

Norwest Ambulance Limited

# Norwest Ambulance

## 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		Good	
Are services safe?	Requires Improvement		
Are services effective?	Good		
Are services caring?	Good		
Are services responsive to people's needs?	Good		
Are services well-led?	Good		

# Summary of findings

## Overall summary

We rated this service as good 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 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 and gave patients pain relief when they needed it. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent.
- 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.

However:

- Staff identified but were not always able to act quickly or in line with service policy when patients were at risk of deterioration.
- The service did not always manage medicines well.

# Summary of findings

## Our judgements about each of the main services

### Service

#### Emergency and urgent care

### Rating

Good



### Summary of each main service

The main service was Urgent and Emergency Care. Where arrangements were the same, we have reported findings in the Urgent and Emergency Care section. We rated this service as good because it was effective, caring, responsive and had good leadership, although safe requires improvement. See the overall summary for details

#### Patient transport services

Good



Patient Transport Services is a small proportion of the provider's activity. The main service was Emergency and Urgent Care. Where arrangements were the same, we have reported findings in the Emergency and Urgent Care section. We rated this service as good because it was effective, responsive, and had good leadership, although safe requires improvement. We had insufficient evidence to rate the domain for caring.

# Summary of findings

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# Summary of this inspection

## Background to Norwest Ambulance

Norwest Ambulance is a registered location of Norwest Ambulance Limited. The provider has been registered since November 2019 to provide the regulated activities Treatment of Disease Disorder or Injury, and Transport Services, Triage and Medical Advice provided remotely. This included provision for children under 18 years old. The service provides emergency and urgent care ambulance services, under contract with an NHS ambulance service provider. The service also provided a very limited range of non-emergency patient transport as well as event medical services across the North West. Event medical services are not in scope of registration and regulation under the Health and Social Care Act 2008.

This was the first inspection since the provider's registration in 2019.

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

## How we carried out this inspection

We inspected the provider's main headquarters which incorporates the service's administrative centre and the ambulance station for deployment of emergency vehicles and crews. We carried out a comprehensive inspection to assess the provider's compliance with fundamental standards of safety and quality. We looked at key questions of the safe, effective, caring, responsive and well-led domains. We reviewed specific documentation, interviewed key members of staff including the managing director; paramedic, emergency medical technician, and administrative staff. We interviewed the senior management team who were responsible for leadership and oversight of the service, and we observed patient care during ambulance transfers.

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 trust **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 **MUST** take to improve:

- The service must ensure that medicines are consistently managed in accordance with best-practice guidelines.

### Action the service **SHOULD** take to improve:

### Core service Emergency and Urgent Care

## Summary of this inspection

- The service should ensure staff consistently follow service policy and procedures for advance contact to the clinical hub centre where there may be deteriorating patient condition.
- The service should ensure that keysafe access is secure and as needed for relevant staff.
- The service should review risk registers to ensure actions are clearly recorded.

# Our findings

## Overview of ratings

Our ratings for this location are:

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

## Emergency and urgent care

Safe	Requires Improvement 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

### Are Emergency and urgent care safe?

Requires Improvement 

We rated safe as Requires Improvement.

#### Mandatory training

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

All staff received and kept up to date with their mandatory training. Mandatory training subjects included consent, fire safety, health and safety, infection prevention and control, duty of care, information governance, patient moving and handling and safeguarding. Training compliance was above 95% in all subject areas, for all staff. All staff completed basic and intermediate life support skills. Paramedic staff completed training in Advanced life support skills.

The mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities and autism and dementia. Managers monitored mandatory training and alerted staff when they needed to update their training. Reminder announcements were placed in a weekly bulletin sent out for attention of staff to check their individual record to ensure they were in date and arrange refresher/renewal training where required.

Ambulance staff completed driver training and were assessed for driver safety at different skill levels. Staff completed their training with an advanced driving instructor who was a level four trained emergency response ambulance driver trainer and was based in the service. All relevant staff completed a baseline assessment of their ambulance driving skills, with regular six-monthly formal driver assessments completed. The driving trainer also completed informal observations of staff's ambulance driving skills periodically. Staff also completed training within the service in emergency 'blue light' driving skills. During the inspection we reviewed service and staff records which confirmed staff were appropriately trained and monitored for maintaining appropriate driving skills. This included 12 staff who were qualified for 'blue lights' driving.

During our inspection and in a follow-up focus group, we spoke with staff who told us about their mandatory training, which they received during induction and at refresher intervals. Staff felt the training was of a good level and equipped



## Emergency and urgent care

them with the skills and knowledge they needed to carry out their role. We also spoke with managers within the service. They described the process of ensuring that staff kept up to date with their training. Managers would receive notifications about training expiry dates for staff. This meant that managers could follow up with individual staff members if their training had not been completed.

### 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. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We observed that staff demonstrated an appropriate professional curiosity when asking questions to ascertain if patients may be at risk of harm. All ambulance staff in the service had completed level three children and adults safeguarding training.

We reviewed information which evidenced staff completed both adult and children safeguarding training. The provider has a policy for this which covers purpose, definitions and responsibilities. The level of training undertaken, corresponded with their role. Staff explained to us the process for reporting safeguarding alerts and knew how to make a referral. The service safeguarding policy did not specifically include reference to Female Genital Mutilation, however staff completed training in this as part of their safeguarding training and were aware of this issue.

In the first instance, safeguarding concerns were reported to the contracting NHS ambulance trust, who then coordinated an alert to the relevant service, in line with their procedures. The alert would also be notified internally within the provider's processes and systems, which allowed development and learning opportunities around safeguarding practice to be shared within the organisation.

Safeguarding reports were made on paper referral forms and placed with the patient report form (PRF) for the incident. All forms were scanned daily and transferred to the NHS Ambulance trust's hub. A safeguarding lead was in place within the organisation and they were responsible for submitting the papers. The safeguarding lead attained the qualification of safeguarding adults and children at First Response Emergency Care (FREC) level 5. They worked two days a week but attended site on other occasions when operationally required. Responsibility was delegated to the operations manager when the safeguarding lead wasn't on site.

The safeguarding lead outlined the process for making a safeguarding referral. The process was aligned to best practice and met regulatory requirements.

The service had a contract with a local NHS ambulance provider and followed the policy and process for safeguarding according to these protocols. Staff we spoke with stated they did not always receive feedback from safeguarding they had raised.

### 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.**

## Emergency and urgent care

We observed the premises had areas and suitable furnishings which were clean and well-maintained. The areas were not cluttered. We observed the premises had designated cleaning preparation and storage areas, which promoted good levels of cleanliness. Cleaning records were up-to-date and demonstrated that areas were cleaned regularly. We reviewed a sample of Infection Prevention and Control (IPC) audits which demonstrated a comprehensive record of checks and a high level of compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE). We noted that PPE equipment was used where appropriate, at times of patient contact. There was sufficient PPE on board vehicles. Staff cleaned equipment after patient contact and labelled equipment correctly to show when it was last cleaned. We observed that ambulance vehicles were clean and well maintained. All ambulances that we observed were within a designated 'deep clean cycle' time period. Vehicles were cleaned every day and a deep clean was completed every four weeks. Completed IPC audit results showed performance achieved between 95% and 100% compliance.

### Environment and equipment

**The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people safe. Staff were trained to use vehicles and patient equipment. Staff managed clinical waste well.**

The design of the environment followed national guidance, however, access to the location where the keys were stored was not adequately controlled. We observed that stock room access was appropriately controlled which was by means of key access. Staff could obtain the key and therefore access to the store room because the keys were kept in one safe within crew room. The concern was raised with the provider during inspection and they took immediate steps to ensure access was more secure and only available for authorised staff as operationally required. They purchased an additional separate safe for the store room keys in order to tighten access and security. Only management have access to the key.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment and vehicles before deploying. We observed that equipment was properly labelled and sign out sheets were in use and correctly filled in. This meant that there was a record of equipment used and who by.

We reviewed a sample of all stock supplies, which were within expiry dates. All relevant equipment was stored appropriately, for example medical gasses. There was piped oxygen in the vehicles which was checked and shown to have been serviced. Sharps bins were replaced every four weeks. They were checked and found to be labelled correctly and stored in closed position.

We noted that staff disposed of clinical waste safely whilst deployed on shift. Each vehicle had a supply of clinical waste bags on board with cable ties to secure. Clinical waste was stored outside the main building in a designated secure container. The provider had deep-clean contracts for clinical waste in vehicles and across the service. Vehicles were cleaned daily by outside contractor and deep cleaned every four weeks by the same contractor.

We saw several electrical devices were without stickers indicating when they were last tested for electrical safety. This meant the provider could not be assured they were safe to use. This was raised with the provider. They stated they were aware of the issue and it had been discussed in a health and safety meeting earlier that same day. They confirmed it would be addressed as a priority.

We reviewed information about the ambulance fleet used by the service including MOT and services records. All were within MOT date where applicable and service schedules were fully up to date.

# Emergency and urgent care

## Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified but were not always able to act quickly or in line with service policy when patients were at risk of deterioration.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We noted that ambulance crew adhered to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines in assessing a patient's clinical presentation. The JRCALC guidelines are a nationally recognised body which produces clinical guidelines for ambulance professionals.

Staff and management told us that crew members would be dispatched to an emergency call via a direct notification to the ambulance vehicle from the contracting NHS ambulance trust. This notification was received by way of individual dispatches automatically delivered to the providers ambulances via on-board electronic systems. The ambulance and crew from the service could be dispatched by the contracting NHS ambulance trust, to any category of emergency response. Ambulance emergency responses are categorised from one through four. Category one is the most urgent and category four is the least.

Staff knew about and dealt with any specific risk issues, for example noting the environmental risks at particular locations or patient addresses. Staff also described an occasion where they returned a patient to hospital following a potentially unsafe hospital discharge. Where an ambulance crew would attend any emergency response, patients were clinically assessed within relevant guidelines and if escalation was required, a suitably qualified paramedic from the contracting NHS ambulance trust would also attend the scene. This was in line with both national industry standards and best practice.

Staff used a nationally recognised tool to identify deteriorating patients but did not always follow service policy to escalate them appropriately. Staff completed life support training as part of the providers essential education modules. In addition, the service supplied us with information which detailed that staff and volunteers completed both first aid and emergency first aid at induction and every three years thereafter.

We reviewed patient record forms, which detailed a section for a patient's National Early Warning Score (NEWS) to be recorded. Staff stated they received some basic information regarding details of the patient incident when they were initially deployed, but for issues such as medication taken and DNAR status they checked and verified these details on the scene. During the inspection we observed one crew who did not call the ambulance control centre in advance to advise of a patient whose NEWS 2 score was over 5. Although there was no immediate harm to the patient, there might have been a risk that non-paramedic crews did not receive the appropriate support for patients whose condition deteriorated during transfers. Ambulance staff told us there could frequently be a delay when calling the NHS ambulance control centre and in these circumstances, they acted in the patient's best interests in order to convey them to hospital as quickly and directly as possible.

In relation to bariatric provision, crews stated that they did not believe they have this vehicle capability within the provider's fleet. If they attend a bariatric patient, they would require the local NHS ambulance provider to send a vehicle. At the start of every shift, they informed the local NHS ambulance control they are not a bariatric vehicle.

Staff shared key information to keep patients safe when handing over their care to others.

## Staffing

## Emergency and urgent care

**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 bank and agency staff a full induction.**

The service had enough staff to keep patients safe. Both management and operational staff told us, that the levels of staffing felt enough to keep patients safe. This meant that the service always maintained safe levels of staffing. Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with required skill set and knowledge. The service had a good skill mix of clinical staff on each shift and reviewed this regularly.

The provider stated they employed 42 staff. The service had low vacancy rates for staff and low turnover rates for staff. The service had low rates of bank staff usage; staff informed us they estimated it to be no more than five regular bank staff, with an average of two shifts per week completed. The contract for services provided to the contracting NHS ambulance trust was three vehicles every shift for 999 deployment and seven vehicles for urgent care deployment.

Management told us that a rota of staff, for the following day, would be planned in advance based on agreed fixed contract numbers. This was then reviewed to ensure that the correct level of qualified staff, were deployed on to a shift. Managers limited their use of bank and agency staff and sought to utilise staff familiar with the service. We observed that the service benefitted from a high proportion of 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.**

Patient notes were comprehensive and were completed during shifts before the next deployment. Staff told us that following an emergency response call, ambulance crews completed a patient report form (PRF). We reviewed a sample of completed PRF's and noted that the documents contained sections to record all relevant and appropriate patient details. Crew notes were comprehensive and written in a clear, legible manner.

Records were stored securely. Upon completion of their shift, ambulance crews would collate the PRF's within a sealed and signed envelope and deposit them in a secure storage facility within the base location which only managers had access to. It would be unlocked, and forms collected in order to process. A new empty replacement folder was taken for the next shift.

Management advised us that the PRF's were scanned into a secure electronic system and a copy was provided to the contracting NHS ambulance trust. Paper copy PRF's were destroyed once they had been electronically scanned. Electronic copies of scanned PRF's were available for management review if required. They were used to evaluate incidents and used for learning where applicable.

The provider advised that a move toward electronic patient record forms was underway. However, at the time of our inspection this had not been implemented.

### Medicines

**The service used systems and processes to prescribe, administer, record and store medicines. However, there was a lack of controls in the oversight and management of some medicines.**

## Emergency and urgent care

Staff followed systems and processes to prescribe and administer medicines safely. Where staff had any queries about patient medicines, they would liaise with clinical leads within the service, as well as at the NHS ambulance clinical hub. We observed staff escalated concerns to a senior clinician within neighbouring NHS Trusts where appropriate.

Medicine management within the provider location is dealt with by the clinical manager. Medicines management and storage was not fully controlled on site and there was not full tracking of controlled drugs prescribed.

Diazepam was the only controlled drug used on the provider's vehicles. On checking the stock register and comparing it to the remaining medication within the store, it was found that some ampoules were initially unaccounted for. 70 ampoules of Diazepam had been delivered to the service in the most recent shipment. The records were checked and indicated 67 ampoules remained and were in the store room or issued to crews. However, there was no accurate record indicating how many ampoules had been signed out by crews. The provider could not immediately track three outstanding doses.

The clinical manager then contacted each crew deployed and asked them to check how many tablets they had on board the vehicle. After receiving updates, it was established there were still three unaccounted for in terms of ampoules administered. The clinical manager had to check through PRF's in order to locate when the three had been prescribed. It was eventually established they were all accounted for, but it took over 24 hours to conclude the process.

Temperature control monitoring of the ambulance station environment was completed regularly. However, lists for three months during June, July and August 2022 had been misplaced and could not be located.

Issues were identified in relation to storage of other medication. A control solution for glucose Gluco RX - 1 was seen in station garage area and labelled as being opened in June 2022. Manufacturer's specification states it should be discarded within 90 days after opening. There was poor compliance with testing liquid dates. There were three available but with dates which indicated 90-day limit had expired. There was evidence that 90 days was not being written on to the medication to inform staff it was within date and it was safe to use.

Three units of Glucagon was seen in a fridge in the kitchen of crew rest room, stored alongside food. It is not required to store Glucagon in a fridge. The clinical manager stated it was their understanding that it should be stored in fridge. We were concerned that the Glucagon may have been removed for patient use and returned to the fridge again for ongoing patient use. The clinical manager was unable to confirm whether this had happened or not. The clinical manager stated that the fridge was the only one on site and he saw no issue with the Glucagon being stored as it was at that time. No temperature controls were in place on fridge within kitchen.

There was no effective temperature control within the medicine storage room itself. We noted a thermometer in place which the clinical manager stated had previously been in an office and they could not say with certainty when it had been placed in the store. It had a function of showing the highest and lowest temperatures it had ever recorded. However, the manager couldn't say over what time period these occurred or whether they related to the store or previously in office elsewhere on site.

Concerns were raised with the provider and they held a clinical meeting the same day and several immediate improvement actions were implemented. A separate fridge was purchased for sole use in the medicines store, thus negating storing medication in a food fridge in the kitchen area. It had temperature monitoring control and addressed concerns raised.

## Emergency and urgent care

The provider also undertook a review of Diazepam procedures. They purchased a batch of controlled drug recording books to ensure accurate record of medicines stock and when it was issued. Each paramedic was issued with a seizure pack with a book allocated to them individually. They also purchased six individual digital safes for use solely by paramedics with full secured access for that member of staff only.

The provider had a digital stockroom system with tolerances set and email prompts sent when stock needed to be reordered. The digital system contained a stock list of orders, however it did not notify when stocks ran low, or provide any real time data. This system was controlled by the operations manager.

The service had Patient Group Directives (PGDs) in place for staff to appropriately administer medicines in a way to maximise patient outcomes.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

### 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. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff explained in the first instance, the incident would be raised to the contracting NHS ambulance trust for escalation under their processes and procedures. Staff were also clear about the need and requirement for the incident to be reported within the service's own internal policies and procedures.

Staff received feedback from investigation of incidents, primarily internal to the service. Staff met to discuss the feedback and look at improvements to patient care. Managers told us that feedback and learning from incidents were used as examples in team meetings. During team meetings, staff were encouraged to share their experiences with other staff members to promote learning and provide opportunities to improve practice.

Managers reported that they did not receive feedback from investigation of incidents which were external to the service, and there was lack of shared learning received from the local NHS ambulance service following safeguarding or incidents raised via their processes.

Managers investigated incidents thoroughly and debriefed staff and supported them after any serious incident. An example quoted by one member of staff detailed how they were exposed to contaminated blood. They were immediately stood down as a result and referred to an occupational health provider.

The provider had their own incident report forms which were stored on vehicles. They were submitted to the operations manager and could be referenced in staff meetings and focus groups in order to identify improvements. The provider also had a lessons learnt document detailing incidents and outcomes.

# Emergency and urgent care

## Are Emergency and urgent care effective?

Good 

We rated effective as good.

### 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 had good awareness of the rights of patients who had mental ill health.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had a range of policies, appropriate for the context and service scope. All the policies we reviewed were current and had a review date. Where relevant, policies referenced current national guidance, such as the service safeguarding vulnerable children and adult's policy which referenced the Care Act (2014) and the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019 '. The service had a comprehensive medication policy, which incorporated guidance for professional responsibilities, use of emergency medicines, recording, medicine storage and administration. Staff had access to service policies through the service's mobile phone app, which we saw staff used in daily practice for seeking guidance. Policies included details of appropriate lead responsibilities for any escalation of concerns, and local standard operating procedures which assisted staff in implementing policies.

Service policies and protocols followed Joint Royal Colleges Ambulance Committee (JRCALC) National guidelines. Amongst those we reviewed were 'clinical update Anaphylaxis shock; clinical update – changes to resuscitation practice; 'clinical update – supporting patients in mental health crisis; and 'guidance for RIDDOR - Reporting Incidents, Diseases and Dangerous Occurrences'.

The service had a 'Scope of Practice Guidance' document providing information about the different levels of staff qualification or responsibilities, and the associated scope of practice related to these. This was a comprehensive document which set out details for the scope of practice including for First Response Emergency Care (FREC) level 3, FREC 4, FREC 5 and for newly qualified paramedics. The document also detailed requirements relating to vehicle driving safety, including specification for when 'blue light' driving should be carried out, as well as the required driver qualifications for this. The guidance stated, 'Blue light driving will only take place when the driver is trained to an appropriate level and has been assessed as being competent to drive under blue light conditions by the Norwest driving instructor.' Scope of practice guidance document also contained direction for crews working on emergency vehicle shifts, requirements for escalation to the clinical hub, and general training information.

Staff assessed patients' physical, mental health and social needs, documenting these in a Patient Response Form (PRF). The guidance document identified the content which staff were required to complete in the PRF for every patient contact. Guidance stated there must be sufficient medical history detail recorded in the PRF, including for example 'presenting complaint', 'history of presenting complaint', 'drug history' 'allergies'. The service audited and reviewed completed PRFs to ensure compliance with guidance and to identify any issues or improvement actions with results reported for review in board meetings.



## Emergency and urgent care

The majority of the service's activities were provided under a service level agreement with a regional NHS Ambulance Trust. Staff in the service followed the NHS ambulance service guidance and clinical pathways for any patients who were conveyed under these arrangements. Clinical guidelines were available for different conditions, such as for stroke, head injury or heart attack. Staff also had direct access to clinical support and advice from the NHS Trust's clinical hub. Senior clinical staff at Norwest ambulance were also available to support staff for any clinical decision making where this was required. Staff liaised with the NHS ambulance service clinical hub to ensure patients, including any who were children, were conveyed to the most appropriate hospital for treatment.

Staff were aware of the rights of patients subject to the Mental Health Act and the Code of Practice. The service did not convey patients who were subject to restrictions under the Mental Health Act. However, staff had good awareness of the needs of patients who were experiencing mental ill health, and could access a mental health assessment toolkit on the service's mobile phone app.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff gave advice to patients for how to seek further help if needed and advised patients on what to do if their condition deteriorated.

### 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 recognised tool and gave pain relief in line with individual needs and best practice. Staff used a pain ladder scoring tool to assess patients' pain and noted this in PRFs. We saw from our review of a sample of PRFs that pain scores and pain relief had been correctly recorded. Crews were experienced in observing and responding to patients who were experiencing pain. Staff described how they were able to assess pain levels where patients had difficulty in communicating, using their clinical judgement to manage patient needs.

Patients received pain relief soon after it was identified they needed it, or they requested it.

### 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.**

The service worked under a service level agreement with an NHS ambulance trust to provide emergency responses for patients. The NHS ambulance control centre allocated and dispatched ambulance crews accordingly. The service had an electronic board in the station headquarters, with individual dispatches automatically delivered to the provider's ambulances via on-board electronic systems. The service met response times within the context of the national challenges for ambulance services. Response times were monitored under service level agreements with the commissioning NHS ambulance trust.

Using these electronic systems, the NHS ambulance trust monitored the provider's performance, identifying and raising any issues directly in feedback with the provider. We were told of a delay which had been noted by the NHS trust, arising as a result of staff break times. The information had been fed back to the provider and was shared with staff in making the required improvements.



# Emergency and urgent care

## Patient outcomes

### **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.**

The service participated in relevant audits. The service had an audit schedule for routine audits in different areas of activity, including for safeguarding, infection prevention and control, weekly routine maintenance and vehicle checks, monthly supervision, and quarterly training audit.

Outcomes for patients were positive, consistent and met expectations. The service performance and compliance with national audits was within the NHS ambulance trust contract. The service received feedback from the NHS ambulance trust regarding any performance issues. Managers and staff used the audit results to improve care and treatment and patients' outcomes. Managers shared and made sure staff understood information from the audits.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service provided details of a Working Time Directive (WTD) audit used to monitor staff working hours and ensure safe practice and compliance with the WTD. Amongst these indicators used were: 'no more than six shifts in a row with no shift breaks'; 'no more than 72 hours total work in a rolling seven-day period'; and 'no more than 13 hours worked in one shift'. The service identified two breaches during September and October 2022 where staff had worked over 13 hours, this was due to ambulance handover delays at receiving NHS emergency departments.

## 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.

Managers gave all new staff a full induction tailored to their role before they started work. Staff completed an on-boarding assessment at the start of their employment and an end of probation assessment. Managers reviewed key areas of staff performance, including assessment of clinical knowledge; adherence to infection prevention and control standards; respect for patients' privacy and dignity; and communication skills.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers and staff said there was ongoing regular day to day communications between staff and managers in the service to share learning and feedback. The service had identified a schedule for annual one to one meetings with staff, although a few individual staff we spoke with said they did not have a documented record of formal appraisal with their manager.

The service had identified a programme of ongoing clinical review procedures for staff, held on a three-monthly basis. Staff would complete a pre-review information template, which included previous training needs identified and actions progressed in achieving these, as well as any safeguarding audit information relevant to individual staff. Staff we spoke with confirmed they had regular opportunities, both formal and informal, to discuss their progress and learning needs. Leaders described how they were available to meet with staff on a daily basis. This was particularly for offering staff a debriefing after they had experienced any significant or challenging issues following a patient transfer. Operational managers also supported staff in completing a weekly shift with a different crew. Staff appreciated having the opportunity for this direct supervision and practical clinical direction during day to day patient contact.

# Emergency and urgent care

The senior leaders supported the learning and development needs of staff. Staff spoke positively about a range of training opportunities they could access, including 'bite sized' learning, for example, in management of suspected ectopic pregnancy.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service routinely offered staff development opportunities to complete training in First Response Emergency Care (FREC) qualifications. Staff were offered entry level training if required, when joining the service, with many staff having completed FREC level 4, and progressing to FREC levels 5 and 6.

Several staff we spoke with told us they had been supported to complete further role specific training, including access to higher education and undergraduate learning for degree qualification. We saw that staff were provided with additional support for any additional learning needs identified, including such as for dyslexia. Also, recently the service had been involved in local training to facilitate closer working with other emergency response services, including fire and mountain rescue services. Staff had an enthusiastic and proactive approach to learning and development, which was fully supported by managers.

Managers made sure staff received any specialist training for their role. Staff had attended a training day during the past six months for updating their knowledge and skills in restraint and patients experiencing mental health illness.

The service had a record of staff who held professional registrations and ensured these were up to date for the required staff.

Managers identified poor staff performance promptly and supported staff to improve. We reviewed records of staff review meetings which indicated where staff had been supported for their development.

Managers made sure staff had access to full notes of staff meetings when they could not attend. The service had introduced a weekly newsletter to collate themes and important updates for sharing with staff, which was shared via the service mobile phone app and displayed on notice boards in crew rooms.

## Multidisciplinary working

**Staff 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. Staff were observed to provide a full and relevant patient handover to receiving emergency departments. Staff had knowledge of any relevant clinical concerns and shared these in a professional manner during handovers.

## Health Promotion

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

The service provided relevant information for patients to promote healthy lifestyles. Crews had access to a service finder on the service's mobile phone app, which they used to signpost patients to other support and services where needed. Staff described how they assisted patients in accessing GP services for provision of a base supply of their medicines, in order to have a continuing and more ready supply available at home.

## Emergency and urgent care

### 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. Staff had completed Mental Capacity Act training and followed the service policy and procedure for assessing patients where they may lack the capacity to consent to care and treatment. Staff explained how they would assume that a patient had capacity to consent, proceeding to assess and record any concerns about lack of consent where these were apparent. Staff described how they would work with patients where they did not give consent, or who lacked capacity.

Staff were clear in their knowledge of consent procedures and gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff taking care to explain their actions to patients in a way they could understand, involving patients in decisions about their treatment and care. Staff described, and we observed, how they would involve family members in discussions to support patients in their understanding. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the Patient Record Form.

When patients could not give consent, staff made decisions in their best interest. Staff described how in an emergency there may be occasions where procedures under the Mental Capacity Act would not apply. Where appropriate and relevant, staff could explain the process of best interest decision in accordance with the Mental Capacity Act 2005.

Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. The service policy described relevant procedures for consent in relation to children, including the consideration of individuals who held parental responsibility in context of providing consent. Staff were familiar with these aspects and described how they applied principles correctly, whilst working with children and their parents or carers.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

### Are Emergency and urgent care caring?

Good 

We rated caring as good.

### Compassionate care

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

## Emergency and urgent care

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. During the inspection we accompanied crews providing urgent and emergency services. We saw that staff consistently had a caring and compassionate approach when looking after patients. They ensured, as far as possible, that a patient's privacy and dignity was maintained during treatment and care. They showed respect and caring towards family members or any carers that may be travelling with patients.

Patients said staff treated them well and with kindness, patients were happy with the care staff provided. Patients and families could give feedback about their treatment and we saw how staff supported them to complete this.

Staff followed policy to keep patient care and treatment confidential. The service had a records policy and staff recorded patient information in accordance with this. Staff were professional and discreet when sharing patient information during handovers.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. They described how they would manage a patient whose condition was deteriorating whilst in the presence of a relative or carer. Staff were alert to the distressing impact of such situations and described how they would communicate in a clear and sensitive manner to provide comfort and reassurance.

### 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 staff were attentive to individual patient concerns and reassured any patients who were anxious or distressed. Staff engaged fully with patients to put them at their ease and supported their families to be involved where appropriate. We observed crews to be very caring and compassionate with patients and it was evident that they took a holistic approach.

Staff supported any patients who became distressed and helped them maintain their privacy and dignity. We saw staff were considerate of patients' privacy and dignity at all times, continually showing kindness and caring.

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. Staff were aware of the challenging experiences faced by seriously unwell patients and responded flexibly and in a professional way to these, where needed.

### 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.

## Emergency and urgent care

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff had access to picture cards on ambulances to assist patients who had limited communication skills. Staff described how they engaged with patients and families in different ways to help patients to be involved in decisions over their care and treatment. Staff supported patients to make informed decisions about their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service offered all patients, their families or carers a patient feedback form. Comments received in feedback forms we reviewed included “the crew were fabulous, put the patient at ease, spoke to them on their level, and were fun professional and nice to be around” and “thank you for dealing with my relative in such respectful, courteous manner. Their attention and care was first class. They explained matters well to us and kept us informed throughout. Such great professionals and a credit to your organisation.”

### Are Emergency and urgent care responsive?

Good 

We rated responsive 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 held its main contracts with a NHS ambulance trust. The service would provide a number of ambulance vehicles and crew, in line with the service level agreements applicable.

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. During our inspection we were informed about how ambulance crew accessed support for any issue. Managers told us that whilst working under a service level agreement, for emergency response, staff had access to the on-duty resources that the contracting NHS ambulance trust's staff had. This meant that timely advice for a wide range of presenting issues could be sought by the crew, if needed.

The service had systems to help care for patients in need of additional support or specialist intervention. Ambulance crews were trained to recognise situations and incidents where a paramedic from the contracting NHS ambulance trust would be required. This meant patients with specialist or significantly higher needs, were cared for by the most relevant clinical professional.

#### 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.**

## Emergency and urgent care

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us they completed training for supporting patients with mental health, learning disabilities and dementia. They also understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Staff had access to a service finder which gave information on a number of agencies they could contact and advise patients to access support services where needed. Staff had access to communication aids to help patients become partners in their care and treatment. Staff utilised language line for interpreter services when patients required this. They also had interpreter/ language function on the app they used on work mobile phones in order to engage with patients. In addition, staff used pictures to supplement communication. They told us they made regular use of these aids when communicating with patients, and that their use improved interactions and quality of care. The provider also had guidance for transportation of patients requiring an assistance dog which ensured the animal could be transported in vehicles, to provide support for patients who needed this.

### 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.**

Patients, relatives and carers knew how to complain or raise concerns and staff understood the policy on complaints and knew how to handle them. We had full sight of the provider's complaints policy which was clear and detailed. It covered roles and responsibilities, objectives and grading.

Managers investigated complaints and identified themes. Managers told us that complaints could be raised to the service in two ways. The main route of complaints was via the contracting NHS ambulance trust. For example, a complaint would be made to them, which would then be forwarded on to the provider. Managers explained to us the process of investigating a complaint and providing a response to the contracting NHS ambulance trust.

If a complaint was received directly by the provider, the process would be the same as described above, however the response would be to the complainant directly. Managers shared feedback from complaints with staff, and learning was used to improve the service. During our inspection we were told that managers used complaint examples in team meetings, to encourage reflection and improve practice.

The service clearly displayed information about how to raise a concern in patient areas. Patients could complete a patient feedback form if they wished which was available in all vehicles. There was information available on vehicles with provider's contact information and also a poster on the vehicles advising how to complain.

## Are Emergency and urgent care well-led?

We rated well-led as good.

### Leadership

## Emergency and urgent care

**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 company director was a paramedic with previous experience in legal services and business management. The service had a managing director, business development manager, clinical director, finance director, human resources and safeguarding leads. This group formed the senior leadership team who met formally to oversee the service activities. The managing director had an operational leadership responsibility, with the clinical director overseeing the clinical activity and performance in the service. There was a medical director who was available where required in an advisory capacity, to support the clinical aspects of the service.

We reviewed the personal files of senior leaders against fit and proper person criteria. We noted that senior leaders underwent a comprehensive and competency-based appointment process. This included validation of professional registrations, qualifications and DBS checks. Senior leaders articulated the top challenges the service faced and how to meet them.

Staff involvement was encouraged. Managers told us they supported staff and provided opportunities to improve practice and discuss their concerns. Formal meetings were originally held but it was found that the same people attended and not all voiced their opinions. It was because of this, alternate approaches were developed and implemented. Managers established that staff felt more comfortable in their own environment and expressed their concerns more openly. A member of the senior management team completed at least one front line shift a week to provide a platform for staff.

The Managing Director had an open-door policy at base or by phone throughout the shift span for any operational or clinical issues. One of the paramedic staff acted as caretaker of the ambulance station in the service and was also available to respond to any issues out of office hours. The Managing Director was available to respond to any calls until the last crew member had left the ambulance station.

The senior clinical leaders shared responsibility for out of hours response and any escalation needed planning rotas between themselves. This offered crew members choice in whom they contact and a blend of operational and clinical expertise on which they could draw. In the event of any significant pastoral issue arising, the Managing Director or Clinical Director would attend base as required.

### 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 vision of the service had been created with reference to a specific set of values, which were well implemented in staff training and development. It was their intention to achieve awarding body approval for FREC 5 delivery. They told us they continued to invest significantly in staff training. They also told us they had developed the clinical staff employed through both external training and internal promotions. Several staff told us they had received support for their development in different role specific and advanced courses, including higher level education and qualification.

# Emergency and urgent care

They relocated to a larger premises in July 2022 to create sufficient capacity for planned additional vehicles and had started to deploy additional crews to conduct work as part of the local NHS ambulance service contract. The additional vehicles were being purchased both to deliver increase in operational capacity and also to replace older vehicles which would exceed maximum age for the local NHS ambulance service specification requirement.

The provider was in talks with another ambulance trust about securing a three year contract to provide services. This would represent a significant expansion of operations.

## 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.**

It was the intention for the provider to have a staff forum, with the remit to hear issues or problems and take suggestions or solutions from colleagues. Senior leaders told us the aim was to have at least one representative from operational crew level. This would ensure staff voice was heard from all locations of the service.

We spoke with staff who told us they were confident in raising issues with their manager and that managers were both fair and approachable. Staff told us there were opportunities for career development and they felt supported in aspirations to complete additional specialised training. They told us management ‘aimed high’ and wanted the provider to be an enjoyable place to work.

## 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.**

We reviewed the structure of the organisation which demonstrated a clear line of management from front line crew to the clinical director and operations director. We reviewed the governance framework. At board level, there was clear structure which was split into operations and clinical. The clinical manager had ownership for infection control and medication management. We noted that a head of safeguarding was in post. We noted that a medical director was also available in a consultancy-based role. They were not directly employed by the organisation.

The policies we reviewed were structured in a way which clearly defined which members of staff were responsible for which actions. Staff could access all policies and procedures by scanning a QR code on the back of their ID badges.

We requested copies of the provider’s service level agreements that were in place with partner organisations. This demonstrated a clear legal framework with stated responsibilities and terms, for the provider and the contracting NHS ambulance trust.

During the inspection we spoke with the registered manager. They told us about an aspect of the governance structure of the service, which was a clinical committee. The purpose of this committee was to review any national evidence-based practice, which would then filter into organisational policies and procedures.

Regular team meetings were held for all staff members. Staff also had regular one to one’s with the operations manager.



# 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 however actions were not always clearly identified to reduce their impact. They had plans to cope with unexpected events.**

Risks were reviewed every month in the management board meeting. We reviewed the provider's risk register. We noted it contained a description of the risk and was allocated a score. This score was then colour coded and categorised as initial, current and target. There were five risks listed for review, all with the same date identified, 5 May 2022.

There were three risk types listed which were financial, operational or estate related. Within the risk register there were a number of tabs which included details about what score the risk should be and also what further action should be taken. There were three elements listed which were triggers, controls and gaps in controls. There was also an actions tab, however nothing was listed in this section for any of the risks identified. The register listed who had ownership of them and a category titled direction which had either static or increasing listed in the text displayed. Risks were reviewed in the quarterly board meeting.

We reviewed the services business continuity plan, which demonstrated the roles and responsibilities of key people. It also detailed arrangements for maintaining services in the event of a range of different disruptions. Examples of this were loss of key premises, loss of telecommunications, loss of a key supplier, loss of utilities, multiple resource failure and industrial action.

Managers told us about the plan for any contingencies. In the event of the need for a contingency, staff were aware that they would have to contact relevant managers. Staff reported managers were proactive regarding risk management. For example, staff had been provided with self-defence training.

Staff were issued with mobile phones which had an 'app' for them to contact the local NHS ambulance service and it had a panic alarm facility. The app provided options to 'request speech' in contact with the ambulance control centre, or 'emergency', this defaulted to 999 procedures and was not direct to ambulance control. There were examples given of where staff were at risk, for example, a patient with a weapon and a crew held hostage. Several staff told us the app didn't work and they resorted to dialling 999 on their own phones. This information was relayed to the operations manager who said they were unaware of these issues. The operations manager informed us they were only aware of the app having been used once during an incident and would be investigating this further.

Service leaders had submitted request to the commissioning NHS ambulance trust to be issued with radios as they were more effective and safer than mobile phones, notably in areas which had little or no mobile signal.

## 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.**

# Emergency and urgent care

Data was collected and processed through an electronic system. This included training compliance, staff absence, staffing rotas and also feedback from staff members and patients. This allowed managers to be able to make real time decisions about operational capability. Documentation was processed electronically. If any paper documents were completed, these were collated within the base premises and then uploaded on site.

Staff told us they were aware of the service leads who would be responsible for making alerts and notifications and what to do if they were not contactable. This was reinforced in monthly newsletters and policies we viewed, which clearly provided required contact numbers.

## Engagement

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

Equality, diversity and inclusion training was in place for staff as part of annual mandatory training and was reflected in the planning and delivery of services and shaping of culture within the service.

Staff told us the management team were very accessible, available and visible. They were deployed operationally and worked shifts on vehicles. Management were readily accessible out of hours to listen and help respond to any problems.

## 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 placed significant importance on learning and development. We noted that the service undertook innovative projects. For example, senior leaders told us they completed joint training with the fire service and mountain rescue. Management encouraged innovation. One of the ambulance staff had developed a mobile phone app for use in the service. This contained a range of information, including service policies and best practice guidance for staff to be able to access during shifts.

## Patient transport services

Safe	Requires Improvement 
Effective	Good 
Caring	Insufficient evidence to rate 
Responsive	Good 
Well-led	Good 

### Are Patient transport services safe?

Requires Improvement 

We rated safe as Requires Improvement.

For our detailed findings on assessing and responding to patient risk, medicines and incidents, please see under these subheadings in the urgent and emergency care report.

#### Mandatory training

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

All staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff compliance with completed mandatory training was above 95%.

The service did not distinguish between staff working on the patient transport and urgent and emergency vehicles and therefore could not breakdown the mandatory training figures to patient transport level. Managers told us that staff worked flexibly between emergency and urgent care and patient transport services.

Ambulance staff completed driver training and were assessed for driver safety at different skill levels. All relevant staff completed a baseline assessment of their ambulance driving skills, with regular six-monthly formal driver assessments completed.

For our detailed findings on mandatory training please see under this subheading in the urgent and emergency care report.

#### 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.**

# Patient transport services

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. All ambulance staff in the service had completed level three children and adults safeguarding training

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding referrals were made electronically by smart phones in the vehicles which contained a secure application. In addition, a safeguarding policy was available for all staff on this device meaning that staff could easily access information they needed to make a referral of concern. Staff had access to safeguarding support from a designated safeguarding level four trained lead in the service for any safeguarding concerns they identified. We saw the service was active in raising safeguarding notifications, for example, if they attended a vulnerable patient who may have received poor care.

For our detailed findings on safeguarding please see under this subheading in the urgent and emergency care report.

## 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 contents which were clean and well-maintained in line with national guidance. Cleaning areas were available on all stations. Cleaning equipment such as disinfectant and spill kits were stored on each vehicle in the event of the vehicle needing cleaning when away from its base.

Staff cleaned equipment after patient contact and labelled equipment correctly to show when it was last cleaned. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

We observed that ambulance vehicles were clean and well maintained. Managers ensured the vehicle deep cleaning schedule was maintained.

Staff followed infection control principles including the use of personal protective equipment (PPE).

For our detailed findings on cleanliness, infection control and hygiene please see under this subheading in the urgent and emergency care report.

## Environment and equipment

**The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.**

The design of the environment followed national guidance. We observed that stock room access was appropriately controlled which was by means of key access. However, access to the location where the keys was stored was not always adequately controlled.

The service did not have designated ambulances specifically used for PTS, however worked flexibly within the service to accommodate patient transfers when needed. The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment and vehicles before deploying. We observed that equipment was properly labelled and sign out sheets were in use and correctly filled in.

## Patient transport services

We reviewed a sample of all stock supplies, which were within expiry dates. All relevant equipment was stored appropriately, including for example medical gases.

We noted that staff disposed of clinical waste safely whilst deployed on shift. The provider had deep-clean contracts for clinical waste in vehicles and across the service. Vehicles were cleaned daily by outside contractor and deep cleaned every four weeks by the same contractor.

We saw several electrical devices were without stickers indicating when they were last tested for electrical safety.

We reviewed information about the ambulance fleet used by the service including MOT and servicing records. All were within MOT date where applicable and service schedules were fully up to date.

For our detailed findings on environment and equipment please see under this subheading in the urgent and emergency care report.

### 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 bank, agency and locum staff a full induction.**

The service had enough staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with required skill set and knowledge. The service had a good skill mix of staff on each shift and reviewed this regularly.

For our detailed findings on staffing please see under this in the urgent and emergency care report.

### 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.**

Patient notes were comprehensive and all staff could access them easily. The patient report form was comprehensive and available to all crew members. Electronic copies of patient report forms were retained and used for monitoring purposes by service leaders.

For our detailed findings on records please see under this in the urgent and emergency care report.

## Are Patient transport services effective?

We rated effective as good.

# Patient transport services

For our detailed findings on evidence-based care and treatment, pain relief, response times, competent staff, multidisciplinary working, health promotion and consent, Mental Capacity Act and Deprivation of Liberty Safeguards please see this subheading in the urgent and emergency care report.

## 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 had good awareness of the rights of patients who were suffering from mental ill health.**

For our detailed findings on evidence-based care and treatment please see under this subheading in the urgent and emergency care report.

## 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 recognised tool and gave pain relief in line with individual needs and best practice. Staff used a pain ladder scoring tool to assess patients' pain and noted this in patient record forms. Staff used a numerical scale to assess and respond to patients' pain levels. Staff followed JRCALC guidelines for the administration of pain relief.

For our detailed findings on pain relief please see under this subheading in the urgent and emergency care report.

## 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.**

The service did not have separate targets for response times for its patient transport services; these were agreed by individual providers on making request and fulfilled accordingly. For our detailed findings on response times please see under this subheading in the urgent and emergency care report.

## 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. Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

# Patient transport services

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 and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

For our detailed findings on competent staff please see under this subheading in the urgent and emergency care report.

## Multidisciplinary working

**Staff 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 worked with other agencies when required to care for patients.

For our detailed findings on multidisciplinary working please see under this subheading in the urgent and emergency care report.

## Health promotion

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

For our detailed findings on health promotion please see under this subheading in the urgent and emergency care report.

## 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. Staff followed the service policy for assessing, obtaining and documenting patients' consent. The service policy reflected current legislation and guidance for consent.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

For our detailed findings on consent, Mental Capacity Act and Deprivation of Liberty safeguards please see under this subheading in the urgent and emergency care report.

# Patient transport services

## Are Patient transport services caring?

Insufficient evidence to rate 

We had insufficient evidence to rate the domain for caring.

For our detailed findings on compassionate care, emotional support, and understanding and involvement of patients and those close to them, please see under these sub-headings in the urgent and emergency care report.

### Compassionate care

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

Patient transport services were a small part of the regulated activities provided by Norwest Ambulance Limited. Urgent and emergency care staff worked flexibly to provide for patient transport services when this need arose. Patient feedback for this service was positive and indicated patients were provided with compassionate and respectful care.

For our detailed findings on compassionate care please see under this subheading in the urgent and emergency care report.

## Are Patient transport services responsive?

Good 

We rated responsive as good.

For our detailed findings on service delivery to meet the needs of local people, meeting individual needs and learning from complaints and concerns, please see under this sub- heading in the urgent and emergency care report.

### Access and flow

**People could access the service when they needed it and received the right care in a timely way.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. The service provided a limited number of private patient transfer services for patients moving between different care facilities. At the time of inspection, there had been a total of 17 such patient transfers over the past six months.

For our detailed findings on access and flow please see under this subheading in the urgent and emergency care report.

## Are Patient transport services well-led?



Good 

## Patient transport services

Good 

We rated well-led as good.

For our detailed findings on leadership, vision and strategy, culture, governance, management of risk, issues and performance, information management, engagement and on learning, continuous improvement and innovation please see under these sub-headings in the urgent and emergency care report.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not always ensure that systems and processes were followed for the proper and safe management of medicines.