

Jigsaw Medical Services Ltd

Jigsaw House Cheshire

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Jigsaw Medical Services provides emergency and urgent care and a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 9 and 10 January 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

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

The main service provided was emergency and urgent care with a smaller level of patient transport activity therefore we have reported findings in the emergency and urgent care core service.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- The provider had strong leadership with a clear focus on high quality provision and care.
- We found all vehicles were in good condition and a comprehensive system was in place to ensure they were fit for purpose.
- An effective compliance process was in place to ensure operational staff had completed induction and mandatory training before commencing employment and also that staff remained compliant during the time they continued to work for the provider.
- Risk assessments were completed for any ad hoc patient transfers to ensure the correct vehicle, equipment and appropriately trained crew were assigned to meet the needs of the patient.
- Arrangements were in place for escalating issues with contracting trusts. A contract manager was identified within each trust and monthly contract meetings took place to monitor performance and provide feedback regarding incidents and referrals.
- Mental Capacity Act (2005) training compliance was 100% for operational staff at the time of our inspection.
- Staff were committed to providing the best quality care to patients and we observed staff demonstrating patience, kindness and respect.
- Staff had access to practitioners trained in Trauma Risk Management (TRiM) to support personnel following traumatic events. TRiM is a peer delivered psychological support system designed to allow organisations to proactively support personnel following traumatic events.

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

- The provider did not have a record of all incidents or safeguarding referrals reported through trust processes and relied on the contracting trust to feed the information back either by telephone or during monthly contract meetings. This meant the provider did not have oversight of all incidents and safeguarding situations operational staff had been involved in and relied on the NHS trust to identify any immediate learning.
- The provider did not have robust processes to ensure the safe disposal of out of date medicines.
- Not all staff had received an appraisal and documentation we reviewed did not indicate any standards or provide a clear scoring system.
- Patient feedback forms were not available on all vehicles we inspected. Staff were not always involved in complaints from the NHS trust and did not always receive feedback.

Summary of findings

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We issued the provider with one requirement notice that affected both emergency and urgent care and patient transport services. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North), on behalf of the Chief Inspector of Hospitals.

Summary of findings

Our judgements about each of the main services

Service

Emergency and urgent care services

Rating Why have we given this rating?

We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

The main service provided was emergency and urgent care.

The service also provided patient transport services. As this was only a small part of overall activities, this has been reported under emergency and urgent care services.

The provider had strong leadership with a clear focus on high quality provision and care.

Arrangements were in place for escalating issues with contracting trusts.

Staff were committed to providing the best quality care to patients and we observed staff demonstrating patience, kindness and respect.

However, the provider did not have a record of all incidents or safeguarding referrals reported through trust processes therefore did not have oversight of all incidents and safeguarding situations operational staff had been involved in.

The provider did not have robust processes to ensure the safe disposal of out of date medicines.

Jigsaw House Cheshire

Detailed findings

Services we looked at

Emergency and urgent care; Patient transport services (PTS)

Detailed findings

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Detailed findings from this inspection

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Background to Jigsaw House Cheshire

Jigsaw Medical Services is operated by Jigsaw Medical Service Ltd. The service opened in 2012 and is an independent ambulance service with the head office in Chester, Cheshire. The service has expanded since 2012 and has ambulance bases situated in Warrington, Buckingham and Basingstoke. The service serves a number of communities including, Greater Manchester, Cheshire, Merseyside, Yorkshire, East Midlands, Buckinghamshire, Oxfordshire, Berkshire and Hampshire. The urgent and emergency care vehicles are operated mainly from the Buckinghamshire base.

The service provides emergency and urgent care to a number of NHS ambulance trusts and is provided in specific emergency vehicles.

The patient transport service provides support to several ambulance trusts as well as NHS acute hospital trusts and individual patients. The service consists of both contract and ad hoc work.

Jigsaw Medical Services also provide an ad hoc events' support service to sports events and festivals.

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

Treatment for disease, disorder and injury

Transport services, triage and medical advice provided remotely.

The service has had a registered manager in post since 2012. In the months preceding the inspection the registered manager role had transferred from the chief executive officer (CEO) to the managing director.

We completed an announced inspection in the head office and the Buckingham base on 9 January 2018 and the Warrington ambulance base on 10 January 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, three other CQC inspectors and a Paramedic specialist advisor. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection (North West).

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Jigsaw Medical Services Ltd was initially established in 2012 by the current chief executive officer. The company provides a wide range of transport to meet the needs of NHS Hospital Trusts, NHS Ambulance Services and events. At the time of our inspection the company contracted the services of 57 emergency care assistants, 40 technicians and 47 paramedics. It operated a fleet of 48 operational vehicles providing patient transport including emergency and urgent care vehicles, patient transport vehicles and rapid response vehicles.

During the inspection, we visited the head office in Chester and ambulance bases in Buckingham and Warrington.

We spoke with 24 staff including; registered paramedics, emergency care assistants, scheduling and operations staff and managers. We spoke with one patient, we reviewed comment cards submitted by people who use the service and observed four episodes of care. We reviewed documentation including policies, staff records, training records and call log sheets.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC.

The provider had key performance indicators for contracted urgent and emergency care and patient transport services delivered to NHS ambulance trusts. These included response times and hospital turnaround performance.

There were 112 ad hoc patient transport journeys undertaken by the provider between January 2017 and December 2017.

All emergency care assistants, technicians and paramedics were contracted to the service on a self-employed basis.

The accountable officer for controlled drugs (CDs) was the medical director.

Track record on safety:

- There had been no never events reported by the organisation. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- There had been no serious incidents reported by the organisation.
- The service had recorded 14 complaints in the 12 months prior to our inspection.

Services accredited by a national body:

The provider was accredited with a number of national organisations including Future Qualls and Quallsafe for training and Investors in People which is a benchmark of good people management practice.

Emergency and urgent care services

Summary of findings

We found the following areas of good practice:

- We found all vehicles were in good condition and a comprehensive system was in place to ensure they were fit for purpose.
- An effective compliance process was in place to ensure operational staff had completed induction and mandatory training before commencing employment. The process also ensured that staff remained compliant during the time they continued to work for the provider.
- Risk assessments were completed for any ad hoc patient transfers. This ensured the correct vehicle, equipment and appropriately trained crew were assigned to meet the needs of the patient.
- Arrangements were in place for escalating issues with contracting trusts. A contract manager was identified within each trust and monthly contract meetings took place to monitor performance and provide feedback regarding incidents and referrals.
- Mental Capacity Act training compliance was 100% for operational staff at the time of our inspection.
- Staff were committed to providing the best quality care to patients and we observed staff demonstrating patience, kindness and respect.
- Staff had access to trained practitioners who could proactively support personnel following traumatic events.

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

- The provider did not have a record of all incidents or safeguarding referrals reported through trust processes and relied on the contracting trust to feed the information back either by telephone or during monthly contract meetings. This meant the provider did not have oversight of all incidents and safeguarding situations operational staff had been involved in and relied on the NHS trust to identify any immediate learning.
- The provider did not have effective processes to ensure the safe disposal of out of date medicines.
- Not all staff had received an appraisal and documentation we reviewed did not indicate any standards or provide a clear scoring system.

- Patient feedback forms were not available on all vehicles we inspected. Staff were not always involved in complaints from the NHS trust and did not always receive feedback.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- There had been no never events or serious incidents reported by the organisation. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- The organisation had a current clinical and non-clinical incident reporting policy. The policy defined a clinical incident as 'any untoward or unexpected event which interferes with the treatment of a patient and which results in, or could have resulted in inappropriate or inadequate clinical care, an injury or a serious injury'. It also provided a definition for an accident and a near miss however did not define a system for grading incidents.
- The policy described action to be taken in the event of an incident and the process for investigation. The customer services, complaints and feedback policy described how the provider would exercise duty of candour. However the senior managers we spoke with could not remember an incident where duty of candour had been required.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Incidents that occurred while delivering services for NHS Trusts were reported using trust processes. Staff reported either electronically or in paper format depending on the contracting trust.
- A Jigsaw incident report form was available for internal incidents. Road traffic collisions and vehicle defect forms were in use and sent to the national operations manager and fleet manager.
- Incidents reported through trust processes were investigated by the trust with involvement of the provider. Clinical incidents were investigated by the national clinical lead and non-clinical incidents by the national operations manager.
- Outcomes of investigations were provided through the NHS contract lead and discussed at monthly contract meetings.
- The provider did not have a record of all incidents reported through trust processes and relied on the contracting trust to feed the information back either by telephone or during monthly contract meetings. This meant the provider did not have oversight of all incidents operational staff had been involved in. They relied on the NHS trust to identify any immediate learning.
- Incidents were recorded on a complaints and incidents log sheet according to contract but did not consistently identify if the concern raised was an incident or complaint. Incidents classified as internal were held on a separate spreadsheet. We saw evidence of incidents being investigated on a case by case basis, but there was no record of trends or themes which could mean that recurring issues were not being identified.
- Staff we spoke with knew how to report incidents and could provide details of learning from previous incidents. Feedback was discussed in relation to individual learning as well as changes in process.
- Staff and managers described involvement in the incident investigation process with NHS ambulance trusts and attendance at multi-disciplinary team meetings as part of the debrief. Operational memos were circulated to disseminate lessons learnt and paper copies were stored in a folder in each base and at head office.
- Between January 2017 and December 2017 13 external incidents and five internal incidents were recorded by the provider and included delayed transfers and staff injury on duty.
- Statutory notifications were not being completed by the provider following reporting of incidents. A service is required to inform the Care Quality Commission about any significant incidents such as any incident which is reported to or investigated by the police, or any abuse or allegation of abuse in relation to a service user. Staff provided examples of when they had made safeguarding referrals and involved the police. However managers confirmed no statutory notifications had been made to the CQC. Managers did however confirm a RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) notification had been submitted to the Health and Safety Executive.

Emergency and urgent care services

Mandatory training

- The service provided induction and mandatory training for staff. A compliance lead was in post to ensure all documentation was received by the provider including evidence of qualifications, references and enhanced Disclosure and Barring Service (DBS) check for all operational staff. The compliance department also ensured all mandatory training was completed before any new member of operational staff could be scheduled to work.
- Managers informed us that any operational staff who had not worked a shift for six months were required to undertake the compliance process again including submission of up to date references and CV (curriculum vitae).
- Mandatory training was delivered on line as well as face to face. It included topics such as resuscitation, infection prevention and control, fire safety and conflict resolution. Face to face training was delivered either in the training academy adjoining head office or on base.
- Mandatory training was also required for internal head office staff and included information governance, health and safety, fire safety and equality and diversity.
- Staff received training to use the equipment on board the vehicles. This included moving and handling equipment and clinical equipment such as defibrillators within basic life support training, if appropriate to role.
- The compliance department notified staff by email one month prior to expiry of mandatory training compliance. If compliance was not maintained no further shifts would be scheduled until training was completed.
- Staff received nationally accredited driver training and blue light driver training met the national standard for ambulance trusts. Driving licence checks were completed annually with the DVLA (Driver Vehicle Licensing Agency).
- Driving was monitored through the use of a global positioning system (GPS) that was present on all vehicles. This was a live tracking system based at head office and could identify the exact position of a vehicle, its speed and if the blue lights were in use.
- Compliance rates for mandatory training at the time of our inspection were 100% for all modules for paramedics, technicians, emergency care assistants and patient transport staff with the exception of dementia training, which ranged from 86% to 100%.
- Safeguarding policies were in place and staff could access these electronically and in paper format. We reviewed Jigsaw's safeguarding policy which included information regarding forced marriage and mandatory reporting requirements relating to female genital mutilation.
- Safeguarding incidents and referrals that occurred while delivering services for NHS Trusts were reported using trust processes. The provider did not have a record of safeguarding referrals made through trust processes. This meant they did not have oversight of all safeguarding activity and may only become aware if further information was required from the operational staff involved.
- Staff we spoke with could describe how they would access advice from the clinical decisions team in the NHS trust ambulance control room. A national clinical lead and safeguarding lead was also available to provide advice and support to front line staff regarding safeguarding concerns.
- Staff discussed how they would initiate a safeguarding referral if needed and provided examples of referrals made.
- The designated safeguarding lead had completed level three safeguarding training and a one day safeguarding leads course.
- Mandatory safeguarding training included safeguarding adults, safeguarding children and Prevent, which is a government led counter-terrorism strategy.
- Managers reported all operational staff received level two safeguarding training as a minimum. Paramedics and all practitioners who may have contact with children were trained to level three.
- Compliance rates for mandatory safeguarding training at the time of our inspection were 90% of PTS staff, 88% of ECA staff, 86% of EMT staff and 93% of paramedics were trained to safeguarding level three for both adults and children. The remaining staff in all groups had completed safeguarding level two training.

Cleanliness, infection control and hygiene

- All staff we saw were in clean and tidy uniforms.
- Staff were seen to use hand sanitizer between episodes of patient care and to clean the equipment that came into contact with patients.

Safeguarding

Emergency and urgent care services

- All vehicles we observed were clean and tidy. There was a system in place to ensure the vehicles were cleaned and checked prior to the start and at the end of each shift. This included mopping, restocking and removal of waste.
- We observed general cleaning records for vehicles that had been consistently completed.
- Personal protective equipment such as gloves and aprons was present on all the vehicles and additional stock was available in each ambulance base. Biohazard kits were available on each vehicle we observed.
- Vehicles underwent a deep clean monthly. However, swab testing following a deep clean was not in place. Staff and managers told us this was due to be implemented to confirm the standard of deep cleaning.
- Ambulance bases were clean and tidy. Clinical waste bins were locked and sharps bins secured. However, not all sharps bins were signed and dated when assembled. Sharps bins should be replaced when three quarters full or after three months in line with current guidance. Appropriate arrangements were in place for the disposal of clinical waste.
- Clinical noticeboards within ambulance bases contained local information for staff from Public Health England regarding local statistics for influenza to raise staff awareness.
- Infection prevention and control training was delivered to staff as part of induction and mandatory training. Compliance rates were 100% at the time of our inspection.
- To support staff in managing infectious patients appropriately, arrangements for ad hoc patient transport journeys included a risk assessment which would identify any potential risks including infection.
- Close circuit television (CCTV) was in use at all bases and head office and included areas where stock and drugs cabinets were situated.
- The majority of urgent and emergency work originated from the Buckingham base. This was a two storey building which included a 'make ready' area, crew facilities, training room and office for the base manager and clinical lead. It also had a quiet reflection room used for debriefs or discussions with staff following attendance at difficult or traumatic incidents.
- Manley base in Warrington was situated in a rural location on a farm. Managers described it as a 'make ready base'. This had a base manager's office, storage and cleaning areas and limited crew facilities. Managers told us this was only visited by staff at the beginning and end of shift and was an area that was identified for development.
- All medical equipment was in date with servicing and had stickers detailing when the next service was due.
- Staff were responsible for completing a daily vehicle check before every shift. This included checking the vehicle was in a good state of repair and had the correct equipment available. We observed a crew completing the checks before departing the base.
- There were 48 operational vehicles within the fleet which included 32 dual manned emergency vehicles, seven patient transport and urgent care vehicles and five rapid response vehicles. Newer generation vehicles had CCTV following an incident where a member of staff sustained an injury on duty.
- Head office had live vehicle tracking screens which identified the position and status of each vehicle so managers would know at a glance if a vehicle was on route, on scene or off the road. The national operations manager and fleet manager also had access to the tracking screens remotely. This meant that vehicle defects were flagged to head office and the fleet manager immediately.
- There were systems in place to monitor the maintenance of the vehicles used by the service. These included a live vehicle status screen at head office which included vehicle maintenance details such as MOT expiry date, last service date, due date for next service and last deep clean date. It also indicated the current status of the vehicle such as base, any defects and whether the vehicle was in use or off the road. All vehicles had current MOT's and we saw a current certificate of motor insurance.

Environment and equipment

- The service had three ambulance stations and a head office in Chester. We visited head office, the Buckingham base and Manley base in Warrington as part of the inspection.
- Head office and bases we visited had secure access arrangements in place and swipe card access could be immediately turned off from head office if required. Swipe card access could be monitored by head office and certain areas had access restricted for example the area containing personnel files could only be accessed by the compliance team.

Emergency and urgent care services

- A screen at each base indicated the live status of all vehicles from that base and included names of crew and their location. It also included any vehicles off the road due to defects or deep cleaning as well as contact numbers for the on call scheduler and on call duty manager.
- Routine inspection and maintenance checks were completed every six weeks on response vehicles and all operational vehicles in use were less than three years old.
- There was equipment available to meet patient's specific needs including seating and safety harnesses and paediatric adaptations for trolleys to convey young children.
- The keys for the vehicles were stored securely in key lockers and combinations were changed monthly.
- The service provided uniforms to staff. This included shirts, trousers and high visibility jackets.
- We observed controlled drugs being checked on an ambulance. Controlled drugs were kept in a locked combination safe and combinations were changed monthly. Records indicated controlled drugs were consistently checked.
- Medicines were ordered electronically from the supplier. Staff told us monthly medicine audits took place and evidence we observed supported this.
- Out of date medicines were removed from stock and stored separately until disposal. However there was no record kept of the disposal of medicines which meant managers could not be assured this had been completed safely in line with the policy.
- The process to dispose of controlled drugs by use of a denaturing kit was detailed in the medicines management policy. However, staff we spoke with who would be required to undertake this task did not appear familiar with the process.

Medicines

- There was a medicines management policy in place which included guidance on the safe storage, administration, disposal and recording of medicines. Medicines were stored in locked cabinets in locked store rooms on base with closed circuit television monitoring.
- Store rooms required access with a key card and key press access codes were changed monthly. Vehicle locker keys were kept on the vehicle key ring and locked in key safe on base.
- Staff we spoke with were aware of their responsibilities and restrictions, dependent on their role and training, for the administration of medicines in line with the policy. It was the paramedics' responsibility to check they had the required medicines in their emergency kit. Paramedic staff checked medicines in the grab bag before they left base. Each bag contained an audit sheet kept with the bag that indicated the contents and expiry date of medicines inside. Medicines were returned to the secure storage on completion of their shift.
- We checked the expiry date of a number of medicines and consumables at both bases. All were in date with the exception of five saline flushes in one grab bag. We raised this with the base manager and operations manager who confirmed that every grab bag would be opened and rechecked.
- Medical gases were stored in accordance with the current guidance from the British Compressed Gases Association.

Records

- Patient record forms were completed and kept in a bag on the ambulance which was secured when the crew were attending a patient. On completion of the shift the forms were returned to base and stored securely before being returned to the contracting NHS ambulance trust.
- Ambulance crews received patient information including any relevant clinical details for ad hoc patient journeys from the requesting trust when the journey was booked. Three forms we reviewed contained information such as a do not attempt cardiopulmonary resuscitation order (DNACPR) being in place and details of accompanying escorts. Bookings were made through the Flex Desk at head office and the information was sent through to the ambulance base.
- Patient records for ad hoc patient journeys or any patient journey forms that did not need to be returned to the contracting NHS ambulance trust were retained by the provider. The forms were returned to head office following the shift, scanned and securely stored.
- A monthly audit of 10 patient care records (PCR) was completed by the clinical lead as part of the contractual obligation with one NHS ambulance trust. Results for audits completed in October 2017 and November 2017 indicated that in both months, all records had the incident date recorded, two sets of patient observations had been documented, medications had been given if appropriate, patient's signature was recorded if not conveyed and 9 out of 10 indicated the time the crew

Emergency and urgent care services

were at the patient's side. However, one record each month did not have a signature for medicines given and in October 2017 only six out of 10 records had a pain score documented.

- Information governance formed part of the mandatory training programme and compliance at the time of inspection was 100% for paramedics, technicians, emergency care assistants and patient transport staff.

Assessing and responding to patient risk

- All emergency call handling was performed by the contracting NHS ambulance trust. Details were sent to the crew who would then contact the emergency operations centre for further details.
- Contracted patient transport work was directed by the contracting organisation, the provider supplied the crew and vehicle but was not involved in managing patient specific information.
- Ad hoc patient transfers were arranged directly with the provider through their Flex Desk. As part of the booking procedure patient details were obtained and reviewed by the national operations manager and the national clinical lead. This ensured staff with the appropriate skills and vehicles with the appropriate equipment were supplied to meet the patient's needs.
- Staff followed protocols, pathways and clinical guidelines from the relevant NHS trust.
- We observed two episodes of care where staff continually and effectively assessed a patient's condition and clinical decisions were made in conjunction with medical staff.
- Automatic external defibrillators (AED) were available on every vehicle and training in the use of AEDs was included in mandatory basic life support training. At the time of our inspection 100% of paramedics, technicians, emergency care assistants and patient transport staff were compliant with this mandatory resuscitation training.
- We observed laminated signs in vehicles regarding the National Early Warning Score assessment tool and the Pre-hospital Sepsis Screening and Action Tool. Both are tools designed to determine the degree of illness of a patient and identify early deterioration.
- Staff and managers told us that in addition to the ambulance staff attending a call, onsite support was

often provided by staff and vehicles from the contracting NHS ambulance trust. At one call we attended we observed additional clinical support provided by a clinical mentor from the contracting trust.

- Staff told us if they required advice or escalation during a call they had a number of support avenues available including the emergency operations centre, the national operations manager, the national clinical lead and the base manager. Out of normal working hours on call managers were available. The provider was also piloting clinical leads at the Buckingham and Basingstoke bases to give additional clinical support.
- Staff told us they often conveyed patients with mental ill health and advised they would contact the Police if patients were aggressive.

Staffing

- Managers told us scheduling for contracted work at the Buckingham and Basingstoke bases was completed six weeks in advance. Contracted work from the Warrington base was arranged through a third party by the Flex Desk and involved a weekly bidding process. Shift lengths ranged from ten to twelve hours in length.
- Recruitment procedures were in place to ensure persons employed had the skills, knowledge and were of good character. Until all compliance checks, documentation and mandatory training had been completed staff were unable to be scheduled for work.
- We reviewed six staff files which included curriculum vitae, applications, contracts, proof of identification and entitlement to work in the UK, DBS certificates, references and evidence of induction.
- Ambulance staff were self-employed and used an application on a mobile device to advise the scheduling team of their availability. Information regarding working time regulations was discussed at induction and managers told us compliance was monitored and staff would be challenged. We observed a crew having a delayed start to a shift due to adherence to working time regulations.
- The scheduling team received information of exact crew requirements from the contracting trust and would allocate accordingly. If exact requirements could not be met the shift would be filled with staff trained to a higher level.

Emergency and urgent care services

- Managers advised by using this business model it meant costs could be kept low during periods of reduced activity. Staff told us they were kept informed in quieter months if the number of available shifts reduced.
- The scheduling team aimed to ensure equitable distribution of any additional shifts and accommodate staff requests such as shifts on consecutive dates.
- Staff fill rates were monitored as part of key performance indicators and the provider aimed to fill 100% of shifts. Managers told us this had been achieved in months where there was less activity. Fill rates for the months preceding our inspection were 98.1% in August 2017, 98.1% in September 2017, 97.5% in October 2017, 94.5% in November 2017 and 89.1% in December 2017.
- The provider ran a training academy next to head office which was nationally accredited with Future Qualls and Quallsafe. Managers told us to assist with addressing workforce challenges in relation to client demand the academy delivered training to staff who did not follow the traditional paramedic route. This meant that staff could begin work as a first aider and develop within their role. Managers told us the first technicians were shortly to qualify as paramedics.

Anticipated resource and capacity risks

- Any shifts that could not be filled would be highlighted on the electronic system to advise other providers.
- Escalation processes were in place and if fill rates went below 90% this was escalated to director level.
- Conference calls were held for all senior managers on Monday and Friday where staffing or resource issues would be raised. A member of the scheduling team was available out of office hours and at the weekend through a pager system.
- Performance contract meetings were held monthly to review performance.

Response to major incidents

- The service had a business continuity plan which covered areas such as loss of premises, vehicles, power, communication or fuel shortage.
- The management team described detailed contingency arrangements in the event of disruption to IT services and provided an example of a recent outage at a data centre with no resulting impact.
- Staff discussed their role in two major incidents involving a bomb explosion and an explosion at a power plant.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- All policies and procedures we reviewed were up to date and staff could access documents through their log in.
- Staff followed protocols, pathways and clinical guidelines from the relevant NHS trust which were based on Joint Royal Colleges Ambulance Liaison Committee Guidelines (2016) (JCALC) and National Institute of Clinical Excellence guidance (NICE).
- Staff could access clinical guidelines on their telephones whilst on a call. In the event of disruption to their telephone service staff told us they would call back to base if they required advice or make contact with the clinical support desk for the appropriate trust.
- Clinical directives were disseminated through the national clinical lead and operations manager. Each base had a number of colour coded files which contained bulletins relating to clinical issues, training and operational issues. The folders were replicated within each base to ensure consistency across sites.

Assessment and planning of care

- Staff received clinical information about patients prior to ad hoc patient transfers which allowed risk assessments to be completed. This meant the correct crew; equipment and vehicle could be assigned to the request.
- No prior information was available about patients staff would be requested to transport in relation to contracted patient transport work arranged through the Flex Desk. The crew would subsequently obtain necessary information from the trust operations centre once they were under the direction and control of the contracted trust.
- Appropriate pathways were followed in the episodes of care we observed including incidents of cardiac arrest and stroke. The stroke protocol we observed was in line with national quality standards.
- We saw the stroke pathway implemented on a call to a patient. The patient who suffered a stroke was promptly placed in the ambulance and conveyed to a specialist stroke unit where a CT (Computed Tomography) scan was immediately performed.

Emergency and urgent care services

- We observed a patient assessed by a paramedic and assessed as a non-conveyance. The patient's condition was discussed with his General Practitioner (GP) and advice was given to the patient regarding pain relief.
- Trust policy dictated where patients were taken for treatment and this was incorporated in the clinical aspects of induction.
- The main contracting trust for urgent and emergency care was reported to be developing a mobile device application for staff. This would provide advice on actions prior to leaving the scene of the call, where to take the patient for treatment, and telephone number to alert the hospital following input of the patient's age and diagnosis.

Response times and patient outcomes

- Monthly contract review meetings were held with contracting trusts to monitor performance. Performance standards were the same as those expected of NHS ambulance trusts. Discussions also included clinical issues such as sepsis and equipment.
- Call response times were monitored and data included the number of calls attended, the number of red incidents and the number of hospital arrivals. A red incident is one where the presenting condition may be immediately life threatening.
- Minutes of contract review meetings between September 2017 and November 2017 indicated assign to mobile times were increasing and breaches were reported in hospital clear up times. However, activity was increasing and mobilisation and overall performance were reported to be good.
- Managers told us clinical outcomes were monitored by the contracting trust and may be shared.
- Internal medicines management audits were completed monthly. Managers told us audit of services was completed by contracting trusts with the main contracting trust for urgent and emergency care performing frequent, unannounced audits.

Competent staff

- An induction programme was completed by all new staff as part of the compliance process before they could be scheduled for any shifts. This included review of clinical qualifications and references as well as completion of all

mandatory training. Any staff member who did not work a shift within a six month period had to undertake the compliance process again including submission of up to date references and CV (curriculum vitae).

- Psychometric testing was incorporated into the recruitment process for staff directly employed by the provider.
- Staff described a comprehensive induction process which included both a corporate and local induction.
- Local induction performed at the base incorporated familiarisation with the location, access to Jigsaw and trust policies, pathways and referral processes, medicines management and safeguarding procedures. The local induction checklist also documented the three observer shifts required by emergency care assistants prior to scheduling of shifts. We observed a checklist completed prior to our inspection which was to be scanned into the staff personnel file.
- Competency was assessed using a competency book developed by the course provider for example technician or emergency care assistant (ECA). One paramedic described following qualification, that the clinical lead accompanied him on three journeys to assess his skills.
- Managers described how poor performance was managed and examples of complaints indicated action taken in response.
- Staff described good career development opportunities. One ECA told us they had recently completed the FREC 3 (First Response Emergency Care) refresher course in work time.
- All members of the senior management team had undergone management training.
- The provider had introduced an appraisal process prior to our inspection. An appraisal is an opportunity for staff to discuss areas of improvement and development within their role in a formal manner. Documentation we reviewed did not indicate any standards and although a scoring system was in place, there was no indication of what the scores meant.
- Not all staff we spoke with had received an appraisal. Data showed that from a total of 26 staff directly employed by the provider 10 were due an appraisal at the time of our inspection. Of the 102 staff who were contracted to the service on a self-employed basis two appraisals had been completed at the time of our inspection.

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- Managers told us this was an area for development and aimed to complete appraisals when any staff member had been working for the company for six months and then annually going forward.

Coordination with other providers

- Incidents reported through trust processes were investigated by the trust with involvement of the provider.
- Arrangements were in place for escalating issues with contracting trusts. A contract manager was identified within each trust and monthly contract meetings took place to monitor performance and provide feedback regarding incidents and referrals.
- Accountabilities and responsibilities were clearly set out by the contracting trust. Staff were aware of which NHS trust they were working for and had developed relationships with key staff members within the trust.
- Ambulance crews liaised with the emergency operations centre if they required clinical advice and contracting trusts often provided additional support on site.
- We observed episodes of care involving the provider and a clinical mentor and a first responder from the NHS ambulance trust. Discussion observed was clear, concise and professional.

Multi-disciplinary working

- We saw examples of where care had been co-ordinated with health professionals in other settings, this included care homes, hospitals and the community.
- Staff described referrals they had made following calls. These included referrals for falls assessments and safeguarding concerns.
- Episodes of care we observed included liaison with the patients GP (General Practitioner) both in person and by telephone, a handover with a stroke unit specialist nurse and a discussion with a care agency regarding a patient's transfer to hospital.
- Crew talked positively about liaising with care agencies and GP's to reduce patient admissions to hospital. However, some staff expressed some frustration when GP's insisted patients were conveyed to hospital against the professional judgement of the paramedic.

- Staff and managers described attendance at trust-led debrief sessions and Mortality and Morbidity meetings following traumatic incidents and deaths. This provided an opportunity for staff to review intervention and identify and share learning points.

Access to information

- Crews had access to information provided through the NHS ambulance trust for urgent and emergency care and contracted patient transport services.
- Ad hoc patient transport journeys booked through the Flex Desk were risk assessed by the national operations manager and clinical lead to ensure the correct crew, vehicle and equipment were available. The patient's details and any additional information were then sent to the operational base for the crew prior to commencement of the journey.
- Where patients had an active DNACPR (do not attempt cardio pulmonary resuscitation) order in place the original document was the only version that could be accepted to travel with the patient. We observed notes on a patient risk assessment reminding the crew to check this before transporting the patient.
- Staff could access clinical guidelines on their telephones whilst on a call. Policies, standard operating procedures and trust bulletins were available electronically and staff received trust specific bulletins by email.
- Head office and each operational base had four colour coded folders containing clinical, operational, training and general bulletins. The arrangement was replicated at each site to ensure consistency for staff who worked across bases.
- All vehicles had satellite navigation which had either a live update or required a computer update. The fleet manager was informed of updates electronically to support this process.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act (MCA) 2005 training was incorporated in to the mandatory training programme and compliance rates for MCA training for paramedics, technicians, emergency care assistants and patient transport staff were 100% at the time of inspection.
- Staff we spoke with were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could

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describe issues relating to consent and explain situations where decisions would be made in the best interest of the patient with particular reference to the unconscious, unaccompanied patient.

- Consent was recorded on the patient record form and audit of medical records for October 2017 indicated consent was recorded in all 10 records reviewed and in November 2017 consent was recorded in eight of the 10 records reviewed.
- Transfers of patients with mental health problems were often arranged through the Flex Desk to ensure any patient specific requirements were addressed.
- Mandatory training included a module regarding handling violence and aggression and a policy was in place for managing violence and aggression in the workplace. Compliance rates for conflict resolution for paramedics, technicians, emergency care assistants and patient transport staff were 100% at the time of inspection.
- Information from the provider stated that Section 136 patients were not conveyed by the service. (Section 136 of the Mental Health Act gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern).
- The provider had undertaken three non-secure mental health transfers in addition to low risk transfers for a provider of acute mental health treatment.
- Restraint training had been completed by 18 staff in anticipation of the launch of a service to deliver secure mental health transfers, however this was not in operation at the time of our inspection.

Are emergency and urgent care services caring?

Compassionate care

- Care was provided by committed, compassionate staff who were enthusiastic about their role.
- We observed staff treating patients and carers with kindness, patience and respect. Patient dignity was maintained at all times.

- We observed an episode of care that involved the crew taking a great deal of time to explain available options to a patient. This assisted the patient to access the most appropriate pathway.
- Staff described a patient transport journey for a patient who was receiving end of life care in a hospice. The lady had requested to make a journey she had taken as a child as a dying wish. The crew transported the lady, her husband and two nurses to help facilitate this request.
- Feedback we received from service users on comment cards was positive, patients stated staff were 'really helpful and understanding', patient's felt listened to and had been treated with dignity and respect.
- We reviewed details of 16 compliments from the 23 received between January 2017 and the time of our inspection. All referred to the compassionate, reassuring, respectful, friendly, kind, honest, person centred, non-judgemental approach patients and their families had experienced from staff members who had provided care. Two of the compliments also detailed support provided by crews in their own time, one where their shift over ran and one when two crew members were off duty.

Understanding and involvement of patients and those close to them

- We observed staff discussing treatment decisions with patients and their relatives and checking their understanding at appropriate points.
- Relatives were invited to be conveyed on the ambulance with the patient.
- We observed a crew member speaking further with a relative following the patient's initial investigations at the hospital and wishing them well.
- One patient told us the ambulance service was 'very good'.

Emotional support

- Staff described how they cared for relatives during distressing events.
- We observed a conversation between a patient and ambulance crew regarding the patient's social circumstances. The crew were observed treating the patient with care and demonstrated a high degree of patience and understanding.
- Messages of thanks and appreciation received from patients were recorded at head office and staff were informed by email.

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

Service planning and delivery to meet the needs of local people

- Urgent and emergency care and patient transport services were provided under contract to two NHS ambulance trusts from the Buckingham and Basingstoke base. Staffing was managed by the scheduling team based at head office.
- Urgent care and patient transport services from the Warrington base were arranged through a third party for two local ambulance trusts and along with ad hoc patient transfers, were managed by the Flex Desk at head office.
- The business model used by the provider allowed staffing requirements to flex up and down according to shift demand.
- NHS trusts performed unannounced visits to monitor performance and identify areas for improvement.
- All emergency and urgent care call handling was performed by the NHS ambulance trust who provided details to the attending crew.

Meeting people's individual needs

- Staff we spoke with told us they had received dementia training and compliance rates at the time of our inspection ranged from 86% for emergency care assistants to 100% for technicians and patient transport staff.
- Staff told us they did not have access to translation services and reported family members would be used to assist in communicating with patients.
- The Flex Desk arranged transport for ad hoc journeys either as a private booking with a patient or carer, or with a healthcare provider such as an NHS trust or hospice.
- Ad hoc transfers included details taken at the time of booking to ensure staff with the appropriate skills and vehicles with the appropriate equipment were supplied to meet the patient's needs.

Access and flow

- Contracting trusts booked the ambulances from the provider for set shift times which varied dependent on the requirements of the service. Shift length ranged from ten to 12 hours and covered up to 7 days a week.
- Performance standards were the same as those expected of NHS ambulance trusts.
- Key performance indicators included response times and hospital turnaround performance.
- Monthly contract review meetings were held with contracting trusts and included discussions regarding performance, shift coverage and training.
- Minutes of contract review meetings between September 2017 and November 2017 indicated assign to mobile times were increasing and breaches were reported in hospital clear up times. However, activity was increasing and mobilisation and overall performance were reported to be good.
- Between January 2017 and December 2017 figures for the Buckingham and Basingstoke base indicated that 24,447 emergency 999 calls had been responded to.
- Between January 2017 and September 2017 7,078 red incidents had been responded to. A red incident is one where the presenting condition may be immediately life threatening.
- Between January 2017 and December 2017 112 ad hoc patient transport journeys undertaken.
- An urgent care providers governance report was prepared by one contracting NHS trust which detailed performance data such as core shift fulfilment, mobilisation and on scene times as well as serious incidents, complaints and statutory and mandatory training figures.
- Minutes of the governance report for October 2017 showed that on scene to non-convey times remained outside the recommended time however performance times were reported to have been fulfilled to an excellent standard.
- Between March 2017 and October 2017 mobilisation times for double manned ambulances (DMA) and rapid response vehicles (RRV) consistently met or exceeded the standard with the exception of August.
- Between March 2017 and October 2017 clear up times for both DMA and RRV consistently exceeded the standard.
- Managers told us that on commencement of the shift all crews were under their direction and control of the contracting ambulance trust. However, all vehicles could be located and tracked by the provider.

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Learning from complaints and concerns

- The provider had a customer services, complaints and feedback policy which detailed the complaint process and timescale for acknowledgement of receipt. However performance against timescales for response to complaints was not monitored.
- Feedback could be provided in writing using a feedback form or electronically online, however no forms were available in the vehicles we inspected.
- Complaints were logged using an incident, complaints and compliments spreadsheet. Managers told us that most information was received through the contracting trust.
- Between January 2017 and December 2017, 14 complaints had been received. Reason for complaints included crew attitude and inappropriate use of ambulance siren. We reviewed the actions documented following complaints which included lessons learned where appropriate.
- Complaints were investigated by the contracting trust in conjunction with the provider. Staff told us they were not always involved in complaints from the NHS trust and did not always receive feedback.
- We saw evidence that complaints were discussed as part of the monthly contract review meeting.
- Staff told us details of compliments were emailed to them and posted on the staff board. We saw evidence of 31 compliments received by the provider between January 2017 and December 2017.

Are emergency and urgent care services well-led?

Leadership of service

- The service was led by a Chief Executive Officer (CEO) supported by the Managing Director, Medical Director, Finance Director and a senior management team.
- The senior management team included a national clinical lead, a national operations manager, head of compliance, head of contracts and workforce and a fleet manager.
- Each ambulance station had a base operations manager and during our inspection a clinical base lead pilot was in progress in Buckingham and Basingstoke.

- Staff told us all managers including the Managing Director and CEO were visible and accessible and they felt comfortable approaching them with any concerns.
- The senior management team participated in a twice weekly conference call to discuss operational issues.
- Base managers worked 08:30-17:30 and took part in an on-call rota with the provider's national operations manager and the provider's national clinical lead.
- We observed members of staff interacting well with the management team during inspection.

Vision and strategy for this this core service

- The provider had core values, a mission statement and strategy.
- The mission statement was to 'Deliver a personalised quality service to clients and patients when they need it, where they need it, focussing on diversity with recognition of the individual'.
- Values included clinical excellence, integrity, respect and courtesy, leadership and direction and innovation and flexibility.
- Staff were aware of the vision of the organisation and described how this filtered down from management.
- A copy of the core values and mission statement was available at each base and sent electronically to all new staff when they had completed the compliance process.
- The provider strategy included the development of teams, growing the business and extending services by creating more innovative ways of supporting government initiatives such as admission avoidance services.

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

- Quality and performance was monitored by contracting trusts either by monthly private provider review meetings or provision of an urgent care provider's governance report.
- Minutes of meetings showed discussions took place regarding performance, training and clinical issues. Urgent care providers governance reports included data such as core shift fulfilment, mobilisation and on scene times as well as serious incidents, complaints and statutory and mandatory training figures.
- Monthly performance and review process meetings were held to discuss internal operational issues.

Emergency and urgent care services

- A governance framework was in place which included clinical governance, corporate governance and information governance committees.
- Clinical governance meetings took place every three months and were attended by the Chief Executive, Managing Director, Medical Director and members of the senior management team. Subjects discussed included approval of new policies and clinical documentation, complaints and audits.
- The clinical governance committee subsequently reported in to the executive board.
- Managers were aware of the key risks and challenges to service delivery.
- There were 18 risks identified on the provider risk register that could impact on the effective running of the business. Documented risks included issues relating to medicines, medical gases and vehicles.
- The risk register detailed likelihood, impact and mitigation of risk. However, risks did not have any planned review date. Minutes of the clinical governance meeting in December 2017 indicated discussion regarding individual risk registers for each department for which work was ongoing.
- The provider did not have a record of all incidents reported through trust processes and relied on the contracting trust to feed the information back either by telephone or during monthly contract meetings. This meant the provider did not have oversight of all incidents operational staff had been involved in.
- On discussion managers also told us they had not submitted any statutory notifications to the CQC. A statutory notification is when a service is required to inform the CQC about any significant incidents, including when a service user has died or any incident which is reported to, or investigated by, the Police.
- The provider had no Fit and Proper Persons Policy in place and on review this was not referenced in the recruitment policy. However, fit and proper person declarations had been completed by the CEO, managing director, medical and finance directors and two additional shareholders. The CEO, managing director and medical director had also undergone an enhanced check with the Disclosure and Barring Service and check of their clinical registration.
- Staff reported a very positive culture in the organisation, describing a “family atmosphere”, good morale and a good culture of trust within the service.
- Staff we spoke to knew about the Malpractice and Whistleblowing Policy and felt comfortable to talk to management regarding any concerns. We were provided with an example involving two members of staff who had experienced issues; the situation was reported to have been resolved quickly by management with a positive outcome for both staff.
- Staff had access to a reflection room at the Buckingham base that was used for debriefs and informal discussion following attendance at difficult situations or traumatic incidents.
- All managers were trained in Trauma Risk Management (TRiM). TRiM is a peer delivered psychological support system designed to allow organisations to proactively support personnel following traumatic events. Input from TRiM practitioners was confidential and not time limited.
- All staff we spoke with were aware of the TRiM practitioners within the organisation and we were advised of one incident involving a crew member who found a TRiM practitioner waiting for them on their return to base following a traumatic event.
- An employee assistance programme was also in place for counselling and ten face to face counselling sessions could be arranged.

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

- Managers reported receiving patient feedback directly and also through contracting ambulance trusts.
- Patients could feedback to the service using a feedback form or electronically online, however no forms were available in the vehicles we inspected. Feedback was utilised by the provider to improve the service.
- Managers told us arranging staff meetings could be challenging and were often arranged to coincide with training. Team talk presentations were developed by each department and six monthly updates were provided regarding tenders and new business developments.
- Weekly emails were sent to staff to provide updates on both internal and external matters.
- Social events were arranged by staff at bases and head office such as barbecues and pizza days. Staff told us

Culture within the service

Emergency and urgent care services

that key dates were recognised and that staff received Easter eggs and birthday cards. All staff who worked on Valentine's Day also received a bottle of wine as a token of appreciation.

- Managers and staff were proud that Jigsaw were the first independent ambulance provider to sign up to the MIND Blue Light Time to Change Pledge. This is a campaign to challenge mental health stigma and promote positive well-being for emergency services staff.

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

- Managers told us they were a young company that had grown rapidly, and discussed their vision for the future development of the service.
- Open days were held at ambulance bases to attract new staff.
- Managers told us there was a focus in recruiting the 'right people' to roles through the interview process and psychometric testing with a view to continuing their development within the organisation and so aid staff retention.
- Through the training arm of the organisation opportunities were available for staff to progress to the role of paramedic outside the traditional higher education route. Managers told us the first technicians were about to qualify as paramedics at the time of our inspection. This was designed to contribute to the sustainability of the workforce.
- The digital arm of the company supported the provider to develop its information technology infrastructure.

Outstanding practice and areas for improvement

Outstanding practice

- The provider ran a training academy next to head office which was nationally accredited with Future Qualls and Quallsafe. Managers told us to assist with addressing workforce challenges in relation to client demand the academy delivered training to staff who did not follow the traditional paramedic route. This meant that staff could begin work as a first aider and develop within their role. Managers told us the first technicians were shortly to qualify as paramedics.
- Support systems were in place to proactively support personnel following traumatic events and incidents. A reflection room was at the Buckingham base for discussions and debrief and all managers were trained in Trauma Risk Management (TRiM).
- Jigsaw were the first independent ambulance provider to sign up to the MIND Blue Light Time to Change Pledge. This is a campaign to challenge mental health stigma and promote positive well-being for emergency services staff.

Areas for improvement

Action the hospital **MUST** take to improve

Action the provider **MUST** take to meet the regulations:

- The provider must ensure robust processes are in place to provide organisational oversight of incidents and safeguarding referrals and identify immediate actions to mitigate risk.
- The provider must ensure all statutory notifications are submitted to the Care Quality Commission as required.

Action the hospital **SHOULD** take to improve

Action the provider **SHOULD** take to improve

- The provider should ensure robust processes are in place for the recording and disposal of out of date medicines.
- The provider should ensure appraisal documentation includes appropriate standards and a clear scoring system.
- The provider should ensure staff receive an appraisal to discuss areas of improvement and development within their role.
- The provider should ensure staff can access translation services to reduce the need for staff to use family members as interpreters.
- The provider should ensure feedback forms are available on vehicles to allow patients to comment on their experience.
- The provider should ensure staff receive feedback following complaints.
- The provider should strengthen the governance framework to support a rapidly expanding organisation.
- The provider should ensure risks documented on the risk register are reviewed in a timely fashion.
- The provider should ensure systems and processes are in place to meet the requirements of the Fit and Proper Persons regulation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have oversight of incidents and safeguarding referrals reported by operational staff using NHS trust processes. Governance processes did not reflect the expansion of the service. Regulation 17: (2) (a) (b)