Inspection framework: NHS Ambulance Services

Log of changes since last version

Section / Report sub heading	Page number	Detail of update
Throughout		Updates to JESIP entries to update links to guidance, add gurther prompts in conjuction with the JESIP programme lead
S1 - Safeguarding	6	Link to Intercollegiate document for adult safeguarding added to professional standards
R1 – Environment & Equipment	10	Link to MHRA guidance on managing medical devices added to professional standards

Additional service: Resilience

This covers the provider's major incident planning and response as a Category 1 provider under the Civil Contingencies Act 2004 (Part 1), as well as planning for and responses to other major emergencies. It also includes preparedness for, and the support of events and mass gatherings.

Special operations such as serious and protracted incidents use many of the resources and techniques used in major incidents such as hazardous area response teams and these are considered as part of this core service.

This core service covers the business continuity management of the service – both when it is only the provider affected, such as loss of facilities, or as part of a wider event such as adverse weather or Pandemic Influenza.

Areas to inspect*
The inspection team should carry out an initial visual inspection of each area. Your observations should be considered alongside data/surveillance to identify areas of risk or concern for further inspection. • **HART depots (including any co-located with other emergency services)** • **Specialist equipment and vehicles** • **Emergency operations centre (EOC)** • **Specialist command and control rooms** • **Training centres** **As well as identifiable elements, such as command structures and HART teams the resilience planning function uses resources from across the ambulance provider. It is important therefore that the Resilience core service team work with colleagues in the other three core service teams to answer the KLOEs for the Resilience core service.*

Interviews/focus groups/observations

You should conduct interviews of the following people at every inspection:

- Trust Chair
- CEO
- Director level accountable emergency officer responsible for EPRR;
- Commanders at Strategic, Tactical and Operational levels (Gold, Silver and Bronze)
- Managers responsible for Resilience Planning & Special Operations (including HART Managers and HART Trainers)
- Accountable officer for JESIP
- Business Continuity Manager
- Medical Director
- Emergency and urgent care staff

You could gather information about the service from the following people, depending on the staffing structure:

Internal to the provider

- Director level accountable emergency officer responsible for EPRR;
- Commanders at Strategic, Tactical and Operational levels (Gold, Silver and Bronze) (including JESIP trainers)
- Managers responsible for Resilience Planning & Special Operations (including HART Managers and HART Trainers)
- Business Continuity manager
- Medical Director
- HART operatives
- HART team leaders
- EOC staff and managers
- Emergency and urgent care staff and managers
- PTS staff and managers

External stakeholders to contact in the planning stage (ask the Trust to provide names and contact details)

- NHS England has an Emergency Preparedness, Resilience and Response (EPRR) team, to whom the mandatory EPRR self-assessment is submitted (this link is to the full, blank copy available on the NSHE website). NHSE has regional representatives for EPRR who scrutinise the self-assessment and who should be contacted as one of the key stakeholders for the resilience

planning core service. It is highly recommended that the NHSE representative is involved in the pre-inspection planning stage of the inspection, allowing for adequate scrutiny of data in advance of the site visit. Ideally the SpA assigned to the core service would also be involved in this discussion. Key standards from the self-assessment have been mapped against the KLOES – the mapping can be found here (this link is to a version of the self-assessment that only includes ambulance-relevant information)

- The Chairs of all Local Resilience Forums (LRF) and all Local Health Resilience Partnerships (LHRPs) (there may be a number depending on the particular Ambulance Trust) should be contacted for their input prior to the inspection.
- The National Ambulance Resilience Unit (NARU) should be contacted for input prior to the inspection**.**

Safe

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Key lines of enquiry: **S1**

S1. How do systems, processes and practices keep people safe and safeguarded from abuse?

Report sub-heading: **Mandatory training**

Prompts	Professional standard	Sector specific guidance
• S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.5 Do staff receive effective training in safety systems, processes and practices?	• NHS Service Specification 2016/17: Hazardous Area Response Teams (HART) • Interoperability standards 1-4: ○ Organisations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. ○ Organisations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. ○ Organisations ensure that comprehensive training records are maintained for each member of HART staff. These records must include: a record of mandated	• Mandatory training arrangements and policies are in place, including: ○ Identification of the mandatory training needs of each staff group – including driving training and driving under blue lights ○ System to monitor uptake of mandatory training against target ○ Actions taken to increase uptake where necessary • Review statutory and mandatory training records: ○ Staff have received and are up to date with appropriate mandatory training and *the average mandatory training rate for staff is x% (please specify elements of training where rates are less than 75%)* ○ Training is multidisciplinary

	training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.	○ Content responds to incidents • Include mandatory training requirements for HART: ○ Does the mandatory training meet the National Training Standards? ○ Are statutory recertification requirements met? (e..g breathing apparatus, safe working at height) ○ What mandatory training is given to non-specialist staff to ensure they can play their part in the resilience function?
Report sub-heading: **Safeguarding**		
• S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.2 How do systems, processes and practices protect people from abuse, neglect, harassment and breaches of their dignity and respect? How are these monitored and improved? • S1.3 How are people protected from discrimination, which might amount to abuse or cause psychological harm? This includes harassment and discrimination in relation to protected characteristics under the Equality Act.	• Safeguarding intranet page and inspector handbook on safeguarding includes guidance on level of training required and CQC inspection of safeguarding. This includes the 2018 position statement on safeguarding children training. • Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' (March 2014) • First edition of Intercollegiate Guidance for Adult Safeguarding (2018) • Intercollegiate standards for children and young people in emergency care	• Safeguarding arrangements and policies are in place, including for: ○ Assessing need and providing early help ○ Safeguarding supervision and training - staff have the appropriate safeguarding training both children and adults: "*the average safeguarding training rate for staff is x% (please specify training level where rates are less than 75%)"* ○ Reporting and learning from safeguarding incidents - staff know how to make a safeguarding alert and do this

• S1.4 How is safety promoted in recruitment practice staff support arrangements, disciplinary procedures, and ongoing checks? (For example Disclosure and Barring Service checks). • S1.5 Do staff receive effective training in safety systems, processes and practices? • S1.6 Are there arrangements to safeguard adults and children from abuse and neglect that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures, including working in partnership with other agencies? • S1.7 Do staff identify adults and children at risk of, or suffering, significant harm? How do they work in partnership with other agencies to ensure they are helped, supported and protected?	setting (2018) • HM Government: Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. March 2015 • CQC cross sector DBS guidance. • CQC Independent ambulance FAQs section on DBS checks. • CQC inspector guidance regarding delays in DBS checks • NHS Employers guidance/advice on DBS checks • Female genital mutilation multi-agency practice guidelines published in 2016 • DH Female Genital Mutilation and Safeguarding: Guidance for professionals March 2015 • Guidelines for physicians on the detection of child sexual exploitation (RCP, November 2015) • Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity. The NHS Standards Contract requires all NHS funded providers to demonstrate they comply with the requirements of the	when appropriate. ○ Automatic alert processes ○ Are there effective procedures in place to update front line staff when changes occur to procedures? ○ What awareness do staff have of how to identify and deal with concerning situations at the locations they attend, particularly homes and care homes? Note any important local safeguarding/serious case reviews - how have the service responded to them? • Is information about safeguarding is shared with others who need to know in a timely way? • Are there are arrangements in place to safeguard women with, or at risk of, Female Genital Mutilation (FGM), in line with DoH Guidelines. • Are there are additional policies in place to safeguard those in vulnerable circumstances? e.g. those with learning difficulties or complex needs, and children under 16 accessing services without requirement of parental consent. • Do staff know how to report PREVENT safeguarding concerns?

	Prevent Duty. This includes ensuring that there is a named Prevent Lead and that there is access to quality training for staff in their organisation.	
Report sub-heading: **Cleanliness, infection control and hygiene**		
• S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.8 How are standards of cleanliness and hygiene maintained? Are there reliable systems in place to prevent and protect people from a healthcare-associated infection?	• 2010 DH Guidance on uniforms and workwear policies for NHS employers ➢ Page 5 footnote: "for some clinical staff working outdoors, particularly ambulance teams, a wrist-watch may be essential. Where worn, these wrist-watches must be washable and be removed for hand washing". • NICE QS61 Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. • Code of practice on the prevention and control of infections	• Review the provider's response to standards mapped to 'S1 Cleanliness, infection control and hygiene' in the EPRR self-assessment and ask to see documentary evidence to support the self-assessment. In particular this relates to: o HAZMAT / CBRN standard 47 • Are all vehicles clean and well maintained? • Are cleaning records are up to date and demonstrate that the vehicles are regularly cleaned? • When cleaning contractors are used, is this effectively monitored? • When vehicles are seriously contaminated how do crews get them clean? • How do staff maintain cleanliness of the vehicle during the course of a shift? • Are sterile consumables stored correctly on ambulances? • What is the process for managing and disposing of clinical waste? • How are crews made aware of specific known infection and hygiene risks

		associated with individual patients? • Is personal protective equipment provided on all vehicles? • Do staff adhere to infection control principles including handwashing? • How do staff maintain their uniforms? • Who do staff go to for advice and support regarding infection control matters?
Report sub-heading: **Environment and equipment**		
• S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.9 Do the design, maintenance and use of facilities and premises keep people safe? • S1.10 Do the maintenance and use of equipment keep people safe? • S1.11 Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.)	• NHS England's 2015 Patient Safety Alert: Harm from delayed updates to ambulance dispatch and satellite navigation systems • NHS Service Specification 2016/17: Hazardous Area Response Teams (HART) Interoperability standards 7-10: • Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment. • Organisations use the NARU coordinated national change request process before reconfiguring and HART procedures, equipment or training that has been specified as nationally interoperable • Organisations ensure that the HART fleet and associated incident	• Review the provider's response to standards mapped to 'S1 Environment and Equipment' in the EPRR self-assessment and ask to see documentary evidence to support the self-assessment. In particular this relates to: ➢ MTFA Standard 6 (there is ring fenced funding for this) ➢ HART Standards 7 and 12 ➢ HAZMAT / CBRN Equipment list • Is the station environment properly designed and maintained? • Review environment and equipment audit documentation • How does the service manage replenishment of vehicle equipment and supplies both at bases and between calls? • Who maintains medical devices and

	technology are maintained to nationally specified standards and must be made available in line with the national HART – 'notice to move' standard • Organisations ensure that all HART equipment is maintained according to British or EN standards and in line with manufacturers recommendations • MHRA guidance on managing medical devices (2015)	how is the quality of service assured? • Are there records of equipment maintenance and schedules (including vehicles and medical devices and insurance) • Are the vehicle keys securely stored? • Is equipment available that is suitable for the role – including specific patient groups such as children? • How is faulty equipment dealt with on or with front line vehicles and how are decisions made as to whether an equipment fault should result in the vehicle being taken off the road? • If transfer / retrieval teams bring their own equipment how is it assured it can be safely and effectively used on the vehicle? • Are vehicles used for the transport of patients who are detained under the MHA appropriate and safe? • Do crews have access to up to date satellite navigation systems, as per the 2015 Patient Safety Alert?
Key line of enquiry: **S2**		
S2. How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?		
Report sub-heading: **Assessing and responding to patient risk**		

Prompts	Professional standard	Sector specific guidance
• S2.5 Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? • S2.6 How do staff identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges? Are staff able to seek support from senior staff in these situations?		• How do crews get specialist advice when on scene or in transit? • Do staff recognise and evidence responding appropriately when there is rapid deterioration in the health of a patient? • Is there a safe and effective escalation process for deteriorating or seriously ill patients? How are additional resources requested and deployed?
Report sub-heading: **Staffing**		

• S2.1 How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times and staff do not work excessive hours?
• S2.2 How do actual staffing levels and skill mix compare with the planned levels? Is cover provided for staff absence?
• S2.3 Do arrangements for using bank, agency and locum staff keep people safe at all times?
• S2.7 How is the impact on safety assessed and monitored when carrying out changes to the service or the staff?
	• Resourcing Escalatory Action Plan (REAP)
	  ○ A national indicator of the pressure in ambulance services across the UK, which triggers specific measures when the trust is operating at significant and sustained levels of increased activity. The levels of REAP are:
	  ▪ 1 – Normal service
	  ▪ 2 – Concern
	  ▪ 3 – Pressure
	  ▪ 4 – Severe pressure
	  ▪ 5 – Critical
	  ▪ 6 – Potential service failure
	• NHS Service Specification 2016/17: Hazardous Area Response Teams
		• Review the provider's response to standards mapped to 'S2 Staffing' in the EPRR self-assessment and ask to see documentary evidence to support the self-assessment. Are their suitable numbers of specialist staff available at all times to fulfil the provider's responsibilities to NARU?
		• What are the actual v establishment staffing levels?
		  ○ Confirm the level of vacancies and secondments in both HART, CBRN and MTFA teams (MTFA standards 1-3) and Resilience managers across the Trust
		• Is each HART unit able to meet the NARU interoperability standard 5 of the NHS Service Specification 2016/17:

	(HART) ○ Interoperability standard 5: Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times	Hazardous Area Response Teams (HART)) • Are staff recruited in accordance with the HART Recruitment and Selection Manual? • Do staff get adequate breaks and time off between shifts? • What are the cover arrangements for sickness, leave, vacant posts etc. to ensure patient safety? • Is there appropriate use of locum/bank/agency staff? • How does the service respond to escalated Resource Escalation Acton Plan (REAP) levels? • Is there appropriate 24/7 "on-call" arrangements for trained Gold, Silver and Bronze commanders, NILO, CBRN and MTFA officers
Key line of enquiry: S3		
S3. Do staff have all the information they need to deliver safe care and treatment to people?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Records**		
• S3.1 Are people's individual care records, including clinical data, written and managed in a way that keeps people safe? • S3.2 Is all the information needed to deliver safe care and treatment available to relevant staff in a timely and accessible way? (This	• Records management code of practice for health and social care • NICE QS15 Statement 12: Patients experience coordinated care with clear and accurate information exchange between relevant health	• Are arrangements for recording triage decisions for mass casualty events clear, consistent and practiced? • Does records management follow JRCALC guidelines? • Are patient records clear and complete – documents dated, timed, with a signature

may include test and imaging results, care and risk assessments, care plans and case notes.) • S3.3 When people move between teams, services and organisations (which may include at referral, discharge, transfer and transition), is all the information needed for their ongoing care shared appropriately, in a timely way and in line with relevant protocols? • S3.4 How well do the systems that manage information about people who use services support staff, carers and partner agencies to deliver safe care and treatment? (This includes coordination between different electronic and paper-based systems and appropriate access for staff to records.)	and social care professionals. • Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guidelines (2016/2017) (Note: CQC can only arrange access to these on a case by case basis. Please request that your SpA bring a copy if they have one.	and identifiable number? • Are records are managed in a way that keeps people safe? • Are regular audits of records undertaken and changes made where necessary to ensure safety of patients? • Is there evidence that improvements are planned and carried out following record audits? • How are records made and shared appropriately across staff delivering care and treatment? • How is it assured that records travelling with the patient are passed to the relevant care / health staff at a receiving provider? • What is the process for managing and disposing of confidential waste?
Key line of enquiry: S4		
S4. How does the provider ensure the proper and safe use of medicines, where the service is responsible?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Medicines**		
• S4.1 How are medicines and medicines-related stationery managed (that is, ordered, transported, stored and disposed of safely and securely)? (This includes medical gases and emergency medicines and equipment.) S4.2 Are medicines appropriately prescribed, administered and/or supplied to people in line with the relevant legislation, current	• NHS Protect guidance about security standards and the management and control of controlled drugs in the ambulance sector • NICE QS61 Statement 1: People are prescribed antibiotics in accordance with local antibiotic formularies.	• Does the medicines management policy adhere to best practice? ○ How does the service make sure that medicines are appropriately and safely managed within the service, taking into account lone workers and storage on vehicles? • Does the provider exhibit good

national guidance or best available evidence? • S4.3 Do people receive specific advice about their medicines in line with current national guidance or evidence? • S4.4 How does the service make sure that people receive their medicines as intended, and is this recorded appropriately? • S4.5 Are people's medicines reconciled in line with current national guidance on transfer between locations or changes in levels of care? • S4.6 Are people receiving appropriate therapeutic drug and physical health monitoring with appropriate follow up in accordance with current national guidance or evidence base where these exist? • S4.7 Are people's medicines regularly reviewed including the use of 'when required' medicines? • S4.8 How does the service make sure that people's behaviour is not controlled by excessive or inappropriate use of medicines?	Paramedics are allowed to purchase and possess a number of controlled and prescription-only medicines for parenteral administration, in accordance with schedule 17 of The Human Medicines Regulations 2012 ('schedule 17'). No patient group directive needed. NHS Protect guidance about security standards and the management and control of controlled drugs in the ambulance sector The MHRA's Rules for the sale, supply and administration of medicines for specific healthcare professionals The law on the administration of prescription only medicines (POMs) is vague. Following guidance is available The Human Medicines Regulations 2012: List of parenteral medicines (injections) that anyone can administer under **schedule 19** of the Human Medicines Regulations – for the purpose of saving life in an emergency **Schedule 17** exemption allows registered paramedics to administer parenteral medicines (Injections) from another agreed list for the immediate necessary treatment of sick or injured persons Non –parenteral medicines (oral, inhaled, rectal, and topical) can be administered by anyone. However, the POM must have	medicines management practice (transport, storage, dispensing) including medication in kit bags, medical gas cylinders, and controlled drugs ○ How are medicines stored and secured? What daily checks are performed? ○ How is stock issue and return recorded? ○ There are appropriate storage arrangements in place, both on vehicles and at depots. • Is there clear guidance on the medication that staff in different roles are able to administer including parental and non parental medicines? • Are patients informed about what medication they have been given and why? How is this recorded and how is the receiving service informed? • Have any medicines audits been carried out? What actions have been implemented as a result?

	been legally obtained (authority to purchase a POM from a doctor, administration guidelines and training) • British Compressed Gases Association leaflet specifically for the carriage of small quantities of gas cylinders on a vehicle. • British Compressed Gases Association leaflet 'Medical oxygen in a vehicle'	
Key line of enquiry: **S5 & S6**		
S5. What is the track record on safety? S6. Are lessons learned and improvement made when things go wrong?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Incidents**		

• S5.1 What is the safety performance over time?
• S5.2 How does safety performance compare with other similar services?
• S5.3 How well safety is monitored using information from a range of sources (including performance against safety goals where appropriate)?
• S6.1 Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses,
	• A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
	  ○ Never events policy and framework 2018
		• Review the provider's response to standards mapped to 'S1 Incidents' in the EPRR self-assessment and ask to see documentary evidence to support the self-assessment. In particular this relates to:
		  ○ MTFA Standards 15-17
		  ○ HART standard 19-21 (there is ring fenced funding for this)
		
		• Has the service identified safety measures to work towards?
		• Is there evidence of continuous

and to report them internally and externally, where appropriate? • S6.2 What are the arrangements for reviewing and investigating safety and safeguarding incidents and events when things go wrong? Are all relevant staff, services, partner organisations and people who use services involved in reviews and investigations • S6.3 How are lessons learned, and themes identified and is action taken as a result of investigations when things go wrong? • S6. How well is the learning from lessons shared to make sure that action is taken to improve safety? Do staff participate in and learn from reviews and investigations by other services and organisations? • S6.5 How effective are the arrangements to respond to relevant external safety alerts, recalls, inquiries, investigations or reviews?	○ Never events list 2018 • Serious Incidents (SIs) should be investigated using the Serious Incident Framework 2015. • Duty of Candour: As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. • Joint Organisational Learning (JOL) online guidance v2 October 2017	monitoring of these safety measures? • What actions are being taken to improve safety performance and results? • Do staff know what to report and how to report? Are all incidents that should be reported actually reported? • If there is a paper based system, how is this managed to ensure that incidents are reported centrally and in a timely manner? • How do frontline staff get the opportunity to report incidents (including incidents associated with the transport of a patient experiencing a mental health crisis) • Is root cause analysis carried out and action plans made as a result of any issues identified? • Do staff receive feedback from investigation of incidents both internal and external to the service? • Are staff de-briefed and supported after a serious incident? • Is learning from incidents shared across all teams? Can staff describe something that has changed as a result of an incident? • How does the service make sure staff on the front line (i.e. remote workers) know about changes in policy or procedure that have been made following safety incidents or safety alerts? • Is there evidence in incident investigations that duty of candour has been applied?

		• Does the service use the Single Sector (LID) and Multi-agency (JOL) learning arrangements to share lessons identified and relevant learning? **Independent ambulance services** • In the event of sub contracted services, is each provider clear on their responsibilities for reporting incidents? • In the event of subcontracted services, how is the IAS and its staff involved in the investigation? • In the event of subcontracted services, how does the IAS ensure that it learns lessons and takes action as a result of investigations when things go wrong? In particular, how does the service make sure staff on the front line (i.e. remote workers) know about changes in policy or procedure that have been made following safety incidents? • In the event of sub contracted services, Is DoC followed and evidenced by the contractor for an incident occurring under their delivery of care and treatment, and is this stated in their contract with the NHS trust? Are staff clear as to who has responsibility for DoC in the event of joint responsibility – both for the immediate verbal apology and the written apology.

Effective

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Key line of enquiry: **E1**

E1. Are people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Prompts	Professional standard	Sector specific guidance
Report sub-heading: **Evidence-based care and treatment**		
• E1.1 Are people's physical, mental health and social needs holistically assessed, and is their care, treatment and support delivered in line with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes? • E1.2 What processes are in place to ensure there is no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions? • E1.3 How is technology and equipment used to enhance the delivery of effective care and treatment and to support people's independence? • E1.4 Are the rights of people subject to the Mental Health Act 1983 (MHA) protected and	• Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guidelines (2016/2017) • NARU National Major Incident Action Cards (October 2015) • NHS Service Specification 2016/17: Hazardous Area Response Teams (HART)	• Review the provider's response to standards mapped to 'E1 Evidence-based care and treatment' in the EPRR self-assessment and ask to see documentary evidence to support the self-assessment. • The NARU provide an action card set for major incidents – do staff have access to the most recent version of these v1.2? • Are local Standard Operating Procedures (SOPs) compliant with the National HART Standard Operating Procedures during local and national deployments? • Have any deviations been agreed through NARU and the National HART

do staff have regard to the MHA Code of Practice? • E1.7 Are people told when they need to seek further help and advised what to do if their condition deteriorates?		Coordination Group? • Are relevant NICE guidelines and quality standards followed? • Are JRCALC national guidelines being followed? • How do staff who are remote working have access to guidelines and protocols? • Are suitable protocols available for children of all ages and other patient groups? • How is enhanced clinical advice and support made available to crews? • In assessing whether NICE or other guidance in followed, take the following into account: o Details of the provider's Clinical Audit programme to support and monitor implementation of NICE guidance o Details of additional prescribing audits that may be completed by junior doctors on rotation. o Utilisation of NICE implementation support tools such as the baseline assessment tools. o A Provider submission demonstrating good practice to the NICE shared learning database. NICE checks that the examples are in line with their recommendations

		and quality statements.
Report sub-heading: **Pain relief**		
• E1.6 How is a person's pain assessed and managed, particularly for those people where there are difficulties in communicating?	• Core Standards for Pain Management Services in the UK • NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.	
Key line of enquiry: **E2**		
E2. How are people's care and treatment outcomes monitored and how do they compare with other similar services?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub heading: **Response times**		

	NHS ambulance services (please see ARP Brief Guide for further information on the ARP)
	• National targets
	  ○ Category 1 – Mean response time ≤ 7 minutes. Standard for 90th centile ≤ 15 minutes
	  ○ Category 2 Mean response time ≤ 18 minutes. Standard for 90th centile ≤ 40 minutes
	  ○ Category 3 - Standard for 90th centile ≤ 120 minutes
	  ○ Category 4 - Standard for 90th centile ≤ 180 minutes
		• Review the provider's response to standards mapped to 'E2 Response times' in the EPRR self-assessment and ask to see documentary evidence to support the self-assessment. This particularly relates to MTFA and HART standards.

	• NHS Service Specification 2016/17: Hazardous Area Response Teams (HART) ○ Interoperability standard 5: ✓ *Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider.* ✓ *Once HART capability is confirmed as being required at the scene, organisations can ensure that six HART staff are released and available to respond within 10 minutes of that confirmation (including the four already mobilised)* ✓ *Organisations maintain a HART service capable of placing six HART staff on-scene at strategic sites of interest with 45 minutes. (these sites are defined within the Home Office Model Response Plan)* ✓ *Organisations maintain any live (on duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service*	

	area	
Report sub heading: **Patient outcomes**		
• E2.1 Is information about the outcomes of people's care and treatment (both physical and mental where appropriate) routinely collected and monitored? • E2.2 Does this information show that the intended outcomes for people are being achieved? • E2.3 How do outcomes for people in this service compare with other similar services and how have they changed over time? • E2.4 Is there participation in relevant quality improvement initiatives, such as local and national clinical audits, benchmarking, (approved) accreditation schemes, peer review, research, trials and other quality improvement initiatives? Are all relevant staff involved in activities to monitor and use information to improve outcomes?	**NHS ambulance services** • NHS Service Specification 2016/17: Hazardous Area Response Teams (HART) (Section 3)	• Is there any evidence that the outcomes identified in section 3 of the Service Specification for NHS Ambulance Services Hazardous Area Response Teams have been demonstrated? • Is there a clear approach to monitoring, auditing and benchmarking the quality of these services and the outcomes for people receiving care and treatment? • Does quality and outcome information show that the needs of people are being met by the services? • Is quality and outcome information used to inform improvements in the service?
Key line of enquiry: E3		
E3. How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub heading: **Competent staff**		
• E3.1 Do people have their assessed needs, preferences and choices met by staff with the right skills and knowledge?	• NHS Service Specification 2016/17: Hazardous Area Response Teams (HART)	• Review the provider's response to standards mapped to 'E3 Competent Staff' in the EPRR self-assessment and ask to see documentary evidence to

• E3.2 How are the learning needs of all staff identified? Do staff have appropriate training to meet their learning needs to cover the scope of their work and is there protected time for this training? • E3.3 Are staff encouraged and given opportunities to develop? • E3.4 What are the arrangements for supporting and managing staff to deliver effective care and treatment? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.) • E3.5 How is poor or variable staff performance identified and managed? How are staff supported to improve? • E3.7 Are volunteers recruited where required, and are they trained and supported for the role they undertake?	• JESIP Exercise objectives JESIP Learning outcomes framework	support the self-assessment. In particular this relates to MTFA and HART standards. ○ Evidence of all Major Incident Commander [Gold, Silver and Bronze] Initial and annual training and exercise competency records (link to EPRR standard 20) ○ Records of compliance against all staff being required to view the MTFA DVD (MTFA standard 19) • JESIP commander and Control Room Manager and Supervisor training records • Does the service use the JESIP exercise objectives and learning outcomes framework? • How are staff supported to use JESIP e.g. JESIP awareness video, JESIP App • Training records for Emergency despatch staff who deploy specialist assets • Control room staff annual refresher training records in EPRR and MTFA • Records of training arrangements for CBRN for front line Ambulance staff • Records of training for Initial Operational Response (IOR) training for all ambulance staff. • How does the service ensure that staff only carry out care and treatment that they are skilled, competent and have experience to perform?

		• How are staff offered the necessary support during induction and training? • How are staff supported to facilitate their development? • How is staff competence of delivering patient care assessed by managers or supervisors? • Are staff working in small or remote teams given equitable support and development opportunities? • How often do staff have an appraisal? What does this entail? How is poor practice identified and managed? • Do staff involve in HART undertake regular Ongoing Physical Competence Assessments (OPCA)?
Key line of enquiry: **E4**		
E4. How well do staff, teams and services within and across organisations work together to deliver effective care and treatment?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Multidisciplinary working**		
• E4.1 Are all necessary staff, including those in different teams, services and organisations, involved in assessing, planning and delivering care and treatment? • E4.2 How is care delivered and reviewed in a coordinated way when different teams, services or organisations are involved? • E4.3 How are people assured that they will	• UK Ambulance Services National Memorandum of Understanding Concerning the Provision of Mutual Aid • Joint Emergency Service Interoperability Programme framework (JESIP)	• Review the provider's response to standards mapped to 'E4 Coordination with other providers' in the EPRR self-assessment and ask to see documentary evidence to support the self-assessment. This particularly relates to EPRR core standards 24-30. • Does the provider adhere to its

receive consistent coordinated, person-centred care and support when they use, or move between different services? • E4.4 Are all relevant teams, services and organisations informed when people are discharged from a service? Where relevant, is discharge undertaken at an appropriate time of day and only done when any necessary ongoing care is in place?	• Local Resilience Forum (LRF) • National resilience standards S7 • NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	commitments in the UK Ambulance Services National Memorandum of Understanding Concerning the Provision of Mutual Aid? • What coordination arrangements exist for working with other services and agencies? (JESIP) (LRFs) (LHRP's) e.g. joint training, meeting representation. This may include, but not be limited to: ○ Acute hospitals ○ Fire and Rescue Services ○ Private ambulance providers (particularly when local PTS services are not provided by the NHS trust) ○ Police ○ Coastguard ○ RNLI ○ Mountain / Lowland / Cave Rescue ○ Military • How well are resilience operations integrated into other elements of the service?

Key line of enquiry: **E5**

E5. How are people supported to live healthier lives and where the service is responsible, how does it improve the health of its population?

Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Health promotion**		
• E5.1 Are people identified who may need		

extra support? This includes: • people in the last 12 months of their lives • people at risk of developing a long-term condition • carers • E5.2 How are people involved in regularly monitoring their health, including health assessments and checks, where appropriate and necessary • E5.3 Are people who use services empowered and supported to manage their own health, care and wellbeing and to maximise their independence? • E5.4 Where abnormalities or risk factors are identified that may require additional support or intervention, are changes to people's care or treatment discussed and followed up between staff, people and their carers where necessary?		
Key line of enquiry: **E6**		
E6. Is consent to care and treatment always sought in line with legislation and guidance?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Consent, Mental Capacity Act and DOLs**		
• E6.1 Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004 and other relevant national standards and guidance? • E6.2 How are people supported to make	• Consent: patients and doctors making decisions together (GMC) • Consent - The basics (Medical Protection) • Department of Health reference guide	• Are crews clear about their responsibility in obtaining consent? Can crews describe a recent example? • How do crews make decisions about consent when patients are unconscious

decisions in line with relevant legislation and guidance? • E6.3 How and when is possible lack of mental capacity to make a particular decision assessed and recorded? • E6.4 How is the process for seeking consent monitored and reviewed to ensure it meets legal requirements and follows relevant national guidance? • E6.5 When people lack the mental capacity to make a decision, do staff ensure that best interests decisions are made in accordance with legislation? • E6.6 How does the service promote supportive practice that avoids the need for physical restraint? Where physical restraint may be necessary, how does the service ensure that it is used in a safe, proportionate, and monitored way as part of a wider person centred support plan? • E6.7 Do staff recognise when people aged 16 and over and who lack mental capacity are being deprived of their liberty, and do they seek authorisation to do so when they consider it necessary and proportionate?	to consent for examination or treatment • BMA Consent Toolkit • BMA Children and young people tool kit • Gillick competence • Association of Ambulance Chief Executive and Nation Ambulance Service Medical Directors: ○ Statutory ambulance services and restraint of patients – position statement (please note this is an internal Y drive link)	or confused?

Caring

By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect.

Key line of enquiry: **C1, C2 & C3**

C1. How does the service ensure that people are treated with kindness, dignity, respect and compassion, and that they are given emotional support when needed?

C2. How does the service support people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible?

C3. How is people's privacy and dignity respected and promoted?

Generic prompts	Professional Standard	Sector specific guidance
Report sub-heading**: Compassionate care**		
• C1.1 Do staff understand and respect the personal, cultural, social and religious needs of people and how these may relate to care needs, and do they take these into account in the way they deliver services? Is this information recorded and shared with other services or providers? • C1.2 Do staff take the time to interact with people who use the service and those close to them in a respectful and considerate way?	• NICE QS15 Statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty. • NICE QS15 Statement 3: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.	• How do staff ensure, as far as possible, dignity is maintained during treatment and care in a public place? • How do staff make sure dignity is maintained as far as possible during transport in and to and from a vehicle?

• C1.3 Do staff show an encouraging, sensitive and supportive attitude to people who use services and those close to them? • C1.4 Do staff raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes? • C3.1 How does the service and staff make sure that people's privacy and dignity needs are understood and always respected, including during physical or intimate care and examinations? • C3.2 Do staff respond in a compassionate, timely and appropriate way when people experience physical pain, discomfort or emotional distress?		
Report sub-heading**: Emotional support**		
• C1.5 Do staff understand the impact that a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially? • C1.6 Are people given appropriate and timely support and information to cope emotionally with their care, treatment or condition? Are they advised how to find other support services? • C2.7 What emotional support and information is provided to those close to people who use services, including carers, family and dependants?	• NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.	• How do staff make sure that patients, relatives and other parties are supported during distressing events? • How do staff support patients who die in their care?
Report sub-heading**: Understanding and involvement of patients and those close to them**		

• C2.1 Do staff communicate with people so that they understand their care, treatment and condition and any advice given? • C2.2 Do staff seek accessible ways to communicate with people when their protected equality or other characteristics make this necessary? • C2.3 How do staff make sure that people who use services and those close to them are able to find further information, including community and advocacy services, or ask questions about their care and treatment? How are they supported to access these? • C2.4 Are people empowered and supported, where necessary, to use and link with support networks and advocacy, so that it will have a positive impact on their health, care and wellbeing? • C2.5 Do staff routinely involve people who use services and those close to them (including carers and dependants) in planning and making shared decisions about their care and treatment? Do people feel listened to, respected and have their views considered? • C2.6 Are people's carers, advocates and representatives including family members and friends, identified, welcomed, and treated as important partners in the delivery of their care? • C3.3 How are people assured that information about them is treated	• NICE QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills. • NICE QS15 Statement 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care. • NICE QS15 Statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences. • NICE QS15 Statement 13: Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care.	• How do patients have proposed treatment and options explained to them? • How do staff make sure patients views are taken into account and consent is obtained particularly in emergency situations? • How are patients involved in decisions about whether to convey? • Do people tell us about good experiences of being involved in their care?

confidentially in a way that complies with the Data Protection Act and that staff support people to make and review choices about sharing their information?		

Responsive

By responsive, we mean that services meet people's needs

Key line of enquiry: **R1 & R2**

R1. How do people receive personalised care that is responsive to their needs?

R2. Do services take account of the particular needs and choices of different people?

Prompts	Professional standard	Sector specific guidance
Report sub-heading: **Service delivery to meet the needs of local people**		
• R1.1 Do the services provided reflect the needs of the population served and do they ensure flexibility, choice and continuity of care? • R1.2 Where people's needs and choices are not being met, is this identified and used to inform how services are improved and developed? • R1.3 Are the facilities and premises appropriate for the services that are delivered?	**NHS ambulance services** • NHS Service Specification 2016/17: Hazardous Area Response Teams (HART) ○ Interoperability standard 5	• Review the provider's response to standards mapped to 'R1 Service delivery to meet the needs of local people' in the EPRR self-assessment and ask to see documentary evidence to support the self-assessment e.g. NARU audit. • How are HART operatives used to support normal operations? E.g. the use of HART RRVs as "nearest and

		quickest" resource in "extreme circumstances"
Report sub-heading: **Meeting people's individual needs**		
• R1.4 How does the service identify and meet the information and communication needs of people with a disability or sensory loss. How does it record, highlight and share this information with others when required, and gain people's consent to do so? • R2.1 How are services delivered, made accessible and coordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances? • R2.2 How are services delivered and co-ordinated to be accessible and responsive to people with complex needs?[1] • R2.3 How are people, supported during referral, transfer between services and discharge? • R2.4 Are reasonable adjustments made so that people with a disability can access and use services on an equal basis to others? • R2.5 Do key staff work across services to coordinate people's involvement with families and carers, particularly for those with multiple	• NICE QS15 Statement 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions • Accessible Information Standard (for those providing NHS care and / or publicly funded adult social care)	• What steps are taken to ensure that patients are treated as individuals, with their needs, preferences and their ethnicity, language, religious and cultural backgrounds being respected? • What arrangements are in place to access translation services? • How are staffed equipped to deal with violent or aggressive patients? • Does the provider comply with the Accessible Information Standard?

[1]. For example, people living with dementia or people with a learning disability or autism.

long-term conditions? • R2.9 How are services delivered and coordinated to ensure that people who may be approaching the end of life are identified, including those with a protected equality characteristic and people whose circumstances may make them vulnerable, and that this information is shared? • R2.11 If any treatment is changed or withdrawn, what are the processes to ensure that this is managed openly and sensitively so that people have a comfortable and dignified death?		
Key line of enquiry: **R3**		
R3. Can people access care and treatment in a timely way?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Access and flow**		
• R3.1 Do people have timely access to initial assessment, test results, diagnosis, or treatment? • R3.3 What action is taken to minimise the length of time people have to wait for care, treatment, or advice? • R3.4 Do people with the most urgent needs have their care and treatment prioritised? • R3.5 Are appointment systems easy to use and do they support people to access appointments?		

• R3.6 Are appointments care and treatment only cancelled or delayed when absolutely necessary? Are delays or cancellations explained to people, and are people supported to access care and treatment again as soon as possible? • R3.7 Do services run on time, and are people kept informed about any disruption?		
Key line of enquiry: R4		
R4. How are people's concerns and complaints listened and responded to and used to improve the quality of care?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Learning from complaints and concerns**		
• R4.1 How well do people who use the service know how to make a complaint or raise concerns and how comfortable do they feel doing so in their own way? How are people encouraged to make a complaint, and how confident are they to speak up? • R4.2 How easy is it for people to use the system to make a complaint or raise concerns? Are people treated compassionately and given the help and support, through use of accessible information or protection measures if they need to make a complaint? • R4.3 How effectively are complaints handled, including to ensure openness and transparency, confidentially, regular updates for the complainant, a timely response and	• The NHS constitution gives people the right to ○ Have complaints dealt with efficiently and be investigated. ○ Know the outcome of the investigation. ○ Take their complaint to an independent Parliamentary and Health Service Ombudsman. ○ Receive compensation if they have been harmed.	• Can staff describe what information they provide to patients/carers that wish to complain? • Does the service benchmark complaints against other providers? • How quickly does the provider respond to complaints? • How does the service ensure that it learns from complaints and concerns?

explanation of the outcome, and a formal record? • R4.4 How are people who raise concerns or complaints protected from discrimination, harassment or disadvantage? • R4.5 To what extent are concerns and complaints used as an opportunity to learn and drive improvement?		

Well-led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Key line of enquiry: **W1**

W1. Is there the leadership capacity and capability to deliver high-quality, sustainable care?

Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Leadership of service**		
• W1.1 Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis? • W1.2 Do leaders understand the challenges to quality and sustainability, and can they identify the actions needed to address them? • W1.3 Are leaders visible and approachable?	• Fit and Proper Persons Guidance	• Review the provider's response to standards mapped to 'W1 Leadership' in the EPRR self-assessment and ask to see documentary evidence to support the self-assessment. • Can all staff (including remote and lone working staff) identify the different leads, their roles and their responsibilities?

• W1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?		• Do operational road staff see sufficient of their manager? • What management structures are being used – e.g. matrix working?

Key line of enquiry: **W2**

W2. Is there a clear vision and credible strategy to deliver high-quality sustainable care to people who use services, and robust plans to deliver?

Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Vision and strategy for this service**		
• W2.1 Is there a clear vision and a set of values, with quality and sustainability as the top priorities? • W2.2 Is there a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care? • W2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners? • W2.4 Do staff know and understand what the vision, values and strategy are, and their role in achieving them? • W2.5 Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population? • W2.6 Is progress against delivery of the	• ARP Brief Guide	• How are staff that work away from main bases or who are lone workers engaged with strategy, vision and values?

strategy and local plans monitored and reviewed, and is there evidence to show this?		
Key line of enquiry: W3		
W3. Is there a culture of high-quality, sustainable care?		
Generic prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Culture within the service**		
• W3.1 Do staff feel supported, respected and valued? • W3.2 Is the culture centred on the needs and experience of people who use services? • W3.3 Do staff feel positive and proud to work in the organisation? • W3.4 Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority? • W3.5 Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do	• NRLS - Being Open Communicating patient safety incidents with patients, their families and carers • Duty of Candour – CQC guidance	• How do staff get support when required? Can staff access confidential support? • Where appropriate what specific arrangements are there for debrief of HART staff including post incident stress debriefing such as TRIMM? • Do staff say that managers demonstrate openness and honesty? • Do staff, particularly those working remotely, feel connected to other teams and sites within their service and to the organisation as a whole? • How does the organisation manage organisational change?

leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised? • W3.6 Are there mechanisms for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations? • W3.7 Is there a strong emphasis on the safety and well-being of staff? • W3.8 Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably? • W3.9 Are there cooperative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?		• What processes and procedures does the provider have in place to ensure they meet the duty of candour? For example, training, support for staff, policy and audits.
Key line of enquiry: **W4**		
W4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?		
Generic prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Governance**		
• W4.1 Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these	• NICE QS61 Statement 2: Organisations that provide healthcare have a strategy for continuous	• Review the provider's response to standards mapped to 'W4 Governance' in the EPRR self-

regularly reviewed and improved? • W4.2 Do all levels of governance and management function effectively and interact with each other appropriately? • W4.3 Are staff at all levels clear about their roles and do they understand what they are accountable for, and to whom? • W4.4 Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?	improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems. **NHS ambulance services** • NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) • NHS Service Specification 2016/17: Hazardous Area Response Teams (HART)	assessment and ask to see documentary evidence to support the self-assessment.

Key line of enquiry: **W5**

W5. Are there clear and effective processes for managing risks, issues and performance?

Generic prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Management of risk, issues and performance**		
• W5.1 Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved? • W5.2 Are there processes to manage current and future performance? Are these regularly reviewed and improved? • W5.3 Is there a systematic programme of	• NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) • NHS Service Specification 2016/17: Hazardous Area Response Teams (HART) • NARU National Major Incident Action Cards (October 2015)	• Review the provider's response to standards mapped to 'W5 Management of risk, issues and performance' in the EPRR self-assessment and ask to see documentary evidence to support the self-assessment. • Is there a risk register for the service which reflects the risk voiced by staff and highlighted on the inspection?

clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken? • W5.4 Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'? • W5.5 Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities? • W5.6 When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?		• How does the service ensure that staff declare working arrangements outside of the service and monitor this to make sure staff are not working excessive hours that may adversely impact on the care and treatment being provided? • Are there risk assessments for training exercises? • The NARU provide an action card set for major incidents – do staff have access to these? • What specific arrangements are there to deal with infection and contamination, particularly for chemical, biological, radiological and nuclear (CBRN) incidents? • What does the provider's self-assessment against the core standards for EPRR say?
Key line of enquiry: **W6**		
W6. Is appropriate and accurate information being effectively processed, challenged and acted upon?		
Generic prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Information management**		
• W6.1 Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is	• NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	• How does the service ensure the accuracy of KPI data?

information used to measure for improvement, not just assurance? • W6.2 Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and do they challenge it appropriately? • W6.3 Are there clear and robust service performance measures, which are reported and monitored? • W6.4 Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified? • W6.5 Are information technology systems used effectively to monitor and improve the quality of care? • W6.6 Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required? • W7.7 Are there robust arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?	• NHS Service Specification 2016/17: Hazardous Area Response Teams (HART) • NICE QS61 Statement 2: Organisations that provide healthcare have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems. • NARU National Major Incident Action Cards (October 2015)	• Where appropriate does the provider monitor and evaluate its performance with respect to HART? •
Key line of enquiry: **W7**		

Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?		
Generic prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Public and staff engagement**		
• W7.1 Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups? • W7.2 Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups? • W7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected characteristic? • W7.4 Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs? • W7.5 Is there transparency and openness with all stakeholders about performance?		• Where appropriate what public engagement and education has taken place in respect of the resilience function?
Key line of enquiry: **W8**		

W8. Are there robust systems and processes for learning, continuous improvement and innovation?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Innovation, improvement and sustainability**		
• W8.1 In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes? • W8.2 Are there standardised improvement tools and methods, and do staff have the skills to use them? • W8.3 How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements? • W8.4 Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation? • W8.5 Are there systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?	**NHS ambulance services** • NHS Service Specification 2016/17: Hazardous Area Response Teams (HART) ○ Interoperability standard 8 • Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable. • JESIP Joint Doctrine – The Interoperability framework • Joint Organisational Learning (JOL) online guidance v2 October 2017	• Does any local innovation and improvement in the HART service get approval from NARU and NHCG? • What learning has there been from JESIP training exercises and use of JOL? How has the service responded to action notes?

Glossary

Hazardous Area Response Team (HART) Capabilities

IRU – Incident Response Unit Allows HART Paramedics to operate safely inside the inner cordon of a major incident using a range of personal protective equipment and specialist logistics. This includes the ability to operate alongside the fire and rescue service using breathing apparatus and gas tight suits. It also allows them to work alongside the police and military in CR1 protection. An IRU response would be provided to incidents involving chemical, biological, radiological and nuclear materials.

USAR – Urban Search and Rescue Allows paramedic care to be delivered to patients where safe working at height or confined space operations are required. Difficult access incidents may include; collapsed buildings, tunnels, caves, cranes or rooftops and industrial settings like towers and storage tanks. HART delivers the USAR capability in close liaison with fire & rescue USAR teams and other specialist providers such as cave rescue and mines rescue.

IWO – Inland Water Operations Allows paramedic care to be delivered to patients requiring water rescue. Situations requiring IWO include flooding and people injured around rivers or lakes. IWO will usually be delivered in conjunction with the fire & rescue service or the RNLI. This capability is also used in conjunction with HM Coastguard to provide an NHS paramedic capability to incidents within the 12 mile UK coastal water limit.

TMO – Tactical Medicine Operations Allows NHS paramedics to work closely with the police and other specialist agencies to deliver a tactical medicine capability. Operations under this capability include firearms, riots or public disorder, VIP close protection / extraction and joint working with the UK armed forces

MTFA - Marauding Terrorist Firearms Attack Allows a specially trained and equipped NHS Paramedic to be alongside a patient in a hazardous environment alongside partner agencies where the threat of ballistics, explosives and other weapons cannot be fully mitigated.

Ballistic cordon	“Hot Zone” controlled by police Authorised Firearms Officers (AROs)
CBRN(E)	Chemical Biological Nuclear Radiological (Explosive)
CONTEST	UK Counter Terrorism Strategy
CR1	Civil Responder 1 suit
DEFRA	Department for Environment, Food and Rural Affairs
DIM	FRS Detection and Monitoring Team (For identification of HAZMAT or CBRN(E) material)

E/SDBA	Extended or Single Duration Breathing Apparatus
FCV	Forward Command Vehicle
FRS	Fire and Rescue Service
GTCPS	Gas Tight Chemical Protection Suit
HAZMAT	Hazardous Materials
HEV	Heavy Equipment Vehicle
Inner Cordon	“Hot Zone” controlled by the FRS where only HART trained crews operate
IOR	Initial Operational Response
JESIP	Joint Emergency Services Interoperability Principles
JOL	Joint Organisational Learning
JRCALC	Joint Royal Colleges Ambulance Liaison Committee (General Ambulance SOPs)
LEV	Forward Reconnaissance / Light Equipment Vehicle
LLGTS	Limited Life Gas Tight Suit
LRF	Local Resilience Forum (Multiagency – one per police area chaired by the police)
MR Location	Model Response Location
MTFA	Marauding Terrorist Firearms Attack
NARU	National Ambulance Resilience Unit
OPCA	Ongoing Physical Competence Assessment
PCA	Physical Competence Assessment

PPE	Personal Protective Equipment
PROCLUS	Incident response evidence base
PRPS	Powered Respirator Protection Suit
RRV	Rapid Response Vehicle
SOR	Specialist Operational Response
SRT	Swift water and flood Rescue Technician
SSNAHART	Service Specification for NHS Ambulance Services Hazardous Area Response Teams
SWaH	Safe Working at Height