Echo Fire and Medical Limited

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Inspection report

Echo Fire and Medical C/O Right Mix
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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	Inspected but not rated
Are services safe?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Due to the responsive nature of this inspection we did not rate the service.

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. The service managed safety incidents well and learned lessons from them.
- Leaders ran services effectively and supported staff to develop their skills. Staff were clear about their roles and accountabilities and were focused on the needs of patients receiving care. The service engaged well with patients and the community to plan and manage services. Leaders operated effective governance processes and had embraced continuous service improvement.

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

- Recruitment checks and records in some areas did not comply with all elements of fit and proper person requirements.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Echo Fire and Medical Limited

Echo Fire and Medical Limited is an independent ambulance service based in Sheffield, South Yorkshire. The provider registered with the CQC on 15 July 2019 to provide the following Regulated Activities:

• Transport services, triage and medical advice provided remotely

• Treatment of disease, disorder or injury

The registered manager has been in post since June 2019.

The organisation principally provided an urgent and emergency ambulance service in conjunction with its NHS ambulance service commissioners. The provider was an approved provider for one specific NHS ambulance service.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once – in May 2021.

How we carried out this inspection

In April 2021 CQC received information of concern about Echo Fire and Medical Limited and decided to carry out an unannounced focussed inspection of the safe and well-led domains to investigate the concerns. During the inspection visit we reviewed evidence related to the areas of concern and found areas of good practice. However, we did issue one requirement notice related to the provider's recruitment compliance with Schedule 3 requirements of the Health and Social Care Act 2009 (Regulations) 2014. We have noted that the provider acted on post inspection feedback immediately.

The CQC inspection was undertaken on 10 May 2021. An on-site inspection team visited the provider's premises located at Chambers Way, Thorncliffe Park Estate, Newton Chambers Road, Chapeltown, Sheffield S35 2PH. The on-site team was supported by an off-site team of inspectors and was overseen by Sarah Dronsfield, Head of Hospital Inspection.

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

Outstanding practice

We found the following outstanding practice:

The provider's business continuity policy (reviewed April 2021) was a live document evidencing that managers prioritised and actively planned to address challenges to quality and sustainability. The business continuity policy included planning and application of business resilience and continuity arrangements which were tested annually as a minimum.

Summary of this inspection

The business continuity policy included equality impact reviews applied to business continuity procedures. We reviewed the results of the previous quarterly business continuity test. The provider tested its business continuity plan with the consent and support of the NHS ambulance service commissioner. The scenario enacted was a catastrophic failure, which identified what went well and what could be improved, helping to ensure the provider continued to deliver sustainable services to patients and stakeholders.

Journeys allocated to the provider were planned for and staffed appropriately. Ambulances were double crewed for urgency and emergency care. The provider's business continuity plan covered arrangements for obtaining appropriately qualified staff in the event none of the provider's own staff were available. Staff did not work excessive hours which supported patients receiving safe care and treatment.

NHS ambulance commissioners undertook regular audits involving the provider. We reviewed the results of a vehicle specialist infection prevention and equipment audit completed in April 2021 which included a detailed audit check and demonstrated a very high level of compliance with elements of innovative practice highlighted by the commissioner.

Areas for improvement

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

Action the service MUST take to improve:

We informed the service that it must take action to bring services into line its legal requirements related to urgent and emergency care services.

• The provider must ensure recruitment processes are in accordance with the Schedule 3 requirements of the Health and Social Care Act 2009 (Regulations) 2014. (Regulation 19 (3) (a)).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Emergency and urgent care

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Emergency and urgent care safe?

Inspected but not rated

Due to the focused nature of this inspection we inspected but did not rate the service.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Training record completion for six members of staff and monthly audit records for six months prior to our inspection confirmed staff had completed 92% of required mandatory training. Audits also confirmed staff received reminders so they knew when to refresh their training.

The provider's statutory and mandatory training policy (reviewed April 2021) set out training requirements for all grades of staff to be consistently delivered and recorded. The policy included arrangements for identifying and delivering induction and training for new employees prior to any lone working and within eight weeks of commencing employment.

The statutory and mandatory training policy also provided for identifying and meeting individual training needs for all grades of staff and for annual personal development reviews to maintain key skills and staff competence. Following development conversations, staff were given an action plan for training compliance and development.

Mandatory training was delivered online or in the provider's on-site training centre. Regular training and development sessions for staff were held with focussed monthly themes. The provider was awarded pre-hospital care training centre accreditation which supported the arrangements for training and development of staff.

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.

The providers safeguarding policy (reviewed April 2021) reflected national intercollegiate guidance (2018 and 2019). The safeguarding policy set out the provider's arrangements for protecting the wellbeing of children and adults at risk. The provider also had in place a chaperone and transport of children policy to support its clinical governance.

The safeguarding policy described the provider's arrangements for checks undertaken when recruiting staff including disclosure and barring service checks and for updates to these checks which were undertaken every three years.

Records for six members of staff and monthly audit records for six months prior to our inspection confirmed each member of staff had undergone disclosure and barring service checks. Where a positive disclosure was identified an associated risk assessment was in place. The audit identified where updated checks were needed and also confirmed when these were completed.

Checks of training record completion confirmed staff received appropriate safeguarding training. Each staff member had received safeguarding training to level 2 or 3 for both adults and children appropriate for their role. The provider's safeguarding lead was a paramedic trained for vulnerable adults and children to level 4.

The provider maintained daily contact with its commissioners to monitor new and ongoing safeguarding referrals and tracked these through the NHS ambulance referral 'hub'. The provider ensured staff received training in mental capacity. Where vulnerable patient concerns were identified, staff liaised with the commissioning NHS ambulance service.

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 and agency staff a full induction. However, we identified some gaps in recruitment information.

The provider's recruitment and selection policy (reviewed April 2021) set out arrangements for the recruitment of staff of all grades. The recruitment policy covered arrangements for employment reference and disclosure and barring service checks. The recruitment and selection policy also included arrangements for driving licence checks and statutory and mandatory training checks.

A complementary disclosure and barring service policy (reviewed April 2021) linked arrangements for disclosure and barring service checks and risk assessments to recruitment arrangements and periodic checks. References were obtained as part of the recruitment process and risk assessments were completed for concerns identified through the disclosure and barring service.

The provider's work-related driving policy (reviewed April 2021) included arrangements for driving licence checks and fitness to drive. The policy also covered driving a vehicle with blue lights. The registered manager confirmed driving assessments were undertaken three yearly as a minimum requirement or more frequently if needed.

We reviewed the provider's information for recruitment compliance with Schedule 3 requirements of the Health and Social Care Act 2009 (Regulations) 2014 for six staff and the registered manager.

Although we mainly found sufficient evidence staff had been recruited in accordance with Schedule 3, we identified some areas where this had not been fully completed. For example, in one member of staff's file the named referee had not provided the reference for the individual and no explanation was included as to why it had not been completed. Another employee reference was provided by a person they had employed. We also identified significant delay between the application and the date of the reference. There was no place on the reference form to state the organisation the referee was aligned to although it did cover the general work related questions and contain areas for the referee's contact details, however, this meant at the time of inspection there was limited assurance whether it was character or an employer's reference. We have received notification following inspection that this has been addressed.

One employee had a volunteer enhanced disclosure and barring service check which was not appropriate for their role within the provider as they were in a paid role. The provider has since carried out a new Enhanced Disclosure and Barring service check appropriate for their role for this individual.

Although endorsements on driving licences were documented, for one employee with a provisional licence we sought assurance that the person was not driving, which was confirmed.

We discussed with the registered manager the concerns we identified in recruitment compliance information. Following the inspection the registered manager shared with CQC the actions taken to address the concerns identified.

Journeys allocated to the provider were planned for and staffed appropriately. We reviewed the patient movement tracker and staffing rotas for six members of staff for March and April 2021 and discussed with the registered manager processes in place for planning journeys. Ambulances were double crewed for urgency and emergency care. The provider's business continuity plan covered arrangements for obtaining appropriately qualified staff in the event none of the provider's own staff were available. The service monitored and managed working hours which supported safe care and treatment.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. 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.

The provider's incident and investigation reporting policy (reviewed April 2021) set out arrangements for the reporting, investigation and management of incidents to support the identification of risk and to support learning and identify improvements in practice. The policy linked with the complementary duty of candour policy.

The provider's duty of candour policy (reviewed April 2021) set out how the provider would meet its obligations to patients, relatives and providers in complying with the requirements of the duty of candour in embedding a transparent and open culture, as well as compliance with the duty of candour following a notifiable safety incident.

Training record completion for six members of staff and monthly audit records for six months prior to our inspection confirmed staff received training in incident reporting and management of safety incidents.

We spoke with the registered manager about the provider's process for handling incidents and were provided with examples of incidents where learning was shared with staff. Staff understood their responsibilities to report concerns, including safety incidents and near misses. Where an incident had occurred, staff completed an incident reporting form and alerted the manager. A similar process was followed for all types of incident.

Safety alerts, bulletins and other external safety information was shared through staff memos. The provider worked jointly with its NHS ambulance commissioner to investigate incidents and to share learning. Where action was taken following the investigation of an incident, for example, development reviews may be arranged for a staff member. Feedback was shared with the NHS ambulance commissioner.

Inspected but not rated

Emergency and urgent care

Are Emergency and urgent care well-led?

Inspected but not rated

Due to the focused nature of this inspection we inspected but did not rate the service.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Leaders 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 registered manager described the leadership arrangements for the service. Senior management roles were clearly identifiable, including clinical, medical, safeguarding, training and quality assurance leads. Managers were readily accessible including being involved in day to day activities and staff were well supported in their roles.

We reviewed the provider's information for recruitment compliance with Schedule 3 requirements of the Health and Social Care Act 2009 (Regulations) 2014. We discussed with the registered manager some areas of concern we had identified in the recruitment processes for staff as detailed above within this report. Following the inspection the registered manager shared with CQC the actions taken to address the concerns identified.

The provider supported training and development for its managers and staff. The provider's arrangements for training and development of staff including the training centre supported the individual development needs for all grades of staff including management staff. Regular training and development sessions were held with focussed monthly themes. Personal development reviews were held regularly to maintain key skills and competence.

The provider's business continuity policy (reviewed April 2021) was a live document evidencing that managers prioritised and actively planned to address challenges to quality and sustainability. The business continuity policy included planning and application of business resilience and continuity arrangements which were tested annually as a minimum.

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.

The provider was focused on meeting the needs of patients and the registered manager and other managers confirmed staff were supported to achieve this. The clinical governance policy set out arrangements for maintaining an open and transparent culture to protect patients from harm and to support their safety, respect and dignity.

The provider's whistleblowing policy (reviewed April 2021) supported a culture of openness in which staff could express their concerns. The whistleblowing policy and procedures were explained to staff at induction. The policy also reflected and supported staff freedom to speak up, which was included in training.

The complaint, concern, comments and compliments policy linked with separate policies for duty of candour and disciplinary and grievance arrangements which enabled inconsistent behaviour and performance to be addressed equitably. Training and development arrangements for staff supported an open culture.

The provider placed emphasis on the safety and well-being of staff, particularly those working remotely. For example, the provider's lone worker policy (reviewed May 2021) linked with lone worker training and supported health and safety provisions for staff, including voluntary staff.

Managers anticipated potentially stressful situations and described arrangements available to support staff. Staff were debriefed at the end of their shift and on following shifts, with support available from NHS ambulance commissioners.

The culture of the service was open and supportive. Values which supported staff were part of the work ethic which encouraged openness and honesty. Managers told us they were keen on making a difference for patients through a caring ethos, and supported staff to achieve this for example, staff feedback was listened to and staff were involved in implementing changes which benefited patients.

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.

Staff of all grades understood their roles, the provider's expectations, and accountability. The provider's disciplinary and grievance policy (reviewed April 2021) set out the provider's approach to maintaining the fair and consistent treatment of employees including those who may have failed to meet expected standards of conduct, attendance or job performance. The registered manager was able to provide examples of the policy being applied effectively.

The provider's clinical governance policy (reviewed April 2021) provided an overview of clinical governance arrangements in the service. The clinical governance policy linked and was supported by other policies and procedures designed to maintain and improve the quality of patient care.

The provider's governance arrangements were set out in separate policies which included clinical effectiveness, duty of candour, whistleblowing, safeguarding, incident and complaints management, records management, recruitment, induction, disciplinary procedures, risk management, training and development, audit and quality improvement.

Clinical governance meetings were normally held monthly and staff meetings held quarterly, however due to the covid pandemic the provider made alternative arrangements to communicate with and obtain staff feedback in order to reduce the transmission of covid-19 and to maintain staff and patient safety. Governance processes and procedures continued to be followed.

Managers communicated regularly with staff to obtain feedback and to provide support, training and mentorship. The provider supported the investigation of incidents and complaints, and a programme of audit was applied in the service.

The provider's complaint, concern, comments and compliments policy (reviewed April 2021) was aligned with NHS complaints handling procedures. The policy supported and prompted equality and diversity and included investigation of complaints and learning from patient feedback.

Inspected but not rated

Emergency and urgent care

The provider's audit programme was coordinated by the lead for audits and service improvements. The audit system had been changed in the 12 months prior to our inspection to reflect an increased workload. Patient report forms were audited and the provider was planning random call-outs to support audit compliance. We reviewed the results of an audit of human resources and training compliance undertaken for the six months prior to our inspection. The provider normally reviewed these audit results monthly at clinical governance meetings. Audit feedback was presented in a structured format and action plans were used to monitor improvement and support staff development.

Managing risks, issues and performance

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

The provider's clinical governance policy provided an overview of clinical governance arrangements including risk management procedures. A separate risk management policy supported assurance of safety arrangements for patients, staff and commissioners. The provider's risk register (prepared since CQC registration) specifically included COVID-19 risks to the service. The risk register was discussed at monthly clinical governance meetings.

NHS ambulance commissioners undertook regular audits involving the provider. We reviewed the results of a vehicle specialist infection prevention and equipment audit completed in April 2021 which included a detailed audit check and demonstrated a very high level of compliance with elements of innovative practice highlighted by the commissioner.

The business continuity policy included equality impact reviews applied to business continuity procedures. We reviewed the results of the previous quarterly business continuity test. The provider tested its business continuity plan with the consent and support of the NHS ambulance service commissioner. The scenario enacted was a catastrophic failure, which identified what went well and what could be improved, helping to ensure the provider continued to deliver sustainable services to patients and stakeholders.

Where patient risk was identified the provider's policy and guidance relating to the Mental Capacity Act 2005 (reviewed April 2021) described arrangements for dynamic risk assessment to be undertaken and recorded. The policy guidance included the responsibilities of ambulance staff to pre-alert the destination hospital and for providing information relating to the patient's condition and relevant risk assessment information.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We informed the service that it must take action to bring services into line its legal requirements related to urgent and emergency care services. • The provider must ensure recruitment processes are in accordance with the Schedule 3 requirements of the Health and Social Care Act 2009 (Regulations) 2014. (Regulation 19 (3) (a)).