.
- There were effective risk management processes to confirm patients' specific needs.

Emergency and urgent care services

- The organisation had a detailed business continuity plan and clear processes to respond to emergency incidents.

However,

- Some of the staff we spoke with did not recognise the term Duty of Candour, but they understood the principles of openness, honesty and accountability when incidents happen.
- There were some challenges with recruitment and retention of staff. This was an identified risk for the organisation. There were concerns about ambulance care assistants' work intensity. There were insufficient numbers of telephone call handlers to effectively respond to the volume of PTS calls, but 99% of telephone calls were answered within agreed times.

Effective

- Ambulance crews kept up to date with national guidelines and good practice. Staff demonstrated this in the application of evidence-based practice.
- Response time performance and shift completion rates were generally good. In terms of patient outcomes, there were low rates of 'out of service' (the unavailability of available staff or vehicles), high levels of compliance with clinical performance indicators and good completion of patient report forms. Feedback from partner NHS trusts was that organisation generally delivered an effective service.
- We witnessed good multidisciplinary interaction and handovers between staff.
- Staff told us that the organisation supported them in their development and progression. There were opportunities for staff to develop their leadership and management skills.
- Ambulance crews had good access to information such as policies and protocols using their handheld electronic devices.
- There were systems in place to ensure appropriate application of consent, Mental Capacity Act and Deprivation of Liberty Safeguards processes.

However,

- No staff had received a formal documented annual appraisal since August 2016.
- Some staff were not clear in the circumstances in which an escort would be needed for certain patients. There was no organisational policy on patient chaperones or escorts.
- There were concerns about frequent delays with PTS arrivals and pickups, and service delays were experienced on a daily basis.

Caring

- Staff demonstrated a caring and compassionate approach.
- Staff communicated in a polite and professional manner.
- Staff worked to maintain patient dignity.
- Staff engaged well with patients' carers and relatives and assisted them to maintain the patient's dignity and respect.
- The service worked with partner NHS trusts to involve patients in service development so that it better met their needs.

Responsive

- Ambulance staff received training in the care and transportation of patients with specific individual needs, including those living with dementia or learning disabilities.
- Staff had timely access to interpretation support.
- Feedback from partner NHS trusts showed that performance targets were being met.
- Complaints processes were effectively managed, including joint investigations and shared learning with partner NHS trusts. There was a dedicated patient experience team which responded to complaints and concerns.
- There were examples of good involvement of patients to develop services that met their needs. For example, the planned provision of computer tablets at departure lounges of hospitals for patients to track their transport arrival times.
- Services were responsive to patients' individual needs, including those living with learning disabilities.

However,

- The organisation needed to improve its understanding of the patient experience and do

Emergency and urgent care services

more to collect more detailed feedback to improve services. Although it collected some specific information from complaints, there were no patient surveys to collect data.
- There were some challenges with the sustainability of services. Senior leaders told us that longer term planning was challenging.

Well-led

- Senior leaders were clearly dedicated to the organisation and ensuring its success. They understood their challenges and vulnerabilities but also recognised their organisational strengths.
- Senior leaders of the company clearly explained their short- to mid-term priorities.
- Non-management staff told us managers and the senior leadership team were visible and accessible. They felt that managers listened to staff.
- Staff told us there was a good team spirit. We observed positive, collegiate and professional interactions between staff.
- The organisation had invested in their training and development of site managers to build leadership capability.
- Recruitment processes were being reviewed to ensure new staff demonstrated the required values and behaviours expected of frontline healthcare professionals.
- There were governance processes in place to ensure performance and risk information was reviewed and addressed by senior managers and we found these mostly worked effectively.

However,

- Although there were comprehensive governance and risk management structures in place, some of the long standing concerns we uncovered relating to completion of staff appraisals, staff engagement, and obtaining and evaluating patient feedback highlighted that the governance systems needed further development to ensure these concerns were addressed and mitigated in a more timely way.
- Some staff sensed that the organisation lacked resilience as a small company, and there was a reliance on staff good will and flexibility.
- None of the operational staff we met could recall or recite the organisations values.
- There remained some challenges with staff engagement.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- Provider data from September 2017 showed that 240 incidents were recorded between January and September 2017. No incidents were categorised as Serious Incidents and there were no Never Events. Never events are serious incidents that are entirely preventable as guidance or safety recommendation providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- At the time of our inspection 216 of these incidents were reviewed and closed, and eight had been rejected. Four were currently under investigation, 16 ready for manager review, and 35 were being investigated by the company's risk and performance management team.
- The Director of First Response and head of health safety environment and quality were responsible for coordinating the investigation of First Response serious incidents. We were told that the last SI occurred in early 2016. The head of health safety environment and quality tracked the length of time incidents had been open for, and chased up where required to do so. Regular management meetings also followed up open incidents against timescales.
- Internally, incident statistics, themes and outcomes were reported by the provider's incident and complaints manager at monthly management meetings called 'sprint' meetings which were attended by senior managers. We were provided with a First Response incident management briefing that was prepared for the August 2017 meeting. It showed an analysis of incident by themes such as vehicle collision, medical devices, patient incidents, staff incidents and medicines management. Accident management trends were also identified as part of the Sprint incident review.
- There were 12 staff trained in root cause analysis investigation to review and identify learning from incidents. We were told that there could be more as demand was increasing due to service expansion. However, it was also felt that incidents were managed appropriately by the staff who were responsible for their coordination.
- The staff we spoke with told us they felt supported and encouraged to report incidents. They were also able to recall examples of incident reports that had been acted upon and where follow up changes to mitigate future risks had been introduced.
- The Station Manager confirmed that in addition to the Falck incident reporting system, incidents relating to First Response services were also reported directly to the contracted provider (for example, an NHS ambulance trust). There were joint incident investigations with partner NHS trusts and any concerns were addressed in joint clinical workplace reviews, reflective learning or staff retraining on aspects of care as needed. Feedback from partner NHS trusts was that Falck staff were open and cooperative, with good levels of self-reporting, and concerns were addressed in a timely way.
- There were specific organisational policies on incident reporting and Duty of Candour. There were also standard operating procedures for serious patient safety incidents. These were current and updated in December 2016.
- We spoke with staff about their understanding of Duty of Candour. Some of the staff we spoke with did not recognise the term Duty of Candour but they understood the principles of openness, honesty and accountability when incidents happen. The staff we spoke with were clear that errors should be shared with the patient in a managed way. Staff told us they would seek advice from clinical services or their manager who they thought would be able to support them well.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The organisation reviewed quality performance data on a monthly basis. Data for a number of quality indicators was collated by partner NHS ambulance trusts and these were assessed at monthly meetings with the contracted trusts. There were separate reports for each trust and the information they contained varied accordingly. All of the reports focused predominantly on performance indicators such as response times, shift fulfilment and conveyance rates. We reviewed a sample of quality reports for the period July to September 2017 which demonstrated good performance against indicators for incident reporting, mandatory training completion, patient record audits, complaints and concerns. The reports highlighted monthly

improvements, for example in shift fulfilment and recorded areas of good practice and areas for development. We saw some printed performance data sheets displayed in the vehicle garage and office areas.

Cleanliness, infection control and hygiene

- There was a current organisational infection control policy, which was updated in December 2016.
- We saw staff followed infection control procedures including washing their hands and using hand gel after patient contact. Crew members were observed to be bare below the elbows during a patient journey to mitigate infection risks.
- There were hand sanitising gel dispensers located at points throughout the vehicle garage and we witnessed staff in the vehicle garage cleaning their hands.
- Personal protective equipment (PPE), such as gloves, masks, aprons and goggles was readily available on the vehicles we checked. The service also provided sleeve protection. Staff wore high visibility jackets with long sleeves. The jackets were an essential part of the uniform of staff for example when responding to a road traffic accident. The sleeve protectors would allow staff to wear their jackets, to remain visible, whilst adhering to infection prevention control guidelines.
- All of the vehicles we checked, including the exterior, cab areas and equipment was visibly clean and tidy. All trolleys and mattress coverings were clean and intact. All re-usable equipment such as splints, blood pressure monitors and slide sheets were visibly clean and free from tears. There were single use disposable blankets on all vehicles. There were secure vessels on board for the safe disposal of clinical waste such as syringes. Decontamination wipes were available but in some of the vehicles we checked the hand sanitising gel dispensers were empty, however personal issue hand gel was available to all members of operational staff.
- All of the vehicles we checked had 'spill kits', which meant crews were able to deal with spillages of bodily fluids safely.
- The station employed vehicle make ready operatives (VMROs), who were responsible for cleaning and preparing all ambulances ready for usage. There was a cleaning schedule for each vehicle. The VMROs carried out deep cleans on First Response ambulances weekly, HDU ambulances every two weeks and on PTS vehicles every four weeks
- The VMROs were also responsible for cleaning the vehicle garage area. Completed cleaning checklists were uploaded to the provider's health and safety monitoring software.
- Clinical waste was removed from ambulances at the end of crew shifts and was stored in sealed orange bags. There were secure clinical waste bins in the vehicle garage. These were sufficiently maintained and there was no evidence of overfull bins or waste not disposed of correctly. There were posters displayed around the vehicle garage with contamination control protocols and instructions demonstrating how to sort and segregate waste. The waste removal process complied with the Department of Health's Health Technical Memorandum 07-01: Safe management of healthcare waste.
- There was a cleaning station for staff to use at the entrance to the vehicle garage. This was tidy and neatly organised. Staff had access to washing machines to clean equipment.

Environment and equipment

- The provider had 18 emergency and urgent care vehicles assigned to its Bow station including five high dependency (HDU); four bariatric ambulances; three stretcher ambulances; as well as multi-seat ambulances and wheelchair-carrying ambulances. The First Response fleet size reflected 110% of peak capacity requirement. At the time of our inspection 5% of vehicles were off-road.
- There were robust systems in place to provide assurance of fleet maintenance. The fleet manager and workshop manager used a bespoke fleet management software package to monitor vehicle servicing, MoT test and vehicle excise licence due dates, defects and repairs. The system was linked to the ambulance crews' data terminals to monitor vehicle mileages, and predicted likely service dates according to each vehicle's odometer reading. We looked at the system records and found no vehicles were overdue their servicing or MoT test.
- The fleet management system also monitored the servicing schedule for equipment such as carry chairs and stretchers on each ambulance. Each item of equipment had an individual asset number which allowed the system to track its location and service history. The provider's engineering staff were well trained and had received training from the

manufacturers of the manual handling equipment used on the ambulances, and were qualified to carry out equipment servicing and repair. All equipment on the provider's ambulances was serviced annually All equipment on the provider's ambulances was serviced annually and following any reported incidents which involved a piece of equipment.

- All of the vehicles and equipment we checked were in good working order and appeared well maintained. All of the sterile supplies we checked were stored appropriately with packages intact and in date. All of the electrical equipment we checked on vehicles had visible portable appliance test stickers and the equipment was within service dates.
- We sample checked a number for First Response vehicles, including one used for paediatric ITU transfers. This vehicle was clean, well maintained and the on board equipment and consumables were well organised. There was some attempt at making the vehicle child friendly, including stickers on the sides of the vehicle. All equipment was present including suction, first aid kits and airways. All consumables checked were within date. Grab bags containing medications were sealed with tags.
- There was a vehicle checklist for VMROs to use to check what equipment and consumables should be on each vehicle. Green tags were used on vehicle stock cupboards to indicate that stocks had been checked by VRMOs and were complete.
- We saw that defibrillators on vehicles received daily checks and the records we checked were complete and up to date.
- The trolley beds we inspected were sufficiently maintained and there were no rips to the fabric.
- There were fire extinguishers located on vehicles at accessible points.
- Keys to vehicles were kept in a secured cupboard in the vehicle garage.
- The Emergency Care Assistants (ECA) we spoke with felt that the standard of equipment and training on it was very good.
- We checked the equipment and consumables stores, which were in a secure metal 'cage' structure within the vehicle parking area. The supply chain manager explained that consumables could be ordered and delivered within a 24 hour timeframe. The supply chain manager had introduced a new supplies management system to ensure there were no over- or understocked items of equipment or consumables. There was a dedicated storage area for staff to place faulty equipment for replacement.
- The walkways in the vehicle garage were clear and free from trip hazards.

Medicines

- There were systems in place to ensure the safe storage of Controlled Drugs (CD). The CD accountable officer for the organisation was the registered manager. The organisation had a Home Office Controlled Drugs licence, however at the time of our inspection the certification had expired. We saw documentary evidence that the organisation was working with approval by the Home Office while the current certification was being processed. Shortly after our inspection the organisation received its Home Office Controlled Drugs licence.
- On a day to day basis the organisation's head of clinical operations or the paramedic on duty were responsible for holding the key to the CD cupboard. There were weekly audits of CD stocks conducted by the station manager and clinical team leader. Crew members were required to update the CD control book which was signed and witnessed by another member of staff.
- There was a system of tags for the medicine bags used by paramedics. This was to ensure they were sealed and secure when re-stocked. There was a system for recording the date of tag removal in a dedicated log book called the drug control record.
- We checked the CD control book and drug control record and found that they were completed accurately and in full. We checked a sample of CD stocks, which corresponded with the recorded stock levels in the register. We also checked a sample of non-controlled medicines and found that stock levels were correct and all samples were within date.
- On the vehicles we checked there were medicines lockers with secure touch pad access. There were also denaturing kits available on each vehicle which rendered controlled medicines irretrievable and unfit for further use and ensured their safe disposal.
- Managers told us that all the relevant staff worked to patient group directions (PGD) in order to administer medication. PGDs are documents permitting the supply of prescription only medicines to groups of patients without individual prescriptions. We were told by

managers that staff proved their competence during their introduction period via in depth discussions. Copies of PGDs were available for individual staff members via an online communication software programme.

- We saw medical gases were stored safely, in line with the British Compressed Gases Association's Code of Practice 44: the storage of gas cylinders. In the vehicle garage there was a dedicated secure area for the storage of medical gas canisters. Canisters were secured in locked metal 'cages' to prevent unauthorised access, with separate cabinets for full and empty canisters. We reviewed the medical gases log which was completed in full and up to date. On the vehicles we checked, medical gases were stored securely and were in date. External engineers carried out servicing of ambulance-based oxygen delivery systems.
- Supply chain staff told us there was a new organisational policy on drugs management, which had arisen from an external review. This was accompanied by targeted training to ensure staff understood their roles and responsibilities and were compliant with the policy.

Records

- There were systems in place to ensure that patient information was accessed, recorded and secured appropriately. First Response ambulance crews used paper records for the recording of all patient details, known as a patient report form (PRF). The PRF documented all clinical procedures and examinations the patient had and any medication given to the patient.
- The vehicles we checked had sealed and tagged plastic boxes on board labelled as private and confidential to store PRF templates and other paperwork. The PRFs were formatted according to the contracted NHS trust's processes. Crews stored completed paperwork in black plastic wallets during theirs shift and they were securely stored in a designed container available on return to the base.
- We checked a sample of eight patient records. All of the records were completed in full, legible and signed. The recorded information included: date and time of arrival, personal details, category, vital signs and early warning scores, mental capacity assessment, pain score, medication administration, allergies, risk assessments and what the patient presented with.
- The provider's training database showed that all staff had up to date training in information governance, data protection, handling patient information, record keeping and the Caldicott principles. The Caldicott principles refer to the justification of information required and how information is used and who has access to it.

Safeguarding

- There were processes in place to ensure patients using the service were protected from harm such as abuse. There was a current organisational policy on safeguarding, which was updated in April 2017. The policy stated that the Care Quality Commission (CQC) as well as the local authority must be informed of safeguarding concerns, which is in line with good practice.
- National guidance from the Intercollegiate Document for Healthcare Staff 2014 recommends that all ambulance staff including communication staff should be trained to level two in safeguarding. This applies to all clinical and non-clinical staff that have contact with children/young people and parent/carers.
- We looked at the training database for safeguarding and saw that 100% of staff were up to date in safeguarding training. Control room staff were trained to level one safeguarding children and vulnerable adults; ambulance crews were trained to level two; and senior managers received level three training. Safeguarding training incorporated 'Prevent' awareness which aimed to safeguard vulnerable people from being radicalised.
- There was a safeguarding lead for the organisation to improve management and ownership of the safeguarding reporting process. This individual was trained to level four along with three other safeguarding trainers within the service. The service had also introduced a dedicated safeguarding 'hotline' telephone number that directed staff to one of the level four trained 'safeguarding liaison' staff members who could provide advice and guidance on how to respond to situations.
- The hotline number was printed on staff lanyards for easy and immediate access. Senior managers told us the number of reported safeguarding concerns and referrals had risen as a result of this piece of work from an average of one or two to double digit figures each month. The leadership team also told us they were now

targeting areas of the service where referrals were lower. The trainers were tasked with going into areas where referrals were lower to discuss safeguarding awareness with crews and managers.
- First Response crews reported safeguarding concerns direct to the relevant NHS trust. All other staff reported safeguarding incidents and concerns directly to the organisation's safeguarding coordinator. From October 2016 to September 2017, staff at this location reported 47 safeguarding referrals to the relevant safeguarding authorities.
- The crew members we spoke with were able to clearly explain the safeguarding procedures and principles, including for safeguarding of children and young people. Staff told us they convey potentially vulnerable children to the hospital as a place of safety and then communicate their concerns to senior staff at A&E and documenting the concern through both the clinical desk of the providing Trust and to their own control room and management team. In relation to a vulnerable adult, staff were able to explain the established pathways and told us they felt confident to seek advice from the clinical desk and their managers if they were unsure. Non-frontline staff told us they would escalate concerns to the safeguarding lead and record it using the online incident reporting system for review by the station manager.

Mandatory training

- We found there was good completion of mandatory training amongst all staff groups. At the time of our inspection the provider's training database recorded 97% compliance with all mandatory training modules, against a target of 100% completion. This included compliance with the training mandated by all contracting NHS trusts.
- There was a specific organisational training and development policy, however at the time of our inspection the policy was not current and was due for review in June 2017. The provider submitted information shortly after our inspection which showed the policy was updated in October 2017.
- Ambulance crews were required to complete an eight day induction training programme when they commenced employment with the service, which included a full induction schedule with lesson plans and completion of all mandatory training modules.
- Paramedics and crew members were required to complete 16 mandatory training modules, with a combination of online and classroom based training. Mandatory training was scheduled to occur at different times during the year so crew members could access it at a suitable time. The paramedics we spoke with were able to recall their recent training and told us it was useful.
- The mandatory training programme delivered by an in-house training team. The programme included manual handling, safeguarding vulnerable adults, safeguarding young adults and children, equality and diversity, managing complaints, conflict resolution, and dementia awareness. Fire safety training was repeated every two years. Training in control of substances hazardous to health regulation (COSHH), infection control information governance, and record keeping was repeated each year. Ambulance staff also had yearly refreshers on advanced life support, airway management, equipment refresher, consent and capacity, duty of care, safeguarding and facemask fitting.
- All ambulance staff such as paramedics, intermediate care technicians (ICTs) and ambulance care assistants (ACAs) were required to complete all mandatory training modules to be considered fit for deployment. Staff who did not complete the required training were considered 'non-compliant' by the organisation's planning team and were not allocated shifts until they had completed all modules or refresher training. The local training coordinator checked compliance rates on a daily basis and liaised with the planning team to provide six month alerts for forthcoming training so that staff rotas could be planned accordingly.
- Ambulance drivers were required to complete mandatory 'blue light' training to ensure they had the required knowledge, skills and aptitude for driving an emergency vehicle.
- Paramedics and ICTs were required to complete annual one day clinical refresher training (First Response Emergency Care (FREC) and First Person on Scene (FPOS) training updates respectively) to maintain their clinical skills and knowledge.

Assessing and responding to patient risk

- When staff were called by the control room to transport a patient they were informed of the situation beforehand. This included whether or not the patient had a history of aggressive or violent behaviour.
- Crews used the National Early Warning Score (NEWS) matrix to appropriately access and monitor their patients' vital signs such as temperature and pulse rate. There were clear standard operating procedures to follow if a patient had deteriorated whilst in the care of the provider. Staff had the option to call the NHS clinical support desk in the first instance or a senior clinical adviser was available to provide clinical support over the telephone.
- There was an organisational protocol in the event of a vehicle break-down or collision. The directive stated that crews should keep the patient(s) warm and safe until another crew attended to continue the patient journey as soon as possible.

Staffing

- At the time of our inspection there were 60 Health and Care Professions Council registered frontline First Response staff, including 40 paramedics and ICTs on a full-time basis. There were approximately 150 staff on the bank, who were deployed on a casual basis as required. First Response crew members were employed as self-employed or through personal services contracts. The service employed four vehicle make ready operatives (VMROs), of which one night shift post was vacant.
- Ambulance crews worked 12 hour shifts, over a variety of different working patterns, for example four days on and three days off. There were two VMROs on day shifts and one at night. VRMOs did shifts of four on four off.
- Senior managers told us there had been some fluctuation with staff in the period since the Falck takeover and some challenges with recruitment. The organisation's HR team had reviewed salaries for ambulance crews to help improve recruitment, and changed some organisational policies which had been seen as punitive by ambulance crews. There were plans to introduce a company sick pay structure. The company provided flu vaccinations for staff to help reduce sickness rates.
- Senior managers told us that managing service and staff resource was an identified risk for the business. There had been no intake of new staff for several months earlier in 2017, which had impacted on workload for some staff. However, the service had conducted a recruitment campaign in summer 2017 which had resulted in a number of new staff being transferred across from another independent ambulance provider.
- The provider worked to NHS standards for recruitment to ensure compliance with professional references and criminal records checks. The organisation's head of human resources told us all front-line staff were required to provide references for a five year period, and to complete a pre-employment questionnaire and an enhanced Disclosure and Barring Service (DBS) check. Successful applicants had to complete all relevant training, vaccinations, DBS checks and provide references before they were formally recruited to post.

Response to major incidents

- The organisation had a detailed business continuity plan, which included actions to be taken to mitigate the impact of a number of possible situations that could impact on its ability to provide its service. These included fuel shortages, severe weather, staff shortages, premises, utilities and IT failures and responses to mass casualty or major incidents.
- The organisation had a clear process to respond to emergency incidents. We saw a documented protocol which clearly explained the actions to be taken by staff in the event of a major incident, which included ensuring staff were safe and accounted for.
- Senior leaders of the organisation had received specific training in business continuity planning.
- Senior leaders of the First Response service told us that each of their contracted partner NHS trusts used different communication technology systems. This presented some challenges to the service in ensuring that there were sufficient numbers of vehicles with the required equipment and staff trained in how to use them. This made planning for major incidents challenging. We were told that in the event of a major incident, directly deployed crews had to return to a Falck base or partner trust for further instruction.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- Senior managers of the service attended regular clinical governance meetings to review compliance with

guidelines, evidence-based treatment and published best practice. The forum was chaired by the Falck Medical Director, who worked on a sessional basis. The head of health and safety, environment and quality was responsible for day to day operational compliance with guidelines.

- There were processes in place to ensure ambulance crews kept up to date with national guidelines such as the National Institute for Health and Clinical Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). Clinical team leaders sent emails to staff to inform them of updates to regulations and new guidelines.
- First Response crews worked to the same clinical practice guidelines as crews in partner NHS trusts and receive similar clinical updates. Information, including best practice, protocols and guidance issued by partner NHS trusts was disseminated to all crews using an online platform called 'CPD me', which alerted all staff through their email accounts. New information was also printed and put into vehicles for staff to review. Ambulance crews told us that the system was an effective method of sharing relevant information.
- The staff we observed understood the specific national guidelines that applied to their work and demonstrated this in application. We observed crew members responding to a patient who had had a stroke. The treatment provided was effective and compliant with national (JRCALC) guidelines.
- Crew members were given comprehension style exercises to allow them to demonstrate an understanding of new updates in national guidelines. This meant that staff could read these updates in the national guidelines and then answer questions on the topics covered, as evidence of understanding the updates. The results were reviewed by the clinical team leaders to ensure staff understood relevant guidance.

Assessment and planning of care

- Assessment and planning of care was conducted using agreed and documented pathways for care. First Response crews used the pathways of the corresponding NHS ambulance trust and their practice mirrored those of the trust's own ambulance crews. The provider submitted a sample of pathways which included those for conveyance to the appropriate hospital, 'see and treat' or discharge to an alternative provider. There were specific protocols for the treatment of children caring for patients with mental health issues and those with suspected heart attack or stroke. All of the pathways we reviewed had clear and accessible instructions for screening and clinical actions, including flow charts and diagrams where relevant, decision tools and assessment forms. Ambulance crews could access the required pathway documents using their handheld electronic device.

Response times and patient outcomes

- There were systems in place to measure response times and patient outcomes. Contracts with partner NHS trusts included key performance indicators (KPIs) which detailed the level of expected performance. KPI performance was monitored at monthly meetings with partner trusts. We sought feedback from a sample of the provider's NHS trust partners and the overall feedback was that response time performance and shift completion rates were generally good. In terms of patient outcomes, there were low rates of 'out of service' (the unavailability of available staff or vehicles), high levels of compliance with clinical performance indicators and good completion of patient report forms.

Competent staff

- The organisation's human resources team used an electronic staff record system to record personnel information such as training completion, annual appraisals, criminal records checks, references, driving licence checks and vaccinations. Senior managers told us that an intern from the Falck head office in Denmark was managing a UK project to overhaul the appraisal and performance management programme. This was called the 'My Contribution' programme. It included an electronic 'dashboard' of information for each member of staff which covered objectives, training compliance, well-being and appraisals. The rationale of the change was to make the appraisal processes more valuable and constructive.
- Senior human resources staff told us that all staff would receive four one-to-one meetings per year to review their performance, one of which was a formal documented annual appraisal. Appraisals would be conducted annually, on the individual staff member's anniversary of appointment to the organisation. At the time of our inspection a new appraisal system was in development. However, on further investigation we found there was no appraisal data for the period August

2016 – September 2017. On further investigation we found that no staff had received an appraisal since August 2016. This meant that staff did not have a formal, planned opportunity to review their performance and learning needs We were informed that the new system was due to be introduced in October 2017.

- As an interim measure, clinical team managers assessed staff skillsets. This was broken down into two categories; one was the skill set needed to work for Falck, known as the internal audit, and the other was what was required to work on individual contracts, known as the external audit. We were provided with examples of these competency assessments. The internal audit showed staff being assessed against what Falck expected staff to carry out such as observations being recorded and logged, management plans documented and appropriate advice given to patients. The external audit assessed competency to work on a specific ambulance trust contract, and showed a number of clinical performance indicators that staff were measured by. These included details of jobs completed while being assessed and areas of good practice and areas for improvement.
- We were also provided with two examples of clinical performance reviews; one successful and one unsuccessful. We were told these occurred regularly and when someone moved up a grade, and were conducted by a clinical team leader. This was a more comprehensive assessment that also assessed staff while out on jobs. It identified which competency was being carried out such as understanding patient confidentiality, responding accordingly to healthcare needs and identifying patients who have conditions that require immediate interventions. These were assessed as whether they had been met or not, with an account of each job the clinical team had observed. Where staff were unsuccessful in passing this review, they were provided with an action plan and reassessed to follow up. The clinical team manager responsibilities also included mentoring staff.
- First Response staff received professional supervision every six months.
- First Response staff used an application called 'CPD Me' on their electronic handheld devises, which was used to promote learning opportunities such as training days and courses at partner NHS trusts. Ambulance staff had access to training on subjects such as airwave management and intubation.
- There were three qualified trainers within the organisation who had higher tier qualifications to deliver training and CPD in house.
- The staff we spoke with told us that Falck supported them in their development and progression, with some staff telling us the level of support was "exceptional". One ECA told us the organisation had funded their completion of a nationally accredited qualification. Falck had continued to support their progression with the completion of a level five qualification to provide the knowledge and skills to administer a range of medicines and enhanced airways management.
- There were opportunities for staff to develop their leadership and management skills. The provider had set up a leadership and management programme, which supported staff to complete level three management qualifications with the Charted Management Institute. Managers also had access to training in specific responsibilities such as fire marshal responsibilities and supporting staff. There were plans to introduce level five leadership training for heads of departments.

Coordination with other providers

- First Response crews worked to operational guidelines for deployment provided by partner NHS ambulance trusts, which detailed expected professional behaviours, how to use trust equipment and systems, as well as agreed care pathways for assessment and clinical interventions.
- There were arrangements in place for escalating issues to partner NHS Ambulance Trusts. Senior managers told us crews could escalate immediate concerns directly to trusts' clinical support teams via their radio systems. Senior managers relayed concerns to their senior operational contacts via telephone or email.

Multi-disciplinary working

- We witnessed good interaction and handovers between staff and other paramedics from another provider, at the scene of an emergency. The patient presented with symptoms of a stroke and we saw crew members worked closely with the patient's carers to gather information. It was recognised that the patient was time critical and on-scene time was minimised. Immediately after an initial assessment and handover the driver went

to the vehicle to prepare the ambulance and fetch the trolley, and the patient was moved from her bed carefully. The patient was conveyed under emergency conditions and the receiving hospital was pre-alerted.
- On arrival at the hospital we observed crew provide a clear and concise initial handover to hospital resuscitation unit staff and a further handover was given to members of the hospital stroke team. Crew members knew what information to give in a succinct and structured way.
- 'Supporting the paramedic' training was delivered to ambulance crew members such as ACAs and ICTs by trainers working for Falck. This provided insight into the work of the paramedic and supported more effective team working.

Access to information

- There were information boards located in the vehicle garage area displaying pertinent information of interest to drivers and crews. This included organisational updates on incident reporting, operational updates, safeguarding, clinical bulletins, urgent bulletins and the Falck values.
- There were learning posters from partner NHS trusts displayed in the vehicle garage area. These included learning points on ventricular fibrillation protocols, and elderly back and neck injury management.
- Ambulance crews used handheld electronic devices to communicate with the control room and access organisational policies and procedures. They also used the relevant radio systems to communicate with partner NHS trusts. There was an online platform where policies, procedures, agreed working practices and operational updates were stored. Staff told us these documents were clearly accessible. There were separate online account folders for each partner NHS trust so staff could easily locate specific documents relevant to their daily work. The database was populated by the Director of First Response.
- At the time of our inspection the service was in the process of introducing a new software system called Global Emergency Management System (GEMS) to ensure timely transfer of information between vehicle and station. Senior staff explained the main benefit of this change was that all crews would have full remote access to operational documentation, and could report incidents directly from their handheld electronic devices. Crews would no longer have to be back at base to complete incident reports, thus reducing delays in the reporting process.
- Patient information was communicated to staff directly via their electronic portable device. This information included the address of where the patient was, the nearest hospital to the patient, and any other key information the crew might need to know.
- Ambulance crews' handheld data terminals were secured with a password to ensure data confidentiality should the terminal be lost or stolen.
- The provider was investing in Wi-Fi capability in vehicles to provide crews with immediate access to online information and to enable more effective and timely communication.
- There were robust ICT network and back-up systems in place to ensure timely and secure data transfers and storage. The provider's ICT manager told us there was regular testing for 'dread events' which reported virtually zero faults. The system was designed by the ICT team so there was a thorough understanding of the technology and software used, which supported effective problem solving and business continuity in the event of equipment failure.
- There were two main call centres within Falck Medical Services, one in Bow and the other, larger call centre in Shropshire, which handled PTS calls for the rest of the UK. There was a 'real-time' video link between both sites but staff felt there was limited sharing of information between the two sites.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a current organisational policy on capacity to consent, which detailed patient consent, how to seek it and what should be done if consent is withdrawn; consent for children and young people, including 'Gillick competence' and how to assess a patient's mental capacity and what action should be taken if the patient did not have capacity. The policy was in line with Department of Health guidance. The policy explained the principles of the Mental Capacity Act 2005, including the assumption that a patient has capacity unless staff have reason to suspect otherwise, and the duties to act in the patient's best interests, in the least restrictive manner.

- The capacity to consent policy stated that in an emergency situation where consent cannot be obtained, for example if a patient was unconscious; staff should provide treatment that was in the patient's best interests and immediately necessary to save life or avoid significant deterioration to the patient's health.
- The capacity to consent policy also included a section explaining deprivation of liberty safeguards (DoLS). However, ambulance staff would not be involved in an application for DoLS. This section of the policy ensured ambulance staff had an awareness of DoLS in case they were involved in transporting a patient who was subject to an application.
- We reviewed the staff training record which showed that all relevant ambulance staff had completed training in DoLS, consent and mental capacity was provided for all ambulance staff during their induction. There was also annual refresher training available if required.
- Staff did not receive specific training in the use of restraint. This was because crews were not required or authorised to use restraint methods when transporting patients. At the time of our inspection the provider was not contracted to provide secure transportation. Ambulance staff completed mandatory training in conflict resolution to provide them with the skills and tools to de-escalate potentially violent or aggressive situations. The organisational policy for transporting patients with known concerns was for the contracted provider to provide an appropriate escort with the patient to support them through their journey.
- The service did not directly monitor the use of restraint by crew members but all staff were required to formally report instances of restraint usage using the relevant organisation's incident reporting system. We reviewed a sample of patient records and found there was appropriate recording of consent and patients' mental capacity.
- We found that some staff were not clear in the circumstances in which an escort would be needed for certain patients. There was no organisational policy on patient chaperones or escorts.
- There were processes in place to ensure staff received a full handover when transporting patients with mental health support needs. Standard procedure was for a mental health nurse to travel with the patient in such circumstances. If a patient appeared confused, staff were trained to explain to the patient what was happening and to offer carers or family members to accompany the patient.
- We looked at the provider's policy for do not attempt cardio-pulmonary resuscitation (DNACPR). The policy stated that all DNACPR patients must be pre-booked as a DNACPR patient. It was the responsibility of the health care organisation caring for the patient to ensure all the necessary information was provided to the service to ensure that the correct arrangements were made and in place prior to providing transport.

Are emergency and urgent care services caring?

Compassionate care

- We joined an ambulance crew on a call and witnessed staff demonstrating a caring and compassionate approach throughout. Crew members communicated in a polite and professional manner. They introduced themselves to patients and their carers and/or family members. We saw that patients were well cared for and constantly reassured.
- We observed crews driving in a calm, smooth and courteous way and the driving fully met anticipated driving standards. For example at traffic lights sirens were turned off when the vehicle was halted behind other road users and other road users were not forced through red lights.
- Staff worked to maintain patient dignity throughout their journey, and ensured patients were covered with a blanket when necessary.
- Feedback from partner NHS trusts highlighted that they had received a number of thank you letters to various members of Falck ambulance crews in the past year, thanking them for their care and support.

Understanding and involvement of patients and those close to them

- In one instance we saw staff actively encourage a care assistant who knew the patient to travel in the ambulance with the patient. The patient was living with dementia and the crew recognised that the carer would help provide the patient some security, comfort and support.

- The crew members we observed engaged well with escorts and assisted them to maintain the patient's dignity and respect.

Emotional support

- We observed the staff communicating with the care assistant and the patient whilst on their journey to check on the patient's wellbeing and if they needed anything.

Supporting people to manage their own health

- Senior managers told us ambulance crews provided support to patients to help them manage their health and care needs. This usually included crew members verbally directing patients to local authority social services, their GP, other NHS services, the police and other agencies if they raised concerns to crews that were best directed to such agencies.
- Ambulance crew members told us this was mostly when managing patients with specific social care needs.

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

Service planning and delivery to meet the needs of local people

- First Response held a number of contracts with NHS ambulance trusts across Greater London and South East England, which were serviced from the Bow office. NHS trusts commissioned First Response services directly. First Response had capacity to directly respond to critical care and urgent care requests from NHS ambulance trusts, and supported NHS ambulance trusts emergency services with flexible deployment of vehicles and crews in a range of configurations to enhance trusts' own front line services when needed. This included HDU transfers, A&E support and paediatric transfers. Different contracts set out the required skill mix of deployed staff.
- In London, contracted partners could make First Response booking requests by telephone or using an online booking form. Providers could request one off journeys or configure a package to suit their service needs, such as standby crews.
- Senior leaders reported mostly constructive relationships with their commissioners but recognised some significant challenges with the sustainability of First Response services because of the reliance on ambulance trusts for contracts. Senior leaders told us that longer term planning was challenging because it was not always clear if commissioners would renew their contracts, or they were renewed with very short notice and with limited timescales for continued work. Senior leaders were actively seeking to expand and develop new First Response business opportunities to improve the organisation's resilience in a challenging commissioning environment, but they were conscious of the need to invest in robust and fit for purpose systems to ensure quality could be maintained.
- There was recognition that the risk of, and actual loss of contracts in the previous year had meant some business activity, such as the provision of learning and development opportunities for staff, had been reduced in response to reduced income. Senior leaders also reported challenges in balancing crew and vehicle resource planning, with client expectations for unplanned, short notice deployment. As some First Response staff were employed on zero-hours contracts, there were business risks to the short notice cancellation of crews.
- First Response operated a paramedic-led paediatric transfer service. Paramedics who work on this service were specifically trained and supported by a range of paediatric specific equipment, including paediatric monitors and ventilators, to ensure the additional and specific needs of children and young people were met.

Meeting people's individual needs

- Ambulance staff received training in the care and transportation of patients living with dementia and learning disabilities as they sometimes transported such patients. This was completed in the induction period and repeated in annual refresher training. Risk assessments were completed for each journey to identify patients' needs and existing medical condition to ensure they were safe to travel in a particular vehicle. On arrival to the scene, crew members discussed the needs of patients with staff or family members, depending on where they were travelling from.
- Staff were made aware if a patient had communication difficulties or did not speak English via control and via their electronic portable device. This meant that staff could prepare to meet patients' need prior to commencing the journey.

- Staff had access to a telephone translation service for interpretation support. There were also posters on vehicles and at Falck premises which demonstrated in multiple languages that translation services were available and patients without English as a first language could indicate which language they needed to be translated.

Access and flow

- The service had specific KPIs according to each contract to monitor the access and flow of the service. Crews used their electronic portal device to capture transport acceptance and completion data, and turnaround times on a daily basis. These data were collected and measured against services KPIs. Provider data and feedback from partner NHS trusts showed that targets were being met.

Learning from complaints and concerns

- Complaints and compliments were reviewed by senior managers on a monthly basis at planned 'Sprint' meetings. We were provided with the First Response and PTS compliments and complaints briefing which was prepared for September 2017. It showed a total of 14 complaints were received between January and September 2017. Complaints were broken down by ambulance base, such as Bow and Alperton (another Falck Medical Services base) as well as by NHS ambulance trust contractor. It itemised the number of complaints per month in each category. Complaints were also broken down by theme, such as conduct, delay in transportation, staff attitude and driver speeding.
- There was a detailed leaflet on how to raise concerns or make a formal complaint about Falck Medical Services. These leaflets and posters on how to provide feedback were in the vehicles we checked. The leaflet contained clear information about how to complain, timelines for response, advocacy and support services, confidentiality, and other avenues of redress.
- There was a current concerns and complaints policy which was updated in January 2017.
- There was a dedicated patient experience team which responded to complaints and concerns. Senior leaders demonstrated examples of joint investigations of complaints and shared learning with partner NHS Ambulance Trusts. However, there was recognition that the organisation needed to improve its understanding of the patient experience and do more to collect more detailed feedback to improve services, such as from patient surveys.

Are emergency and urgent care services well-led?

Leadership / culture of service

- The executive management team consisted of the chief executive (CEO), chief finance officer, Director of Emergency and Urgent Care, Director of PTS, Director of Operations and Quality and Commercial Director.
- At the time of our inspection the Director of Emergency and Urgent Care (First Response) line managed the head of clinical services and the senior operations manager for First Response. The head of clinical services managed the clinical team leaders and the senior operations manager managed three station managers. Station managers were also attached to PTS work.
- In July 2015 the organisation became a subsidiary of the Denmark based Falck Group. At the time of our inspection, the provider was going through a change process as the new parent company's policies and processes were rolled out across its UK bases.
- The senior leaders we met understood their organisational challenges and vulnerabilities but also recognised their organisational strengths. Senior leaders told us they had autonomy but were well supported by the leadership team in Denmark. Senior leaders reported improvements in the stability and sustainability of the organisation since the Falck takeover, as a result of substantial organisational redevelopment and cost savings. However, they also recognised that meeting those demands had created some challenges in engaging with staff.
- Non-managerial staff told us their managers and the senior leadership team were visible and accessible. They told us they had clear understanding of their roles and felt that managers listened to staff and considered their suggestions. Some staff sensed that the organisation lacked some resilience as a small company which relied on staff good will and flexibility. However, they believed this was transitional as the company becomes more stable.

- Staff told us there was a good team spirit. However, there were some isolated comments that the organisation could do more to ensure respect and recognition of female staff. Some staff also told us that the scale of change in the organisation had resulted in some resistance to further change, which in some cases had manifest as unprofessional behaviours.

Vision and strategy

- Senior leaders of the company explained their short to mid-term priorities to stabilise the organisation and improve ownership and accountability amongst all staff. Senior leaders recognised the need for better staff engagement to improve morale. There were plans for senior staff to join crews on journeys to improve visibility and understanding of frontline concerns.
- An operational excellence team was set up to address identified organisational challenges. This consisted of a team of three senior staff members who were allocated to organisational change projects, which focused on meeting the requirements of provider contracts, particularly around safe recruitment and ensuring First Response staff had the required skill sets to fulfil client expectation.
- The Falck values were displayed in the office lobby and on information boards in the vehicle garage. These values were based on principles of being efficient, reliable, competent, helpful, accessible, and fast. The service vision was recorded as 'working as a united team, to be the preferred provider, preferred brand and preferred workplace'. The overall philosophy linked to the company's Danish founder, was 'people helping people'. However, when we spoke with staff, none could recall or recite the values, despite posters displaying these located at points throughout the premises. We also noted mixed branding of the company image on vehicles, with some still in old branding before the Falck takeover in 2015.
- Senior managers told us that the company's values needed to be more embedded and plans were in place to achieve this through 'My Contribution'; the new appraisal and performance system. This would align all staff objectives to the business and organisational aims and philosophy. Senior managers told us the programme aimed to improve the profile of the company vision and values so staff were more aware of them and how their roles contributed towards the organisational goals. The organisation's governance framework described the Falck values and culture as being of the highest importance and stated that the corporate values should be displayed in all stations and sites.

Governance, risk management and quality measurement

- There were governance processes, meetings and documents in place to ensure current performance and risk information was reviewed and addressed by senior managers and we found these mostly worked effectively. Each division within the organisation was required to update and monitor a risk register. Responsibility for completing the divisional risk register was taken by directors, regional contract managers (RCMs), First Response managers, the corporate team and the director of operations and quality. Divisional information was escalated to a quarterly 'primary' risk register, which was then escalated to the Falck head office in Denmark for review by the company board.
- The primary risk register included all issues and risks and also included organisational objectives and strategy matters. We reviewed the primary risk register and accompanying risk report and found that it identified critical issues relating to key parts of the business such as fleet management, staffing matters, safeguarding concerns and incidents. All risks were rated and included a description, root cause and action plan.
- The executive team met on a monthly basis to review First Response and PTS performance. We were provided with two recent agendas for this meeting. It included a review of the risk register and sign off, performance management targets, feedback and expectations from the Falck head office in Denmark, financial update and a number of project updates that included the new Cleric system, standardising processes, recruitment, contract bids, contract negotiation and fleet. Papers that accompanied the agenda were also provided. They included financial updates on revenue and business updates on First Response and PTS work. They included updates on individual contracts and any issues arising therein. Staffing, modelling for bids, competitor updates, organisational performance and development updates were also provided in supporting papers for the meeting.
- 'Pulse' meetings occurred weekly, and were attended by all executive directors. The governance framework

described them as the executive decision making meeting. An action log was produced for each Pulse meeting. We reviewed a recent action log which demonstrated meetings had taken place between once and four times a month between February and June 2017. Executive actions were set with named staff assigned to actions.

- 'Sprint' meetings were held on a monthly basis. This meeting was split into categories of performance and quality. The meetings were held monthly and led by the directors of First response and/or PTS. They lasted half a day and were attended by all directors. There were slots to discuss finance, HR, training, despatch, planning, safeguarding, the risk register and all key areas of the business.
- We reviewed the organisation's governance framework which identified other meetings such as the governance forum which was quarterly in its frequency with some ad hoc meetings; an audit and policy development forum which was held in alternate months; operational meetings which were ad hoc and monthly contract review meetings.
- Non-management staff were required to record information which fed into local governance systems. For example, there were daily vehicle inspections and reviews of patient care records. Staff told us they received constructive feedback if any areas were missed or below standard.
- Although there were comprehensive governance and risk management structures in place, there were some long standing concerns related to completion of staff appraisals, staff engagement, and obtaining and evaluating patient feedback which highlighted that governance systems needed further development to ensure these concerns were addressed and mitigated in a more timely way. Senior managers told us that the governance structure was in the process of being streamlined.

Public and staff engagement

- Throughout our inspection staff told us there had been frequent management changes in the organisation over the past five years. This had created a sense of instability and uncertainty for some staff. However, frontline staff told us that the company had become more professionalised and corporate since the Falck takeover of the company. They felt that this was somewhat destabilising at first but on reflection they understood the reasons behind the changes. They felt it had been mostly positive in terms of making the organisation more effective. Although they felt that there were still some areas for improvement, there was now a clearer direction, more stability and plans in place.
- Most of the staff we spoke with told us that Falck had been good at consulting them on changes. However, there remained some challenges with staff engagement, particularly around recent changes to rotas. Senior managers told us this had been a long process and there had been some reluctance from staff about the changes which had led to some staff leaving the organisation. Senior managers told us they met with affected staff in groups and one to one to explain why the changes were necessary.
- The non-managerial staff we spoke with such as VMROs told us they enjoyed working for the organisation and it was a good employer with a good reputation. Staff told us that Falck was a supportive organisation which supported their development, their experience was respected, there was open communication and that "employees are listened to".

Innovation, improvement and sustainability

- The provider was accredited for a number of International Standards Organization (ISO) recognised systems, including security management (ISO 27001), quality management (ISO 9001) and environmental management (ISO 14001).
- Each ambulance driver used a personal-issue fob to log on to the ambulance's telematics system before the engine could be started. This identified the crew member who drove on every individual journey during the shift. The provider's fleet management software provided managers with data on the manner and efficiency of each member of staff's driving. The vehicle tracking system also allowed managers to replay a vehicle's journey, including its speed, acceleration, braking and cornering forces, fuel efficiency and in the case of HDU vehicles, whether blue lights were in use. This helped managers by providing evidence for incident and complaint investigation and for use in staff appraisals.
- Each ambulance had a set of red, amber and green lights on its dashboard. At the end of each journey, when the driver switched off the ignition, one of the lights illuminated to give an indication of how smoothly

and efficiently the vehicle had been driven, based on analysis from its on-board telemetry. This gave staff instant feedback on the quality of their driving. The system also sent reports to the provider's managers, to allow them to monitor staff members' driving patterns. The introduction of this system supported good driver behaviour to reduce occupational road risks.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Patient transport services (PTS) are the non-urgent and non-specialist services that transport patients between hospitals, home and other places such as care homes.

Summary of findings

See Summary of Findings in Emergency and Urgent Care Services section for information.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- There were appropriate processes for the reporting of incidents in patient transport services (PTS). When an incident occurred crews were expected to deal with the immediate emergency, including dialling 999 if required. All incidents were escalated to the control room which completed an incident report and escalated it as appropriate. Crew members were required to complete a paper incident report form, which included the incident details and action that had been taken. All incident reporting activity was coordinated by the patient experience coordinators.
- The head of health safety environment and quality led the investigation of Serious Incidents that occurred in PTS. After incidents were reported to the patient experience coordinators, they assessed who the incident would be shared for investigation and learning. There was a 48 hour timescale to allocate and acknowledge all incidents.
- The organisation's process was for incidents within PTS to be reviewed by a manager, addressed and closed within 25 working days. For First Response we were told this could take longer, which was put down to following the processes and procedures of the NHS trusts with which contracts were held. The Falck clinical team were allocated all incidents that had a clinical element to them and asked lines of enquiry to trusts and liaised with them regarding learning outcomes. We were told that it was sometimes necessary for incident investigations and enquiries to be open for a while due to delay in receiving information back from other providers that Falck had contracts with.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- See 'Are emergency and urgent care services safe?' section of this report for main findings.

Cleanliness, infection control and hygiene

- See 'Are emergency and urgent care services safe?' section of this report for main findings.

Environment and equipment

- The provider used a range of vehicles for its PTS work, which included ambulances adapted for high dependency, stretchers, wheelchairs and bariatric patients and cars. The fleet manager told us there were 120 active PTS vehicles available, and 30 spare vehicles, which was sufficient for current contract demand and fluctuations.
- Most PTS vehicles were unmarked and did not have Falck or NHS branding (some had the previous company name branding on them). Individual vehicles were used solely by the same PTS driver and the vehicles were kept by the driver after their shift finished. This enabled direct deployment at the start of a shift. Individual drivers were responsible for keeping their vehicles clean and roadworthy. They were required to undertake weekly oil, tyre pressure and other safety checks to maximise performance and reliability.
- The provider used a local garage for vehicle recovery in the event of breakdown. They also had their own vehicle maintenance teams. MOT inspections were up to date.
- PTS vehicles did not carry medicines on board. Some PTS vehicles carried medical gases and there was provision for these to be stored securely.

Medicines

- See 'Are emergency and urgent care services safe?' section of this report for main findings.

Records

- Control room staff recorded patient and journey information electronically and sent details to PTS drivers via handheld mobile data terminals. The information included patients' names, contact telephone number, collection and destination addresses, and any special notes about patient mobility needs or medical conditions.
- The provider did not use paper records for patient journeys. All patient records were stored electronically on the organisation's computer-aided dispatch and booking system.

Safeguarding

- See 'Are emergency and urgent care services safe?' section of this report for main findings.

Mandatory training

- See 'Are emergency and urgent care services safe?' section of this report for main findings.

Patient transport services (PTS)

Assessing and responding to patient risk

- Control room staff conducted routine telephone calls called 'call aheads' the day before planned PTS journeys were due to take place. This was to confirm patients' specific needs such as mobility, medication, premises access, appointment time and any other relevant information.
- At the time of our inspection the service was introducing a new computer software system to enable control room staff to send a text message alert to patients when their transport had been dispatched.

Staffing

- At the time of our inspection there were 140 PTS drivers known as ambulance care assistants (ACA) employed on a permanent basis. Bank staff were deployed on a casual basis as required. There were 40 whole time equivalent ACA vacancies, and senior staff told us the service required 30% additional workforce to meet current contractual expectations. Some staff told us the number of vacancies limited the organisation's ability to respond to capacity demands and pressures.
- As an interim measure the provider was working with other PTS companies to outsource work and used trained agency staff to fill some gaps. There were due diligence audit processes in place to assess sub-contractor organisations' suitability to provide PTS services on their behalf. Sub-contractors fed in to Falck's systems such as safeguarding and incident reporting. Work was allocated to sub-contracted, pre-approved PTS providers in the event of patient overload, and circumstances such as staff absenteeism, treatment and discharge delays, traffic congestion and inclement weather. The triggers for outsourcing were not clearly defined, but staff told us that it occurred on an almost daily basis.
- There was a recruitment drive in place but progress had been slow. To attract potential applicants the organisation had changed the job title from PTS driver to ACA to demonstrate the emphasis to care, rather than driving. This was made clear in the job advert and in interviews.
- Senior managers told us delays to DBS criminal records checks was an identified recruitment challenge. There was an average six week waiting period for returns, in which time staff who had been offered employment but were waiting for clearance, found other employment because the delays caused loss of income.
- Part of the provider's strategy was to offer incentives and development opportunities to existing staff to improve retention. For instance, offering training and clearer career paths for ACAs and introducing a better insurance policy that meant vehicle drivers did not have to pay the excess in cases of accidents.
- ACAs worked 12 hour shifts, over a variety of different working patterns according to the contract that was being fulfilled. We were told that PTS shift patterns had been identified as inefficient in some areas. For instance, there was an over-supply of staff working early morning shifts where there was not the same level of demand. Falck had followed a consultative process in early 2017 to reorganise driver shift patterns towards later working and weekend shifts. We were told they had worked to accommodate individual needs. For instance, staff with childcare commitments were given a two month notice period before shift changes were enacted so they could make suitable arrangements.
- There were some reported concerns about ACA work intensity, and an over reliance on those staff who would forfeit their break times to meet patient demands for timekeeping. Some staff told us there were disagreements between dispatchers and ACAs about the allocated time for different jobs, and that there was a reliance on the goodwill of ACAs to achieve demanding targets.
- Senior managers also reported insufficient numbers of telephone call handlers to effectively respond to the volume of calls, but 99% of telephone calls were still answered within the contractual requirement of 30-45 seconds. At the Bow station there were two permanent dispatchers and one supervisor, plus two night staff. Dispatchers usually worked 12 hour shifts on a four days on, three days off basis. Two further staff members had been recruited to build capacity, however it was likely that the new dispatchers would require time to develop and so would work on non-urgent PTS calls initially. The provider did not use agency staff to cover gaps in the control room but we found there were insufficient contingency arrangements in place in the event of sickness or annual leave for dispatchers, and a reliance on staff goodwill to cover shift gaps.

Patient transport services (PTS)

- There were at the time of inspection at least 4 permanent dispatchers, one supervisor, one manager plus 2 night supervisors and 2 night dispatchers

Response to major incidents

- See 'Are emergency and urgent care services safe?' section of this report for main findings.

Are patient transport services effective?

Evidence-based care and treatment

- The staff we spoke with were able to demonstrate how they accessed the organisation's policies and procedures. In accordance with the provider's policies, call handling staff used different flowcharts to assess patients' eligibility for transport, depending on whether the call was being made by the patient or their representative, or a healthcare professional. Different flowcharts were used depending on whether the transport was required on the same day or was an advance booking. The flowcharts ensured call handlers obtained accurate patient details, and included questions about the patient's mobility needs, any access issues at the collection or destination addresses, the patient's medical conditions and whether anyone would be escorting the patient. Patients and healthcare staff were also able to book transport through an on-line form if they preferred.
- The organisation had introduced new roles of senior ACAs to help provide guidance and support to more junior staff. Part of this role was to improve staff awareness of policies and practices.

Assessment and planning of care

- The organisation's fleet management software interfaced with its computer-aided dispatch system to allocate vehicles to transport jobs automatically, according to vehicle type and capacity.
- Control room staff shared case details with vehicle crews using hand-held electronic data terminals. Control room staff told us patient information included details of any mental health concerns, infection control alerts, mobility needs and special notes, for example if the patient was living with dementia.

Response times and patient outcomes

- Contracts included key performance indicators (KPIs) which were reviewed on a monthly basis. The KPIs were based on the length of time patients waited for transport, or on how close to their appointment time patients arrived at hospital. We sought feedback from a sample of the provider's NHS trust partners. The overall feedback was that Falck Medical Services generally delivered an effective service based on the standards agreed in contract specifications. These standards were mainly linked to a set of outcomes to ensure patients were transported in a caring, comfortable, efficient and timed manner.
- Partner NHS trusts reported some concerns about frequent delays with arrivals and pickups, but they did not report concerns in relation to other outcomes. We were told that service delays were experienced on a daily basis, in particular the transportation of patients to and from outpatient appointments. On average, 10% of patients were arriving later than 15 minutes after their appointment times. Approximately the same percentage (10%), were waiting longer than one hour to be taken home.
- Partner NHS trusts told us that Falck Medical Services was actively working with them to implement measures to improve performance. This had included reviewing on site management structures, adding additional vehicles to the service and undertaking a review of staff terms and conditions to help with staff recruitment and retention.

Competent staff

- There were opportunities for development for senior PTS drivers who were suitable and wanted to develop in their roles. For example ACAs could train to become ICTs. The organisation supported staff with funding for training in 'first person on scene' and first 'response emergency care' training programmes, as well as 'blue light' driving.
- At the time of our inspection the organisation was working with a higher education institution (HEI) to develop an accredited qualification for senior ACAs to get recognition for their skills and enable them to formally assess and mentor junior ACAs. Additional advanced training was also provided in areas such as moving and handling, and organisational policies and procedures. The organisation also worked with other HEIs to provide placement opportunities for trainee paramedics.

Patient transport services (PTS)

Coordination with other providers and multi-disciplinary working

- See 'Are emergency and urgent care services effective?' section of this report for main findings.

Access to information

- See 'Are emergency and urgent care services effective?' section of this report for main findings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- See 'Are emergency and urgent care services effective?' section of this report for main findings.

Are patient transport services caring?

Compassionate care

- See 'Are emergency and urgent care services caring?' section of this report for main findings.

Understanding and involvement of patients and those close to them

- A patient experience coordinator had worked with a partner NHS trust renal unit to better understand and anticipate the needs of their patients using the PTS service. The project involved patients directly to seek their feedback on how to improve the service. It resulted in the production of leaflets to provide guidance to patients on what to expect from the service and the installation of Wi-Fi on some vehicles to enhance the patient experience. This model was subsequently applied at another trust to improve the service for children and young people who regularly used the PTS service.

Emotional support

- See 'Are emergency and urgent care services caring?' section of this report for main findings.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The Bow station provided PTS services to seven NHS trusts, predominantly in London and the South East of England. PTS schedules were determined in advance in consultation with the needs of each trust. The profile of PTS work consisted of 70% outpatient appointments, 25% discharge and 5% admissions. ACAs mainly worked solo. During our inspection there were 100 solo ACAs on shift and 40 double staffed vehicles assigned to journeys for patients with complex or specific individual needs. Approximately 75% of journeys were for individual patients and 25% for two or three patients at a time depending on their needs, location and destination.
- The Director of PTS and two London regional contract managers (RCMs) were responsible for service standards and delivery against individual contractual expectations. These were measured by key performance indicators (KPIs), through managing relationships and contract monitoring with partner NHS trusts. RCMs held regular meetings with partner NHS trust site managers to discuss any performance issues that arose. The business development team and Director of PTS also developed relationships with partner NHS trusts at a more strategic level.
- We were told that individual contracts set different needs and skill set requirements. Contracts were based on what each client considered to be patient centred, but also based on financial constraints. For instance, target PTS response times varied from contract to contract. Daily management reports were measured against central KPIs, which also differed between each contract. Performance data reporting was generated from the provider's online booking system. Feedback from a sample of the provider's partner NHS trusts highlighted some concerns with transport delays (see 'Response times' and 'Patient outcomes' for more information).

Meeting people's individual needs

- Bookings for high dependency patient transfers were recorded using an online form, where control staff made note of any specific requirements.
- The staff we met demonstrated an awareness of patients living with learning disabilities. Control room staff told us, where necessary, they accepted bookings for carers to travel with patients, to minimise distress to the patient.

Patient transport services (PTS)

- If there was any doubt that the patient could not be kept safe in a single-crewed vehicle, crews would contact the control room and request a double-crewed ambulance.
- The service was planning to provide computer tablets at departure lounges of hospitals so that patients could track their transport and arrival times.

Access and flow

- Control room staff told us 90% of all journeys were booked by hospital staff directly using the provider's online booking system. Falck Medical Services' site managers were located in hospitals, and provided training to hospital staff on how to use the system and make bookings. Staff told us the online booking system was reliable and functional.
- 10% of journeys were booked through the provider's call centre. These included journeys that might not be booked in advance or where specific individual needs were identified and the booking needed further consultation in order to book appropriate transport to meet patients' needs.
- The PTS service used mobile telephones to communicate with ACAs. However, beyond telephone calls to check the location of the driver, there was no provision for real-time mapping of vehicle location. Therefore, in cases of an incident or unexpected delay, ACAs were expected to telephone the control room to provide a status update. This could be potentially difficult should dispatchers be busy or lines engaged.
- Control room staff were expected to respond to all external telephone calls within three rings to ensure calls were answered in a timely manner. If calls were not answered within 45 seconds, they were diverted to another control room elsewhere in the country.

Learning from complaints and concerns

- There was an organisational standard for formal complaints to be acknowledged within 48 hours of receipt and for complaints to be investigated and closed / responded to within 25 working days.
- Dispatchers told us they rarely received patient complaints and, when they did, it was mainly concerns around lateness or delays. Dispatchers told us they tried to resolve telephone complaints at the time, situationally and rapidly, and this resulted in fewer formal complaints. They told us informal complaints were mainly from dialysis service patients who sometimes had unexpected delays with their treatment which impacted on the planned patient transport timetable and rota patterns.

Are patient transport services well-led?

Leadership / culture of service

- The Director of PTS line managed five regional contract managers (RCMs), who were responsible for service standards within their own regions. Within London there were two dedicated RCMs for north and south London. We were told that responsibility for London contracts was divided in the previous year to ensure a manageable workload for staff. Each RCM was responsible for line managing between two to five site managers, who were based in partner hospitals.
- Senior managers of the organisation had identified the development of PTS site manager leadership capability as an area for improvement. In response, the organisation had invested in their training and development. All site managers were given opportunities to complete BTEC level 3 leadership and management qualifications and managers told us 19 of the 20 site managers had signed up for this training.
- We observed positive, collegiate and professional dialogue and appropriate discussion during calls between drivers and dispatchers, which demonstrated mutual respect.
- Senior managers told us that recruitment processes were being reviewed to ensure that the organisation recruited staff with the required values and behaviours expected of frontline healthcare professionals, including for compassionate care. Senior managers told us they were encouraging staff to identify unprofessional behaviours and empower them to report it. The service was developing clearer guidelines for ACAs on acceptable behaviours and relationships with patients.

Vision and strategy for this this core service

- See 'Are emergency and urgent care services well-led?' section of this report for main findings.

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

Patient transport services (PTS)

- See 'Are emergency and urgent care services well-led?' section of this report for main findings.

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

- See 'Are emergency and urgent care services well-led?' section of this report for main findings.

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

- See 'Are emergency and urgent care services well-led?' section of this report for main findings.

Outstanding practice and areas for improvement

Outstanding practice

- The introduction of a dedicated safeguarding 'hotline' telephone number for staff to seek advice, guidance and support from 'safeguarding liaison' staff. The lanyard with printed hotline telephone numbers ensured staff could access support in a timely way.
- The patient experience coordinator project to better understand and anticipate the needs of patients using the PTS service. This directly engaged patients on how to improve the service. It resulted in the production of leaflets to provide guidance to patients on what to expect from the service and the installation of Wi-Fi on some vehicles to enhance the patient experience. This model was subsequently applied at another trust to improve the service for children and young people who regularly used the PTS service.
- The use of technology to monitor and record driving performance and safety which supported good driver behaviour to reduce occupational road risks.

Areas for improvement

Action the hospital MUST take to improve

- Take urgent action to ensure all staff receive a formal documented appraisal.

Action the hospital SHOULD take to improve

- Implement measures to improve staff understanding of their responsibilities under the Duty of Candour.
- Continue to take action to ensure sufficient numbers of appropriately qualified staff.
- Develop an appropriate organisational policy and protocol on patient chaperones to ensure staff are clear on when to request a patient escort.
- Take action to reduce patient transport arrival and pickup delays.
- Implement measures to improve the collection and use of patient feedback to improve services.
- Review governance processes to ensure long-standing concerns, risks and issues are addressed and mitigated in a timely way.
- Implement measures to improve staff engagement and ensure staff feel respected and recognised for their work.

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
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There was no clear appraisal system in place and no staff had received a formal documented annual appraisal in the period August 2016 – September 2017.