Polaris Medical Services Limited

Polaris Medical Services Limited Registered Office

Inspection report

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Date of inspection visit: 20 September - 21 September 2022
Date of publication: 11/11/2022

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as outstanding because:

- The service had developed a proactive approach using Quick Response (QR) codes to monitor safeguarding referrals. They used innovative technology in the form of an employee app to share the information that was needed to deliver effective care, providing real-time information and support to all staff wherever and whenever they needed it. Staff were open and transparent, and fully committed to reporting incidents. Learning from incidents was based on a thorough analysis and investigation of things that went wrong, and managers shared this with all staff in quarterly 'lessons learnt' bulletins. Staff managed medicines consistently and safely. They stored medicines correctly and disposed of them safely.
- The provider recognised continuing development of the staff's skills, competence and knowledge as being integral to ensuring high quality care. Managers proactively supported and encouraged staff to acquire new skills, use their transferable skills, and share best practice. Staff planned and delivered people's care and treatment in line with current evidence-based guidance and best practice. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care.
- Feedback from people who used the service and those close to them was continually positive. Feedback showed that staff went the extra mile and their care and support exceeded patients' expectations. Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. The service could show where improvements had been made as a result of learning from feedback. Facilities were appropriate for the services being delivered.
- Leaders had a deep understanding of the issues, challenges and priorities in their service and beyond. They had an inspiring shared purpose and strived to deliver and motivate staff to succeed. Staff understood the service's vision and values, and how to apply them in their work. They felt respected, supported and valued. They were focused on the needs of patients receiving care and were clear about their roles and accountabilities. The service engaged well with NHS ambulance trusts to plan and manage services and worked with them to improve care outcomes. The service had invested in innovative information systems and processes. There was a fully embedded approach to improvement. Managers empowered staff to develop and learn, and staff development was a priority for the service. There was a clear and proactive approach to be sustainable and the service aimed to be carbon neutral by 2024.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Outstanding ☆	Our rating of this service stayed the same. We rated it as outstanding because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. • Staff provided good care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Patient transport services

Outstanding ☆

We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

PTS is a small proportion of activity. The main service was EUC. Where arrangements were the same, we have reported findings in the EUC section.
We rated this service as outstanding because it was safe, effective, caring, responsive, and well led.

Summary of findings

Contents

Summary of this inspection

Background to Polaris Medical Services Limited Registered Office

Polaris Medical Services Limited Registered Office is operated by Polaris Medical Services Limited. The service is split into South and North Regional Headquarters. The South Regional Headquarters is based in Slough and has 7 satellite ambulance stations and 1 medical response post which is based at London Bridge Station. The North Regional Headquarters is based in Chester and has 3 satellite ambulance stations.

The location is registered with Care Quality Commission (CQC) to provide the following regulated activities:

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

The service provides an Emergency and Urgent Care (EUC) service 24 hours a day, 7 days a week for 6 NHS ambulance trusts. This includes high dependency transfer services and mental health transfers.

The service provides a non-emergency Patient Transport Service (PTS). At the time of our inspection, there were 2 shifts per day operating for 1 NHS ambulance trust. The service had appointed a new PTS lead who was joining the service the month after the inspection. Their role was to drive and expand the PTS arm of the service.

The service provides medical support to events, and the film and TV industry. The CQC does not currently regulate medical support at events. However, in the 12 months leading up to the inspection the service had transported 4 patients from events to hospital, which is an activity regulated by the CQC.

The service has 70 frontline ambulances, 4 mental health vehicles, 17 PTS ambulances, 4 high dependency vehicles and 24 mixed event vehicles.

The service has had a registered manager since December 2016. A registered manager is a person who has registered with the CQC to manage the service. They have a legal responsibility for meeting the requirements set out in the Health and Social Care Act 2008.

The service was previously inspected by the CQC in 2019 and was rated as outstanding for the core service EUC. PTS were not inspected or rated at the 2019 inspection. The service has expanded since the last inspection after buying out another independent ambulance provider in August 2021.

The main service provided by this service was EUC. Where our findings on EUC– for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the EUC service.

How we carried out this inspection

We carried out a comprehensive short notice inspection on 20 and 21 September 2022. The team comprised of 3 CQC inspectors and 2 specialist advisors who were experienced paramedics. The inspection team had off site support from an Inspection Manager and was overseen by Carolyn Jenkinson, Head of Hospital Inspection. The inspection looked at Emergency and Urgent Care (EUC) and Patient Transport Services (PTS) core services.

During the inspection visit, the inspection team:

Summary of this inspection

- Visited 3 ambulance stations and the head office in Slough.
- Spoke to 19 members of staff, including members of the make ready team, paramedics, ambulance technicians, administrators and station supervisors.
- Spoke to 10 members of the management team, including the head of human resources, operational managers, the managing director and the fleet manager.
- Inspected 9 ambulances, including 5 EUC vehicles, 2 PTS vehicles, 1 event vehicle and 1 mental health transport vehicle.
- Observed how caring staff were for 2 PTS service users by conducting an observed journey on a PTS service.
- Observed how caring staff were for 2 service users by conducting an observed journey on an EUC ambulance.
- Reviewed 10 sets of medical records which were for 2 NHS ambulance trusts.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

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You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- It was evident that staff development was a priority. There had been many success stories where staff had been supported to professionally develop and promoted within the service. Training was delivered within the Polaris Academy, which had a fully furnished simulation apartment. The Polaris Academy offered qualifications which were accredited with several education organisations, including Birmingham University. This promoted a positive culture amongst staff.
- The service used innovative advances in technology in the form of QR codes to achieve better oversight of safeguarding referrals and to make it easier for service users to give feedback.
- The service was passionate about sustainability and aimed to be carbon neutral by 2024.
- The service had identified there was a national shortage of ambulance service clinicians. In addition to recruiting, promoting and retaining existing staff, they used government backed sponsorship schemes. The service sponsored paramedics from international countries to work with them for 2 years. They also offered Irish qualification conversion courses to give Irish paramedics the opportunity to work in the UK.
- The service had an employee app (this was an employee app for healthcare workers, which allowed staff access to people, processes, and communications). This promoted communication and cohesiveness in the team. It served to keep staff members in touch, and allowed easy access to necessary policies, clinical pathways documents and updated guidelines.
- Feedback from service users showed that staff treated them with kindness, dignity and respect.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure all staff receive mandatory training in learning disabilities and autism. (Regulation 18)

Summary of this inspection

- The service should ensure that all stations are secure to unauthorised access to ambulances and consumables stored on site. (Regulation 15)

Urgent and Emergency Care

- The service should ensure that all equipment available for use is stored in a manner that does not compromise the packaging to keep those items sterile. (Regulation 15)

Patient Transport Services

- The service should ensure that all consumables and equipment available for use are in date on all vehicles. (Regulation 15)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Outstanding	Outstanding	Outstanding	Good	Outstanding	Outstanding
Patient transport services	Outstanding	Outstanding	Good	Good	Outstanding	Outstanding
Overall	Outstanding	Outstanding	Outstanding	Good	Outstanding	Outstanding

Outstanding ☆

Emergency and urgent care

Safe	Outstanding ☆
Effective	Outstanding ☆
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Outstanding ☆

Are Emergency and urgent care safe?

Outstanding ☆

Our rating of safe improved. We rated it as outstanding.

Mandatory training

The service provided mandatory training in key areas to all staff and made sure everyone completed it.

All EUC staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. The provider used Skills for Health for all online mandatory training (Skills for Health is a not-for-profit organisation committed to the development of an improved and sustainable healthcare workforce across the UK). Online training modules included for example, deprivation of liberty safeguards, safeguarding adults and children, fire safety, and infection control.

Clinical staff completed training on recognising and responding to patients with dementia as part of their mandatory training. From 1 July 2022, all health and social care providers registered with CQC needed to ensure that staff had received training in learning disabilities and autism, at a level appropriate to their role. Polaris Medical staff had not completed this training. The service planned to introduce a revised Skills for Health bundle from October 2022.

Polaris Medical used a technology platform for electronic storage of staff training records. A compliance team monitored mandatory training and alerted staff when training neared expiry. Training records showed EUC staff had completed 100% of the relevant mandatory training and none of this training had expired at the time of the inspection. Polaris Medical ensured staff completed all mandatory training even if they had completed a course elsewhere. This was to ensure all staff had the up-to-date knowledge and skills required to work for this service.

The education and standards team at Polaris Medical carried out life support training for 'train the trainers' annually. Those trained ensured their teams received life support training and the education team assessed crews regularly to ensure they had the skills to provide life support.

The service's lead in Driving Standards was 1 of 5 qualified instructors in the UK. They delivered blue light driving training for urgent and emergency crews. They trained staff to level three Emergency Response Driver Training (ERDT), which is the industry standard accepted by trusts. We spoke with a senior manager who told us a software system was

being introduced, which automatically highlighted staff needing a driving assessment. In accordance with section 19 of the Road Safety Act (2006) drivers need to be assessed every five years. Polaris Medical had specific vehicles for driver training kept at the Reading site. Staff trained on the roads and used blue lights in accordance with section 87 of the Road Safety Act (2006).

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. This included training in both adult and children safeguarding. All staff were trained to level 3 safeguarding via the online Skills for Health package (level 3 training implies that the individual has an extremely active role in any safeguarding situation and requires the knowledge to help shape the safeguarding policies of their workplace). Paramedics and technicians working for NHS ambulance trusts received face-to-face training in adult safeguarding in addition to their online learning. Safeguarding officers were trained to level 4 and were working towards level 5 safeguarding (level 4 safeguarding is designed to build on the knowledge of lead professionals involved in safeguarding people at risk of harm; level 5 provides managers with an understanding of their roles and responsibilities when managing staff who have safeguarding responsibilities).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service displayed a variety of information relating to safeguarding on staff notice boards. This included, for example, information on how to recognise signs of child exploitation, female genital mutilation and the abuse of older people. Notice boards also displayed phone numbers for a variety of helplines and were updated each month by managers. A safeguarding pathways document quoted the service's safeguarding mantra, 'See Something, Do Something.' Safeguarding information posters had the 'See Something, Do Something' mantra clearly displayed.

Polaris Medical had an up-to-date safeguarding policy in place. This policy comprehensively covered several safeguarding topics; for example, confidentiality, types of abuse, and how and when to refer a patient. Managers showed us the clinical standards document, which clearly outlined the importance of safeguarding in their service.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. As part of Polaris Medical's contract arrangements with trusts, Polaris Medical staff reported all safeguarding concerns to the relevant trust. The trust was responsible for investigating these and for referring them to the local authority as required.

Polaris Medical's run sheets included a column to show whether a safeguarding referral was made during a call-out (run sheets are standard documents used by first responders and other emergency medical services to document the patient's physical examination, and treatment). This made it easier for managers to track the number and dates of safeguarding referrals.

Senior managers told us it had been difficult to always monitor safeguarding situations effectively as NHS ambulance trusts held the information. They received some feedback during their quarterly governance meetings with the trusts. The service had recognised that it needed to have more oversight on safeguarding referrals. The service had developed a new system where staff could use QR codes to access a safeguarding reporting assessment tool. This tool gathered information on who had made the referral, the reason for the referral and how the referral had been made. It also gathered information on if consent had been obtained and if a capacity assessment had taken place.

The QR safeguarding reporting tool had only recently been introduced and was not fully embedded with all staff at the time of inspection. The safeguarding lead was enthusiastic and excited to see how the new system would develop.

Between 21 and 28 September 2022, the service had collected details of 9 safeguarding referrals that staff had made using the new QR safeguarding reporting tool. They involved concerns regarding domestic violence, neglect, emotional abuse and fire risks. The service was in the process of embedding the use of the QR codes across all sites. Managers planned to use the data collected to monitor safeguarding referrals, look for any themes and trends, and identify any learning needs for staff.

All policies, clinical guidelines and standard operating procedures referred to safeguarding. All policies were available on the service's employee communications app. Staff had training in a variety of safeguarding topics during induction and this covered topics such as female genital mutilation (FGM), looked after children, and county lines.

The recruitment process of the service included enhanced disclosure and barring service (DBS) checks for staff.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained in line with the National Standards of Healthcare Cleanliness 2021 and the Health and Safety at Work Act 1974.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Make ready teams working with the station supervisor ensured cleaning of vehicles (make ready teams are responsible for ensuring ambulances are cleaned and restocked, and equipment is checked before the beginning and at the end of every shift). Station cleaners ensured cleanliness of all other areas.

Staff followed infection control principles including the use of personal protective equipment (PPE). Every vehicle carried gloves, aprons, face masks, hand-cleansing gel and decontamination wipes. PPE was available across stations and offices. The provider gave self-employed staff PPE free of charge.

Permanent Polaris Medical staff wore a branded uniform provided by the company. Self-employed staff bought their own branded uniform and boots. The service ensured that spare kit was available at each station. If vehicles or uniforms became contaminated during a call-out, crews returned to the station. The station had shower facilities for staff and washing facilities for uniforms on site.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. A make ready team ensured they cleaned vehicles at the end of every shift. Each vehicle displayed a sign on the dashboard showing whether it required cleaning or had been made ready for the next shift. At the end of each shift the paramedic crew displayed a sign saying it needed preparing for the next shift. Following the clean, the make ready team turned the sign to show the vehicle was ready.

The service used Adenosine triphosphate (ATP) testing for all clinical areas before and after cleaning (ATP is an enzyme that is present in all living cells, and an ATP monitoring system can detect the amount of organic matter that remains after cleaning an environmental surface, a medical device or a surgical instrument).

Each vehicle used by Polaris Medical underwent a deep clean every six weeks. Make ready teams emptied out every piece of equipment during this procedure, cleaned equipment and the interior vehicle, and checked and recorded the stock. We saw deep clean vehicle checklists detailing deep cleans with ATP testing results, signed by the staff member responsible.

The provider stored all equipment in the storeroom and within the station area appropriately. They kept equipment and consumables off the floor on pallets or shelving units.

The service had large notice boards in the staff room with IPC information and advice. This covered topics such as hand hygiene, correct use of sharps bins, and correct use and disposal of mop heads.

Station supervisors completed monthly and quarterly IPC audits at each site. The audits looked at the cleanliness of the station, whether staff used clinical waste and sharps bins appropriately, and the availability of personal protective equipment (PPE), amongst other parameters. If any issues were raised, an action plan would be drawn up. Audit results for all Polaris Medical sites from August 2021 to September 2022 showed either good or outstanding scores for IPC. It was evident that managers acted when issues had been identified as they did not come up as an issue on subsequent audits.

An external IPC consultant visited all ambulance stations twice a year. This gave the service assurances that their IPC auditing systems were robust and valid. One visit was unannounced, so staff could not prepare in advance.

We saw records for hand hygiene audits carried out across Polaris Medical sites. During the period of November 2021 to September 2022, 303 out of 307 audits scored outstanding (98.7 %). The remaining four scored good.

Staff accessed all relevant IPC information via the employee app. For example, if a staff member was unsure how to deal with certain infections, they could check the app for current guidelines. We saw a demonstration of this app which was easy to navigate and intuitive to use.

Each ambulance carried sharps bins accessible via a 'cat flap'. Staff needed a key to open the compartment holding sharps bins, thus avoiding unauthorised access and potential injury to staff and patients. A senior paramedic told us crew members or make ready teams rotated sharps bins every 3 months or when three-quarters full, according to company policy. Staff recorded start and closed dates for each sharps bin. We saw evidence staff completed this consistently.

Polaris Medical had a contract with a waste disposal company for clinical and non-clinical waste. The contract we saw clearly outlined the type and frequency of waste collected from the company's sites. Polaris Medical received a monthly report from the waste management company outlining how much waste was collected and how much of it recycled.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The service had robust fire safety testing and documentation. Fire alarms and fire extinguishers were tested monthly, with servicing carried out annually. Fire marshals were based at every station. The service secured fire extinguishers to the wall and tagged them with a recorded date. This was in line with the Regulatory Reform (Fire Safety) Order 2005. Offices and stations were spacious, tidy and well-organised. Lines on the ground of the station showed where staff had to park vehicles when returning to the station. Space between vehicles was wide enough to get in and out quickly. Vehicles could easily access and exit the station through electric shutter doors.

Emergency and urgent care

Ambulances were compliant with the European Committee for Standardisation (CEN). The service ensured new vehicles would meet the standards set out in the Carter report (Lord Carter carried out a review into ambulance productivity in September 2018). The CEN standard specified the requirements for design, testing, performance and equipping of road ambulances. The Carter Report looked to standardise ambulance design, including the use of black box technology and Closed-Circuit Television (CCTV).

Stations had a locked cage for faulty equipment. Staff logged any faulty equipment in a record book and tagged each item with details of the defect. The caged area was kept locked to prevent staff using faulty equipment. The station had a separate small area for staff to place and log defective items until they could be placed in the cage.

One station was not kept secure at the time of the inspection. Staff had left doors to the station unlocked, allowing unauthorised access. Staff had left one ambulance unlocked. The service was improving the security arrangements in all stations and aimed for this to be completed by the beginning of 2023. All stations had CCTV in place. The service stored keys for ambulances, medicines and confidential documents securely.

Staff carried out daily safety checks of specialist equipment. As part of the daily duty, ambulance crews completed a vehicle inspection before their shift; for example, all lights and indicators, seatbelts, blue lights and siren, bodywork and doors. In addition, crews checked the equipment within the vehicle.

Staff reported faults on vehicles in numerous ways, for example via the employee app, by phone or by email. The fleet team and mechanics were available 24 hours a day. Staff could report faults on the run sheet and email the run sheet to the fleet team. Each vehicle carried a driver accident pack. This, together with photos and closed-circuit television (CCTV) from within the vehicle, helped fleet to understand the fault. If a vehicle needed to be taken off the road, the fleet team informed the station supervisor. Additionally, a 'vehicle off road' (VOR) sign was displayed in the window of the ambulance. The fleet team logged all vehicle defects. We saw an extract from the log showing who repaired a vehicle, what they did, the date they made repairs, and if the vehicle was back in service.

Staff felt the reporting of vehicle and equipment faults was simple. A member of staff showed us how he had reported a broken camera on one of the vehicles on the employee app. They reported it at 09:58am, received a reply via the app by 10:18am and a mechanic arrived on station to look at the issue at 11:50am.

The Maidenhead site had an on-site garage for all vehicle checks and maintenance. Three mechanics and 1 fleet manager worked from this site. A rota ensured that mechanics were available 24 hours a day to cover most of the sites. Their work included their main site at Maidenhead and call outs to vehicles needing support whilst away from the station.

A member of the fleet team told us some sites in the north of the country used garages Polaris Medical Services had contracts with. This meant crews in those areas did not have to wait long to ensure mechanics could repair defective vehicles or take them off the road.

Polaris Medical had enough vehicles. The service ensured replacement vehicles were available when needed. The fleet manager told us all vehicles were replaced after seven years. Vehicles which belonged to the company taken on by Polaris Medical in August 2021 tended to be leased. Those leases were due for expiry in 2024 and the fleet department was planning the replacement of the vehicles.

Emergency and urgent care

Crews securely stored ambulances either inside or outside the station. They locked vehicles and stored keys within secure lockers inside the station office. Each ambulance had its own locker and staff ensured they stored keys to the lockers in a secure key box.

Make ready staff used a checklist to show equipment had been checked and re-stocked. Once they had completed this, staff ensured cupboards and drawers were sealed. This was to prevent unauthorised access to the equipment. Vehicles had a variety of locking mechanism, including seals, push buttons and a green/red lights system (green meant cupboards had been locked, red meant cupboards had been opened). All mechanisms required a master key to be re-set.

Make ready teams did not always seem to re-stock equipment fully. Crews had to complete run sheets and give reasons for any delay in starting shifts. We saw several delays happened because vehicles had not been re-stocked adequately by one of the Make Ready teams. This meant the clinical crews had to ensure they stocked their vehicles themselves before starting their shift. The service had developed a new induction and competency booklet for new make ready staff, as they had identified they had to improve this part of the service.

We carried out 5 EUC vehicle inspections. In one instance we found several sterile items had been pushed into a container too small for the number of items. As a result, the sterile items' packaging had been damaged and needed to be disposed of.

Staff disposed of clinical waste safely. They placed clinical waste in large lockable waste bins within the ambulance station. An external company collected and disposed of clinical waste.

The contractor they used promised that none of the waste they collected would go to landfill. Every station had recycling facilities for batteries, metal and waste electrical equipment. The workshop used for servicing and maintenance of all vehicles fully recycled all waste including oil and tyres. The service replaced ambulances every 7 years and aimed for its fleet to be electric by 2024.

The service had enough suitable equipment to help them to safely care for patients. The service had a contract with an external company who serviced and calibrated all equipment annually. Managers told us that they were advertising for an internal biomedical engineer. This meant the provider could manage all servicing and repairs of equipment could be managed internally.

Senior managers told us staff manually checked and recorded temperatures daily across the estates, for example temperatures of fridges and in storerooms. The provider was rolling out new remote live temperature recording across the estates. This electronic reporting will show live temperatures and will warn if temperatures exceed or be less than a certain limit.

All ambulances had access to a 5-point harness system to transport children. Staff told us they used this if a child's own car seat was not available.

Polaris Medical provided transport for patients detained under the Mental Health Act. A vehicle and special crews had been ring-fenced to provide this part of the service. The ambulance used for these patient transports had suitable equipment; for example, hard and soft handcuffs and leg restraints.

Outstanding ☆

Emergency and urgent care

Polaris Medical had contracts with several NHS providers. These usually supplied digital ambulance radios to crews working within the contract agreement. Radio communication allowed quick contact with relevant others; for example, if crews entered potentially dangerous situations or if crews needed clinical advice. Polaris Medical managers told us one ambulance trust did not supply radios and crews had to use mobile telephones to communicate. Managers raised this issue with us as one of their current biggest risks. They confirmed this was on the service's corporate risk register.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The service had 24-hour access to the clinical support desks of the relevant NHS ambulance trust if they needed specialist clinical or mental health advice on scene. Crews could also call the clinical support desk at Polaris Medical. Each ambulance carried a folder holding a variety of flowcharts to guide crews; for example, mental health cards containing information on the Deprivation of Liberty Safeguards (DoLS), and paediatric drug charts.

Staff had clear guidelines about the different options of patient care; for example, when and how to convey a patient to hospital, non-conveyance of patients and discharge, and transfer to other suitable treatment facilities. Staff had to evidence their decision-making clearly in clinical documentation.

The service had an up-to-date control and restraint policy. This clearly stated restraint was only used as a last resort. It included definitions of types of restraint, who could restrain patients, and the importance of monitoring a patient throughout a restraint episode. The policy clearly outlined the only reason to restrain a patient was to maintain their safety and that of others. A paramedic staff member told us crews only used restraints if a patient was at risk of harming themselves or others. The vehicle for the transport of mentally unwell patients had a cell at the back of the ambulance. Crews only transported patients with challenging or violent behaviours in the cell to keep themselves and the patient safe from harm.

Staff shared key information to keep patients safe when handing over their care to others. The clinical and operational standards document clearly outlined what and how crews needed to hand over on conveyance of patients.

Each ambulance carried a smart triage pack for use in mass casualties. Each pack held, for example, easy-to-access triage cards and tapes, which helped crews to triage both adult and paediatric patients effectively, and light sticks for poorly lit casualty scenes.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Score (NEWS) tool (NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients).

Staffing

The service took a flexible approach to meeting their staffing requirements. They had staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

Polaris Medical employed a core of permanent staff and subcontracted several self-employed staff. Self-employed staff signed an agreement including a clause about rest periods between shifts and breaks during a shift. This was in line with Regulation 10 of the Working Time Regulations 1998.

Managers and a planning team accurately calculated and reviewed the number and grade of Emergency Care Assistants (ECAs) and paramedics needed for each shift in accordance with national guidance. The planning team arranged the staff rota across Polaris Medical EUC.

When staff members called in sick, the planning team contacted bank staff to fill shifts. Polaris Medical did not use agency staff. Managers told us there was a pathway in place if Polaris Medical could not fill a shift. In this case the planning team called the provider's duty bronze manager who called the duty bronze manager at the NHS trust to re-plan the shift. Polaris Medical had a shift cancellation policy in place.

Managers listed staffing as one of the key risks for Polaris Medical. Managers told us the establishment in EUC should equal 176 full time members of staff. We heard there were currently 58 vacancies. Several reasons accounted for this; for example, new competitors entering the market and offering higher pay. To mitigate this, Polaris Medical launched a pay review in April 2022 and raised every member of staff's pay by 12%.

At the time of inspection managers told us Polaris Medical did not always fulfil its contracted requirements with one trust due to a lack of available qualified clinicians. They had put plans in place to improve the situation and to ensure the service met its contractual requirements going forward regardless of staff availability. For example, managers planned to use an increased number of emergency medical technicians to increase capacity.

Managers told us they had put plans in place to mitigate staffing risk. For example, they planned seasonal demand changes in advance. During the colder months the events and film business reduced. Managers redeployed staff usually working in these areas to the frontline during those times. Managers told us several self-employed staff would be travelling to Qatar for the World Cup. Managers had enough notice to plan and mitigate for this reduction in staffing.

Polaris Medical had a recruitment strategy in place. The service used 'safe recruitment'; a method designed to deter unsuitable applicants from applying for roles. Recruitment included a meeting with HR, a clinical interview, a clinical and a driving assessment, and a short clinical test.

Managers made sure all bank staff had a full induction and understood the service. Bank staff completed the same induction and training as permanent staff.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Clinical staff completed Patient Report Forms (PRFs) for every call-out (PRFs are specifically designed forms for the use of clinicians who attend and give first aid at the scene of an accident or illness). PRFs were either in electronic or paper form, depending on the trust.

Records were stored and returned to the trust securely. For paper records, staff stored a copy in an envelope in the glovebox of the vehicle for the duration of the shift. On return to the station, staff ensured they locked the paperwork in a lockbox. Managers told us that the NHS ambulance trusts collected medical records regularly. Medical records were the property of the NHS ambulance trusts and they did not keep copies as a service; however, they could access copies if required.

NHS ambulance trusts carried out regular patient record audits. Managers discussed PRF audits at monthly meetings with the trusts. They shared results with staff if any problems had been identified to ensure learning.

Managers at Polaris Medical told us they conducted internal records audits regularly and usually audited ten sets of randomly selected records. Polaris Medical had developed an internal framework to score records against including, for example, response time, medicines administered, and location of patient admission. We saw examples of audits and managers consistently included actions to be shared with teams.

Polaris Medical ambulance crews received special notes from NHS providers about patients in two different ways (special notes include, for example, key-safe codes, access warnings, patients' Do Not Attempt Resuscitation (DNAR) status). Some trusts passed on information electronically and crews could access the information on their tablet devices. Other trusts used airway radios to communicate special notes to the ambulance crew.

The service had a clinical standards document, providing staff with a basic template of how clinical notes needed to be written and what needed to be included; for example, presenting complaint, consent, examination of patient, social circumstances.

We reviewed 10 sets of paper records. All were comprehensive, with patient details, times of observations and any refusal of care clearly documented. The records included NEWS2.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to administer medicines safely. The company's medicines management policy clearly outlined what medicines could be administered per skill grade. Polaris Medical had Patient Group Directions (PGDs) in place for all medicines used. (PGDs are written instructions outlining who can administer medicines and should be written by a multi-disciplinary group including a doctor, a pharmacist and person expected to give the medicine). Each PGD included detailed information about medicines; for example, when and how to give medicines, cautions, dosage for adults and children, and what to do if a patient deteriorated. All PGDs had expiry dates and we saw they were in date. Staff could access PGDs on the employee app.

Staff completed medicines records accurately and kept them up to date. We looked at medicines records at various Polaris Medical sites and saw records had been completed correctly in the offices and on the vehicles. We carried out various stock spot checks and found all records tallied with stock and staff had signed and dated records consistently.

Staff stored and managed all medicines safely. An up-to-date medicines management policy clearly outlined various aspects of the safe storage, monitoring, management, and disposal of medicines across all sites of Polaris Medical.

All EUC vehicles carried medical oxygen cylinders. Staff stored these securely in cupboards. Oxygen cylinders we saw were in date.

Polaris Medical only stored controlled drugs (CDs) on Home Office licensed sites. For example, at time of inspection, the Maidenhead site did not store CDs. However, managers told us they recently had a successful Home Office inspection and were waiting for the CD licence to be issued. The Controlled Drug Accountable Officer (CDAO) had responsibility to ensure the safe and effective management of CDs within Polaris Medical. The CDAO was also in charge of the renewal and management of the Home Office CD licence, which expired every twelve months.

Vehicles carrying CDs had a secure drug safe to hold code locked pods which contained the CDs. Paramedics checked and recorded CDs daily, prior to starting their shift. Drug safes held a drug register and paramedic crews had the responsibility to complete this after CD use.

Emergency and urgent care

Polaris Medical had a thorough system of medicines governance and reported few incidents relating to medicines. The clinical operations manager, or a delegated deputy, carried out and recorded weekly medicines site inspections. Managers nominated clinical managers to conduct monthly CD audits and to oversee that all staff followed the medicines management policy. We saw many examples of weekly and monthly audits showing what was checked and how each site scored.

Polaris Medical had a T28 exemption certificate from the Environment Agency. This certificate allowed them to denature CDs on-site for disposal, in compliance with the Misuse of Drugs Regulations 2001 (denaturing of CDs involves physically mixing the medicines with a chemical, which makes it harmless and unfit for use). The Head of Clinical Operations was a nominated witness for all disposals of CDs. The pharmaceutical supplier handled the safe removal of medicines waste. We reviewed examples of medicine disposal logs and staff had completed them thoroughly, legibly, and accurately. A witness had countersigned each log.

We asked managers about the potential misuse of oral morphine. Vehicles carried this liquid medicine in 100ml bottles. Once the ambulance crew opened the bottle during a call-out and given the medicine to a patient, they disposed of the rest of the bottle once they returned to the station. Clinical and non-clinical managers showed awareness of the risk of misuse and told us they had considered several ways to reduce this risk. They had talked to NHS trusts to see if they could obtain smaller volumes; however, these were no longer available to buy. Managers had considered siphoning the liquid medicine into smaller bottles or getting their pharmacy supplier to do this; however, the cost of this outweighed the risk. Managers had put in place various ways to mitigate this risk. CCTV was in place across all vehicles and sites, and the disposal of the medicine was closely monitored.

The medicines management policy, the medicine standard operating procedure, and the medicines management guide outlined the importance of involving patients, where possible, in the decision-making process around medicines. It stated the importance of advising patients of potential side effects and the right of the patient to refuse treatment.

Polaris Medical worked for several NHS ambulance trusts. Medicine requirements from trusts varied and the service managed this through their drugs bag process. Managers provided clinicians with front line medicine bags for the specific contract they worked for. We saw a clinical memo sent to staff by managers in July 2022 in which they clearly outlined medicines required for each contract. This memo also had guidance on administration rights per skill grade.

Polaris Medical ensured staff followed the '10 Rights of Drug Administration' developed by the Royal College of Nursing. This tool was developed as a memory aid to prevent medicine errors and includes, for example, 'right drug, right patient, right dose, right route'.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

The senior leadership team at Polaris Medical encouraged staff to report incidents.

Emergency and urgent care

Staff reported incidents both to the trust they worked with and internally. Staff logged trust incidents via a web-based incident reporting software. Internally, staff logged incidents using a risk, quality, and compliance software programme. Managers showed us the process of completing an incident. The incident form was simple, intuitive and quick to complete. It included a body map in case of physical injury and a risk assessment for staff to complete. Once submitted, the incident was automatically linked to the most relevant manager for investigation.

Polaris Medical had a clinical governance administrator who oversaw the administration of incident reporting and timelines. They received incidents either from the trusts or via the app and ensured they recorded all incidents on a tracker using a risk, quality, and compliance software. The clinical governance administrator ensured that incident investigations took place and concluded within a given timeframe. Staff involved in incidents had five days to return a statement, which formed part of the investigation. The service supported staff in learning how to write statements. We saw the service's incident tracker and noticed it included complaints and concerns within the same spreadsheet and under one tab.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The service had a duty of candour policy. They were committed to ensuring they were open and honest with service users when things went wrong. They endeavoured to provide service users with reasonable support, truthful information and a written apology were necessary. However, managers told us several trusts did not want Polaris Medical to become involved with this part of a serious incident investigation process. The trusts tended to complete the duty of candour.

Staff received feedback from investigation of incidents, both internal and external to the service. A senior clinical lead wrote a quarterly 'lessons learned' bulletin, which they sent to all Polaris Medical staff. They told us if an incident occurred that may be relevant to the service, learning was shared at once, even before the investigation had started. For example, an ambulance crew did not convey a patient with a forty-eight-hour history of a headache to hospital. This patient was later diagnosed with a brain haemorrhage. Managers sent clinical guidelines about headaches to all staff as soon as they learnt of this incident. All staff had access to changes in policy or procedure following an incident through the employee app.

Through regular meetings with their contractors, Polaris Medical managers had access to learning from incidents conducted by trusts. They shared lessons learned information from these investigations with their staff, via the employee app.

There was evidence that changes had been made as a result of feedback. For example, managers expanded discharge paperwork to include a pathway ratification tool for brain haemorrhage following an incident involving a late diagnosis. This was shared with all staff on the employee app.

Managers investigated incidents thoroughly. A review of records demonstrated they used statements from crews, information from the relevant trust, patient records and a review of the ambulance dispatch notes to understand the background of incidents. Each investigation ended with a conclusion and, where appropriate, recommendations. We saw several incident reports completed by Polaris Medical.

Managers debriefed and supported staff after any serious incident. They gave an example of a member of staff involved in a serious and dangerous situation. Following the incident, this staff member did not have to work clinically until they felt ready to recommence their frontline role.

A clinical lead told us the service had not had any never events since its inception.

Outstanding ☆

Emergency and urgent care

Are Emergency and urgent care effective?

Outstanding ☆

Our rating of effective stayed the same. We rated it as outstanding.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Polaris Medical followed the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) national guidelines. JRCALC combines expert advice with practical guidance to help paramedic crews in providing safe and high-quality patient care. Staff accessed JRCALC information on their employee app. Staff could also access the updates via some of the NHS ambulance trust's Electronic Patient Care Reporting (EPCR) tablets. The service followed guidance from the National Institute of Clinical Excellence (NICE), and The Resuscitation Council guidelines on resuscitation and treating anaphylaxis.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Managers ensured staff did not print on paper to avoid the use of date guidance. We saw several Polaris Medical policies, which were all in date. Each policy stated dates of last and next review. Staff accessed policies on the employee app. We saw numerous policies, and saw they referenced the National Institute for Health and Care Excellence, JRCALC, and other national guidelines as relevant; for example, the Health and Social Care Act 2008 or the Mental Capacity Act 2005.

The service audited patients' care using Clinical Performance Indicators (CPIs). CPIs focused on eight areas of care, namely documentation, elderly falls, cardiac arrest, difficulty in breathing, mental health for patients with diagnosed and undiagnosed psychiatric problems, discharged at scene, and sepsis. As a service Polaris Medical added some additional clinical care bundles against nationally set patient treatment criteria.

Staff followed guidance on avoidable conveyance and identified initiatives to avoid taking patients to hospital when appropriate. One staff member told us how they were able to help an elderly patient stay at home by organising help from carers, the fall team and district nurses. Another staff member told us that they were able to get advice from the mental health nurses. Service users were required to sign their records to confirm that they agreed or refused to not be transferred to hospital.

Staff followed the service's Control and Restraint Policy and had received training in Polaris Medical's approved techniques in restraint. Training followed the Restraint Reduction Network (RRN) standard which provide a benchmark for training in supporting people who are distressed.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Polaris Medical had an up-to-date Consent and Mental Capacity policy, which a senior director had recently reviewed. This policy was comprehensive and covered necessary contents, including clear links to the Mental Health Act 1983 and the Mental Capacity Act (2005).

Outstanding ☆

Emergency and urgent care

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a pain scoring tool and gave pain relief in line with individual needs and best practice. All vehicles carried a tool to use for those patients that had difficulty communicating. The tool showed a variety of different facial expressions, and the patient could point to the one that most closely resembled their level of pain.

Staff administered and recorded pain relief accurately. On all ambulances checked, staff had access to a variety of pain relief; for example, paracetamol, nitrous oxide and oxygen referred to as gas and air, and morphine. We reviewed 10 sets of records where an assessment of pain was clearly recorded. All pain relief was in date, stored appropriately and staff correctly recorded amount of medicines used.

We saw feedback from a patient which stated: "They (the crew) did everything in their power to make sure I was comfortable and got decent pain relief onboard. They both have hearts of gold, and I really couldn't thank them enough."

Response times

The service monitored and met agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

Polaris Medical managers informed all frontline staff of the ambulance response times they aimed for as a service based on national expectations. For example, the target from call received from the dispatch desk to mobilising was 30 seconds. The target time for treatment on-scene was 30 - 45 minutes, depending on whether a patient needed to be conveyed to a treatment facility or not.

Polaris Medical received monthly contract reviews and performance reports from the trusts they had contracts with. These reviews included data on key performance indicators (KPIs), such as staffing and shift coverage, and ambulance mobilisation and response times. Managers told us this data was used to monitor trends within their service. When performance decreased in certain areas, they ensured they put actions in place to address any issues. For example, at a time when the service was performing below the target for conveyance time of patients, managers arranged training sessions to address this.

The clinical operations team produced their own reviews to monitor the service's performance closely. Each review included operational statistics, data on resourcing and recruitment, and the top five risks facing Polaris Medical. Where breaches occurred, the clinical operations team ensured they put actions in place to improve performance. For example, between January 2022 and August 2022 hospital clear up times were above the target time. Actions to remedy this included discussing KPIs at station meetings with staff, asking clinical leads to investigate reasons for the delay, and ensure all staff received data sets for their individual performance.

Polaris Medical performed above target for 'See and Treat' between August 2021 and August 2022. 'See and treat' means treatment of a person at home or on scene without conveying them to hospital.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients

The service participated in relevant national clinical audits following the national care bundles set out by NHS England for ambulance services. This included, for example, audits of cardiac arrest, stroke, heart attack, and sepsis.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service had an audit schedule in place. This outlined audit titles, responsible audit leads, and frequency of audits. Audits on this tracker included for example, station checks, medicines, uniforms, safeguarding, and mental health patient record forms.

Managers shared and made sure staff understood information from the audits. Staff accessed audits performed and the results on their employee app.

Polaris Medical had developed various internal tools to support frontline staff in assessing adult and paediatric patients at the scene quickly and effectively. The service had also created various pathway tools to help paramedic crews make decisions on whether to convey patients to hospital, treat them at the scene, or convey them to another appropriate location; for example, a mental health unit. Each vehicle carried a pack holding easy-to-access and wipeable guidelines and flowcharts to aid clinical staff in the treatment of adult and paediatric patients; for example, we saw guidance for emergency intubation, paediatric resuscitation, and sexual assault/rape.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. During inspection and in interviews with managers we saw many indicators on how much emphasis the company placed on training and development. A senior manager told us "better care is achieved through training and development". Managers emphasised how important training was to improve any gaps in knowledge staff may have. For example, managers told us health problems in children were often subtle and difficult to identify and they offered training to their staff to improve knowledge and understanding of paediatric health.

Make ready teams attended a training programme designed for their role when they joined Polaris Medical. Following the programme, they had to complete a competency and evaluation booklet, which a mentor oversaw. The booklet covered all areas make ready staff would be working with; for example, cleaning and care of various pieces of equipment, medicine pods, and vehicle checks. Make ready staff had received training in Control of Substances Hazardous to Health (COSHH) and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). This was necessary as they worked with cleaning products which could be hazardous to their health.

There was proactive support in place for staff to develop their knowledge and skills. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager. Polaris Medical had an extensive education and development arsenal. Their Reading based Polaris Academy was the main base for training with access to full clinical facilities and experienced clinical tutors. Staff told us they had protected time for training.

The service offered many accredited courses covering diverse topics. For example, the prevention and management of violence and aggression accredited by the National Federation for Personal Safety (NFPS); major incident medical management and support accredited by Advanced Life Support Group (ALSG); First Response Emergency and Urgent Care (FREUC) courses and diplomas accredited by Qualsafe.

Emergency and urgent care

Polaris Medical had developed a network for continuing professional development and learning called 'Alphabet lectures'. This was a commercial package for learning about subjects across the health industry; for example, safeguarding and mental health. Polaris staff accessed Alphabet lectures free of charge. People external to Polaris had to pay to access courses.

Another commercial course Polaris Medical had developed and now offered via their academy was Paediatric & Neonatal Decision-based Assessment (P&NDA). This was a course designed to increase the confidence of ambulance staff for paediatric clinical assessments.

Managers told us they worked with an Irish company on Irish qualification conversions. This was to attract people from Ireland to work for Polaris and ensured their qualifications would be recognised in the UK.

Managers told us they had worked on and would soon offer an internal level 6 paramedic BSc (Hons) degree, apprenticeships for paramedic emergency care assistants (ECAs) and technicians, and internal online training linked to the Core Skills Training Framework (CSTF) – Skills for Health. The provider had established links with Birmingham university to link the apprenticeships to a high-level educational institution.

Polaris Medical used a technology platform which handled their hiring, onboarding and compliance. This software monitored staffs' professional registration status and alerted the compliance team if somebody's registration neared expiry. As part of their role, paramedic staff needed to be registered with the health and care professions council (HCPC) who ensured registrations did not expire.

Senior managers told us the organisation had a simulation suite at the Reading site, which staff accessed often for detailed scenario training. The use of the area and the types of training offered were a practical way to train and develop staff. It ensured staff could put their learning into practice to help deliver outstanding care that met patients' individual needs. The type of scenario changed on a regular basis; for example, the training suite could be designed as a cramped and untidy environment and staff practised how to take a sick patient to street level from this type of housing.

Polaris Medical had an in-house driver educator who regularly assessed drivers. Drivers received a Red/Amber/Green (RAG) rating following assessment. The driver educator told us newer drivers had more frequent assessments. The provider checked staffs' driving licences annually and used a compliance technology platform to record this. We saw several completed response driving assessment reports. They detailed the name of the person being assessed, their role, the date of assessment, and their competency after the test. Each assessment sheet included tick boxes to show checks had been carried out; for example, driving licence, vehicle safety, and eyesight checks. The assessor did not always complete this part of the assessment form. The service had an up-to-date driving policy in place. We also saw an Internal Quality Assurance (IQA) policy. This did not have a date of issue or review date, nor did it indicate whether it had been approved.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us the induction "was not just a tick box exercise". Staff also received an induction talk from the NHS ambulance services they were contracted to work for. Examples of trust induction covered expectations as well as topics such as safeguarding adults and children, consent, and incident reporting.

Managers supported staff to develop through the service's appraisal and supervision process. We saw examples of completed personal development reviews (PDRs), performance reviews, clinical contact shift reports (CCSRs), and probation reviews. Each process allowed two-way communication between staff being supervised/appraised and staff leading. Both parties had completed processes fully and dated and signed the document.

Managers identified poor staff performance promptly and supported staff to improve. We saw evidence of discussions around staff performance in the supervision and appraisal documents. These discussions were honest and supportive, and supervisors recorded agreed actions to help staff develop.

We spoke with a senior member of staff from Human Resources (HR) about disciplinary procedures. They told us Polaris Medical had a comprehensive process in place to investigate allegations of poor performance and behaviours not deemed suitable or appropriate. The provider shared seven cases with us, and we saw they had conducted disciplinary procedures fully, professionally, and with legal advice when needed. Managers ensured they explained decisions about disciplinary outcomes and communicated this formally to members of staff. Following a disciplinary process, staff completed a reflective learning piece.

A clinical operations manager told us clinical support and supervision also took place on an ad hoc basis. For example, following a call-out, senior clinician discussed cases seen and treated informally to offer reflection and development.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. A senior manager told us one of the executive team's main goals was to keep staff in a constant communication loop. Managers ensured feedback from internal and external meetings was provided to all staff. The employee app kept staff up to date with any news, changes, and other relevant information.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked across health care disciplines and with other agencies when required to care for patients. Managers met with each NHS ambulance trust monthly to share data and discuss KPIs. They shared information from these meetings with Polaris Medical staff to ensure everybody was sighted on the service's performance.

Managers had worked with local NHS partners to ensure ambulance crews had access to appropriate local NHS pathways. They had created a pathways document, which they reviewed regularly, and the most recent review took place in early 2022.

Polaris Medical managers worked hard to improve communication with NHS ambulance trusts. In the past it had been difficult to obtain data about incidents and safeguarding. However, at the time of inspection managers told us this had improved. Meetings with NHS ambulance trusts now included this type of data as part of the agenda.

Polaris Medical was not involved in direct contact with clinical commissioning groups as this was the trusts' responsibility.

Polaris Medical Clinical and Operational Standards, written in 2022, clearly outlined the role of the lead clinician in terms of handing over a patient to a suitable treatment facility. The duty of the lead clinicians was to record the handover on the PRF, and the standards asked clinicians to include who they handed the patient over to, and the medical status of the patient at the time of handover.

When staff treated patients in their own home and when they felt conveyance to a treatment facility was not necessary, they worked with GPs to agree decisions. Although paramedics were not mandated to do so, Polaris Medical strongly recommended they did. This was to ensure thorough clinical reasoning and decisions took place and patients kept safe.

During the COVID-19 pandemic Polaris Medical stepped in to help. For example, they carried out many doorstep assessments to help GPs. The service had vehicles on stand-by to help transport patients to the Nightingale hospitals or to the mortuary. These arrangements had now ceased.

Sometimes Polaris Medical staff attended scenes also attended by other paramedic crews from different providers. We saw feedback sent to the service by healthcare professionals from other providers, thanking them for their help. For example: "I am a paramedic. I was writing to say thank you to (crew) and for their help. They backed me up on a job with a young boy who was suffering from a seizure. Their professionalism and help made the difference and I wanted to commend them on their skills." "Could I please request a commendation for (crew) as he smashed a cardiac arrest this morning, doing everything from chest compressions, helping me with airway and hauling kit up and down three flights of stairs, all whilst talking to family members and reassuring them."

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

it was not always possible or feasible for EUC staff to give patients advice on leading healthier lives

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The service had an up-to-date consent and mental capacity policy in place. This policy covered definitions of consent and capacity, how to obtain consent and assess capacity and it made reference to adults and children. The policy referenced the Mental Capacity Act 2005 and the Children Act 1989. It clearly outlined core principles of capacity; for example, the fact that a capacity assessment was a decision-specific test and that a person must be assumed to have capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We spoke with staff who said they asked every patient to give consent in terms of treatment or conveyance options. Staff knew it was important to give patients a lot of information and reasons so that patients could make decisions about their own care. We saw a compliment letter sent to Polaris Medical about a particular crew, which read: "By giving us the factual information we needed, I was able to make an informed choice, as I didn't have to go to hospital that morning, but you were there should I decide to."

The service's clinical and operational standards document addressed the steps to take when patients refused to be conveyed to hospital. This included: ensuring the patient had capacity to make the decision against medical advice; detailed documentation referencing conversations with the patient about the risks; calling the clinical support desk at the trust and asking the patient to speak with the clinician on the recorded phone line as additional evidence.

Staff ensured they recorded assessment outcomes in patient records, in line with company policy and clinical and operational standards.

Consent, mental capacity and DoLS training was a part of mandatory training.

Outstanding ☆

Emergency and urgent care

When patients could not give consent, staff made decisions in their best interest. The provider's consent and mental capacity policy contained a section on best interest decisions. This section showed recognition of the fact that many emergency situations may make a consent and capacity discussion impossible.

Polaris Medical had one vehicle covering mental health transports. Crews working with this part of the business had received training specific to their role; for example, prevention and management of violence and aggression, and restraint training. The service had an up-to-date restraint policy, which clearly outlined definitions of types of constraint, when to use it, and what staff had to consider before using it. The policy explained the roles and responsibilities of crews and managers. Two staff members told us they would always use the least restrictive options first.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. The service's consent and mental capacity policy included consent for children and referred to Gillick competence (Gillick competence is the principle used to judge capacity in children to consent to medical treatment). Staff could click on a link within the policy to learn more about Gillick competence. The policy outlined how to support children who wished to make decisions about their treatment.

Staff understood DoLS in line with approved documentation. DoLs form part of the Mental Capacity Act 2005 and ensure that people are receiving care in a way that does not inappropriately restrict their freedom. Two staff members told us they would always use the least restrictive options first. The service's Consent and Mental Capacity Policy stated that transporting a patient who lacked capacity from their home to another location would not usually amount to a deprivation of liberty. The policy gave examples of when staff would be required to carry out a DoLs assessment, and staff told us they would take advise from the NHS Ambulance Trust's clinical advisors when required.

Are Emergency and urgent care caring?

Outstanding ☆

Our rating of caring stayed the same. We rated it as outstanding.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Patients said staff treated them well and with kindness. We saw twenty compliments sent in by patients, or relatives of patients, thanking members of staff for their treatment of them during call outs. The overriding themes related to staff's kindness, care, and professionalism. An example included: "You had my best interests and my health and my safety as the first and only priority, and with balance, objectivity and measure it requires. True experts with a level of integrity that is what any patient would wish for." "I suffer with anxiety and in situations of excruciating pain (crew) was able to keep me extremely calm, he was a wonderful person, very attentive, so helpful and really just an all-round delight."

We saw and heard of some examples when staff had gone the extra mile. For example, a crew went to an elderly patient who was struggling to cope in their own home. The patient did not want to move into a care home and the Polaris Medical crew helped to put measures in place to support them to remain at home. This included liaising with the GP to arrange a medicine review and referring the patient to a falls team and the district nursing team.

Polaris Medical also received feedback via the trusts; for example, we saw feedback about a member of staff investigating an incident. It was from the daughter of a patient who passed away and read: "The daughter wished to express her thanks to the attending staff who she felt were compassionate and went above and beyond to support her."

In an informal conversation with senior managers, they told us about the types of call outs the ambulance service received. They gave examples of situations when a caller was not in a medical emergency but an elderly person not coping or feeling isolated. One of the senior managers said these were often the "best calls because they could make a cup of tea for the person and chat with them for a while". It was clear that the wellbeing of patients, both medical and emotional, was at the forefront of Polaris Medical's values.

The service followed the General Data Protection Regulation (GDPR) to keep patient care and treatment confidential. Their public-facing website had a data protection policy and a GDPR Privacy Statement.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff ensured they attended to both the patient and those around them. They supported and reassured everyone affected by the situation. For example, we saw staff attending to a paediatric call out. As well as caring for the child, they established good rapport and worked well with the family. We saw feedback relating to patients who suffered from anxiety and staff supported them well through the stressful clinical situation: "I suffer with anxiety and in situations of excruciating pain (crew) was able to keep me extremely calm, he was a wonderful person, very attentive, so helpful and really just an all-round delight."

Staff treated patients and families and carers with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided personalised high-quality compassionate care.

We saw feedback from families of patients; for example: "Want to pass on my thanks and appreciation. Both staff were amazing, giving help and support to my husband but also information to myself and family, going over and above what we expected, very thorough, kind, professional. Couldn't have asked for more."

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw crew speaking with an unconscious patient during transfer. They explained what was happening and what they were doing and made the patient as comfortable as possible. We saw feedback from a patient who suffered from anxiety: "They were absolutely fantastic, and I can't thank them enough. I suffer with anxiety and they wouldn't leave me until there was a cubicle, so they didn't leave me in the corridor. Stayed past their shift and I can't thank them enough. So lovely and ever so helpful." "The crew were incredible with me, my husband and my toddler who was panicking." "I write once again to thank you most sincerely for the support we received from two crew members of your wonderful service. (Crew) responded to our call for help when one of our elderly sisters had an awful fall in a very public area. When they arrived, they very gently reassured her and all that was necessary to make her comfortable before transferring her to the stretcher."

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Feedback from the relative of a deceased patient read: "We wanted to show our entire family's gratitude for their humanistic care and pure professionalism when dealing with my nan and also comforting my mother in distress. They were so gentle with the questions they had to ask me. There was great emphasis on when (crew) suggested opening the window to free my nan's spirit. It really meant a lot in comforting my mother."

Outstanding ☆

Emergency and urgent care

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We saw examples that crew guided patients through what was happening and what the treatment plans were. This was reflected in feedback received from patients; for example: “By giving us the factual information we needed, I was able to make an informed choice.” “The crew also spoke to our father in A&E. They were really sensitive and kind. Their manner reassured him that mum was in the best possible place and that all that could be done for her had been.”

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff had access to a picture reference guide. The booklet contained instructions for staff on how to communicate with patients unable to speak or understand verbal language. It contained pictures in various categories to help staff and patients to communicate. Picture categories included people, places, food and drink, body parts, and feelings.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw several ways patients could give feedback. We saw posters in all vehicles encouraging patient feedback. The service displayed Care Quality Commission (CQC) posters in vehicles for patients who wished to feed back to the CQC rather than the service itself. Polaris Medical’s public-facing website provided a telephone number and email address.

Are Emergency and urgent care responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The service was provided through contracts with NHS ambulance trusts; therefore, Polaris Medical were not directly responsible for the planning of the service.

Polaris Medical had several sites across the UK. In August 2021 the service acquired another ambulance provider, thus expanding their business. Senior managers visited every station and ensured all processes were uniform across the business. For example, they ensured each site had make ready teams put in place. Further, they ensured all staff carried out the same vehicle checks and followed the same policies and procedures This ensured fair performance and outcomes for patients across Polaris Medical sites.

Staff had access to all UK major trauma centres, hyper acute stroke units and heart attack centres. This meant that they could transfer patients who had critical injuries threatening life or limbs quickly and effectively to the nearest and most suitable treatment facility. Additionally, staff had access to a variety of community referral pathways. For example, the service had a pathway for patients needing mental health care. Rather than conveying this type of patient to an accident and emergency department, crews could transfer them straight to a more suitable treatment facility. This helped to reduce the number of admissions to hospital.

Outstanding ☆

Emergency and urgent care

The service had a contract to provide on-site medical support within a busy London train station. Crew members were able to provide medical assistance to commuters and travellers should they become unwell.

The service had developed excellent working relationships with NHS ambulance trusts and had a proven track record at being able to deliver at short notice. They had provided an extra 49 manned vehicles with 72 hours' notice to cover the Queen's funeral. The service had provided 2 NHS ambulance trusts an extra 10 ambulances per day throughout the pandemic. They had agreed to do additional services such as mortuary runs. The service had received excellent feedback from control rooms about their staff members and the service had received a thank you letter from the Chief Executive of one of the NHS ambulance trusts.

The service had identified that there was a national shortage of ambulance service clinicians. They used innovative ways to recruit and train up new staff members and promoted existing staff through the Academy. All staff who we spoke with told us that they felt supported to develop. The service used a government backed sponsorship scheme, where paramedics from international countries were sponsored by the service to work with them for 2 years. They offered Irish qualification conversion courses to give Irish paramedics the opportunity to work in the UK.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff told us of an occasion where a mental health nurse called them back within 2 minutes when they required advice.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could tell us who to contact both internally and at the NHS ambulance trust if they needed clinical advice. Additionally, each ambulance vehicle carried packs containing medical and clinical information to aid crews on-scene.

Polaris Medical received feedback from staff from trusts they worked with. We saw examples of feedback relating to staff helping in the community, whether they were on or off duty. "I am a paramedic with another ambulance service. I was writing to say thank you to (crew) and for their help. They backed me up on a job with a young boy who was suffering from a seizure. Their professionalism and help made the difference." "I just wanted to feedback on a pleasant encounter with two of your techs on Monday. I came across a lady who had fallen. The two girls were very pleasant, listened to my handover and took on board my recommendations, even though I was in civvies. They had a lovely demeanour with the patient, her husband, me and other passers-by."

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

Staff made sure patients living with dementia received the necessary care to meet all their needs. All staff had received training in dementia as part of their mandatory training. Mandatory training in learning disabilities and autism was being introduced with a revised Skills for Health bundle from October 2022.

Managers made sure staff, patients, and carers could get help from interpreters when needed. Staff had access to a phone translation service twenty-four hours a day and could thereby communicate with patients for whom English was not their first language.

The service used a communication tool for patients who could not communicate verbally or whose first language was not English. This included simple pictures divided into topics to help both the patient and crew to communicate. For example, it helped to explain to patients what tests staff needed to do and whether they needed to convey a patient to hospital. It helped a patient describe symptoms and pain they experienced, asked whether they had taken drugs or alcohol, and whether they took any medication.

The communication guide was appropriate for use with adults as well as young children. It included, for example, pictures for patients to point to, an alphabet chart, and a chart with pictures of the two-handed fingerspelling alphabet for deaf people, based on British sign language. The tool had instructions on diverse ways to communicate with patients; for example, patients who could not use their hand to point at pictures or those with learning disabilities. It reminded staff to check how patients usually communicated by asking a close family member or other professional involved in their care.

Polaris Medical had two vehicles ring-fenced for bariatric patients, one in the south and the other in the north of the country.

An incident was reported in a ''lessons learnt'' bulletin. A patient had expressed a preference to be addressed with a she pronoun and a female name. The name and gender were different to what was on the patient's NHS records and there was some confusion from hospital staff when handing over the care of the patient. The crew respected the patient's wishes and supported them. Lessons were learnt as the patient's preferences should have been clearly written in the patient's care records, in addition to verbally communicating the patient's wishes to hospital staff.

Staff had training in conflict resolution and knew how to deal with patients who may become aggressive.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Polaris Medical worked under contract to various NHS ambulance trusts, and it was each trust that managed the access and flow of the service. The crews logged on with the trust at the start of their shift and logged off at the end. They received direct communication and direction from the NHS ambulance trust they worked for on that day.

Managers constantly monitored other KPIs to ensure the service met targets. Senior managers told us Polaris Medical performed well in terms of mobilisation time, often better than when compared to NHS times. At the time of inspection, the service did not meet their KPI in terms of time on scene. A KPI review in February 2022 showed that the KPIs for hospital clear up times were on average over 15 minutes. Hospital clear up time is the time it takes for the crew to leave the hospital after handover of the patient. This was attributed to the integration of new staff after the service had expanded. The clinical operations teams worked on improving these KPIs. In September 2022, non-convey times and convey times were above target. However, hospital clear up times continued to be above the 15 minutes KPI. The service could not influence some KPIs such as hospital handover to clear time.

Polaris Medical had processes and teams in place to ensure fast turnaround of vehicles. This included Make ready teams who cleaned, prepared and re-stocked vehicles as quickly as possible, ready for the next shift. The in-house fleet team ensured they dealt with vehicle faults as soon as possible to keep ambulances on the road.

The service had an up-to-date business continuity plan in place to ensure key services to stakeholders continued during any disruptive event.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

The provider understood complaints to be part of working in healthcare and ensured their staff knew this as well. The approach was non-punitive and inclusive, and the view was complaints could help to learn, and to develop and enhance the company's reputation. Polaris Medical had an up-to-date complaints policy and clinical and operational standards to set out the complaints process.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. All vehicles across the service displayed posters on how to give feedback. Additionally, all vehicles carried feedback forms, which staff gave to patients where appropriate. Senior managers told us they had tested a new system of QR codes on ambulances. These were for patients and families to scan on a mobile telephone and easily report areas of excellence, improvement or concern. At the time of inspection, this system had been tested for one week and managers told us it would be fully implemented across the business within the next two weeks. All vehicles also displayed CQC posters which showed how patients and families could report any feedback to an external organisation.

Managers investigated complaints and identified themes. Senior managers investigated all complaints thoroughly and relied on various sources; for example, statements from crews involved, reviews of the complainant's information, ambulance dispatch notes, and clinical records. They wrote reports outlining the background of the complaint and their findings. Each report included a conclusion and recommendations. We looked at six investigation reports and saw the investigating officer had completed them thoroughly.

The clinical governance administrator kept a log of complaints. They gave each complaint a unique identifying number and ensured they did not record any confidential information on the tracker. The tracker included the date of complaint, a brief description and outcome, and which contract it affected. In the seven months prior to inspection the service received five direct complaints from patients and twelve complaints from other services about crews' attitudes or clinical decisions; for example, from GPs or hospital departments.

Polaris Medical processed complaints received from trusts in the same way as they processed complaints received directly. Once an investigation had concluded, managers ensured they sent reports to the trust in question.

The service tried to respond to complaints within 7 to 14 days. Polaris Medical's company policy set the response time as up to 28 days. However, due to the trusts' policies being 14 days, the provider tried to complete their investigations and recommendations within the same period.

A senior clinical advisor told us Polaris Medical had dealt with all complaints to date internally and no case had gone to the ombudsman.

Patients received feedback from managers after the investigation into their complaint. Patients received a letter following a complaint investigation outlining the conclusion and recommendations. Patients had the choice of contacting the service if they wished to discuss the outcome further.

Outstanding ☆

Emergency and urgent care

Managers shared feedback from complaints with staff and learning was used to improve the service. A senior clinical advisor told us they shared any learning from complaints in a quarterly internal staff meeting. Additionally, they shared learning via clinical updates and process updates made because of a complaint. If the service received a complaint requiring immediate learning, the senior clinical advisor ensured they shared this immediately via the employee app.

Complaints and compliments formed part of the agenda in monthly meetings with the trusts. Trusts provided analyses of complaints compared to other providers.

Are Emergency and urgent care well-led?

Outstanding ☆

Our rating of well-led improved. We rated it as outstanding.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The managing director and senior team mostly had clinical backgrounds relevant to the service themselves. Many had started their careers as make ready staff and progressed through the ranks to become paramedics. This meant the senior management had real insight into the daily work of their staff.

Leaders promoted compassion within the management team. Management teams monitored each other's skills and performance, with audits being overseen by different management teams. Important decisions, such as disciplinary action, always had 2 managers involved. This ensured equity and fairness.

The senior management team had a visionary and innovative approach to the business. This included all areas; for example, recruitment, communication with staff and people external to the business, training and education, and welfare support.

The Registered Manager was on annual leave throughout the inspection period. The leadership team led the service in their absence. Systems and processes in place were established and operated effectively.

We heard from managers and staff that Polaris Medical offered great opportunities for progression. For example, some of the paramedics we spoke with had come to the provider as make ready staff and managers had encourage them to advance their career. We also heard several paramedics started their career with Polaris Medical as students or work experience and returned to work there once they had completed their education. One senior clinical lead told us they "loved working here and you can't often say this about your job".

Staff said leaders were visible and approachable. Senior managers told us they had an 'open door policy' and encouraged staff to contact them directly with any queries or concerns. We spoke with 19 members of staff. They all said they felt supported by managers. One station did not have a station supervisor officer appointed at the time of inspection. Senior management staff covered this role. Staff told us that managers were not always available on site, but staff could contact managers through the employee app. They felt empowered to raise concerns and could do this in several ways.

Staff members from different grades told us that the team felt like a 'big family'. One subcontracted staff member told us how managers supported them through the death of his father. The service paid them for their time off, which was not in their contractual arrangements. Another staff member told us how the managers had supported them through a difficult personal time.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

At the time of inspection Polaris Medical had recently selected a vision and strategy team. This team had started discussing the next five-year plan, which revolved and focused around the provider's core values:

Respect – patients care, customer loyalty and staff welfare

Integrity – keeping high standards, no compromise on honesty and safety

Service – high availability, consistent scheduling, prompt attendance, accurate reporting

Excellence – professionally qualified staff with recognised standards of patient care

The vision and strategy team had responsibilities for monitoring progress of the company's five-year plan and to drive change. Posters displayed within the ambulance stations told staff that 'our values guide everything we do.' The service was committed to excellence and strived to be one of the best in the country.

We spoke to 4 members of staff who had previously worked for the independent ambulance service who had been bought out by this service. They understood the values of the service and had bought into them.

The senior management team showed clear focus on environmental issues. All Polaris Medical sites had recycling facilities for the following: automotive and domestic batteries; automotive and commercial waste; Waste Electrical and Electrical Equipment (WEEE); garage waste including oil and tyres. The service had a contract with an independent waste management company which was committed to recycling and recovering all waste.

In August 2022, the service had produced:

- 547 kilograms of dry mixed recycling
- 729 kilograms of general waste
- 571 kilograms of medical waste
- 5 kilograms of sanitary waste
- 6 kilograms of sharps waste

The independent waste management company had recycled 1307 kilograms and recovered 550 kilograms of all the waste produced in August 2022. No waste was unrecoverable during this month.

Emergency and urgent care

Polaris Medical managers focused on enlarging their clinical workforce. They advertised on a large social media app and through recruitment campaigns. The provider offered incentives and flexibility to staff, including access to free training and education, good career progression, options to be either self-employed or permanently employed, and high levels of support. Managers told us they tried to base staff on sites close to home.

The service's fleet needed expanding and replacing. The service had a new fleet of 14 vehicles on order. All new vehicles were 'seven-trust vehicles' – this meant logos of trusts the service worked with had been placed on the vehicles. This allowed the service to use the new fleet across all sites. Managers told us that they aimed for all vehicles to be electric by 2024.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Senior managers we spoke with were extremely friendly and welcoming with our inspectors. This was reflected in the way we saw them communicate with their staff. It was clear staff felt comfortable with the senior team. All staff spoke highly of the service they worked for and many times we heard them say they felt "part of a family".

Managers recognised staff when excellence was identified by patients, the public or colleagues. When the service received positive feedback, the managing director wrote an individual letter to that member of staff including a £20 gift voucher in recognition of their hard work. On the day of our inspection, we saw 4 members of staff had received a letter and voucher in recognition for their work. One of those staff members had received 4 separate positive feedbacks and had therefore received 4 letters and vouchers.

The service had rapidly expanded, going from 30 to over 600 staff members. This had caused some instability within the organisation, and some staff members had left the service. One new member of staff told us the owners had made it very clear what their values were, and most staff had bought into these values.

In the months leading up to the inspection, we received whistle blowing enquiries which suggested a bullying culture within the service. Managers were aware of the allegations of bullying and poor culture and shared their investigations into these allegations with our inspection team. Managers followed due diligence in the investigation process. For example, they collected evidence from several members of staff and looked at driving statistics for a particular incident, where managers could see the speed, acceleration and braking statistics of the vehicle involved. The service had redeployed the members of staff involved to work in other areas of the organisation, while the investigation was ongoing. Evidence showed that managers were supporting the individuals who had made the allegations of bullying, but also recognised the impact that the investigation was having on the staff members accused of bullying. The allegations involved a small proportion of the work force.

Managers recognised that the rapid expansion of their service could raise problems with keeping a cohesive team. The employee app was initiated a month before the expansion, and feedback from staff was positive. We spoke to a member of staff who had only been with the service for a week. He said 'the app is great. It's very accessible and we can also get guidance on medicines on there.'

The welfare of staff members was a priority for senior managers. Staff accessed help and support from Trauma Risk Management Practitioners (TRiM - a trauma-focused peer support system designed to help people who have

experienced a traumatic event). They gave an example of an event when one of their paramedic staff had attended a dangerous scene without prior knowledge. The member of staff was traumatised by this experience and managers decided to deploy them to a non-clinical post until they felt ready to return to frontline duties. Staff also accessed a private healthcare service when needed, which managers had introduced into the company.

During a heatwave, one member of the management team took a welfare vehicle to a busy hospital, providing cold drinks and ice creams for ambulance staff who were working in the heat.

Senior managers told us they focused very much on communicating with their staff and wanted this to be an open and continuous loop. Managers used various platforms to do this; for example, the employee app, bulletins and newsletters, new electronic screens at some sites, and direct communication either in person or on the telephone. In terms of the employee app, we saw data showing 100% of staff had registered with the platform. Sixty-two per cent of staff actively engaged on this app.

Polaris Medical ran a colleague council once a month. One of the directors of operations chaired this group and invited a different senior member of staff each month. This meeting allowed staff a direct channel of communication with the executive team. The director of operations recorded questions or feedback raised at the meeting and passed them to the most relevant senior executive to answer. For example, in one meeting staff raised a problem with their Personal Digital Assistants (PDAs), which had been ongoing. The executive relayed this matter to the trust and staff were issued with new PDAs. We saw three sets of meeting minutes, which all included points raised by staff and answers to those points. For example, a question was raised about pay rise and the answer stated: “The changes to pay from the 21 March provided a 12% uplift for all staff, we continue to monitor the market rates and what is financially viable and will align our pay rates to remain competitive.”

We heard from one member of staff who told us they had recently had a life-changing health problem. They said senior managers and the managing director had supported them through this personally but also ensured they made any necessary changes to enable the staff member to work. Another member of staff told us managers had supported them through a bereavement period. “It felt like they cared rather than doing it as part of the HR process”.

The service trained staff to be Mental Health First Aiders and aimed for them to be available at every station.

The service had a Freedom to Speak Up Guardian. Freedom to Speak up Guardians support workers to speak up when they feel they are unable to do so by other routes. However, the service had appointed a senior manager for the role. Managers we spoke with agreed that this may not be appropriate as staff may not have felt comfortable raising issues with someone from the executive team. Managers planned to look into this further. Staff told us that there were many routes to raise concerns, and they felt empowered to do so.

Senior leaders investigated internal complaints thoroughly. We saw three examples of internal complaints, which the HR team dealt with. We saw evidence each complaint was investigated, and HR staff had clearly recorded evidence, outcomes, and further actions. Leaders told us they tried to ensure complaints were dealt with internally. However, the service had routes for staff to take if they felt the outcome of their complaint was not to their satisfaction. This including involving external investigators, the Advisory, Conciliation and Arbitration Service (ACAS), or going to tribunal.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Managers monitored the quality of the service continuously and had systems in place to help with this. This included, for example, monitoring the service's performance and KPIs, reporting and investigation of incidents, internal and external feedback, risks, and staffing. The clinical governance team collected data on several trackers and ensured not to include confidential information on the these.

Regular meetings took place internal and external to the business. The make ready teams met monthly to discuss and keep abreast of any changes to processes, performance and feedback. The heads of departments (HOD) met monthly to review compliance, governance, operations, and resourcing. A senior member of the HR team told us the team had started to meet once a month following the HOD meeting. We saw the minutes from the first meeting, and they included who attended, date and time of meeting, discussion points and actions. The clinical teams also met monthly to cover clinical governance topics, such as incidents, complaints, clinical changes and training matters.

Managers constantly evaluated pay and other benefits to ensure they offered a competitive package compared to other independent ambulance providers.

Polaris Medical managers met monthly with each NHS ambulance trust they worked for. They told us they continued to work hard to ensure they received all relevant information and data from the trusts. Feedback on safeguarding remained on the service's risk register, however, the risk rating had reduced, and managers reviewed this regularly.

We saw an example of slides from meetings between Polaris Medical and one trust and it showed operational statistics, clinical overview, complaints and risks were discussed.

Managers had introduced Quality Improvement (QI) initiatives in 2021. These helped the service achieve better performance. For example, they offered staff a pay incentive if they completed their run sheets correctly and started the shift on time, with all vehicle and equipment checks completed. Other QI initiatives included the introduction of QR codes for safeguarding referrals and feedback.

Managers relied on staff's honesty to ensure they declared working arrangements outside of the service. During induction, managers made clear to new staff the importance of not working excessive hours as it could impact on the care and treatment provided to patients.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a corporate risk register which identified current risks. The register was divided into 4 categories:

- Compliance and Regulatory
- Financial
- Operational
- Strategic

Each category listed risks with unique identifiers, risk description and type of risk, controls in place for mitigation, actions to reduce the risk, and the risk owner responsible for monitoring the risk. The risk registers clearly recorded dates of when risks needed review. The service rated risks using the Health and Safety Executive's (HSE) risk matrix,

based on severity and likelihood of risks occurring. Only 2 risks listed in the operational section of the register had a review date, as the risks were ongoing. Operational risks included staff sickness, terrorism, fuel shortages, and the mental health of staff. The service had identified that rapid business growth was an operational, strategic and financial risk, and continually reviewed this. The executive board closely monitored finances and compliance. The latest risk register gave fuel costs, staff recruitment and the lack of radio airwaves for one of the NHS ambulance trusts the highest risk ratings.

It was clear from conversations with senior managers that they had oversight over current and potential future risks. The clearly outlined risks around staffing numbers, seasonal demands, competition, and finances. They had put plans for mitigation in place against each risk area and continued to monitor their performance.

Staff we spoke with showed they knew about some of the risks currently affecting the business. Where relevant, staff became involved and engaged in raising risks to the management. For example, an ongoing risk involved an issue for staff working for one trust who did not have access to radio airwaves. We heard staff did not have access to digital ambulance radios and used mobile phones instead (ambulance radios ensure crews can quickly communicate in potentially dangerous situations). The service's managers had been, and continued to be, in discussion with the trust. We heard a meeting between Polaris Medical and the trust was taking place a few days after the inspection to discuss the issue further. The absence of ambulance radios was on the service's risk register.

Managers told us that some staff had left the service to join other ambulance services who were offering better pay. The service had conducted a pay review, which aimed to retain existing staff. Following a successful tender with one NHS Ambulance Trust, the service was able to offer a 12% pay rise for each member of staff on 21 March 2022. The Colleague Council asked about pay rises to be in line with inflation in the meeting held in July. Managers assured staff that they would continue to monitor the market rates and would align their pay rates to remain competitive.

The service did not have an overall emergency plan in place. However, they had an Emergency Preparedness, Resilience and Response Steering Group (EPRR) attended by representatives from operations, control, Health and Safety, fleet and logistics, information management and technology, training, finance and the managing director. This group met quarterly to monitor the provider's emergency preparedness.

Polaris Medical had a business continuity policy to ensure they provided a continuous service to the public when faced with disruption; for example, local or national risks such as severe weather, fuel or supply shortages, industrial actions, or terrorist attack. The business continuity policy provided the framework for compliance with statutory requirements by introducing a business continuity management system (BCMS) that aligned with the International Organisation for Standardisation ISO) 22301:2012 (ISO – this is an independent nongovernmental organisation developing voluntary international standards). At the time of inspection, the provider was in the process of working towards ISO 23001-2019 with an expected completion date of 3 November 2022.

Polaris Medical had an incident response plan for major car crashes in place and ensured regular staff training/ simulation.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Outstanding ☆

Emergency and urgent care

NHS ambulance trusts collected data relating to Polaris Medical to monitor their performance against contractual obligations. In instances when the provider did not meet the KPIs set out in their contracts, the relevant trusts informed them.

Additionally, the provider ensured they recorded and analysed their own data to monitor their performance. We saw spreadsheets and presentation slides presenting data for internal and external use. The service collected information in various areas; for example, safeguarding, incidents, complaints and compliments, time spent mobilising, treating, and handing over patients. Managers put mitigation plans in place when performance in any of the areas fell, mostly in the form of tailored training for staff. For example, during a time when the provider received an increase in concerns raised regarding staff's attitude, they introduced more in-depth customer service training sessions.

Managers shared data with staff in internal meetings and communications. The induction process ensured staff knew about KPIs and how to achieve them. We saw slides from the induction outlining KPIs. Staff knew who to contact when they needed data.

Managers communicated urgent communications through the employee app, with priority posts within the feed being highlighted. For must elements, staff could only click to confirm they had read the post after an appropriate amount of time had passed.

A total of 461 staff members were registered to use the service's mobile communications app. The service looked at staff engagement with the app between June and September 2022.

- 62% of staff members engaged on the app each day
- 32% of staff members were passive
- 6% of staff members were inactive.

Staff members classed as passive, were staff members who were not commenting or posting on the app.

Between June and September 2022, there had been 204 posts, with 85 comments and 752 likes. There had been 7502 direct messages and 10,183 group messages. Staff told us the app was invaluable as it provided a direct line to managers, the fleet team and colleagues. There were groups for each station, and it gave direct access to important information while out on the road.

The service wanted to have more oversight on safeguarding referrals. They developed a new system where staff could use QR codes to access a safeguarding reporting assessment tool. This tool gathered information on the safeguarding referrals made. Between 21 and 28 September 2022, the service had collected details of 9 safeguarding referrals that staff had made. They involved concerns regarding domestic violence, neglect, emotional abuse and fire risks. The service was in the process of embedding the use of the safeguarding reporting tool with all staff members. The data collected would be used to monitor the safeguarding referrals, look for any themes or trends and look for any learning needs for staff.

The mobile communications app linked to an online incident reporting programme. This allowed for easy reporting of incidents. The incident reporting programme was used to record audits that were carried out by the service.

The service was expanding the incident reporting programme's capabilities to integrate with the NHS electronic reporting system. This would allow for immediate reporting to NHS trusts and would link the service's risk register to learning outcomes from incidents.

Staff could also report incidents via a paper-based incident reporting form. Some incidents needed to be reported directly to the trusts, following their own protocols. Managers wanted to embed the use of the online incident reporting software with all staff.

The service used an online rostering system, used by other NHS ambulance trusts and over 60% of all police and fire services. This system was due to be added to the mobile communications app, for ease of access. The system enabled staff to request leave, swap shifts and informed subcontracted staff of available work. The system helped with planning and notifying staff of statutory and mandatory training.

Managers discussed their social media marketing at monthly head of department meetings.

The service carried out a comprehensive range of audits. Audits were carried out by either online audit tools or on a paper-based system within the individual ambulance stations. The service kept an Audit Tracker which detailed how often each audit should be completed, and who should undertake them. Examples of audits that the service undertook included:

- Uniform audits, which included random spots check on 4 members of staff
- Daily, weekly and monthly controlled drugs audits
- IPC audits at each station, carried out monthly, quarterly and yearly
- Procurement audits
- Stock audits
- Monthly clinical governance audits.

The service's Information Technology (IT) lead was developing an internal IT based auditing system, which would ensure all audits were stored securely and could be analysed remotely.

The service was installing electronic temperature recording systems in all stations. This gave live reporting of the temperature in storerooms and fridges were medicines and consumables were stored. The new system warned staff if the temperature went over or below a temperature range, with temperatures being read every 5 minutes. The current method of checking temperatures was once a day and was paper based and audited.

The service had General Data Protection Regulation (GDPR) and Data Protection Policies on their website, which outlined how the service used and stored data. Compliance audits and checks on GDPR were carried out 6-monthly at each station by the Caldicott guardian (a Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information). The Caldicott guardian for the service was the registered manager.

The service ensured they saved and stored confidential information securely. Inside Polaris Medical sites records were mostly held electronically and passwords required to access information. Any confidential paper records had to be locked away in fire-safe lockboxes. The buildings themselves had access controlled, usually via identification card entry systems.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Managers valued feedback from the public and had systems in place to gather this. The service analysed data and continuously sought ways to improve their business.

We felt managers communicated openly, honestly, and actively with our inspectors. Managers appreciated any inspection opportunity because they saw it as a chance to develop and shape their service.

Leaders told us they actively listened to their staff. Staff we spoke with confirmed this; they felt they could approach any manager at any time and felt listened to. Senior teams visited each Polaris Medical site monthly and spoke to as many staff as possible. This allowed a direct communication route. The service's colleague council offered additional space for active listening.

The service carried out several staff polls using the employee app. Managers used feedback from polls to make changes. Additionally, an annual staff survey took place, run by an external company on an anonymous basis. Staff also had the option of raising feedback anonymously using lockboxes across sites. Staff placed feedback in the lockbox and a senior manager regularly emptied the boxes and collated anything raised by their staff.

The provider was committed to promoting equality and diversity best practice and had an up-to-date equality and diversity policy in place. The policy was in line with the Equality Act 2010 and the Employment Rights Act 1996. It outlined the duty of all staff to adhere to consistent standards, both internal and external to the business. It clearly said any failure to comply with these standards resulted in an investigation and potential formal action.

We spoke with a member of staff whose first language was not English. They initially had concerns this would hinder their recruitment to Polaris Medical. However, the member of staff reported managers provided excellent support to ensure they were not disadvantaged. We spoke with managers who told us about another member of staff who was dyslexic. They had experienced difficulty accessing a higher education course and managers supported them by communicating with the educational facility and ensuring their application went ahead.

Polaris Medical had a lesbian, gay, bisexual, transgender, and queer (or questioning) (LGBTQ) group in place and planned to start a black, Asian, and minority ethnic (BAME) group in the future.

The service encouraged feedback from service users. Posters were displayed in all ambulances advising how service users could give feedback directly to the service or to CQC. The service's public website gave an email address for service users and feedback forms were stored on all ambulances. The service was developing the use of QR codes. Staff members, patients or families could use these to easily report areas of excellence, improvement or concern. The QR codes were not fully embedded at the time of the inspection. Managers recognised that improvements could be made from feedback. Managers communicated any 'lessons learnt' from incidents, complaints or complements in a quarterly 'lessons learnt' Bulletin. This was communicated to all staff via the service's mobile communications app.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

During our inspection and on review of data received from the service, we saw evidence of a lot of innovation. Managers spent time and resources to put in place ways to continuously develop their service. This ranged from equipment and technology to training and staff incentives.

Outstanding ☆

Emergency and urgent care

Staff development was a clear priority for Polaris Medical Services Limited. The service had opened an education centre, The Polaris Academy, in 2020. The academy gave students access to emergency ambulances, an ambulance simulator, a fully furnished simulation apartment and an indoor scenario training area. This meant that students could train in 'real life' scenarios, being able to practice handling patients in difficult situations, such as baths and deep armchairs.

The academy was accredited with several educational organisations, including Birmingham University and Future Quals. Courses included a range of vocational qualifications, such as level 3 certificate in Emergency Response Ambulance Driving (CERAD), Pre-hospital Paediatric Life Support (PHPLS), and Major Incident Medical Management and Support (MIMMS). The service ran a Health and Care Professions Council (HCPC) approved Return to Practice Course and mentorship. The CERAD courses ran for 4 weeks, with a maximum of 3 students to each instructor.

The academy offered diplomas in First Response Emergency and Urgent Care up to level 5 (FREUC5). Managers told us they would soon be able to offer an Internal Level 6 Paramedic honours degrees through the academy, along with Emergency Care Assistant and Technician apprenticeship programmes. These were through accreditation schemes with Birmingham University. Staff could enrol on these courses at discounted prices compared to external candidates.

Employed and subcontracted staff members were actively encouraged to train and develop. One member of staff told us how they had been supported to develop through the academy. They were initially apprehensive, as English was not their first language, but the executive team had supported them. This member of staff had started as a care assistant and trained with the academy to become a technician. They planned to continue with their education. One external student gave feedback on the academy, which said "Staff and facilities are amazing. The course was presented in a very professional manner to a very high standard."

The service told us of 6 different success stories, where members of staff had been supported to professionally develop through the academy. One member of staff had started as work experience directly from school and had just passed the exams to become a technician.

The Polaris academy delivered innovative and specific CPD courses to its own staff members and to external staff. These courses included taught pre-hospital clinicians advanced trauma pathophysiology. The Paediatric and Neonatal Decision Based Assessment (P&NDA) course was a 2-day course and increased confidence in paediatric clinical assessment in the pre-hospital environment.

Polaris Medical Services Limited had recognised that there was a national shortage of paramedics in the United Kingdom, with a study conducted in 2021 stating that the UK was 10,000 clinicians short. In addition to developing and promoting staff internally, the service had a Tier 2 License, where paramedics from international countries were sponsored by the service to work with them for 2 years. They had sponsored 30 international paramedics in 2022 and aimed to sponsor another 30 paramedics in 2023. Similarly, the service helped paramedics from Ireland to work with them with an Irish qualification conversion course.

The service made use of a wide range of technology apps and platforms to increase staff engagement and communication. All staff we spoke with mentioned the employee app, which was used for service-specific updates on policies and guidelines but also for a variety of chats. The service had completed testing on new electronic screens for use in staff areas. Manager had introduced this as an additional tool to communicate important business-related information to their staff.

Each time the service received a compliment about staff, the managing director sent a personal email including the feedback to the staff member(s) in question. Additionally, staff received a voucher as a thank you for their work.

Outstanding ☆

Emergency and urgent care

At the time of inspection Polaris Medical were applying for a United Kingdom Accreditation Service (UKAS) accredited laboratory on site. This nationally recognised accreditation body assessed for their ability to provide high-quality, certified testing. Managers told us this was to set up an internal occupational health service.

Outstanding

Patient transport services

Safe	Outstanding
Effective	Outstanding
Caring	Good
Responsive	Good
Well-led	Outstanding

Are Patient transport services safe?

Outstanding

We had not previously rated this service. We rated it as outstanding.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. There were 8 active Patient Transport Service (PTS) staff members working on an NHS ambulance trust PTS contract. They had all completed their mandatory training. Staff members would not be deployed for work unless they had completed their mandatory training. Five PTS staff members were paused for deployment until they had completed their outstanding mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training followed the Skills for Health core framework. Training modules included; infection prevention and control (IPC), equality, diversity and human rights, safeguarding adults and children, conflict resolution, and fire safety.

Clinical staff completed training on recognising and responding to patients with dementia as part of their mandatory training. They had not completed training on learning disabilities and autism. From 1 July 2022, all health and social care providers registered with CQC were required to ensure that their staff had received training in learning disabilities and autism, at a level appropriate to their role. The service was introducing a revised Skills for Health bundle from October 2022.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service kept a log of all mandatory training. Staff members told us that they were sent reminder emails a month before their training was due for renewal. All staff members were required to complete their mandatory training with Polaris Medical Services Limited, even if they had completed mandatory training with another service.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

PTS staff received training specific for their role on how to recognise and report abuse. The service had 2 safeguarding leads, who were both trained to level 4 Safeguarding and were working towards level 5. Staff knew who the safeguarding leads were.

All deployed PTS staff had received training to level 3 in Safeguarding Adults and Children. Training was in line with guidelines and included training in female genital mutilation.

Staff were instructed on how to make safeguarding referrals within their induction training. Procedures were clearly detailed in pathways documents, which were stored on the service's mobile communications app. The service had introduced the employee app a year before the inspection. Important policies and documents were stored on the app and could be accessed wherever and whenever staff needed them.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff had a good understanding of the signs of abuse. If they felt that a patient was not safe at home, they would return them to the hospital and make a safeguarding referral.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They told us that they would report safeguarding concerns following the relevant NHS Ambulance Trust's protocols. These were available on the employee app. If staff were not working for a trust, they would report safeguarding concerns directly to the safeguarding leads for the service. Any safeguarding referrals made were logged on a daily run sheet. This meant that the service could see how many safeguarding referrals had been made.

Staff followed safe procedures for children visiting the service. Children were not treated by the PTS arm of the service, but all PTS staff had received training for safeguarding children level 3.

For additional information on safe management of safeguarding please see emergency and urgent care.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. We inspected 2 vehicles which were used for PTS. Both were visibly clean and had stickers, which confirmed that the vehicles had received a deep clean.

All vehicles were deep cleaned every 6 weeks or earlier if they became contaminated. Deep cleans were carried out by the make ready teams and took a full day to complete. All consumables and equipment were removed from the vehicles. Ten preselected locations in the rear of the vehicle and 5 preselected locations in the front cab were swabbed and tested electronically. All surfaces were wiped down and cleaned with multispectrum cleaners, using disposable mop heads and steam cleaners. The same preselected locations were then re-swabbed and tested. The pass rate for the swab testing was a score below 30. The make ready teams re-cleaned any areas which did not pass the swab test.

We looked at deep clean records for PTS vehicles, which had check lists of all equipment and surfaces that were cleaned in the process. The records clearly documented what disinfectants to use in each area and outlined each step of the deep clean process. There were clear instructions on how to clean the electrical equipment, including the automated external defibrillators (AEDs) which were carried on the PTS vehicles.

Consumables, such as oxygen masks and tubing, were single use and disposed of in the clinical waste after use. We observed PTS staff wipe down the stretcher and the hard surfaces around the stretcher after each transfer.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Deep clean records were paper based and were kept on file at each station.

The service completed monthly and quarterly IPC audits at each site. The station supervisors and managers of the service completed these. The audits looked at the cleanliness of the station, if clinical waste bins were being used appropriately, and the availability of personal protective equipment (PPE), amongst other parameters. If any issues were raised, an action plan would be drawn up. We looked at IPC audits from the PTS ambulance station. One of the audits had indicated that there was no eye protection available in the sluice room. Issues were raised in the action plan and subsequently signed off. Those issues were not seen again in the following audits. If there were any concerns raised from the audits, further training was arranged, and lessons learnt would be cascaded to other members of the team.

An external IPC consultant visited all ambulance stations twice a year. This gave the service assurances that their IPC auditing systems were robust and valid. One visit was unannounced, so staff could not prepare in advance. We saw the last external IPC audit which was completed at the PTS ambulance station. It had identified that there were holes in 2 mattresses. The issue had been raised on 9 March, and the action plan had been signed off on 10 March 2022, to state that the mattresses had been repaired.

Staff followed infection control principles including the use of personal protective equipment (PPE). All PTS staff had received training in infection protection and control as part of their mandatory training. We inspected 2 PTS vehicles. They had appropriate PPE on board, including gloves, masks, aprons and disinfectant wipes.

We observed 2 PTS crew members wear the correct PPE when seeing and treating patients.

Hand hygiene audits were carried out at each station twice a week. These audits assessed if staff could demonstrate effective handwashing and hand gel application. Auditors looked to see if nails were clean, short and free from nail polish, and if staff were aware of the 5 moments of hand hygiene. The 5 moments of hand hygiene defines the key moments when health care workers should perform hand hygiene. Records showed consistent outstanding results from the hand hygiene audits.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Stickers were placed in a visible location on all ambulances, which showed when they had received a deep clean. We observed PTS staff wipe down equipment with disinfectant wipes after transferring each patient.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. For additional information please see emergency and urgent care.

Patient transport services

Staff carried out daily safety checks of specialist equipment. The make ready staff prepared the vehicles by stocking them according to load sheets. The make ready team were on site from 5am to 10pm each day. If stock was needed outside of these hours, staff could restock consumables from running stores lockers. The running stores locker on the PTS site did not have an obvious stock rotation system in place, with consumables with shorter expiry dates at the back of the cupboard.

PTS staff were responsible for undertaking daily vehicle inspections and completing an Operational Order log. It was the driver's legal responsibility to complete a Vehicle Daily Inspection (VDI) before each shift. The VDI checked lights and batteries, washers and wipers, seats and seat belts, horn and steering, tyres and wheels, exhaust, brakes, fluids, fuel, oil and batteries. The driver signed to say these checks had been completed. Any defects were reported to the station supervisor and raised as an incident with the fleet manager.

We inspected 1 PTS ambulance and accompanied a crew in another PTS vehicle on a shift. The ambulance which was used to carry out the PTS service was clean and well stocked, with equipment in date and appropriate to use. The other PTS ambulance we inspected had 19 consumables on board which were out of date, including bandages and dressings. However, this ambulance was not in use and had travelled from another ambulance station for servicing. The consumables which were on the vehicle were not normally used on PTS vehicles and were not on the load sheet. The manager at the station was informed, and the out-of-date consumables were removed.

PTS vehicles normally only carried manual handling equipment, such as slide sheets, turntables, carry chairs and stretchers. They also carried basic resuscitation equipment, automated external defibrillators (AEDs) and oxygen. IPC consumables, such as gloves, hand gel, aprons and disinfectant wipes were also included.

The service had enough suitable equipment to help them to safely care for patients. For additional information please see emergency and urgent care.

Staff told us that vehicles were well stocked by the make ready teams.

The service had 17 PTS ambulances. A fleet manager and 3 mobile mechanical engineers serviced vehicles. The fleet team gave 24-hour cover, with the team taking it in turns to be on call overnight. Some of the vehicles inherited from the other independent ambulance provider, were still on a lease, which included servicing and maintenance. The service aimed to increase the capability of the fleet team for when these leases expired and was advertising for mobile mechanics.

At the time of the inspection, many PTS vehicles were not in use. We saw records of 7 PTS vehicles as having faults reported to the fleet team in the 2 months before the inspection. Three had had flat batteries, 1 required new tyres and 1 had a loose handbrake. This showed that the vehicles were still being maintained despite not being in use.

Staff were required to complete a Work Ready checklist before starting work. This included ensuring they had the correct uniform, 'High Vis' jackets and safety footwear. Staff who were subcontractors for the service were required to supply their own uniform.

Staff disposed of clinical waste safely. Clinical waste was disposed of in clinical waste bins. We saw clinical waste bins were locked. The service had a contract where clinical waste was collected weekly.

The service was aiming to be carbon neutral by 2024. The contractor they used to collect clinical and general waste promised that none of the waste they collected would go to landfill. Every station had recycling facilities for batteries, metal and waste electrical equipment. The workshop used for servicing and maintenance of all vehicles fully recycled all waste including oil and tyres. The service replaced ambulances every 5 years and aimed for its fleet to be electric by 2024.

The PTS staff we spoke with told us they had allocated phones and if there was an emergency, they were required to dial 999. Staff told us if they had airwave radios, they would be able to automatically access the control desk to get help. Some staff members felt unsafe working for this NHS Ambulance Trust. This had been raised repeatedly by the service with the NHS ambulance trust and the service was in talks with them to come up with a solution.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff responded promptly to any sudden deterioration in a patient's health. The service provided a non-emergency patient transport service (NEPTS). Patients had a medical condition which meant that they would struggle to attend or return from hospital independently. The majority of the transfers were to outpatient appointments, inter-hospital transfers, or to dialysis departments. If a patient's health deteriorated, staff told us that the first point of call would be to contact the NHS ambulance trust clinical advisors. Each vehicle was supplied with a telephone. The service also had their own clinical advisors available on 24 hours call. If required, an Urgent and Emergency Care vehicle would be sent, or the crew would pre-alert the nearest hospital.

PTS vehicles carried oxygen and a defibrillator to use in emergencies. PTS staff had received training in basic life support and resuscitation.

Staff knew about and dealt with any specific risk issues. Risk issues were communicated to all staff through the employee app. Recently, staff had received communications about the increased cases of Monkeypox within the UK. Staff told us that they had received extra learning on headaches and how to deal with them through the mobile communications app. Staff were required to indicate that they had read about these important communications but could only check the box to say they had read it after an appropriate amount of time had passed.

The service had access to mental health liaison and specialist mental health support. Staff told us of an occasion where they had contacted the trust's clinical advisors for advice. The mental health nurse called them back within 2 minutes and gave appropriate advice on how to manage the patient.

Staff shared key information to keep patients safe when handing over their care to others. There were clear guidelines around accountability for patients. Staff told us that responsibility for the patient commenced when they had received the paperwork from hospital staff.

Handovers included all necessary key information to keep patients safe. We observed a PTS crew hand over a patient's medicines to staff within a care home and communicate necessary handover information.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave staff a full induction.

Patient transport services

The service had enough staff to keep patients safe. The service was currently using 8 members of staff who worked on a PTS contract. Six were trained in First Response Emergency Care qualifications to level 3 (FREC3) and 2 were trained to level 3 in First Aid at Work.

Another contract had ended abruptly due to a lack of funding. The service had used 6 PTS staff members to cover that contract. They were not being deployed at the time of the inspection.

Meeting minutes for a Head of Department meeting in September 2022 showed a total of 637 members of staff working across the service, including subcontracted staff. This included 25 members of employed PTS staff and 3 subcontracted PTS staff.

The service could adjust staffing levels daily. Shifts were arranged a month in advance with the NHS Ambulance Trust. The service used a planning software, which allowed for planning to demand up to 3 years in advance. This software was used for subcontracted staff members to bid for shifts, informing them of any vacancies by area and grade. The software also allowed full recording of absences and notifications of shift changes.

Staff followed guidance on alerting managers if they were unable to attend a shift. Urgent and Emergency Care (UEC) staff and student paramedics would work on PTS shifts if required. The service had completed 99% of all journeys for the contract in a 4- month period between February and May 2022.

Staff members were either employed or subcontracted. Staff who were subcontracted were offered work on an 'ad hoc' basis, which meant that the service would only offer work when there were operational demands.

Subcontracted staff members told us they liked the flexibility. One staff member told us they never worked weekends and would not get that option if they were employed. Some subcontracted staff members had planned to work at the football World Cup in Qatar. The service was arranging extra cover for this period.

All ambulance workers were covered by the Working Time Regulations except in emergencies. Staff were encouraged to take a rest break within a 6-hour period, and if they were unable to, they would be offered compensatory rest at another time. Subcontracted workers were trusted to take adequate breaks between shifts, and staff were not able to take more than 6 consecutive shifts without a break.

The service had employed a PTS lead who was due to start in the next month. Their role was to develop the PTS arm of the service. Managers told us that competition for PTS contracts was high. In some areas of the country, the NHS ambulance trusts would advertise all required PTS shifts on an online platform, where independent ambulance services would bid for these shifts. When the PTS lead started, it was anticipated that the PTS service would expand, and more staff would be required.

The service had high vacancy rates. The service was advertising for a bio-medical engineer, fleet mechanics and make ready staff to support the PTS and the service as a whole. The service had rapidly expanded in the year preceding the inspection and was continuing to expand.

The service had identified that there was a national shortage of ambulance clinicians in the UK. They were actively training and upskilling staff members. Members of staff could start as part of the Make Ready team, and the service would support their development through the service's academy to progress to roles in the PTS or EUC arms of the service.

The service had reducing sickness rates. Monthly meetings between Heads of Department discussed sickness rates across the service due to Covid-19. In January 2022, there had been 36 positive Covid-19 cases. In August 2022, there had been 8 staff members who had tested positive for Covid-19.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and stored securely.

It was not clear if patient notes were comprehensive. We were unable to view patient care records for the PTS service as they were electronic, and they belonged to the NHS ambulance trust. The service told us that a minimum of 10% of all patient care records from the service were subjected to auditing each month by the NHS ambulance trust. If any issues were identified through the auditing process, this would be fed back to the service, and they would communicate any learning needs to the individual member of staff who was responsible for those records.

Records were stored securely by the NHS ambulance trust electronically.

The service had provided a PTS contract for another NHS Ambulance Trust over a 2-month period, but it had ended due to a lack of funding. Patient care records for this trust were paper based. We were told that these records would be securely stored in an envelope and in the glovebox of the ambulance throughout the day. At the end of the shift, the patient care records would be returned to the ambulance station and stored in a secure box. The NHS ambulance trust collected the records on a weekly basis and would audit at least ten per cent.

Staff were required to complete a log sheet after each shift. This paper record gave the service important information on the exact times the shifts took place, the numbers of jobs attended, equipment used and other key facts. The logs were used to provide the police with evidence if the vehicle had been caught on a speed camera while driving on blue lights. PTS services would not normally need to drive on blue lights.

Medicines

The service followed best practice when administering, recording and storing medicines.

PTS ambulances only carried oxygen. They did not carry any medicines or controlled drugs. The oxygen cylinders were stored at ambulance stations and on the ambulances in line with guidance.

Staff stored and managed medicines safely. They followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. We observed a PTS crew check a service user's medicine was all accounted for and signed off by staff in the discharge lounge. The medicine was transported in sealed bags and handed over to onsite staff at the service user's accommodation on arrival.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The PTS service did not carry any controlled drugs.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Outstanding ☆

Patient transport services

The senior leadership team at Polaris Medical encouraged staff to report incidents. They felt the reporting of incidents helped to learn and improve the work the service did. Staff knew what incidents to report and how to report them. They gave examples of incidents and near misses during the inspection.

The service understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The service had a duty of candour policy. They were committed to ensuring they were open and honest with service users when things went wrong. They endeavoured to provide service users with reasonable support, truthful information and a written apology were necessary. The PTS service had never been required to exercise duty of candour in relation to any incidents.

Managers met to discuss the feedback and look at improvements to patient care. The service held quarterly meetings with the NHS Ambulance Trust to discuss the PTS service. The trust would feedback incidents within these meetings. The PTS service had no incidents in the last 12 months preceding the inspection.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The service's Complaints, Concerns and Complements Policy stated that a member of the Senior Management Team would communicate either verbally or in writing the outcome of the investigation. This may be to the trust or directly to a service user depending on how the incident had been raised. If a service user was not happy with the outcomes, the case would be referred to the Parliamentary and Health Service Ombudsman.

We observed the service's incident tracker from 15 March to 27 September 2022. Only 1 of the 190 incidents on the incident tracker related to the PTS service. This was regarding the out-of-date consumables which were found on the day of our inspection

Staff received feedback from investigation of incidents, both internal and external to the service.Managers debriefed and supported staff after any serious incident. Incidents and learning from incidents were discussed in quarterly 'lessons learnt' Bulletins. These were shared with all staff members. Staff told us that they felt well supported by managers after incidents. If staff members had attended a difficult job, the NHS Ambulance Trust, or the individuals involved, would alert managers. Managers would activate the Trauma Risk Management (TRiM) system. This was a peer support system designed to help people who have experienced a traumatic event. Managers told us they would make welfare calls at regular intervals after an incident. Staff members told us of occasions when they had received welfare calls. The service could refer staff members to BUPA and MIND when required.

Are Patient transport services effective?

Outstanding ☆

We had not previously rated this service. We rated it as outstanding.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Patient transport services

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff followed guidelines from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). The JRCALC guidelines were an essential resource for pre-hospital clinicians. They were an important part of clinical risk management and ensured uniformity in the delivery care. Staff accessed JRCALC information on their employee app.

The service shared all updates of the JRCALC guidelines on the employee app. All staff members had access to important updates. Staff could also access the updates via some of the NHS ambulance trust's Electronic Patient Care Reporting (EPCR) tablets.

The employee app gave staff members access to the NHS ambulance trusts' policies and standard operating procedures. Staff were required to follow the policies and procedures of the relevant NHS Ambulance trust that they were working for.

The services own policies were stored on the mobile communication app. This meant that there were no paper copies available in the ambulance stations, which can quickly become outdated. Staff could easily access the relevant policies wherever and whenever they needed to reference them.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. All staff had access to the Consent and Mental Capacity Policy on the mobile communications app. Staff were able to tell us of their understanding of it. The policy quoted the Mental Capacity Act 2005, which provided a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. This policy was comprehensive and covered necessary contents, including clear links to the Mental Health Act 1983 and the Mental Capacity Act (2005).

Nutrition and hydration

As the service did not undertake long journeys there was limited need for staff to provide refreshments on journeys. Staff ensured patients had sufficient supplies at home.

Response times

The service monitored and met agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

Managers met with the ambulance trusts quarterly to discuss PTS key performance indicators (KPIs). We looked at the KPIs between February 2022 and May 2022.

The service was required to complete between 399 and 426 journeys each month in that quarter. The service met the trust's requirements by 99% in that period of 4 months.

The service performed consistently well in meeting the KPIs for planned inward and outward journeys. The performance averaged at 93% for planned inward and planned outward journeys.

The service had strict KPIs to adhere to in respect of patients attending hospital for dialysis. The KPIs required patients to be dropped off no later than 30 minutes before and collected no later than 30 minutes after their appointment. KPIs were more difficult to achieve in these cases, as appointments could run late. The service had achieved the KPIs in 97% of all inward transfers of patients to one renal unit, and 89% of outward transfers from the same department. PTS crews would activate their Personal Digital Assistants (PDAs) when arriving at the department. If this was activated 20 seconds earlier than the 30-minute target, there would be an immediate failure in terms of meeting the KPI.

The service's KPI performance for short notice discharge and transfer patients was 79%. The NHS ambulance trust had not highlighted a concern with this KPI in their quarterly meetings.

The service would be penalised financially by the NHS ambulance trusts if they were repeatedly below 10% of the KPIs.

The trust identified measures they could take to implement to improve the KPIs. One of these measures was introduced in May 2020. A financial incentive bonus was introduced for staff who logged on to their shift within the first 5 minutes of the shift starting. Any log on after 6 minutes was considered late, and the incentive bonus would not be paid for that shift. Individuals who logged on late more than 2 times in a week lost the incentive bonus for all shifts that week. If a member of staff was late more than 3 times in a month, the incentive bonus would not be paid for all shifts within that month.

The NHS ambulance trusts did not give any comparison on how the service was compared to other independent ambulance providers. Managers were confident they were performing well from feedback from the quarterly meetings. If there were any areas of improvement, the trust would communicate this to them.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service only employed fully vetted associate ambulance practitioners, emergency care assistants and ambulance care assistants for the PTS service. The service operated robust safe recruitment processes when recruiting staff members. Enhanced Disclosing and Barring Service (DBS) checks were carried out and renewed yearly. These checks, along with checks on correct registration with the Health and Care Professionals Council (HCPC) were stored electronically.

The service had 8 PTS staff who were currently being deployed to work on the contract. Six had First Response Emergency Care (FREC) to level 3 qualifications and 2 were qualified to First Aid at work, level 3. The skill mix for each shift was determined by the NHS ambulance trust a month in advance. Most of the shifts were manned by 2 crew members.

All staff members were required to complete ongoing driving skills assessments every 5 years. These assessments included driving licence checks, an eyesight test, a theory test and a practical driving assessment.

Make Ready staff had received training in Control of Substances Hazardous to Health (COSHH) and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). This was necessary as they worked with cleaning products which could be hazardous to their health.

Managers gave all new staff a full induction tailored to their role before they started work. PTS staff told us it was not just a 'tick box exercise.' We observed a Non-Emergency Patient Transport Service (NEPTS) induction presentation. The induction presentation covered an overview of the history, the culture and the philosophy of the service. The induction presentation covered the expected clinical standards for staff, complaints and incidents, health and safety, safeguarding, uniform and PPE. Handy tips were shared, and daily duties were explained. Staff were informed of the financial incentive that the service paid to all staff members who were able to be on the roads before or on start time after completing daily checks.

Patient transport services

All staff were expected to follow the service's clinical and operational standards, which outlined key information such as the correct uniform, expectations on paperwork and clinical notes, clinical pathways documents and dealing with complaints. All necessary documents were available to new staff on the service's mobile communications app.

PTS staff completed a day's driving assessment at induction. This was assessed to the current UK standard in line with the Level 3 Award in Patient Care Service Ambulance Driving (L3APCSAD). If further training needs were identified during this assessment, the learner was required to undertake the full L3APCSAD course. This was delivered over 5 days by an approved instructor. The service's lead in driving standards was 1 of 5 qualified instructors in the UK.

As new staff members worked on contracts with NHS ambulance trusts, they were also required to complete the necessary induction training with the trust.

The service had developed a new Make Ready Training Competency and Evaluation booklet to support make ready staff's induction and ongoing training. This outlined site specific health and safety information and site orientation, standard IPC precautions, sharps bin management, use of PPE, and vehicle familiarisation amongst other parameters. Once a section had been completed it would be signed off by the make ready staff member and their mentor.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff completed a Personal Development Review (PDR) yearly with a member of the Clinical Leadership Team. The PDR looked at areas of strength and areas for development. It gave staff members an opportunity to create SMART objectives for the following 12 months. The objectives needed to be Simple, Measurable, Achievable, Realistic and with a Timeframe for completion. We looked at a sample of 6 PDRs which covered all roles throughout the service. The PDRs gave staff members an opportunity to give constructive feedback on the service as an employer. One said, 'Polaris have been helpful throughout the recruitment phase and have been good communicators.'

We saw evidence of a probation review and job chat documents with station supervisors.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Staff told us that they felt supported by the management team to progress and develop. One ambulance technician told us they had started as make ready and had been supported to develop. Two of the current PTS staff were due to qualify as frontline ambulance technicians. Two Make Ready staff members were training to become emergency care assistants and would be able to work as PTS staff.

The clinical educators supported the learning and development needs of staff. The service's philosophy was to attract the best staff in order to promote and grow the business organically. The service aimed to train staff well and set high standards, which were achievable and measurable.

The service had recognised that there was a national shortage of ambulance clinicians. The service was committed to developing and promoting within its own workforce. Staff who we spoke with confirmed this. The service had developed the Polaris Academy, which incorporated a frontline ambulance station and gave access to full clinical facilities. The tutors employed by the academy were experienced pre-hospital consultants.

The academy offered First Response Emergency Care (FREC) qualifications to levels 3 and 4, and First Response Emergency and Urgent Care (FREUC) level 5. These qualifications allowed candidates to progress from Make Ready staff

to PTS work and then to frontline ambulance work. Courses were offered to internal staff and external candidates. Internal staff, including subcontracted staff, received discounts for these courses. The academy was developing a new scheme with Birmingham University and had plans to deliver apprenticeships and an Internal Level 6 Paramedic BSc (Hons) degree.

Managers believed that better care and treatment is achieved through training and development. The service put a lot of emphasis on staff development. The service had recently developed a series of Alphabet Lectures, which covered different topics for Continued Professional Development (CPD). One PTS staff member told us that the topic that month had been Learning Disabilities. The Alphabet Lectures were free for staff members and were sold as a commercial package for external students.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers completed Personal Improvement Plans (PIP) with staff who exhibited poor performance. They identified areas of improvement and provided support to access further training. Managers gave an example of when a PIP was implemented, the support measures put in place and the outcome for that member of staff.

Managers made sure staff received any specialist training for their role. PTS staff were trained in effective Basic Life Support and using AEDs. Staff were supported by managers to learn, develop and promote into other roles through the academy.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

PTS staff communicated with hospital staff, carers and families to ensure they had all the information they needed. This included patient wishes, such as any Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) wishes of each patient, any relevant medical history and details of any medicines. The service only operated a non-emergency PTS service and did not normally transport patients with complex needs. The service did not provide a paediatric PTS service.

We observed PTS staff communicating with nursing staff within a discharge lounge. They asked appropriate questions and gathered all the information required. There were clear guidelines around accountability of the patient. While the patient was on the ward, the patient was the responsibility of the hospital. The PTS staff took responsibility for the patient when the paperwork was handed over. Once the patient was settled in at home, and the paperwork was handed over to staff within the care home, responsibility transferred to the care home staff.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff could access advice from clinical advisors who worked for the trust. This included advice from mental health nurses. One crew member told us how he had sought advice from a mental health nurse recently. Staff told us that they would never leave a patient in an environment which they thought was unsafe. They had sound knowledge on how to make a safeguarding referral.

Health promotion

Staff did not always give patients practical support and advice to lead healthier lives.

It was not always feasible for staff to give patients advice on leading healthier lives.

Outstanding ☆

Patient transport services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All staff had access to the Consent and Mental Capacity Policy on the service's online communications app. They were able to describe their understanding of consent and how to obtain it.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood the difference between implied consent and expressed consent. They gave us examples on how they would obtain consent. This followed the guidance in the service's Consent and Mental Capacity Policy.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. They were able to describe how they would assess a patient's capacity. The Consent and Mental Capacity Policy detailed the Diagnostic Test, where in emergency situations, staff would act in a patient's best interests.

Staff made sure patients consented to treatment based on all the information available. One member of staff explained that they would always fully explain and keep the patient involved in any decision making. PTS staff collected all relevant information from hospital staff, relatives or carers before the handover of care. This included any Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) wishes of the patient.

Staff clearly recorded consent in the patients' records. When making a record relating to the capacity of a patient, staff included what the decision was and how the decision had been made, including any family involvement and referrals. If a patient refused to travel with a crew, they would record this in the records and ask the patient to sign it.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. All policies were available to all staff on the employee app.

Staff understood Deprivation of Liberty Safeguards (DoLS) in line with approved documentation. DoLs forms part of the Mental Capacity Act 2005 and ensures people are receiving care in a way that does not inappropriately restrict their freedom. Those planning care should always consider all options and provide care in the least restrictive way possible. Two staff members told us they would always use the least restrictive options first. The service's Consent and Mental Capacity Policy stated that transporting a patient who lacked capacity from their home to another location would not usually amount to a deprivation of liberty. The policy gave examples of when staff would be required to carry out a DoLs assessment, and staff told us they would take advise from the NHS ambulance trust's clinical advisors when required.

Are Patient transport services caring?

Good

We had not previously rated this service. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We accompanied crew members on a PTS shift. We observed how caring staff were with their patients, relatives and carers.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed the crew calmly talking to an unconscious patient continuously throughout a journey. They alerted the patient to bumps in the road. The crew took time to ensure the patient was as comfortable as possible.

Crew members observed that a patients' top was wet, as they were dribbling profusely. The crew changed the patient into a new top so they would not get cold outside. The crew members chatted with the patient, ensuring that they were comfortable and happy throughout the journey.

We observed the crew settling the patient in at home, making sure that their mail was close to hand for later.

Patients said staff treated them well and with kindness. Feedback received from patients included, "Your crew members were kind, helpful and very professional. They both have hearts of gold, and I really couldn't thank them enough." Other feedback letters said, "They very gently reassured her and did all that was necessary to make her comfortable." Another said, "He was able to keep me extremely calm, he was a wonderful person, very attentive, so helpful and really just an all-round delight."

The service rewarded all staff members who had received positive feedback. Staff received a personalised letter and a 20 pounds gift voucher from managers every time they had received positive feedback. One staff member received 4 letters and vouchers on the day of our inspection.

Staff followed policy to keep patient care and treatment confidential. They followed the guidelines from the relevant NHS ambulance trusts they were working for.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed PTS staff interacting with family members kindly and compassionately.

Feedback from a patient's family said, "How amazing they both were, so kind and thoughtful and showed so much respect to our Nan. They were so gentle and professional with us."

We saw a thank you card in one of the ambulance stations, which said, "the reassurance to myself, a very anxious family friend, was very much appreciated. Thank you to 2 wonderful people."

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. One family member was very distressed, and the crew offered to take her on the ambulance. As they wanted to drive themselves, the crew took time to ensure she was ready to drive before leaving. They explained their roles patiently and kindly. It was the service's policy that communications with all service users were undertaken with dignity and respect. This was detailed in the service's Equality and Diversity Policy.

Outstanding ☆

Patient transport services

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed the crew members transfer a patient to a hospice. They introduced themselves to family members and explained what was going to happen. They gave the family time and space to say goodbye to their relative before leaving. They were kind, compassionate and understanding that this was a distressing time for the family.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. All vehicles had communication aids to use for patients who needed them. They included pictures so patients could indicate if they had any pain, allergies or if they were hungry or thirsty. Staff could also access a translator service when required.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Posters were displayed in all vehicles which directed service users on how to give feedback to both the service and to CQC. Feedback forms were also available on all ambulances. The service promised to listen, respond and resolve. The posters stated that Polaris Medical Services prided itself on patient and customer care. They wanted to learn from feedback and improve.

Patients gave positive feedback about the service. We saw thank you cards displayed within one of the ambulance stations. One said, 'the professionalism, care and kindness went way beyond anything I've ever witnessed.' Another card said, 'we couldn't wish for a better service and we are most grateful that you are always there when we need you most.'

Are Patient transport services responsive?

Good

We had not previously rated this service. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The NHS ambulance trust allocated PTS work to the service a month in advance. At the time of the inspection, the service was operating 2 PTS shifts per day. A contract with another NHS ambulance trust had ended abruptly due to a lack of funding.

A review of NEPTS, published in August 2021, reported that eligibility for NEPTS was inconsistent across England, and service commissioning and planning had been poor in some areas. The service had appointed a new PTS lead, who was due to start in the month following our inspection. They would explore ways that the service could support the new national framework for patient transport, which had been implemented following the review. They had 17 PTS vehicles within the fleet which could be used to support this. The national framework highlighted that NEPTS services needed to be more sustainable and needed a clear path to net zero carbon. The service aimed to be carbon neutral by 2024.

Patient transport services

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff contacted the NHS ambulance trust's clinical advisors. Staff told us of an occasion where the mental health nurses called them back within 2 minutes when they required advice.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff told us they would call the trust's clinical advisors when they needed advice and if a patient was deteriorating. They could also get 24 hours advice from the service's own clinical leads if required.

Managers monitored and took action to minimise missed appointments. The service supplied the resources and the staff to the NHS ambulance trust, and they were deployed by the trust's control room. Managers attended quarterly meetings with the NHS ambulance trust to discuss performance and any required improvements. They had implemented a financial incentive for staff who started their shifts on time.

Facilities were appropriate for the services being delivered. The service had 17 PTS ambulances at the time of the inspection. The service was waiting for the new PTS lead to start and expand this arm of the service.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with dementia, received the necessary care to meet all their needs. We observed a PTS crew treat a patient who was living with dementia with care and compassion. They introduced themselves and ensured the patient had everything to hand when they settled her in at home. All staff had received training in dementia as part of their mandatory training. Mandatory training in learning disabilities and autism was being introduced with a revised Skills for Health bundle from October 2022.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service used a translator service when required which was accessed by telephone.

Staff had access to communication aids to help patients become partners in their care and treatment. All ambulances we observed had access to a prehospital communication guide. This tool helped staff communicate with people with a learning disability, hearing impairment or for people who had acquired communication difficulties through injury.

The pictures within the communication tool were used to explain to patients what staff needed to do to help them and ask patients important information about themselves. The tool could also be used to help patients make choices and give consent.

An incident was reported in a 'lessons learnt' bulletin. A patient had expressed a preference to be addressed with a she pronoun and a female name. The name and gender were different to what was on the patient's NHS records and there was some confusion from hospital staff when handing over the care of the patient. The crew respected the patient's wishes and supported her. Lessons were learnt as the patient's preferences should have been clearly written in the patient's care records, in addition to verbally communicating the patient's wishes to hospital staff.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Patient transport services

Managers monitored key performance indicators and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. As the service worked under contract to NHS ambulance trusts, it was the trust who managed the access and flow of the service. Crews communicated directly with the trust for direction. The commissioning arrangements were that Polaris Medical Services Limited would provide the resources (the fully equipped PTS ambulances and staff), and the trust would use those resources accordingly.

Key performance indicators (KPIs) and targets were discussed in quarterly governance meetings with the NHS ambulance trusts. The service had strict KPIs to adhere to in respect of patients attending hospital for dialysis. The KPIs required patients to be dropped off no later than 30 minutes before and collected no later than 30 minutes after their appointment. The service had achieved the KPIs in 97% of all inward transfers of patients to Portsmouth Hospital's Renal Department, and 89% of outward transfers from the same department.

Managers worked to keep the number of cancelled shifts to a minimum. In the 4 months between February and May 2022, the service had completed 99% of all agreed PTS journeys. Staff knew the procedures to follow if they were unwell or could not attend their shift. Student paramedics, emergency technicians and frontline paramedics would occasionally work on PTS shifts to provide cover if required.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

The service clearly displayed information about how to raise a concern in patient areas. All vehicles had posters displayed within them. They gave information on how to give feedback and complaints to the service and to CQC. Staff also had access to feedback forms which were handed out to service users. The service was trialling the use of QR codes, which would be displayed within the ambulances and provide a direct link to a feedback form.

Staff understood the policy on complaints and knew how to handle them. The complaints, concerns and compliments policy was available to staff on the service's mobile communications app. The policy stated that failure to comply with guidance may result in investigation and subsequent formal action in line with the service's capability and disciplinary procedures.

Managers investigated complaints and identified themes. Managers told us that they discussed complaints with representatives from the trusts at quarterly governance meetings. Complaints were analysed and compared to other ambulance service providers, but this would not be done as a percentage of calls and was not a true reflection and comparison between other providers. The PTS arm of the service had not received any complaints in the 12 months prior to the inspection.

The service's complaints administrator told us that any complaints received were immediately acknowledged with an email and logged on the service's compliance system. An electronic file was made for each incident and assigned to an investigating officer. The complaint procedure involved all cases being managed and cascaded through the company, from the operations manager to the managing director, with escalation to independent review when appropriate. If the complaint was regarding a clinical matter, the clinical supervisor would conduct a full investigation, which would include interviewing the crew members and collecting all evidence.

The service aimed to act on outcomes of concerns or complaints as positive learning tools to improve the service.

Outstanding ☆

Patient transport services

The service had received internal complaints from staff who had felt bullied and intimidated by other members of staff. We saw audit trails of the investigations into these complaints, which included interviews with staff members involved.

If a complaint could not be resolved internally, the service would refer the case to the Parliamentary and Health Service Ombudsman. For internal complaints from staff, they would refer them to ACAS.

Managers shared feedback from complaints with staff and learning was used to improve the service. The senior clinical advisor kept a monthly log of all complements and complaints from across the service. Staff received a ''lessons learnt'' bulletin quarterly. This discussed incidents and complaints, and any changes that had been implemented as a result. We saw 5 ''lessons learnt'' bulletins.

Another ''lessons learnt'' bulletin praised a crew for refusing to carry out an interhospital transfer for a patient who had complex medical needs. Managers praised the crew for their sound judgement, as the interventions the patient required were not within the skill set of the crew.

Are Patient transport services well-led?

Outstanding ☆

We had not previously rated this service. We rated it as outstanding.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

We spoke with PTS members of staff who had started up as make ready staff and were in the process of training to become paramedics. The service had an academy where staff were encouraged to learn and develop. Upskilling of existing staff was discussed in monthly Head of Department governance meetings. In June 2022, 2 staff members had qualified as paramedics, and 1 emergency care assistant had qualified as a technician.

For additional information about leadership please see emergency and urgent care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The NHS NEPTS Review written in August 2021 acknowledged that the NHS NEPTS sector was not environmentally sustainable and advised carbon neutrality by 2040. Managers told us that they aimed to be carbon neutral and for all vehicles to be electric by 2024.

Managers understood that the PTS sector was highly competitive and had employed a new PTS lead to expand and drive the PTS service forward.

Outstanding ☆

Patient transport services

For additional information about vision and strategy please see emergency and urgent care.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

For information about culture please see emergency and urgent care.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had developed good working relationships with the trusts that they worked with. The commissioning agreements for the PTS service were that the service would provide the resources and the NHS ambulance trusts would utilise those vehicles and staff members to plan their bookings.

The service had quarterly meetings with the trusts to discuss any incidents, safeguarding referrals, and performance. It was difficult to benchmark performance compared to other independent ambulance services, as they were reliant on the NHS trusts giving them the information. Managers told us that the biggest indicator of success was that the trusts repeatedly returned to the service.

The service had provided 2 months of another PTS contract to another NHS ambulance trust. This had ended with only 48 hours' notice due to a lack of funding. The service had invested in a number of PTS vehicles, which were currently not in use. A PTS lead was joining the service in the month after the inspection, who would look at innovative ways to develop the service.

The service held bi-weekly meetings with the clinical operations, fleet and compliance teams. These discussed any issues over the week and planned for the weekend and the week ahead.

Monthly governance meetings were held with the head of departments. These meetings discussed recruitment, staff absences due to Covid-19, competition from other independent ambulance services and social media aspects of the service. Throughout August 2022, the service had 8 staff members who had tested positive and were isolating with Covid-19.

For additional information about governance please see emergency and urgent care.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Outstanding ☆

Patient transport services

Managers told us that one of the main risks within the PTS arm of the service was competition. In some parts of the country, NHS ambulance trusts published their PTS requirements on an online platform, and independent ambulance services bid for the shifts available. Managers told us that it was a competitive environment.

The service had run a regular contract for another NHS ambulance trust for 2 months, but funding had stopped abruptly with only 48 hours' notice. The service was ready to take on a contract with them again if funding became available due to winter pressures. The service had a proven track record of being able to deliver on demand.

Another risk for the PTS arm of the service was staff resourcing and transience of staff. The service's ethos was to support the development of its staff. PTS staff would often train and be promoted into frontline ambulance roles within Urgent and Emergency Care (UEC). There were 3 PTS staff members who would qualify and join UEC roles in the month after the inspection. The service had developed good working relationships with local schools and unemployment centres, to encourage new staff to join the service as make ready staff. The service encouraged make ready staff to train and promoted them into PTS roles.

Some staff were subcontracted and not employed by the service. This allowed the service to offer work on an 'ad hoc' basis when operational. Subcontracted staff told us that they liked the flexibility as they could work for other services, do event work and they could choose their hours. Some subcontracted staff members planned to go to Qatar and work for the Football World Cup. Staff told us that the disadvantages of being subcontracted were that they were required to supply their own uniform and work boots. Subcontracted staff did not receive holiday pay or a pension.

A PTS lead had been employed and was starting in the month after the inspection. Their role was to develop the PTS arm of the service and explore new ways to promote this side of the business. The service recognised that the PTS arm of the service was essential for the progression of training new paramedics. The service had a history of training up make ready staff, who progressed to become ambulance technicians, working on PTS vehicles and then progressing on to working on frontline ambulances as a paramedic.

For additional information about management of risk, issues and performance please see emergency and urgent care.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

For information about information management please see emergency and urgent care.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

For information about engagement please see emergency and urgent care.

Outstanding ☆

Patient transport services

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service told us of 6 different success stories, where members of staff had been supported to professionally develop through the academy. One member of staff had started as work experience directly from school and had just passed the exams to become a technician.

For additional information about learning, continuous improvement and innovation please see emergency and urgent care.