Essex Ambulance Service Limited

Essex Ambulance Service Limited

Inspection report

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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

We rated Patient Transport Services and Emergency and Urgent Care as inadequate.

Following our inspection, we issued a notice of decision under Section 31 of the Health and Social Care Act 2008, to impose conditions on the registration in respect of the regulated activity Treatment of disease, disorder, or injury. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we did not do so.

We told the provider they must take some actions to manage the regulated activity in a way which complied with their conditions of registration.

We will reinspect the service to check that improvements have been made. We will produce another report of that inspection and include an update of our actions.

For details of the individual services, see the service sections of this report.

This is the first time we have rated this service. We rated it as inadequate because:
• The service did not have effective medicines management or legal mechanisms in place for medicines and medical gases management.
• The service did not manage staff effectively to ensure they were trained and managed. The service did not manage safety and safeguarding incidents well and did not learn lessons from them. The service did not manage infection control risk and clinical waste well.
• The service did not have effective and robust governance systems and processes. The service did not monitor the quality of the service. The service did not have an effective risk management process in place. The service did not monitor and improve the quality and safety of services provided.

However:
• Vehicles were visibly clean and well maintained.
• Staff worked together for the benefit of patients.
• Staff felt supported and valued.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate 	This is the first time we have rated this service. We rated it as inadequate because: • The service did not have effective medicines management or legal mechanisms in place for medicines and medical gases management. • The service did not manage staff effectively to ensure they were trained and managed. The service did not manage safety and safeguarding incidents well and did not learn lessons from them. The service did not manage infection control risk and clinical waste well. • The service did not have effective and robust governance systems and processes. The service did not monitor the quality of the service. The service did not have an effective risk management process in place. The service did not monitor and improve the quality and safety of services provided. However: • Vehicles were visibly clean and well maintained. • Staff worked together for the benefit of patients. • Staff felt supported and valued. Urgent and emergency care is a small proportion of the service activity. The main service was patient transport services. Where arrangements were the same, we have reported findings in the patient transport services section. We rated this service as inadequate because it was not safe, effective, responsive, and well-led. There was insufficient evidence to rate caring.
Emergency and urgent care	Inadequate 	This is the first time we have rated the service. We rated it as inadequate because: • There was no training for medicines management for all staff. • Patient records were not clear and accurate. Additional concerns identified during this inspection are described under the patient transport service section of this report.

Summary of findings

We rated this service as inadequate because it was not safe, responsive, and well-led. There was insufficient evidence to rate caring. We rated effective as requires improvement.

Summary of findings

Contents

Summary of this inspection

Background to Essex Ambulance Service Limited

Essex Ambulance Service Limited is operated by Essex Ambulance Service Limited (EAS). The service registered with the Care Quality Commission (CQC) in February 2020, as an independent ambulance service based in Essex. EAS supplies paramedics, emergency technicians, first responders, and first aiders to provide first aid cover and conveyancing at organised sporting and public events. It provides ad-hoc frontline urgent and emergency care services at weekends on behalf of a local NHS trust and transports patients from hospital to home or other care services. The service also transports patients from home to outpatient appointments.

The service is registered to provide the following regulated activity:

• Transport services, triage and medical advice provided remotely

• Treatment of disease, disorder, or injury

The registered manager for this service had been registered with the CQC since February 2020. The service had 3 managers, including the registered manager, and employed 29 other members of staff on zero hours contracts.

The fleet consisted of 15 vehicles and the service carried out 3,063 patient transport journeys and 361 urgent and emergency care between 30 March 2022 and 29 March 2023. This is the first time the CQC have inspected and rated the service.

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

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology in response to concerns raised. We carried out a short notice announced inspection on 7 November 2023. The inspection was announced in order to enable us to access the service for inspection. We have not previously inspected or rated this service.
During the inspection, we spoke with 6 members of staff, reviewed policies and documents relating to the management of the service, reviewed the storage and management of medicines, assessed the environment at the ambulance station and inspected 4 vehicles. The team that inspected the service comprised a CQC lead inspector, medicines inspector, 2 CQC inspectors and specialist advisor. The inspection team was overseen by Hazel Roberts, Deputy Director of Operations.
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.

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.

Summary of this inspection

Action the service MUST take to improve:

- The provider must ensure effective system for the management of medical equipment, medicines and medical gases (Regulation 12(1)(2)(g)).
- The service must ensure that all staff are compliant with mandatory training. (Regulation 12(2)(c)).
- The service must ensure safeguarding leads are trained in line with national safeguarding guidance. (Regulation 13(2)).
- The service must ensure safeguarding concerns are referred, evidenced, and acted upon where allegations of abuse are substantiated. (Regulation 13(3)).
- The service must ensure that it operates a robust recruitment procedure, including employment checks to ensure all staff employed are fit and proper people for their roles. (Regulation 19(2).
- The service must ensure staff have access to personal protective equipment. (Regulation 12(2)(h)).
- The service must ensure that it has effective systems and processes to maintain cleanliness and control infection. (Regulation 12(2)(h)).
- The service must ensure that it has effective systems and processes to ensure that equipment is properly maintained. (Regulation 12(2)(e)).
- The service must ensure that there is an effective incident reporting and learning system within the organisation. (Regulation 12(2)(b)).
- The provider must ensure policies accurately reflect the service provided and are complied with. (Regulation 17(1)(2)(d)).
- The service must complete periodic staff appraisals and supervisions. (Regulation 18(2)(a)).
- The provider must ensure governance processes provide an assurance of the quality of the service. (Regulation 17(1)(2)(a)).
- The provider must ensure it has a risk management process to identify current risks to the service, monitor and identify actions to reduce the level of risk, and that risks are kept under review. (Regulation 17(1)(2)(b)).
- The service must assess, monitor, and improve the quality and safety of the services provided, through the implementation of regular audits. (Regulation 17(2)(a)).

Action the service SHOULD take to improve:

- The service should ensure feedback to staff on the outcomes of safeguarding concerns. (Regulation 13(3)).
- The provider should ensure evidence of regular governance meeting minutes to demonstrate effective systems and processes are in place to assess and monitor the service against regulation. (Regulation 17(1)).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate
Emergency and urgent care	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Effective	Inadequate
Caring	Insufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate

Is the service safe?

Inadequate

This is the first time we have rated this service. We rated it as inadequate.

Mandatory training

The service did not provide mandatory training in key skills to all staff and did not ensure everyone completed it.

Staff received mandatory training but this did not cover all key skills, for example staff were not trained in medicines management.

Mandatory training for safeguarding children and adults, infection prevention and control (IPC) and manual handling was completed by all staff prior to carrying out front line activities. Staff were required to complete the remaining 15 modules within two months of employment. Staff we spoke with told us they were expected to complete this in their own time. In the event of transport being cancelled staff would be provided with a laptop to complete any training they had not completed.

During inspection we could not see evidence that staff had received any medicine training and there was no record of any competency checks for those handling medicines. The Essex Ambulance Service Employee Handbook did not cover the use of medicines. Following inspection, the registered manager told us that all staff were to have training on how to use oxygen at the appropriate level within their scope of practice.

There was no team leader to monitor mandatory training at the time of inspection to alert staff when they needed to update their training. All training was logged electronically on an IT based system with colour coding to demonstrate compliance. The service lacked an effective system to ensure all staff were compliant. We reviewed the staff mandatory training compliance for the service after the inspection. The overall compliance was 53% against the service target of 95%. Of the 19 modules reviewed, 16 modules had a compliance score of less than 79%. We were not assured that the service monitored staff compliance with required mandatory training. Following inspection, the service developed a training plan to improve training compliance.

Safeguarding

Staff had training on how to recognise and report abuse. The service did not fully investigate concerns raised and follow up with other agencies.

All staff were required to complete level 2 safeguarding adults and children level. Compliance was 90% against the service target of 95%, Emergency and urgent care staff were required to complete level 3 safeguarding adults and children training, compliance was 100%.

On inspection we found a total of 11 safeguarding forms completed by staff in the last 12 months. There was no evidence recorded of any decisions taken in relation to safeguarding concerns raised by staff. The service was unable to evidence escalation of these concerns to commissioners or show any outcomes. There was no process in place to ensure staff were kept up to date with regards to safeguarding arrangements, for example the change of a safeguarding lead.

The service had a safeguarding policy in place for adults and children, both were in date. The policy provided staff with relevant information including the safeguarding procedure and relevant contact details. However, staff did not have access to this policy as it was stored on the manager's computer, and it did not reflect the service. For example, the policy said the service had a safeguarding team, however we found no staff in these roles during our inspection. During our follow up inspection on 10 November 2023, we saw a copy of the services safeguarding policy in the staff area.

We reviewed records in relation to the service referring safeguarding concerns and were not assured these had been made correctly or in line with the local policy. The registered manager could not provide evidence that investigations had been carried out for safeguarding raised by staff or that mitigations were in place in line with local policy.

The named safeguarding lead was incorrect and therefore staff were not informed of the current safeguarding leads for the service. We informed the registered manager of this during our follow up inspection on 10 November 2023.

The service could not provide assurance that full fit and proper persons checks, or recruitment processes had been followed. We reviewed five staff files during our inspection. Whilst Disclosure and Barring Service (DBS) and reference checks had been completed in the files that we reviewed, dates for interview and DBS checks did not correspond.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff did not have all the equipment to protect patients, themselves, and others from infection.

All areas were visibly clean and had suitable furnishings which were clean, but equipment was not always well-maintained or available. For example, we found full personal protective equipment (PPE) was not always available, a seat cover was torn and covered with medical tape and patient linen was not washed separately to domestic cleaning cloths.

Deep cleans of the vehicles were carried out every six weeks by an external company. They were carried out more frequently if required.

Hand gel was available on all four vehicles we inspected and at various locations at the service's base location.

Daily cleaning of the vehicles and equipment was carried out by staff. Vehicles were cleaned after every patient transfer. These were evidenced on a paper vehicle inspection form and daily cleaning log. We requested the last audit data to

monitor compliance of cleaning, but none was provided. There was limited internal audit data available, we were provided with 2 audits since April 2022. These showed inconsistencies with the completion of vehicle inspection forms and expired cleaning wipes on a vehicle, expired gloves, and unclean vehicle. The registered manager reported feedback was given to staff, however, there was no evidence to support this. We were not assured that the service carried our regular formal audits to monitor cleanliness and that findings were shared with staff.

We requested results of any current infection prevention control (IPC) audits or environmental hygiene audits and action plans for the last 12 months. We received 1 hand hygiene audit tool for October 2023, which showed a compliance of 64% with no action plan. The service reported no environmental hygiene audits were held.

Staff disposed of clinical waste safely on vehicles. The service stored clinical waste correctly and an external company collected it regularly. However, a sharps bin was not assembled correctly, and we found loose sharps within a main bin which had not been disposed of in accordance with HSE regulation. This was fed back following inspection and was rectified on our follow up inspection.

We inspected 5 vehicles and found that two vehicles did not have full personal protective equipment (PPE) for staff to follow infection control principles. A vehicle was about to be deployed for patient transport services (PTS) work but did not have aprons, visors, or sleeve protectors for staff to follow infection control principles. This was escalated to the team leader who placed the required PPE on the vehicle immediately. The lack of PPE meant staff could not follow universal precautions for every patient contact in line with the services infection prevention control policy. Following inspection, the registered manager reported all vehicles were stocked with full PPE and each item was added to the vehicle checklist to ensure that ambulance crew had all necessary PPE when transporting patients.

The service did not have an NHS linen contract in place. There was a limited single use bed sheets but no purchased service blankets or linen for patients. Hospital linen was washed on site in a domestic washing machine for reuse for all services. We were told that vehicle cleaning cloths were laundered in the same machine. This meant that there was potential for cross contamination of infection. We raised this after our inspection, and we were told that in future all linen would be placed in a dissolvable laundry bag and placed in a dirty laundry bin and washed the next day. These changes did not address the potential for cross contamination.

Environment and equipment

The maintenance and use of facilities, and equipment did not always keep people safe. Staff did not always manage clinical waste well.

The maintenance and use of facilities and equipment did not always keep people safe. For example, we found cleaning liquids in unlabelled bottles, cleaning chemicals not stored in accordance with Control of Substances Hazardous to Health (COSHH) requirements and expired consumables on vehicles.

We identified gaps in the completion of daily safety checks of equipment and vehicles. Staff told us they should complete checklists each day that the vehicle is used to transport patients. We checked two vehicle inspection forms, both were not fully completed and had missing amounts of oxygen documented for each vehicle. At our follow up inspection on the 10 November 2023, a vehicle was ready to leave. When asked staff reported they had not completed the daily safety checklist as they were running late. The registered manager present was not aware that the vehicle safety check had not been completed. There was no formal vehicle audit in place, this meant that leaders were not assured the vehicle or equipment were safe.

Equipment or vehicle faults were reported verbally to the team leader or manager who would take action. Staff were not aware of a formal log where they could report a fault. Following inspection, the registered manager reported all vehicle defects were logged but we did not see evidence of this on inspection.

The service had enough suitable equipment to help them to safely care for patients. The service used an external company to check all electrical and ambulance equipment. Vehicles contained equipment such as suction units, defibrillators, fire extinguishers and stretcher. Equipment checked during inspection was within date for testing on vehicles.

Processes were in place to check equipment; however, these were not effective. We found expired items such as oxygen and airways on 3 of the 5 vehicles we checked. We highlighted this during our inspection and were assured by the registered manager that all the items had been removed and replaced from the vehicles prior to being used the next day. At our follow up inspection on 10 November 2023, we found the same expired oxygen cylinder still on a vehicle. We were not assured that the service had effective systems in place to manage the safety of medical gases.

We found adult, infant and baby oxygen masks with no manufacturer or expiry dates on vehicles and in the services storeroom. We asked staff and the manager how they were assured these items were fit for purpose; they were unsure. We advised that they speak to the manufacturer to find out how long they can be kept as per Health and Safety Executive (HSE) guidance.

We found a stock of venturi masks stored for use if patients required oxygen. The venturi mask allows accurate delivery of oxygen concentrations by attaching the corresponding flow rate valve. The team leader was unable to evidence that staff were trained to use this safely and effectively.

Medical gases were stored appropriately in a lockable, external metal cage with full and empty cylinders separated as per HSE guidance. The service replaced empty and expired cylinders through an external company every 6 to 8 weeks. We found 5 expired cylinders ranging from September 2019 to August 2023 stored. This was raised with the registered manager on the day of inspection, and we were told that these had been removed. Three days later, at our follow up inspection, we found 3 expired oxygen cylinders remained in the storage area. The service did not have an effective gases management system in place.

The service had 15 vehicles which were kept at the registered address for the service. We carried out visual checks of 4 ambulance vehicles and found them to be clean, fit for purpose, and in a good state of repair. The vehicles had up-to-date MOT certificates, service, and road tax records.

Assessing and responding to patient risk

Staff did not complete risk assessments for each patient. Staff did not always identify and quickly act upon patients at risk of deterioration.

Ambulance crews were made aware of all relevant information before collecting a patient. Staff would also obtain a handover from hospital staff. However, the patient record forms did not have sufficient space to allow staff to record relevant information relating to patient risks. The service did not carry out any patient safety checklist audits.

Inadequate

Patient transport services

Staff did not receive any training to deal with specific risk issues such as sepsis or recognising deterioration. Staff did not use a nationally recognised tool to identify deteriorating patients. Following inspection, we reviewed the patient illness during journey policy. There was inadequate guidance for staff for managing deteriorating patients. It was unclear when staff must call 999. This meant staff may not respond quickly. Patients with any life-threatening conditions may not receive the most appropriate emergency response and treatment.

The service did not have formalised inclusion and exclusion criteria to ensure that the service only conveyed patients whose needs could be met by the service.

The service provided patient transport services for patients that were not acutely unwell, therefore crew did not undertake routine observations of vital signs for standard patient transport journeys.

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

The service had enough staff to keep patients safe. The service employed 29 staff, this included paramedics, emergency medical technicians (EMT), ambulance and emergency care assistants (ACA,ECA) as well as first response emergency care staff (FREC) trained to FREC levels three and four. All staff were employed on a zero-hour contract, and some were also employed by other healthcare providers on a part-time basis. The service did not use agency staff.

Staff booked shifts they were available to work via a mobile app. Two staff members reported that shifts were only available to book a week in advance. The registered manager reviewed any potential gaps and phoned staff to support unfilled shifts.

Two ambulance staff were always on shift together and staff skill mix was reviewed by the service manager to ensure that number and grade of staff met the demand on the service. The team leader or manger were always available either on-call or on-site to support staff if needed.

Records

Staff did not always keep detailed records of patients' care and treatment.

During inspection we reviewed 3 patient record forms. Patient record forms were not fit for purpose due to a lack of space and prompts on the document to record relevant information relating to patient risks. For example, there was no space to clearly document patient's weight, mobility, and any need for oxygen. This meant we were not assured that staff transporting patients had the required information to mitigate individual patient risks. We requested audit data on completion of records, this was not provided.

Records were stored securely. Completed patient record forms were completed by hand and given in at the end of the shift. These records were stored in a locked room at the service's base.

Medicines

The service did not have systems and processes to manage medical gases.

Staff did not prescribe or administer any medicines. Patients own medicines were transported with the patient in sealed, named bags. The ambulance transport staff did not take any responsibility for controlled drugs (CDs) carried by patients.

The service stored oxygen cylinders at their base and in their vehicles, to supply to patients who could self-administer this during their transport. We identified concerns during our inspection regarding an expired oxygen cylinder on a vehicle and 5 expired medical gases in the services storage area. This was raised during inspection and the registered manager told us action was taken. During a follow up inspection on the 10 November 2023, we found that the expired oxygen cylinder was still present on the vehicle and 3 expired medical gas cylinders stored on site. This meant that we were not assured the service had an effective system in place to manage medical gases.

We requested copies of invoices to demonstrate timely removal and delivery of medical gas. The registered manager could not provide us with evidence that the gases had been removed from the service on 9 November 2023.

Incidents

The service did not manage patient safety incidents well. Managers did not evidence investigated incidents and did not share lessons learned with the whole team and the wider service.

Staff did not always know what incidents to report and how to report them. A member of staff we spoke to on inspection was unclear of what to report as an incident. They stated if there was a problem with a vehicle, they would report it to the service manager or team leader verbally and complete a form if required. When prompted with an example of a slip, trip or fall they stated they had been informed to verbally report incidents to the team leader or manager. We spoke to five staff who were unclear of the process to report incidents. We were not assured that staff were reporting incidents in line with the service policy.

Incident reporting forms were available on the vehicle and staff knew where to find them but did not always use them. Staff told us they would call to report an incident to their leader or manager and complete one if advised.

The registered managers did not have a formal process for sharing learning from incidents. A staff member reported they had not received any team emails to feedback from reported incidents in the last 12 months. Staff did not meet to discuss the feedback and look at improvements to patient care.

The service did not investigate incidents thoroughly. All incident and safeguarding forms dating back from when the service started were placed in a folder. We requested the number of incidents reported in the last year and were told there were not any. During inspection, we found 4 incident forms completed in the last 12 months. We reviewed each of these and found staff statements but there was no evidence of sharing with commissioners, or evidence of a thorough investigation. In one incident, training was recommended for staff, but this training was incomplete. We were not assured that all incidents were reported and investigated in accordance with the services incident reporting policy.

The service had an incident policy which provided information on the types of incidents that should be reported, timeframes for reporting, and process for carrying out investigations and learning. We did not see evidence of sharing learning from incidents in line with the services incident reporting policy.

Inadequate

Patient transport services

During inspection the registered manger reported incidents were discussed at the monthly governance meetings. We requested to review governance meeting minutes from the last 12 months. After inspection we were told these meeting minutes were missing and the service could not evidence the review of incidents over the last 12 months. Following inspection minutes were shared from 3 March 2023 and 4 September (no year recorded). Incidents discussed were not detailed, there were no action plans or outcome of investigation.

The service did not learn from incidents to improve practice. There was an incident reported in July 2023 where oral medicine blister packs were found cut and not stored within their original packaging to show their batch and expiry date. During our inspection we found the same failures and practice in medicines management and were not assured that the existing governance supported safe storage, use and administration of medicines.

The service also had an incident reporting policy which stated a risk score must be assigned (using a matrix) to all incidents to identify the level of investigation required for the incident. We did not see any risk ratings assigned to incidents stored in the file. The policy did not have a matrix to support this stage within the policy. We were not assured that the service operated in line with their policy.

Is the service effective?

Inadequate

This is the first time we have rated this service. We rated it as inadequate.

Evidence-based care and treatment

Staff could not access policies or standard operating procedures on shift. The service did not always follow the processes set out in provider policy documents. Managers did not check to make sure staff followed guidance.

Staff did not have access to policies or standard operating procedures. Staff told us they did not have access but could request a copy of a policy if needed. In the absence of the manager staff were unsure how they would be able to access them. Following inspection, the registered manager told us a QR code was placed in the staff area to allow staff direct access to all policies when required on their mobile phone.

After our inspection we reviewed 6 policies, 5 were not version controlled to reflect they were reviewed since the service commenced in 2020. The governance policy was amended following our inspection, however the policy amendment date was documented as August 2023, version 1. It did not state who had last amended the policy. This meant staff could not identify if they were working from the services current policy.

Staff were given an employee handbook which outlined key aspects of the service policy. This handbook had a review date of 2021. This meant that changes to policies and procedures may not have been reflected in the handbook given to new staff.

We identified some examples of processes stated in the infection prevention control policy that were not reflective of the service. For example, the infection prevention control policy stated that registered manager and team leaders would ensure PPE and sanitation compliance was met in line with policy. When we requested these audits, none were provided.

Inadequate

Patient transport services

The registered manager told us the service routinely monitored care and treatment, to ensure it was delivered in line with evidence-based guidance. We requested evidence of formal audits carried out in the last 12 months covering topics such as vehicle inspection form, hand hygiene, patient safety checklists and patient feedback. We were not provided with any data and were not assured that the service monitored performance in line with policy and evidence-based guidance.

Nutrition and hydration

Due to the nature of the service provided, food was not routinely offered to patients. Bottled water was available on vehicles.

Patient outcomes

The service did not monitor the effectiveness of care and treatment.

The service did not audit patient record forms to ensure staff provided care and treatment in line with national guidance and best practice.

Leaders and staff did not carry out a comprehensive programme of repeated audits to check improvement over time.

The service could not provide evidence that improvement is checked and monitored.

Response times

The service did not routinely monitor response times so that they could facilitate good outcomes for patients.

The service had carried out 3,063 patient transport journeys from November 2022 to October 2023.

The service did not have agreed response times as commissioners had not set any key performance targets for the patient transport service. The service did not collect response time data to monitor against their own internal performance targets.

The registered managers met with commissioners monthly to discuss performance and there were no minutes to evidence this.

Staff told us that they documented pick up and drop off times on the daily running sheets. Any delays were written at the bottom of the sheet as there was no space to document such delays to performance. This meant that the service did not collect data to reflect performance against their internal targets.

We requested data on the number of cancelled patient transport journeys and any data regarding response times. These were not provided. We were not assured that the service monitored response times to facilitate good outcomes for patients and make improvements.

Competent staff

Inadequate

Patient transport services

The service did not monitor staff competency. Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development.

Staff were experienced and qualified to meet the needs of patients. Most staff employed had previous experience of working in patient facing roles.

We reviewed five staff records. All had current registration and qualification certificates present. A staff member carried out registration checks for staff and recorded this in the personnel Human Resources (HR) file. Dates for qualification and training were not always accurate. For example, we found a staff member was interviewed on 6 December 2022 with a qualification date of 14 December 2022. The in-house ambulance training record was signed and dated 30 November 2022, which was prior to their interview date. This meant that the staff member received training prior to their interview date. We were not assured that dates were accurate in training records.

During our inspection we reviewed 5 staff records. Staff files were stored securely both digitally and in paper form. There was a recruitment check list in place for every employee. Whilst Disclosure and Barring Service (DBS) and reference checks had been completed in the files that we reviewed, there were inconsistencies with timeframes in which checks and qualifications had been obtained by the provider. The provider at the time of inspection was unable to explain these inconsistencies which led to concerns that applications and DBS checks were not obtained in line with their recruitment and selection policy.

The services lead for HR and training had left employment at the service a month before the inspection and another staff member had taken over aspects of the HR role. We were told training was being outsourced to an external company.

The registered manager did not support staff to develop through yearly, constructive appraisals of their work. The registered manager told us appraisals were carried out every three months and recorded within personal HR files. There were no supervision sessions for staff. Staff told us they were appraised every six months but could not be sure. We requested compliance for appraisals for all staff, we were told that no staff had a current appraisal. We were not assured that staff were appraised and supported in their development. Following inspection, a training action plan was developed by the newly appointed training lead to ensure staff were appraised regularly.

Managers did not support staff to develop through regular, constructive clinical supervision of their work. The registered manager told us operation workplace reviews were carried out for staff by team leaders. This involved a work-based observation whilst staff were on shift to assess their understanding of processes and procedures. However, there was no formal audit data available to evidence this was being carried out for all staff. Of the five staff files we reviewed on inspection we could not see evidence of clinical supervision.

The service did not support the learning and development needs of staff. Staff were advised of required mandatory training through emails. However, there was no formal process in place to identify additional learning or development needs for staff.

Managers did not ensure staff received any specialist training for their role. Following our inspection the service implemented an action plan to ensure all staff received specialist training to administer medical gases and how to recognise a deteriorating patient.

Multidisciplinary working

Inadequate

Patient transport services

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

Staff worked well together and as a team. Staff reported feeling supported by their team leader and manager.

Staff reported there were no meetings to discuss patients and improve their care. However, they felt confident to raise service improvement ideas verbally to their manager. The service was not able to give any examples of improved care in the last 12 months.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked well with other agencies to establish all the relevant information they needed to accept a booking.

The registered manager said they had positive relationships with stakeholders and were in regular contact with them. However during inspection the service was not able to evidence regular contact or feedback.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

The service did not ensure that all staff were compliant with Mental Capacity Act and Deprivation of Liberty training. Staff could not access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. The service did not formally monitor how well the service followed Mental Capacity Act and consent processes.

Staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were 41% compliant with MCA training and 45% compliant in DoLS training. We spoke to 2 staff who reported they would contact their team leader or manager if they had concerns about a patient's mental health.

Staff could not access the services policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Following inspection, the registered manager told us staff now had access to the policy electronically on their mobile phones to get accurate advice.

Managers did not formally monitor how well the service followed the Mental Capacity Act.

Staff understanding and application of the Mental Capacity Act and consent processes were not obtained, as we were not able to speak with staff after the inspection.

Staff did not record consent in patients' records. Staff obtained verbal consent to transport patients.

Is the service caring?

Insufficient evidence to rate

We inspected but did not rate Caring.

Compassionate care

Inadequate

Patient transport services

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

The service had received positive feedback from patients and relatives. These were displayed in the staff area. Feedback included “both of them were extremely caring, patient, gentle and professional”.

We did not observe any patient transport service being delivered on inspection.

The registered manager reported their priority was to ensure that staff respected service users’ dignity at all times and that this would be observed during on the road assessment carried out by the team leader or manager and through feedback from service users. We were not provided with any evidence to support any on the road assessments being carried out.

Emotional support

We did not see evidence of how staff provided emotional support to patients, families and carers to minimise their distress.

We requested to speak to staff and patients following inspection to evidence emotional support given. We were not provided with any data or contacts to assess the emotional support provided to service users.

Is the service responsive?

Inadequate

This is the first time we have rated this service. We rated it as inadequate.

Service delivery to meet the needs of local people

The service did not plan and provide care in a way that met the needs of local people and the communities served.

The service carried out subcontracted work from 3 commissioners. They were notified of work the day before or on the day. The registered manager or team leader planned staffing in response to the demand. This meant that it could not always meet the needs of local people and the communities it served due to staff and availability. For example, an external stakeholder we spoke to after the inspection expressed concerns about the provider being unable to complete contracted work.

The service supported local NHS trusts by providing conveyance for patients that other contracted services were unable to complete. On 6 separate occasions from 3 September to 2 November, Essex Ambulance Service were unable to provide the subcontracted patient transport. This resulted in 30 patients being returned to wards and unable to be discharged as planned.

The registered manager said that they held regular discussions with stakeholders to review the service. We requested to review evidence of meeting minutes and data shared, the service was not able to demonstrate evidence of these meetings.

We requested a copy of the patient eligibility criteria policy following inspection. We were not provided with a current criterion and the registered manager stated this was being reviewed. This meant that we were not assured that the service could plan and provide care against a set inclusion and exclusion criteria.

The service did not plan effectively to be able to fulfil any additional support required within the communities it served. Staff told us that shifts were only offered at short notice.

The service had supported with conveyancing member of the public at organised sporting and public events. A staff member reported that the last time the service did this was in July 2023.

The service accepted bookings over the telephone. The service normally operated between 8am and 6pm Monday to Friday.

Meeting people's individual needs

The service was not inclusive and did not train staff to meet patients' individual needs and preferences. The service did not have access to interpreters, communication boards or signers when needed.

Staff had access to training modules in learning disabilities and dementia, the service achieved 38% and 17% compliance. There was no training evidenced for staff understanding or supporting patients living mental health conditions. This meant that the service could not demonstrate that staff were trained to deliver the necessary care to meet all the needs of patients living with mental health conditions, learning disabilities or dementia.

We asked a staff member how they would support a patient living with dementia or learning disabilities. They were unable to give any examples of how they would apply the training.

Staff, leaders and the registered manager could not demonstrate how they understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Leaders did not make sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. A staff member reported a colleague could speak Polish and would be able to communicate with a patient easily in this instance. Staff did not have access to communication aids to help patients become partners in their care and treatment.

Staff were unable to state how they would adapt communication due to a language barrier.

Access and flow

Managers did not routinely monitor performance data to make sure patients could access services when needed.

Inadequate

Patient transport services

The service did not monitor performance data to make sure patients could access services when needed. The service did not gather data on response times for other providers. The service was not able to provide evidence that response times were discussed and monitored at management meetings or with staff.

The service did not monitor the number of cancelled journeys. We requested this information as part of our inspection, and this was not provided. Staff said that if patient journeys were cancelled these would be documented at the bottom of their daily patient transport form. The service did not monitor this data.

Requests for transport was subcontracted by another provider the day before or on the day it was provided. This meant shifts were available for staff via its online app to accept for the next day. A staff member told us the most notice they would have for shifts was a week. We requested data to review cancellation, but this was not provided.

We were unable to review any feedback from stakeholders during the inspection.

Learning from complaints and concerns

People could give feedback on care received. The service did not share lessons learned with staff.

Vehicles displayed posters for patients, relatives, and carers to feedback on care received. The service reported no complaints or concerns raised to them in the last 12 months.

We spoke to 2 staff who did not know how complaints were managed by the service. They were not aware of how patients, family and carers could provide feedback on care.

The service reported no complaints in the last 12 months so we were unable to review how they were investigated. There were no staff meetings or systems in place to acknowledge complaints or share patient feedback from the registered manager or team leaders.

Staff were not able to give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Inadequate

This is the first time we have rated this service. We rated it as inadequate.

Leadership

Leaders did not always understand and manage the priorities and issues the service faced.

There was a clear management structure. The service had a registered manager who was 1 of 2 company directors. The registered manager held overall responsibility for the leadership of the service and worked full-time. The service had 2 team leaders, a newly appointed clinical lead and a training manager. The chief executive officer had been in post for 6 months at the time of inspection.

The registered manager had experience of working within the ambulance service for 13 years. Although the registered manager had no formal qualifications, they had 9 years experience as an ambulance services operational manager.

Leaders lacked an understanding of their roles and responsibilities in relation to compliance with the Health and Social Care Act (2008) and the associated regulations. For example, chemicals were not stored in accordance with guidance and there were no formal appraisals or oversight of mandatory training in place for all staff.

The registered manager was not available on the day of our inspection. In their absence the leadership team were not able to access policies and procedures to demonstrate how the service complied with regulation.

During inspection we raised issues that the service faced, and leaders did not ensure that these has been actioned fully. For example, on the day of inspection we found 1 expired medical gas cylinder on a vehicle and in 5 expired gases in storage. The lack of formal audit programme and performance monitoring meant that leaders were not aware of the concerns that we found on inspection. We were told actions had been taken immediately to rectify this. We carried out an additional follow up inspection on the 10 November 2023 and found that these concerns had not been fully addressed. For example, we found 1 expired medical gas on one vehicle and 3 expired medical gases remained in the services storage medical gases storage area.

The registered manager told us that the lead for training and human resources had left a month prior to inspection. This had impacted the service significantly, for example there was no oversight of training compliance, induction process and who was responsible for disciplinary processes. There was a lack of consideration for business continuity. We raised our concerns with the registered manager at the time of inspection.

Staff told us that leaders were visible and approachable. Staff we spoke to felt confident to discuss any concerns with the registered manager.

Vision and Strategy

The service had a vision for what it wanted to achieve. However, there was no documented strategy in place to turn this into action or monitor progress.

The registered manager was not able to outline the vision for the service when asked at our follow up inspection on 10 November 2023. There was no evidence of a documented strategy. When asked we were told that the strategy was discussed in the clinical governance meetings. There was no evidence of discussion regarding the vision and strategy in the governance meeting minutes for 3 March 2023. The service was unable to provide any other quarterly clinical governance meeting minutes.

The service vision statement was centred around being innovative and responsive whilst always putting the service user at the centre of their own care. Staff were unable to demonstrate how their roles and responsibilities worked in line with this.

The registered manager was able to state what their main priorities for the service were but were unable to evidence how these were being monitored and progressed.

Culture

The service did not have systems in place to promote equality and diversity, career development and raise concerns without fear.

Staff told us that they could raise concerns with their managers. However, staff were not aware of any other formal procedures in place to raise concerns such as incident reporting. There was no freedom to speak up guardian, should staff not feel comfortable speaking to a manager.

The service did not have a system in place to provide staff with the development they needed. We were told that staff had an on the road assessment with team leader to support staff and review work-based skills and a 6 monthly appraisal. Compliance for appraisals was 0% and on the road assessment was 17%. This meant there was no oversight from leaders.

The service had a policy in place to manage behaviours and performance that was inconsistent with the vision and values. Staff were not aware of the policies and procedures in place within the service. Leaders could not demonstrate they managed performance in accordance with policy. During our inspection, the registered manager could not provide documentation to support steps taken in response to 2 concerns raised by staff.

We requested to speak to more staff who worked for the service following inspection to gather from staff what the working culture was like. We were not contacted by any staff following inspection.

Leaders were unable to state how they promoted equality and diversity in daily work.

We spoke to 2 staff who told us they felt respected and valued. A staff member told us that they were employee of the month and received a £100 voucher in recognition of compliments received from service users. Staff reported that the manager or team leader was always on call to provide support if they required.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service.

The service did not have effective governance processes in place. During our inspection the team leader told us governance meetings were held every month. Following inspection, the registered manager told us they were held every 3 months. We requested the meeting minutes for the last 12 months. The registered manager could only provide minutes from March 2023. This meant that we could not gain assurance about the content of meetings, the attendance at meetings or the frequency of meetings. The lack of meeting minutes also meant that the service did not have an audit trail of discussions held and actions identified to address any areas of concern.

We raised concerns following our inspection about the lack of governance systems and processes for the service. Leaders acted and told us that quarterly meetings would be minuted and distributed to all attendees. Updates from leaders would be sought in their absence to ensure that there was oversight and discussions to address any concerns.

During our inspection the registered manager reported regular audits were carried out to monitor performance. We requested audit data for the last 12 months; we were not provided with any data.

There were no systems in place to discuss performance or risk with staff such as staff meetings, emails, or newsletters. Staff were not aware of service performance such as outcomes of audits, number of incidents reported, or compliments received. This meant that staff were not provided with updates about any changes within the service or given an opportunity to discuss and raise questions about the policies and procedures that were in place.

The registered manager told us that they met with stakeholders to discuss the service being provided. The service did not hold minuted meetings and had no service level agreement in place for patient transport.

The service had a range of policies and procedures to support staff. However, during inspection we were told that these were not accessible to staff when needed. We raised this at inspection and staff were able to access all policies and procedures via a QR code on their mobile phones.

The service was operational since February 2020, however some policies such as infection, prevention control and end of life, were dated August 2023 version 1. There was no evidence of previous policies in place due to the inconsistency recorded within the policies. The medicines management policy had differing version and issue numbers within the same policy.

Management of risk, issues and performance

The service did not manage risks and performance effectively. Leaders did not identify and escalate relevant risks and issues and did not identify actions to reduce their impact.

At the time of our inspection the provider's risk register contained generic risks related to some day-to-day operations within the service. The risk register included 154 risk entries referring to a range of generic risks, for example noise pollution and staff sickness. The risk register did not have a date for how long the risk had been on the register for, risk rating or who was responsible for mitigating the risk. There was no evidence that the risk register had been reviewed by directors at their meetings as there were no minutes or action points. The risk register did not flag the issues that we found on inspection, this included the lack of poor training compliance, storage of Control of Substances Hazardous to Health (COSHH) and expired medical gases.

Leaders told us that monthly, quarterly, and biannual audits to monitor quality and operational processes were carried out by a nominated staff member. However, the service was only able to provide 2 records for Apil 2022 and March 2023 on inspection. Following inspection, we asked for audit data for the last 12 months, 1 hand hygiene audit was provided. This meant there was no robust systematic programme of audit to monitor the safety, quality, and performance of the service.

Due to the lack of governance meeting minutes, there was limited evidence to demonstrate that the service identified and mitigated risks to service users. Following our inspection, the service reinstated quarterly governance meetings, however a review of audit outcomes was not added as a standing agenda item as per the service governance policy.

The service captured some data, for example, the cleaning of vehicles and servicing of equipment. However, leaders were unable to demonstrate how they audited this information to improve performance or safety over time. The service was unable to provide any up-to-date records of management or staff meetings.

Information Management

Inadequate

Patient transport services

The service did not collect reliable data and analyse it. Staff could not find or access the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Leaders did not formally monitor all data relevant to the quality and performance of the service. For example, staff completed daily checklists at the beginning of every shift, but the service did not have any formal audits to assess the quality and feedback to staff.

The lack of have data collection by the service meant it could not be used to understand performance and drive improvement.

The registered manager stated outcomes of audit were emailed but these were not available to review on inspection when requested.

Engagement

Leaders had limited engagement with patients to plan and manage services.

The service attempted to gather patient and relative views and experiences through the completion of feedback forms and phone calls following a transport journey. We requested patient feedback data over the last 12 months following inspection. Leaders were unable to give any examples of how feedback had shaped or improved the services and culture.

Staff told us there was a suggestions box where staff could reflect and feedback on the planning and delivery of the service. They were not aware of any communication of changes that had been made through this initiative. The registered manager and team leader did not hold regular team meetings to provide an opportunity for staff engagement. Due to all employees being on zero hours contract the service relied upon verbal communication at the beginning of shifts and an online messaging app to provide updates.

The service did not keep records of monthly stakeholder engagement meetings. The registered manager told us that any key performance indicator data that was shared by stakeholders was fedback to staff but there was no evidence of meetings, minutes, or messages to staff to evidence this took place.

Learning, continuous improvement and innovation

There were no formal process in place for continually learning and improving services. Leaders did not have a good understanding of quality improvement and did not encouraged innovation.

No formal processes were in place for quality improvement of the service or making change to the service following incidents, complaints, patient, relative or stakeholder or staff feedback.

Leaders were unable to give any examples of innovation or improvements made in the last 12 months.

Leaders told us they welcomed staff suggestions and ideas for quality improvement. The service could not demonstrate any log of suggestions of improvements from staff that had been made verbally or in writing.

Inadequate

Emergency and urgent care

Safe	Inadequate
Effective	Inadequate
Caring	Insufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate

Is the service safe?

Inadequate

This is the first time we have rated the service. We rated it as inadequate.

For mandatory training, safeguarding, cleanliness, infection control and hygiene, environment and equipment, staffing and incidents please see patient transport services.

Assessing and responding to patient risk

Staff were notified of risk for each patient.

Staff were notified of risk over the radio when requested to attend an emergency. These were documented using the commissioner's patient reporting form (PRF).

Staff carried out routine observations of vital signs during transfer and logged these within the PRF. We reviewed a clinical incident for an interfacility transfer where a patient reported having chest pain. An electrocardiogram (ECG) was carried out and staff called the team leader and registered manager for advice. The A&E nurse reported staff did not administer medications to treat the symptoms which were with the patient. There was no evidence of the incident being shared with staff, or lessons learned following this incident. We were not assured that staff were able to quickly act upon patients at risk of deterioration.

We were unable to speak with staff during the inspection to understand how they managed patient risk.

We requested a copy of the blue light policy but were not provided this.

Records

Staff did not keep detailed records of patients' care and treatment. Records were stored securely.

Patient notes were not comprehensive, for example there were missing oxygen saturations and incorrect neurological scores recorded.

Following the inspection, we reviewed 5 patient report forms following HDU transfers. There was a lack of consistent monitoring of clinically complex patients. We found 2 out of 3 tracheostomy patients did not have their oxygen saturations monitored during transfer. This record did not demonstrate the patient was monitored to deliver safe care and reduce risk. This meant staff did not hand over all information relevant to that patient to ensure they continued to receive the appropriate care.

We found 2 out of the 5 patient report forms did not record the patients Glasgow Coma Scale (GCS) correctly for their neurology condition. Inaccurately recorded GCS could present a risk and have impacted patient care and treatment. There was not a process in place to audit and monitor completed patient report forms. This meant there was no oversight of staff's compliance with record keeping for patient care episodes. Staff were not informed of performance against policy and procedures.

Patient records were stored securely in a locked cabinet.

Medicines

The service did not used systems and processes to safely prescribe, administer, record and store medicines.

The service did not have safe systems and processes to prescribe, store or administer medicines.

Ambulance staff were trained to diagnose and treat people with medicines utilising national service clinical guidelines. Medicines were decanted into technician pouches or paramedic bags along with cannulation packs and stored at the base. Tamper evident seals were attached to the bags but the tag number was not recorded anywhere so proved impossible to know whether the bag had been opened since packing. One member of staff was responsible for this but there was no written procedure in place. There was no agreed list of contents for each bag although there was a list of medicines. There were not enough giving sets to allow the administration of intravenous fluids. There were inadequate amounts of amiodarone (a drug used in myocardial infarction) in the paramedic bag to comply with national treatment guidelines, and one analgesic on the list was absent from the bag.

Legal mechanisms were not in place to allow paramedics to administer some of the prescription only medicines held within the paramedic bag. The service was unaware that they required PGDs (Patient Group Directions which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) that have been approved for use and are accessible to staff.

Medicines were stored securely but some of the medicines were not fit for use. The service did not have a fridge for medicines storage. Two medicines that if not stored within a fridge must be given a shortened expiry. Syntometrine (an injection used to manage postpartum bleeding) should have its expiry shortened to 2 months once it has been taken out of the fridge. This had not been done and had been used to replenish the paramedic bags. Glucagon (an injection used for low blood glucose) should have its expiry shortened to 18 months once out of the fridge, this had not been done and we found some had expired within the paramedic bags. Within the paramedic bags, 1 medicine was unidentifiable, others were not sealed in their original packaging and the packaging of others had been cut so you could not see the batch number or expiry date. One strip of ibuprofen had expired in January 2023. Salbutamol nebules (used for breathing difficulties) had not been kept within the original packaging to protect from light.

Inadequate

Emergency and urgent care

Staff completed medicines records, but these were not always accurate. Vehicle checks did not record how much oxygen was in cylinders and available for use. Documentation showing the administration of medicines to patients had not been completed accurately. Expiry dates on the documentation did not match some of those held within the paramedic bags.

The service did not monitor and manage medicines effectively. We were told that governance meetings happened every month where medicines were discussed but we only saw minutes from the meeting held in March 2023. There was no clinical lead present at that meeting. There were no terms of reference for this meeting. There was no audit of medicines other than a stock check.

The service did not learn from incidents to improve practice. We saw that one incident in July 2023 reported medicines were not fit for use because they had been cut and expiry dates and batch numbers were not visible; no learning had taken place following this incident as we found the same problems during our inspection.

Staff had not received any medicine training and there was no record of any competency checks for those handling medicines. The Essex Ambulance Service Handbook did not cover the use of medicines.

Is the service effective?

Inadequate

This is the first time we have rated the service. We rated it as inadequate.

Please see patient transport services

Is the service caring?

Insufficient evidence to rate

We inspected but did not rate Caring.

Please see patient transport services

Is the service responsive?

Inadequate

This is the first time we have rated the service. We rated it as inadequate.

For meeting people's individual needs, access and flow and learning from complaints and concerns see patient transport services.

Service delivery to meet the needs of local people

Inadequate

Emergency and urgent care

The service planned and provided care in a way that met the needs of local people and the communities served.

The service had carried out 361 urgent and emergency care journeys from November 2022 to October 2023. We requested data for the number of cancelled urgent and emergency care journeys but none was provided.

Facilities and premises were appropriate for the services being delivered. Staff had access to radios to receive information for emergency and urgent care patients.

The service did not monitor the service delivered and were unable to provide evidence of the care provided.

Is the service well-led?

Inadequate

This is the first time we have rated the service. We rated it as inadequate.

Leadership

Leaders did not always understand and manage the priorities and issues the service faced.

The registered manager was not always able to demonstrate that they had appropriate knowledge of applicable legislation and regulations. For example, patient group directives (PGD) were not in place for medicines that were stored on site. When we raised this concern, we were told that they were not required. This demonstrated a lack of knowledge of the Human Medicines Regulation from leaders. This was addressed at inspection with the registered manager who told us that relevant PGDs were being produced and would be implemented.

Please see patient transport services