Medrescue 24 Ltd

Medrescue Headquarters

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We carried out an unannounced inspection using our comprehensive methodology on 22 November 2022 and the provider's registration was cancelled on 5 March 2023.

We rated it as requires improvement because:

- The service did not always control infection risk well. We also saw that deep cleaning of vehicles was not completed in line with schedule.
- They did not always manage medicines well. There was a lack of controlled medicines oversight and effective audit process.
- Staff did not understand the service's vision and values, or how to apply them in their work.
- The service's audits did not always ensure leaders could monitor compliance fully.
- The service did not always correctly label sharps bins, these were also not stored in line with guidance.
- Staff could not always access the relevant clinical policies and procedures required to deliver safe care. Staff could not access clinical best practice policies they may require while delivering care.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, and gave patients pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.
- Key services were available seven days a week.
- The service had enough suitable equipment including defibrillation equipment and manual handling aids.
- Leaders had not received any concerns from the NHS ambulance service or NHS hospital regarding transfer times for their patients in the 12 months prior to our inspection.

We rated this service as requires improvement in Safe, and Well led. We have rated Effective Caring and Responsive as good.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Requires Improvement 	See the summary above for details.

Summary of findings

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Summary of this inspection

Background to Medrescue Headquarters

Medrescue 24 is an independent ambulance service that provides urgent and emergency support and patient transport to across the region. The service is based in Newbury, Berkshire.

The service registered with the CQC in June 2021. The service had two registered managers in post at the time of inspection. They are registered to undertake the regulated activity of

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

The service provides the following services:

- Emergency and Urgent Care Services (EUC)
- Patient Transport (PTS)

The main service provided at this location was Emergency and Urgent care.

How we carried out this inspection

We carried out an unannounced inspection using our comprehensive methodology on 22 November 2022. This inspection was carried out by three CQC inspectors. A Specialist Advisor also supported the inspection, with experience in both emergency and urgent care, and patient transport services. An inspection manager oversaw the inspection team.

During the inspection we looked at the service base, and inspected four ambulance vehicles. We spoke with three patients. We also spoke with seven members of staff and the registered managers.

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

Areas for improvement

If the provider had still been registered we would have set out the following list of 'musts' for their action. Action the service MUST take is necessary to comply with its legal obligations.

Action the service MUST take to improve:

Ambulance – Emergency and urgent care

- The service must ensure that vehicle cleaning, including deep cleaning, take place in line with policy. And that systems are in place to control infection prevention and control are monitored appropriately to identify areas of improvement. Regulation 12 (1).
- The service must ensure refrigerator temperatures are monitored effectively and that medicines are being stored at the manufacturer's recommended temperature. Regulation 12(1)

Summary of this inspection

- The service must ensure Patient Group Directions are authorised correctly and easily available to staff while working for the service. Regulation 12(1)
- The service must ensure that systems in place to monitor medicines provide effective oversight. Regulation 12(1)
- The service must ensure all staff are able to access electronic files and systems relevant to their role, and that files contain all information specified within the relevant policies. Regulation 17 (1).
- The service must ensure that it follows correct process when submitting statutory notifications to the CQC under their responsibility as a registered provider. Regulation 18 (1)

If the provider had still been registered we would have set out the following list of 'SHOULD's' for their action. Action a service SHOULD take is because it was not doing something required by a regulation but itwould be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

Ambulance – Emergency and urgent care

- The service should ensure that additional aids are available in all vehicles to support for patients who have additional communication needs. Regulation 9 (1).
- The service should ensure infection, prevention and control audits monitor hand hygiene practice to ensure leaders are assured that staff are following best practice. Regulation 12(1).
- The service should ensure it correctly labels sharps' bins when they are in use and that there is effective oversight to monitor this. Regulation 15 (1).
- The service should ensure it has effective oversight for the licensing of controlled drugs and that applications to renew are made in a timely manner. Regulation 17(1).
- The provider should consider the process used to receive and act on medicines alerts.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Emergency and urgent care

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

Is the service safe?

Requires Improvement

We rated safe as requires improvement.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The service supplied evidence that their overall completion was currently at 98%, however they planned to reach 100% by the end of the year. The target for mandatory training compliance was 100%.

Leaders told us staff were required to be fully compliant with mandatory training in order to provide frontline services for the commissioning NHS ambulance trust

The mandatory training was comprehensive and met the needs of patients and staff. There was training in wide range of areas such as consent, paediatric and adult basic life support, and manual handling. Training was provided through an online platform which staff could access with individual log in.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

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. However the understanding of completing safeguarding notifications to the CQC was not well established.

Clinical staff received training specific for their role on how to recognise and report abuse. All staff received training in safeguarding adults and children up to Level 3. The safeguarding lead had completed safeguarding training up to a level 5. This was in line with national guidance.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke were able to give examples of when safeguarding concerns had been raised or the things they would look for.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. In addition to safeguarding training staff also completed training in Prevent. Prevent training aims educate professionals on how to take action to safeguard vulnerable children and adults from radicalisation.

The service had provided information in newsletters regarding domestic abuse and how staff could recognise the signs of this while attending to patients. This also gave information on how to report concerns.

The service had a safeguarding policy. However, it had not been reviewed in line with the provider's policy as it was due for review in May 2022. The service understanding of completing safeguarding notifications to the CQC was not well understood. We saw safeguarding referrals had been completed to the local authority but not reported to the CQC. We advised the service that all safeguarding concerns should be reported to the CQC, in line with their responsibilities as a regulated provider.

We also saw safeguarding referrals that remained open over 6 months since referrals had been made with no updates. This was not in line with policy which stated that referrals for persons under 18 should be followed up on in 24 hours and adults 30 days.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. We saw that equipment; vehicles and the premises were not visibly clean.

Staff completed an end of shift form which prompted staff to acknowledge if tasks such as mopping inside of vehicles had been completed. The service supplied cleaning records; and these were up to date. However, we saw that the inside of three vehicles that were stored in the garage were not visibly clean, this included suspected bodily fluids on overhead lockers in one vehicle. We also saw bed linens in two vehicles that had visible soiling. We observed a vehicle in use during our inspection had visibly unclean flooring and ingrained dirt in the vehicle tracking. This indicated that cleaning was not being completed effectively or in line with the cleaning standards the service supplied.

The service did have staff who solely completed cleaning tasks, such as make ready staff. Leaders told us the crew had the responsibility for completing internal vehicle cleaning , however crew were allocated a short time period to complete this task following shifts and they felt was not always adequate.

The overarching infection prevention and control (IPC) policy for the service also did not give any detail on the methods that should be used to complete effective IPC within vehicles or for equipment, it instead referred to separate policies. This policy also referred to an external IPC nurse conducting audits and providing quarterly reports to the clinical

governance meeting however we saw no evidence of these taking place. Following the inspection, the service supplied a document which detailed areas that should be cleaned and the method to be used. However, we did not see this document during our inspection and these policies were not available on the staff portal. This document also did not reference any guidance that the IPC methods were based on.

We reviewed records during our inspection which were labelled IPC cleaning audit. However, these records did not constitute an audit as were a checklist of cleaning tasks to be completed within the location. We saw these records showed daily cleaning tasks had not been evidenced in full since September 2022. For example, the records for the 2 weeks prior to inspection in the week prior to inspection daily cleaning tasks had only been completed on 2 days. The week commencing 31 October 2022 did not have a cleaning record present.

The limited use of cleaning checklists meant that oversight of vehicle cleaning was not effective. There were no cleaning monitoring audits in place.

The service used an external contractor to complete deep cleaning on the vehicle, however in 2 vehicles we saw that the last deep clean had not been performed and was due in September 2022. The cleaning schedule provided by the service following inspection also confirmed this had not been performed. These vehicles included one that was in use on the day of inspection. This issue had also been raised in a recent staff newsletter where it stated staff were reporting vehicles being left unclean. Although the newsletter reminded staff to clean, there was no evidence of any further action to ensure cleaning was effective.

Leaders told us they had had problems with the external cleaning contractor not attending and were in the process of reviewing their services. However, there was no evidence the service had completed deep cleans on the vehicles themselves in order to ensure this was still done.

The staff newsletter in August informed staff that hand hygiene audits would be performed. The service had completed some hand hygiene audits however this was last completed in September 2022. There was no evidence of outcomes of these audits.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw masks and gowns were available in all vehicles. However, alcohol gel was present in only one vehicle we inspected. Staff told us they often wore personal alcohol gel dispensers however this would not have enabled patients to use this.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff cleaning equipment following use. However, in one vehicle we inspected we saw some equipment that had a visible ingrained dirt on the surface. There were also pieces of reusable equipment such as splints that had visible soiling in one vehicle.

Staff accessed policies through a staff portal, however we observed that the infection prevention and control policy was not available on the staff portal when we attended or the following day. The service submitted the infection prevention and control policy following our inspection; however this policy had a review date of May 2022 and there was no evidence to demonstrate this had been completed.

Environment and equipment

The use of facilities, premises, vehicles and equipment did not always keep people safe. We saw that staff did not always manage waste well. Staff were trained to use equipment.

Requires Improvement

Emergency and urgent care

During our inspection, we found expired items in all vehicles. These included airway tube holders and medical dressings. We also found sterile items with damaged packaging, this meant that they may not be sterile. Staff told us they replenished items by keeping a note of those used during a shift, there was no formal method in place to monitor stock used. There were no audits in place to monitor stock in vehicles. This indicated that oversight of consumables was not effective. In all 4 service vehicles we inspected, we saw used sharps bins had not been labelled with a date or location. In one vehicle the sharps bin had been overfilled and the locking mechanism tampered so it could not seal adequately. We also saw that they were not closed in line with guidance which meant there was a risk of spillage if these containers were knocked over. This was not in line with the sharps policy provided by the service or best practice guidance.

The service had enough suitable equipment to help them to safely care for patients. Following the inspection the service provided an interior layout document which gave clear instructions on items to be stored within the ambulance's and standardised layout. However this document was not available on the staff portal therefore it was not clear if staff used this.

Staff could report faulty equipment so that it could be repaired. Following the inspection, the service supplied servicing documents which showed when equipment was serviced and any actions taken from this.

The design of the vehicles supported safe storage of consumables. Staff disposed of clinical waste safely. Clinical waste bins were secured within the vehicle to reduce the risk of spillage. The end of shift checklist prompted staff to remove clinical waste from vehicles. The service told us they had a contract in place for waste collection.

Staff carried out daily safety checks of specialist equipment. Staff completed a vehicle checklist before commencing work. This checklist covered the safety of the vehicle and consumables that would be required. The format of the checklist was electronic and did not allow staff to progress through the form until all areas had been completed

Assessing and responding to patient risk

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

Staff completed risk assessments for patients thought to be at risk of self-harm or suicide, in order to determine the best pathway for the patient. Staff demonstrated a good understanding of patients at risk of self-harm.

Staff completed risk assessments for each patient using a recognised tool, and reviewed this regularly, including after any incident. Staff had the knowledge to identify and deal with any specific clinical risk issues. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff told us how they undertook clinical observations in line with the National Early Warning Score (NEWS2) and completed a Glasgow Coma Scale (GCS) assessment for every patient. When treating paediatric patients staff used PEWS (Paediatric Early Warning Score). Where indicated, staff undertook a Facial drooping, Arm weakness, Speech difficulties and Time (FAST) assessment to identify potential strokes.

We observed staff attending emergency calls and assessing patients appropriately and in line with guidance. All healthcare professionals who worked for the service received intermediate life support training. We saw policies regarding patient deterioration were also available via the staff portal.

Requires Improvement

Emergency and urgent care

The service completed compliance audits in areas, such as National Early Warning Score 2 (NEWS2), completion of the clinical impression section, pain assessment completion and whether a safeguarding referral was required. We saw these compliance audits highlighted areas for clinical improvement.

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 gave bank staff a full induction.

The service had enough staff to keep patients safe. This location had approximately 30 staff at the time of our inspection however not all of these were regular shifts. Staff were allocated shifts using an online rota system. Staff could use this to check when they were working. Managers told us that if there were staff absence then team leaders would work with the other member of staff where possible.

The service had a recruitment policy that included requirements for references, background checks and employment history checks. We reviewed 10 staff recruitment folders and found they contained all information that was required by the recruitment policy.

Managers reviewed paramedics fitness to practice by checking on the Health and Care Professions Council (HCPC) at the recruitment stage. Leaders told us that professional registration was continually monitored and alerts received monthly regarding fitness to practice investigations. Disclosure and Barring Service (DBS) checks were renewed in line with the provider policy.

The service was in the process of recruiting staff as they were increasing the number of vehicles they provided for the commissioning service. Managers accurately calculated and reviewed the number and grade of paramedics, technicians or emergency care assistants needed for each shift in accordance with national guidance.

Managers made sure all staff had a full induction and understood the service.

Records

Staff kept detailed records of patients' care and treatment.

Records were stored securely. The service completed electronic records for patients via PDAs. These were also submitted to the commissioning service. When the service completed PRF's (Paper record forms) they were structured in a way to safely record relevant information about care and treatment received. On completion of a shift, staff posted these records into a locked post box. Access to these records was restricted and team leaders told us they emptied the records from here on a daily basis. The service undertook monthly audits of electronic patient records to ensure they were being completed correctly.

Medicines

The service did not always use systems and processes to safely administer, and record medicines.

Requires Improvement

Emergency and urgent care

Staff did not always use safe systems to administer medicines. Ambulance staff were trained to diagnose and treat people with medicines utilising national ambulance service clinical guidelines. However, patient group directions (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) were not always in place or appropriately authorised to be used by staff members to treat people.

Staff did not have access to the appropriate national policies when administering medicines. Staff used their professional knowledge to make decisions surrounding medicines. However, staff told us they could not access the JRCALC (Joint Royal Colleges Ambulance Liaison Committee) guidelines. Leaders told us this was being arranged.

Staff reviewed and provided advice to patients and carers about their medicines. Staff informed us they explained to patients what medicines they were administering to them. Staff explained they advised patients to purchase over the counter medicines for pain relief, indigestion or allergic reactions. They would also recommend patients sought further advise from a community pharmacist or their GP when appropriate.

Medicines were stored securely. All medicines including controlled drugs were centrally purchased. However, the temperature of the medicine's refrigerator was not monitored. During the inspection we found the thermometer used to monitor the refrigerator temperature was not working. If medicines are not stored as per the manufacturer's instructions at an appropriate temperature, they may not be suitable for use. We also saw fridge temperature records were not completed daily in line with policy.

During the inspection, we saw that the service had not updated their Home Office controlled drugs license in line with timescales set by the Home Office. We saw evidence that a new licence application had been made however this was made after the expiry of the previous licence. Controlled drugs are medicines which have strict legislative requirements for storage and record keeping because of their risk of misuse. Since the inspection, the service has updated this.

The provider moved stock of controlled drugs from this registered location to ambulances that operate on another site. Full and accurate records of the transfer of controlled drug stock were not made in this instance.

Leaders told us there was a process in place to receive medicines alerts. There was also a system to report and investigate medicines related errors. We saw these were investigated, and learning was shared with staff. For example, where a medicine was not given to a patient due to a gap in staff awareness, communications were sent to staff reminding them of alternatives.

Paramedics and emergency medical technicians visiting patients had access to a pre-authorised medicines stock. They did not prescribe medicines. This provided assurance that medicines were being used appropriately.

There were limited audits for medicines. Staff carried out monthly stock checks for medicines. The National Institute for Health and Care Excellence defines an audit as 'A systematic review of a practice, process or performance to establish how well it meets predetermined criteria'. However, there were no records to evidence what was audited and the outcome of the audits. Following the inspection, we requested medicines audits however the evidence did not demonstrate what was being audited or the outcomes from them. We also saw no evidence that the outcome of these was shared with staff.

Incidents

Requires Improvement

Emergency and urgent care

Staff recognised and reported incidents and near misses and reported them appropriately. Managers shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However, Managers did not always record and resolve incidents in line with policy.

Staff knew what incidents to report and how to report them. The service had an incident reporting policy. Staff raised concerns and reported serious incidents in line with the service's policy. We saw evidence of incidents that had been reported by staff. The incident policy informed staff to report an incident within 24 hours. We saw all incidents reported met this period.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. We saw evidence that staff received training in this area as a part of mandatory training. In a recent staff survey, 88% of staff stated they were aware of duty of candour.

Supervisors and managers apologised when things went wrong and where appropriate in complaint responses.

Managers debriefed and supported staff after any serious incident. Leaders always spoke to staff following an incident to establish if there was an emotional or physical impact to them. If it was determined they required further support, for example emotional support, this was offered.

We saw learning bulletins sent to staff regarding incidents for example we saw a bulletin sent to staff reminding them of processes, for example the need to wear high visibility clothing when attending road traffic incidents. Leaders told us they sent learning bulletins using a service that showed when staff had read these. The service told us they had monthly staff meetings.

The service had an incident policy in place but did not always follow this well. Managers recorded incidents in a spreadsheet, where these incidents involved the commissioning services systems and processes this was referred to them. However, the process for following up on incidents reported to the commissioning service was not detailed in the policy.

In addition, to this the classification of incidents in the tracker forms did not match the service policy. For example the service policy used the classifications minor, moderate, severe, and catastrophic. Whereas the incident tracker used terms as hazard, risk, concern. The incident tracker did not contain timeframes for investigation and we saw at least one investigation had passed the services period of 28 days with no information explaining the reasons for this, this indicated that the service policy was not followed accurately or well embedded.

Is the service effective?

Good

We rated effective as good.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance. Managers did not monitor compliance with guidance.

Requires Improvement

Emergency and urgent care

Policies and procedures did not support staff to manage patients in a way that followed national guidance. There was limited access to some policies when staff were not at base. We saw an update had been provided from the commissioning service regarding some areas of JRCALC guidance. Staff told us they could not access policies such as the JRCALC (Joint Royal Colleges Ambulance Liaison Committee) guidelines. JRCALC guidelines are an important part of clinical risk management and ensure uniformity in the delivery of high-quality patient care. They form the basis for UK paramedic training and education. During our inspection leaders told us they were negotiating access to these guidelines with the commissioning service. Following our inspection the service told us that this was now in place.

Within the service base there were displays of guidance and best practice information. However, it was not clear when staff would review this information or how it was evidenced that they were aware of it. The service also did not perform clinical audits or record observational checks to evidence staff followed guidance. Leaders told us they completed clinical ride outs but were unable to provide any evidence of them.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff explained how they conveyed patients in the manner that preserved their dignity and privacy whilst managing risk to their health and safety or to other people.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The service followed the commissioning service policy to undertake 2 sets of observations on a patient 20 minutes apart. Analgesia appropriate to the score of the pain was administered by the clinician unless refused by the patient. Staff administered and recorded pain relief accurately. We saw staff asking patients if they were in pain, handing over to hospital staff what the patient's pain score was, and any pain relief given by the crew. The effectiveness of analgesia was recorded through pain scoring. The service provided evidence that they undertook pain audits to assure this was in line with best practice.

Response times

Response times were monitored by the commissioning organisations. If any response time issues were identified, then the commissioning service would raise this.

The NHS contracted the service to provide emergency responses to patients. As part of this service level agreement, an ambulance and crew on shift were allocated and dispatched by the contracting NHS trusts control headquarters. The dispatches were automatically delivered to an on-board electronic control unit within the provider's ambulances. The timings relating to a response were collected and monitored by the commissioning trust. If any response time issues were identified, this would be raised and discussed with the provider during contract meetings.

The commissioning service provided data of each incident assigned to the service. The service then published this data in full on a notice board and highlighted the jobs where job turnaround had been met. We saw no evidence that the service analysed this data. This limited staff ability to understand the information. This meant that quality and effectiveness of the service regarding services provided to patients was limited to reviews by the commissioning service.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service employed staff with a wide mix of skills and experience.

We reviewed personal development plans for 3 staff and saw they followed a clear format and gave opportunities for reflection and areas for improvement. Leaders told us the commissioning service could supply data on each staff members performance. Leaders told us they planned to review and use this data in professional development reviews but had not yet been able to implement these because had been working for the commissioning service for less than 12 months.

Not all staff had an appraisal at the time of our inspection as the service timetabled these throughout the year. We were told 86% of staff had received an appraisal in the form of a personal development plan. The target for the service was 100% and leaders told us they were on track to complete this.

Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Managers identified any training needs their staff had and gave them the opportunity to develop their skills and knowledge. For example, safeguarding referrals had highlighted an area of improvement for staff knowledge around PREVENT. PREVENT is a government led training module that covers Safeguarding Children and Young People against Radicalisation and Violent Extremism. The service completed additional staff training to ensure awareness was improved.

Leaders told us all staff completed clinical assessments and contact shifts before commencing work for the service. Staff completed induction paperwork in advance of commencing shifts, this would then be submitted before they could work for the commissioning service. Between July and October 2022 newly qualified practitioners (NQPs) had on average 20 shifts with a qualified paramedic. The service told us all NQPs had more than 2 contact shifts with a clinical educator.

Managers identified poor staff performance promptly and supported staff to improve. We were told if staff had raised clinical concerns these would be addressed with them. The service told us they would refer staff to the HCPC (Health and Care Professions Council) if they felt they had not met clinical expectations and we saw examples of when this had been done. The service ran internal CPD sessions, this included a learning session on the mental capacity act and a session in pain management planned for 2023.

Multidisciplinary working

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

Staff worked alongside health care disciplines and with other agencies when required to care for patients. Team leaders worked with the NHS ambulance trust to determine which patients to prioritise when the demand for the service outweighed the available vehicles and crews. All bookings were arranged by the control centre of the trust.

Leaders reported they had a good relationship with the trust and issues were raised and dealt with promptly.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Requires Improvement

Emergency and urgent care

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The service had a clear policy and procedure for capacity to consent which covered the Mental Capacity Act.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' electronic records.

All staff had received training in relation to the Mental Capacity Act and understood how this applied to their role. We saw 100% of staff for the service had completed this training.

Managers were available to give advice and support relating to capacity and consent. Staff had access to the provider's policy which covered the Children Act, consent for those under 18 years of age and how to assess for Gillick Competence for those under 16 years. Gillick competency is often used to assess whether a child is mature enough to consent to treatment. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

We reviewed a recent staff newsletter where information was given to staff regarding best interest decisions and how these should be made. Staff were provided with a flow chart to support them when treating patients under best interest policy.

Is the service caring?

Good

We rated effective as good**.**

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a considerate and kind way. Throughout our inspection we saw staff caring for patients who were waiting in emergency departments. Staff told us they always had supplies of blankets and sheets to keep patients warm and maintain dignity. We observed staff attending to a paediatric patient and saw they communicated clearly with the parents and child to provide reassurance.

Staff followed policy to keep patient care and treatment confidential. All staff we spoke with understood patient confidentiality.

Requires Improvement

Emergency and urgent care

The service explained patient feedback was difficult to obtain when responding to emergency attendance. Following inspection, the service provided an image of feedback cards they stated were provided for patients however these were not present in any of the four vehicles we inspected. The service did not provide any feedback obtained from these cards. This meant we did not receive significant levels of feedback with regards to patient care.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff providing emotional support to patients and their families.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff told us about an incident where they had acted as an advocate for a patient when communicating with another medical discipline. This helped the patient stay calm and reduce anxiety.

Staff understood communication needs of patients with a disability or sensory loss. The service provided an example of a patient who had additional needs where they had made adaptations to the environment. This included not using sirens when transporting to hospital, and dimming the lights in the vehicle.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We spoke with a family member who the service had treated and they told us the crew were 'professional and compassionate'.

Patients and their families could give feedback on the service directly to the commissioning service who would then pass this information on to the provider.

Is the service responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people

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

Requires Improvement

Emergency and urgent care

Managers planned and organised services, so they met the needs of the local population. The service was contracted to undertake frontline emergency NHS work.

Facilities and premises were appropriate for the services being delivered. The base unit was secure and had enough space to store all vehicles and necessary equipment and stock.

The service relieved pressure on other departments when they could treat patients without conveying them to hospital. When working with a patient with severe injuries, staff liaised with the wider system including emergency departments and specialist units to ensure patients were seen by the right medical team in the quickest time.

Meeting people's individual needs

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

Staff made sure patients with mental health conditions received the necessary care to meet all their needs. Staff treated patients for a range of medical conditions and injuries including those relating to symptoms of mental ill health.

Staff were inclusive and provided advice, guidance and care based on their own clinical knowledge. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to a telephone-based interpretation service to support communication with patients who did not speak English as a first language.

The service told us they used communication books to support patients who had communication needs or patients with a disability or sensory loss. These books were not present in any of the 4 vehicles we inspected. Following our inspection the service advised us these could be accessed digitally but we did not see evidence of this on the document library during our inspection.

Access and flow

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

The service supported the local NHS ambulance trusts across the south region. The service carried out their work based on requests from these services.

Staff told us they would utilise direct access to wards where appropriate for patients.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations. However, information on how to complain was not easily available.

Requires Improvement

Emergency and urgent care

Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the steps they would take if a patient wanted to complain. We heard how due to the service providing frontline ambulances, complaints were made after the patient had left the vehicle. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. In the majority of cases, complaints were made to the commissioning service who would investigate the complaint and refer their finding back to the provider. We saw instances of this being done and learning outcomes shared with the provider.

Managers investigated complaints and identified themes. We reviewed all complaints received by the service in the 6 months prior to inspection and saw they followed the service policy.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw learning outcomes shared with staff, for example conversations with staff regarding clinical handovers when a complaint was made regarding the quality of these.

However, information on how to complain was not located in any of the vehicles we inspected. We also saw no leaflets to advice patients of the complaints process. The service website had a feedback form to leave a feedback but this information was not available on service vehicles.

Is the service well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles. However, senior leaders were not always visible and approachable in the service for staff. They also did not always manage the priorities and issues the service faced.

The leadership team at the service consisted of 1 director, who was also a CQC registered manager, a registered manager who focused on patient transport, and two paramedic team leaders. In addition, there were also staff in other specialist roles within the business. Staff told us they felt local team leaders were approachable however staff often went for periods of time where they did not see senior managers. The service had recently undergone a period of leadership change, this meant There were no regular messages directly from leaders and staff told us they felt this would be beneficial. Some staff we spoke to told us they were not always of the names of senior leaders in the service.

Following inspection, we extended the opportunity to staff to contact us with feedback and to further support the process and understanding of the service. We spoke with several members of staff in the week after inspection.

Staff told us they were not always clear on who held responsibility for each area but they would escalate concerns to the team leaders. The most recent staff survey, undertaken in August 2022 highlighted that staff knew who their line manager was, however 63% of staff said they did not see senior managers on a regular basis. Staff we spoke with during the inspection process also told us they did not see senior managers often. All staff spoke positively of their relationship with team leaders. Following our inspection the service advised this survey had been completed during a period of leadership change.

Requires Improvement

Emergency and urgent care

Vision and Strategy

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

Staff told us they worked together to provide safe care for patients and this was their goal. Leaders told us they had a vision for what the service wanted to achieve. We reviewed values information for the service and saw that these were identified as:

- Excellence
- Integrity
- Innovation
- Expertise

These values had been reviewed at a management meeting in August 2022 and it had been agreed among leaders these reflected the service. However, no staff we spoke with were aware of specific service values or how they applied to their roles. This was also identified in the staff survey where 38% of staff stated they did not know what the service values were, 25% of staff also replied neutrally to this statement.

Culture

Staff were focused on the needs of patients receiving care. Most staff felt respected, supported and valued.

The overall culture of the service was professional. Staff told us they felt there was a positive culture in the service and were supported by leaders.

Staff told us that if they had frustrations, they could raise these concerns with managers and felt listened to. Staff spoke highly of their colleagues and stated it was a pleasure to work with the crews and for the service. Some staff felt communication regarding job applications and promotions was not always forthcoming and they often had to chase for outcomes.

The service completed equality and diversity training as part of their training package and could seek advice from managers. Feedback from patients, relatives and carers was limited.

The service had introduced an external freedom to speak up guardian. Whilst this was not a requirement in independent healthcare organisations, it brought it in line with NHS services. The service had promoted the speak up guardian within the staff newsletter.

The service provided support and de-briefing for staff experiencing difficulties. If managers felt that staff could benefit from reflective conversations following a traumatic incident, this would be offered and we saw evidence of this.

Governance

There was limited evidence of effective governance processes. Staff at all levels were clear about their roles and accountabilities.

Requires Improvement

Emergency and urgent care

Staff were employed in specific roles with job descriptions and responsibilities. Staff at all levels understood their roles and responsibilities. Staff understood the areas they had oversight for. We reviewed a staff structure which showed the areas of responsibility for each member of staff however this was not available on the staff service portal. This reflected feedback from staff that they were not always clear on some senior staff roles.

There were limited governance processes in place throughout the service however these were not always in line with policy. The service held clinical governance meetings monthly, we were supplied with a copy of the meeting minutes from August 2022 and saw that it followed a clear agenda. However, we were not provided with recent copies to follow up on outcomes. The service had a staff portal which stored service policies; we were told was accessed via QR codes located in the service base. However, following inspection we were advised these documents could be accessed without a QR code and this was instead used to provide a quicker route when required. We did not see QR codes in any service vehicles.

Staff told us they could not always access information when they required it. We also saw that not all service polices were available on the staff portal, for example infection prevention and control and clinical policies such as patient group directives.

Leaders told us changes in policy were issued to staff via a memo system, this enabled oversight of recipients so that staff who had not read updates could be contacted to be reminded to read them. When new staff joined or new policies were issued staff were required to download and sign these.

Management of risk, issues and performance

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

The service told us they completed audits quarterly however we saw minimal evidence of audits undertaken by the service. Following our inspection, we requested an audit schedule but the service did not supply this. Where audits were performed these were not performed in a way that gave effective oversight or identify areas for improvement. For example, there were no independent checks of cleaning of vehicles, this meant when cleaning was not performed it was not identified. During our inspection, we were shown cleaning audits which were not completed regularly and did not had outcomes detailed. Following our inspection, the service supplied a digital cleaning audit which they told us was used to identify improvement however leaders did not refer to this audit during inspection following feedback on the day. The service told us they had a stock tracker which highlighted when items were due to be replenished or expire. However, we found expired items and damaged packaging on sterile items in all vehicles we inspected, this indicated that monitoring was not effective.

The service told us they did not have a major incident policy in place as they used the commissioning services policy, we were told this document was available on the staff page.

Information Management

The information systems were integrated and secure. The information systems were integrated and secure. Staff could find some of the information they needed, however some information was not easily accessible at the time of inspection.

Requires Improvement

Emergency and urgent care

The service had received limited data from the commissioning service as they had only started working with them recently, this limited the services ability to perform independent analysis. The service advised us they would be doing this once they had completed a commissioning service review.

The provider operated a staff portal which enabled the distribution of information such as policy updates and bulletins. Staff were required to sign into the email as proof of reading new policies.

Staff had access to mobile phones however they told us they could not access applications such as Patient Group Directions or clinical guidance applications such as the JRCALC on these. Following out inspection the service assured us these were now in place.

The service utilised QR codes, digital codes that contain information and can be scanned using a smartphone or other handheld device, to help staff access the organisations systems.

Vehicles were equipped with global positioning system-based navigation and location systems, this meant managers were able to see where their staff were on shift and if there were any issues, staff could be easily located.

Engagement

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

The service had recently resumed its monthly staff newsletter. These provided staff with a range of information such as recent incidents and new member of staff. There were details from the most recent staff survey where the service responded to concerns and informed staff of any actions they were taking.

However, it was not always possible to evidence these changes has been implemented. For example, staff had said they did not have a forum to discuss ideas concerns and questions. In response to this the service stated they would be holding an open staff forum each month; we did not see any evidence of this being done. This had also been raised in the staff survey where 72% of staff disagreed the organisation held staff meetings to discuss concerns.

Learning, continuous improvement and innovation

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

Staff had raised training opportunities in the most recent staff survey stating they would like more learning opportunities. The service had recently launched clinical mentoring where staff who had completed their clinical inductions were being trained to support newly qualified members of staff. They had also launched apprenticeships for staff. Staff newsletters promoted the opportunity for staff to upskill and improve their qualifications.