Southern Medical Rescue Ltd

Southern Medical Rescue

Inspection report

Unit 8/9a/12
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Overall summary

The service did not have a previous rating. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. 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. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs. They provided emotional support to patients, families and carers.
- The service took account of patients' individual needs and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services.

However:

- The service did not always control infection risk well.
- The service did not always manage medicines well.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Good 	

Summary of findings

Contents

Summary of this inspection

Background to Southern Medical Rescue

Southern Medical Rescue Limited is an independent ambulance provider. The service provides emergency and urgent care (EUC) services. The service carries out contracted work for an NHS ambulance trust. The service does not subcontract work out to smaller independent ambulance services.

They were registered with the Care Quality Commission in 2021. The provider is registered for the following regulated activities:

Transport services, triage and medical advice provided remotely,

Treatment of disease, disorder and injury,

There is a registered manager in post.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 23 November 2022 at one of their locations. During the inspection we visited the registered office location, met with the registered manager, the nominated individual, 3 ambulance crew and 1 patient. We observed 1 patient journey, reviewed 1 paper patient record, inspected 2 vehicles and reviewed policies.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that staff have dedicated hand hygiene facilities that meet guidance (Reg 12) (2))
- The service must ensure the proper and safe management of medicines (Reg 12) (2))

- **Action the service SHOULD take to improve:** The service should consider reviewing their infection prevention and control policy (Regulation 17)

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	Insufficient evidence to rate	Good	Good	Good
Overall	Requires Improvement	Good	Insufficient evidence to rate	Good	Good	Good

Good

Emergency and urgent care

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

Are Emergency and urgent care safe?

Requires Improvement

The service did not have a previous rating. We rated it as requires improvement.

Mandatory training

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

All urgent and emergency staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. The provider used the same training modules as the NHS trust they were contracted to and all mandatory training was done online. The training aligned to the Skills for Health online mandatory training (Skills for Health is a not-for-profit organisation committed to the development of an improved and sustainable healthcare workforce across the UK). Online training modules included for example, deprivation of liberty safeguards, safeguarding adults and children, fire safety, and infection control. There were 15 mandatory training modules covering topics such as safeguarding adults and children, infection prevention and control, moving and handling, fire safety and information governance. Mandatory training was completed via e-learning with any additional training carried out either face to face or via e-learning. Training records showed that of the 35 urgent and emergency staff, 34 had completed the relevant mandatory training and none of this training had expired at the time of the inspection.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. However, the learning disabilities module had only recently been introduced, so only 8 of the 35 staff had completed it so far.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept a spreadsheet of staff training and staff were alerted when training modules were due to be completed. Training was stored and undertaken online via an electronic system. Staff did the online training in their own time and within their home environment. Any face to face training would be carried out at the service location.

Good

Emergency and urgent care

Evidence provided showed that 2 staff members were trained to level 3 emergency response ambulance driving. The provider told us that all staff were trained in blue light emergency work. In accordance with section 19 of the Road Safety Act (2006) drivers need to be assessed every five years. During the inspection we did not experience a blue light call, but our specialist adviser who went out with a crew, stated that the driving was of a good standard.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. This included training in both adult and children safeguarding. All staff were trained to level 3 safeguarding in adults and children (level 3 training implies that the individual has an extremely active role in any safeguarding situation and requires the knowledge to help shape the safeguarding policies of their workplace).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The provider had safeguarding information displayed in staff areas, such as a safeguarding everybody everyday poster. Staff we spoke with gave previous examples of referrals they had made and were able to clearly explain the referrals process.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. As part of Southern Medical Rescue's contract arrangements with a trust, Southern Medical Rescue's staff reported all safeguarding concerns to the relevant trust directly from electronic tablets. The trust was responsible for investigating these and for referring them to the local authority as required. Staff told us they did not always receive feedback from any referrals they made. Managers said the trust did not provide any feedback from safeguarding referrals, which impacted on their ability to monitor safeguarding outcomes. Managers said they sometimes get an acknowledgement email from the trust to inform receipt of the referral. Southern Medical Rescue told us they did log safeguarding referrals on their own internal system.

Southern Medical Rescue had an up-to-date safeguarding policy in place. This policy comprehensively covered several safeguarding topics; for example, confidentiality, types of abuse, and how and when to refer a patient. The policy contained clear guidance for staff on the referral process if they were working on an NHS contract or non NHS contracted work. Contact details for the safeguarding lead and local authority contacts were contained in the policy. The policy was available to staff both online and paper form.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment clean. Vehicles were generally well maintained and visibly clean. Premises were clean but untidy in places.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Staff did not always clean equipment after patient contact. Staff did not always change their gloves after patient care or use hand gel before or after patient care. Staff did not wipe down handrails or seating after patient use. This was not in line with their policy or national guidance. However, staff were bare below the elbow and wore masks when giving patient care and did wipe down electronic record equipment. Vehicles carried gloves, aprons, face masks, hand-cleansing gel and decontamination wipes.

Good

Emergency and urgent care

We viewed records for hand hygiene audits carried out across the service between April and October 2022 that showed 15 staff had been audited and had used appropriate hand hygiene. One staff member was not recorded for correct hand hygiene techniques, so it was unclear whether they had performed good or poor hand hygiene. One staff member was recorded as not being bare below the elbows, but overall hand hygiene was good amongst most staff.

Handwashing facilities at the ambulance station base did not meet guidance. Signs showing information on handwashing techniques were present throughout the premises. Managers have confirmed staff do not have dedicated handwashing facilities in the clinical or decontamination areas. This poses the risk of the spread of infection for patients and staff. Since the inspection, the provider told us that a dedicated handwashing sink has been installed and advised a photograph had been attached. We did not find any attached photograph, so requested that to be sent to us, but did not receive the evidence requested, therefore we cannot be assured this has been installed.

We reviewed the providers infection prevention and control policy and it did not contain specific advice or guidance on hand hygiene.

The station had shower facilities for staff. This was deemed as a low usage outlet and risk assessed to undergo a weekly flushing and temperature regime to control the possible risks of legionella. Records showed that weekly checks for cleaning, flushing and water temperature of the shower system were carried out and documented.

Vehicle cleaning records were up-to-date and demonstrated that vehicles were cleaned regularly

Vehicles were cleaned in a large garage area. Some basic maintenance of vehicles was also carried out there. The service used Adenosine triphosphate (ATP) testing for all clinical areas before and after cleaning and documented outcome scores of cleanliness. (ATP is an enzyme that is present in all living cells, and an ATP monitoring system can detect the amount of organic matter that remains after cleaning an environmental surface, a medical device or a surgical instrument).

The service had, had contracted arrangements for deep cleans of vehicles, however this agreement had concluded, and this was now being managed in house. There was a staff member employed to carry out deep cleans and make ready tasks 4 days a week. In their absence, managers and staff, who had been trained to do so, carried out these tasks. Vehicles were deep cleaned, as a minimum, every six weeks.

Vehicles had a deep clean at 6 weekly intervals. We looked at 2 vehicles which were clean throughout, well stocked with personal protective equipment (PPE), hand cleansing gel and decontamination wipes. However, in one vehicle there was a torn seat cover which may pose an infection risk. This was reported in the vehicle cleaning report of 27 July 2022. The torn seat was brought to the attention of the service and managers stated they would address this issue. The same vehicle had a damaged door with a hole in it. In another vehicle a piece of equipment used for resuscitation had a torn cover which may also pose an infection risk. Following the inspection, the provider tried to identify the piece of torn equipment but was unable to. We spoke to our specialist adviser who had raised the issue and they confirmed the piece of equipment that was torn, and we informed the provider of this. As yet the provider has not responded to that information, so that piece of equipment may still be in use.

Environment and equipment

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

The design of the environment followed national guidance. Cleaning equipment used on ambulances were not stored correctly. Some buckets used for the cleaning of ambulances were not stored inverted, therefore allowing soiled fluids to remain in buckets.

There were a number of patient trolleys with miscellaneous equipment, such as training mannequins, linen and boxes on them that were stored next to the clinical waste bin in the vehicle and make ready area. We were told these were for patient use when new vehicles arrived. These trolleys were cluttered, with pillows close to the ground which would place them at risk of becoming dirty. The trolleys had in date servicing labels. There was a hoist in this area and staff told us this was not in use but had come with a vehicle purchase. Since the inspection, the provider has assured us the pillows were not intended for patient use and have since been disposed of.

There was a COSHH cupboard in situ which displayed clear sign of its contents. There was a second storage cupboard next to the COSHH cupboard for general stock storage such as PPE.

Fire exits were sign posted and fire extinguishers were present. One extinguisher was not in date. This was brought to the attention of the managers and was replaced with an in date one. Smoke detectors were present.

Most equipment in the storage area was stored off the ground, clearly labelled and had in date servicing labels. Items not in use were placed into a locked cupboard and marked as not for use. Storage areas where clinical use equipment was stored, were untidy in some areas. Bench areas where clinical stock was handled, were untidy on top and below. This can impede hygiene maintenance and may pose the risk of infection.

Hand sanitisers were present throughout the premises and fixed to walls. Eye wash stations were present in the make ready and vehicle cleaning area.

Staff carried out daily safety checks of specialist equipment. A vehicle inspection was completed by the staff before their shift; for example, all lights and indicators, seatbelts, blue lights and siren, bodywork and doors. In addition, crews checked the equipment within the vehicle. Vehicle faults or concerns could be reported on these checklists. Managers kept electronic service and repair records for their fleet of vehicles which were up to date. Any vehicles not in use, were highlighted on the electronic record as not in use.

The service had enough suitable equipment to help them to safely care for patients.

Staff did not always dispose of clinical waste safely. Staff did not separate clinical waste and sharps bins into separate bins but placed both together in the 1 clinical waste bin at the ambulance station. Whilst this was adhering to their policy, this was not in line with guidance for management of clinical waste.

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 had access to a nationally recognised tool to identify deteriorating patients and knew how to escalate them appropriately. The staff we observed did not have a patient who met the deteriorating patient criteria, so we could not observe the escalation process in action. The staff documented patient observations which would calculate the NEWS2 (National Early Warning Score) scores (NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients). The tablet system would prompt the staff to escalate

a patient if required. Staff were aware of the escalation procedure which was to contact the clinical help desk at the contracted NHS trust. This service was available 24 hours daily, 7 days a week. Staff advised they also had the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) app on their phones to provide information and clinical guidance. Additionally, Southern Medical Rescue have a clinical lead available for advice and guidance.

Staff said the different options of patient care and guidelines; for example, when and how to convey a patient to hospital, non-conveyance of patients and discharge, and transfer to other suitable treatment facilities, were decided by the contracted NHS trust.

Staff had access to specialised clinical help such as the midwife line, where staff can call a midwife using a specific call sign, to seek advice and guidance on maternity related patient needs.

The service had an up-to-date control and restraint policy. This clearly stated restraint was only used as a last resort. It included definitions of types of restraint, who could restrain patients, and the importance of monitoring a patient throughout a restraint episode. The policy clearly outlined the only reason to restrain a patient was to maintain their safety and that of others.

Staff shared key information to keep patients safe when handing over their care to others. Staff liaised well with patients and their families and updated them on their care needs.

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 staff a full induction.

The service employed 36 staff in total with 32 being made up of paramedics, technicians or emergency care assistants and 4 being management. There were no agency or locum staff employed in the service, all staff were self employed.

Emergency care assistants were trained to FREC level 4 (First Response in Emergency Care) and technicians to FREC 5 level. The service had 6 trained paramedics.

Staffing levels and skills mix were planned using an electronic system which automatically ensured the skills mix was appropriate for each shift and adhered to the contracted NHS trust's requirements. If the required skills mix of staff was not achievable, then the system would not allow a shift to be allocated. If staff were absent, for example due to sickness or leave, managers would call on other staff in their pool to covers shifts or managers would cover shifts themselves.

All staff had an induction prior to commencing any shifts. The provider had an induction policy that was current and included the induction schedule.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Good

Emergency and urgent care

Clinical staff completed Patient Report Forms (PRFs) for every call-out (PRFs are specifically designed forms for the use of clinicians who attend and give first aid at the scene of an accident or illness). PRFs were either in electronic or paper form. Paper records were scanned then securely emailed from NHS trust premises and IT equipment. Paper records were stored by the NHS.

Patient notes were comprehensive and all staff could access them easily. Staff used electronic tablets to record patient care and treatment information. The records included NEWS2. These were automatically uploaded to the contracted to NHS ambulance trust for their records. These records were shared with Southern Medical Rescue if required.

Records were stored securely in electronic tablets that were password protected. Any paper records used were taken to the contracted to NHS ambulance trust's resource centre and processed securely.

Managers told us they audited patient care records and correlated them with their own records, looking at, see and treat times, non conveyance of patients and any onward referrals to other services. Southern Medical Rescue had developed their own system to monitor multiple aspects of patient care journeys such as, response times, average handover times, time on scene and numbers of patients seen and conveyed to a hospital.

Medicines

The service had systems and processes to safely prescribe, administer and record medicines. Medicines were not always stored securely.

Staff had systems and processes to prescribe and administer medicines safely. Staff on the day did not attend to a patient that required any prescribing or administering of medications. The ambulance staff used pre prepared medicine bags, stored in secure lockers when not in use. These bags were colour coded for specific roles, such as technician or paramedic. All prepared bags were sealed with security tags and placed in secure lockers which were marked for specific vehicles. Keys to the lockers were stored in a key safe.

Staff did not always store medicines safely. We observed a medication bag left unattended on the vehicle dashboard. This bag contained prescription only medications as covered by section 17 of the Human Medicines Regulation Act 2012. This did not follow the providers own policy in the safe storage of medicines.

The operations director carried out monthly medicine audits. Controlled drugs (CD's) were checked daily. We reviewed the CD book and saw that only 1 daily check was missed. Managers told us that if they do not always have 2 staff available to check CD's, then they would not check, as checks require 2 staff.

CCTV monitored the locker area and where controlled drugs were stored (a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction). The controlled drugs were stored in a safe within a second safe which was fixed to a wall. On vehicles, controlled drugs were stored in a separate locked case and within a safe. The service location had been issued with a Home Office license to store controlled drugs.

The service had an in date medicines management policy which outlined the safe storage, use and disposal of medicines. It also contained a patient group directive (PGD) guide for the medicines different grades of staff could administer. (PGDs are written instructions outlining who can administer medicines and should be written by a multi-disciplinary group including a doctor, a pharmacist and person expected to give the medicine). The policy stated

that controlled drugs stock levels were to be checked daily. However, we reviewed the documents for this and saw that this did not always happen. There were gaps in checks in October 2022 and incorrect dates in November 2022. This did not follow the providers own policy or good practice. The provider told us that these gaps were due to not having 2 members of staff available to check the controlled drugs, therefore they have missed days.

Medicines stored at the ambulance base were monitored for temperature and recorded daily electronically. Managers told us if the temperatures go out of range for medicines stored in fridges or cupboards, they would consider moving medications to a different room where the temperature may be more suitable or would review expiry dates of those affected. Any affected medicines would then be disposed of appropriately and following guidance. We reviewed the medicine temperature checks and found them to be in range. We viewed a random sample of medicines and they were within expiry dates.

Medical gases were stored securely in locked cages which were clearly marked for empty and full cylinders. Warning labels were present to inform that smoking was prohibited in that area.

Staff completed medicines records accurately and kept them up-to-date. Staff completed run sheets which had medicines listed, which staff would tick when they had used them. The run sheets were used to monitor stock levels. There was a QR (quick response) code system in use and each staff member had their own code. Crews would use their own unique QR code to scan the medicine bags and this would electronically assign that specific bag to that crew member. This allowed medicines and stock levels to be tracked accurately and in real time as crews carried out their shift.

Staff learned from safety alerts and incidents to improve practice. Any safety alerts would be sent to staff via secure media by the senior management team. The provider also used an internally created electronic system to alert staff to any unread messages. When staff logged on to the system, it prompted them to read mandatory messages. The system did not allow staff to progress further until they have read important messages.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The service had a misuse of drugs and alcohol policy which outlined clearly staff and management responsibilities in the workplace.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The service had an adverse incident and management policy which outlined roles and responsibilities of staff when reporting incidents. Staff raised concerns and reported incidents and near misses in line with provider policy.

The policy contained examples of reportable incidents and the method by which staff must log incidents. Staff used electronic tablets to report incidents into the providers internal system. Management staff were responsible for investigations and support of staff following reported incidents. We reviewed the incident log and saw 7 recorded

Good

Emergency and urgent care

incidents between May and November 2022. Clinical or operational incidents were led by the clinical lead or a manager. Staff statements would be taken within 7 days of the reported incident, and any other required evidence would be collated and a report compiled. The log showed that team debriefs would occur following incidents and managers shared information with relevant stakeholders to discuss and determine any next steps and necessary actions.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared incident learning through memos in their electronic systems, via secure social media applications. These would occur after incidents and when issues arose.

The service had, had no never events. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Managers debriefed and supported staff after any serious incident. Managers advised that anyone in their organisation can make a referral to trauma risk management (TRIM) and receive support they require following an incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. A review of records demonstrated they used statements from crews, liaised with the relevant trust, and a review of the ambulance dispatch notes to understand the background of incidents. Each investigation ended with a conclusion and, where appropriate, recommendations.

The service had an in date duty of candour policy that covered staff responsibilities, explanations of duty of candour, patient safety, timescales of incidents and duty of candour process and guidance relating to regulatory requirements.

Are Emergency and urgent care effective?

Good

The service did not have a previous rating. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff followed guidelines from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). The JRCALC guidelines were an essential resource for pre-hospital clinicians. They were an important part of clinical risk management and ensured uniformity in the delivery care. Staff accessed JRCALC information on their tablets.

The services own policies were stored on the mobile communication app. There were also paper copies available in the ambulance stations. Staff could easily access the relevant policies wherever and whenever they needed to reference them. We reviewed the service policy on guidance and use of defibrillators which incorporated clarification on training for specific staff, usage, additional training and care and maintenance of defibrillators.

Medical related updates such as medicine alerts were sent out by the service through secure social medica applications.

Response times

The service monitored response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

Managers told us they met regularly with trust for clinical review meetings and would call them on an informal basis when issues arose. We requested minutes from clinical review meetings but did not receive any. Managers told us the NHS ambulance trust sent them raw data which they used to correlate with their crew run sheets, to ensure they were meeting their set key performance indicators (KPI's) from the NHS trust. From the evidence we requested, we could not see what percentage the benchmark KPI's were, so could not ascertain if they were meeting their set targets or not. The service's custom built database did show that monitoring of average response times, number of journeys and arrival on scene times was undertaken. Following the inspection, the provider submitted further supporting evidence of their KPI's. It showed that for the last quarter of 2022, average response times for patients then conveyed to hospital, met the expected KPI of 45 minutes, but average response times for those patients not conveyed to hospital, did not meet the expected KPI of 1 hour and had an average response time of 93 minutes. They did meet the expected KPI for average clear up rate of 15 minutes, and evidence provided for the month of December 2022, showed they had reduced that time to an average of 14 minutes.

For November 2022, the average time to drive to a call was 21 minutes and to arrival on scene was 44 minutes. For December, the average drive time to a call was 16 minutes and arrival on scene was 46 minutes. The service would be penalised financially by the NHS trust if they failed to meet their KPI's, and we saw evidence that estimated costs of fines were included in the database information.

Patient outcomes

The service did not monitor patient outcomes as this was carried out by the NHS trust.

Competent staff

The service made sure staff were competent for their roles. Managers had not yet appraised staff's work performance or 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 a mix of emergency care assistance (ECA), technicians and paramedics. There were 9 ECA staff, 14 technicians and 6 paramedics. ECA staff were trained to FREC 4 (First Response Emergency Care) level and technicians to FREC 5 level. Certificates for training were held electronically and the system alerted for any required training that was due for renewal. Certificates for blue light driving qualifications were checked and stored electronically. The service operated robust safe recruitment processes when recruiting staff members. Enhanced Disclosing and Barring Service (DBS) checks were carried out, logged electronically and checked yearly.

Managers gave all new staff a full induction tailored to their role before they started work. All staff undertook an induction when starting with the provider. We reviewed their induction policy and checklist, which was in date and covered topics such as Health and Safety, Safeguarding, Infection prevention and control, Medicine management and equipment familiarisation. The induction was a full day of classroom study and clinical assessment.

Managers had not yet carried out annual appraisals of staff. Managers told us they had not yet entered a full year of staff being employed with them, so had not yet completed any annual appraisals. Managers said they were intending to carry out appraisals, but staff could raise any concerns or issues at any time.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.The clinical educators supported the learning and development needs of staff. There was a clinical lead available to staff to support with any enquiries, questions or development needs they had. Managers identified poor staff performance promptly and supported staff to improve. Managers monitored patient care records, investigations and complaints, to identify themes trends and any areas for staff development. Learning from these were shared with staff and factored into continuous professional development (CPD) days. The service also had a mentoring system in place, to support staff who may have been identified as requiring further training, or to support those staff who had requested it. Managers or mentors would join staff on shifts at times, to observe their practice. This helped focus the learning for those staff who may require development. Managers would incorporate specific training into their planned CPD training days held quarterly. Any other training such as refresher training could be arranged by the service if staff requested it.

Managers did not hold regular formal staff team meetings but communicated with staff primarily through secure social media applications to provide operational updates or medical alerts. Staff could respond within the social media applications with any concerns.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they felt they could raise any training requirements they needed and said the managers were responsive to their requests. Managers told us staff had recently requested refresher training in areas such as maternity, as they had not experienced many calls of this nature. Managers told us these were now planned for future CPD training days.

Managers made sure staff received any specialist training for their role. Managers ensured staff were trained to the correct level for emergency and urgent care work. Staff would not be allowed onto a shift until appropriately trained as this was part of the contractual agreement with the NHS ambulance trust. Additional specialist training can be provided by the NHS ambulance trust to Southern Medical Rescue if they request or require it, such as the maternity support line.

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 communicated with hospital staff, carers and families to ensure they had all the information they needed to ensure patient care needs were shared. Staff handover times were monitored by the service and staff would report any concerns or issues they had during handovers. We saw that any issues arising from handovers with hospital trusts were investigated and actions put in place to mitigate or minimise any incidents from reoccurring. Any escalation needs were handled by the NHS ambulance trust, and staff would follow those processes and procedures. Staff would keep in contact with managers at Southern Medical Rescue to update them on handover issues and updates.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff could access advice from clinical advisors who worked for the trust. This included advice from mental health nurses and a newly implemented maternity helpline for clinical advice.

Good

Emergency and urgent care

Managers told us that learning was shared with trusts and gave the example of "Assessing the sick child" which was an NHS training session that was now in use at Southern Medical Rescue.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All staff had access to the Consent and Mental Capacity Policy on their electronic tablets. They were able to use their understanding of the MCA to understand consent and how to obtain it. Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed a patient journey and staff understood the requirements of the MCA and recognised that their patient had the mental capacity to make their own decisions.

Staff made sure patients consented to treatment based on all the information available. We saw staff had continual dialogue with patients to keep them informed of any treatment requirements and possible options for the next steps in their care and ensure their wishes were listened to and consent gained. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were aware that policies were available in their electronic tablets and in paper form at the ambulance base.

Are Emergency and urgent care caring?

Insufficient evidence to rate

The service did not have a previous rating. Insufficient evidence to rate.

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 and those close to them in a respectful and considerate way. We observed one patient journey and the crew showed care and compassion with the patient. They kept the patient informed of their care needs and any next steps. The crew also kept family members informed and involved in any discussions around care.

Staff understood and respected the individual needs of each patient. Staff took account of patients wishes when discussing the possible steps in additional healthcare support. One patient did not wish to see their GP, preferring an alternative route for their needs and staff respected this.

Understanding and involvement of patients and those close to them

Good

Emergency and urgent care

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. Staff spoke with patients and their families showing care and support for their needs and wishes.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff were clearly spoken and took the time to speak with patients in their care and those supporting their care. The service trialled language cards but reported these were not successful. Staff have used generic translation service on the internet, pen and paper and language line facilities.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and families could leave feedback on their experience of care. There were information posters in vehicles information patients and families as to how they could leave any feedback on the service they received. We reviewed patient care feedback which included compliments about a crews attendance to a patients home and the care they received along with good communication from the crew to allied healthcare staff. We also viewed complaint from patients

Patients and their families could give feedback on the care they received verbally to staff who record feedback electronically, which was then directly dealt with by the contracted to NHS trust patient experience team. This would then be fed back to Southern Medical Rescue where appropriate.

Are Emergency and urgent care responsive?

Good

The service did not have a previous rating. 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.

Managers organised services so they met the needs of the local population. The service was provided through contracts with an NHS trust, therefore, Southern Medical Rescue were not directly responsible for the planning of the service.The service had 2 locations and the registered manager divided their time between the 2 locations. The service covered a wide geographical area and patients were conveyed to the most appropriate health setting.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff had access to clinical support which was available both from the NHS trust and Southern Medical Rescue clinical lead. Staff had access to policy and clinical information to help guide them on appropriate care and any next steps. Southern Medical Rescue had a duty manager rota which provided on call cover throughout staff shifts.

Good

Emergency and urgent care

The service had systems to help care for patients in need of additional support or specialist intervention. Staff were able to contact GP's when required or to seek support from the police if required. We reviewed documents that showed staff had called on these services to seek support with challenging situations.

Managers said there were agreed care pathways for patients and policies in place for patients that may experience long waits.

Meeting people's individual needs

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

Staff made sure patients living with dementia, received the necessary care to meet all their needs. All staff had received training in dementia as part of their mandatory training. Mandatory training in learning disabilities and autism had recently been introduced, so not all staff had completed the training yet.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. Staff had access to a phone translation service twenty-four hours a day and could thereby communicate with patients for whom English was not their first language. Staff had access to communication aids to help patients become partners in their care and treatment. Staff would also use internet based translation applications to aid communication with patients, families and carers.

The service had the equipment provision to meet those patients categorised as bariatric. We saw evidence that the service had assisted with such a patient when the NHS trust could not provide this.

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.

Southern Medical Rescue staff worked under contract to an NHS ambulance trust, and it was the trust that managed the access and flow of the service. Crews were assigned shifts covering a 24 hour period.

Southern Medical Rescue monitored the flow of the service via an electronic dashboard system. This could see response times, average on scene times, average conveyance times and average handover times. Data showed there was 1 incidence of a missed a key performance indicator on an ambulance clear up time.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

The provider understood complaints to be part of working in healthcare and ensured their staff knew this as well. The approach was non-punitive and inclusive, and the view was complaints could help to learn.

Good

Emergency and urgent care

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas All vehicles across the service displayed posters on how to give feedback.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew how to inform patients of how and where to complain and knew who to contact within Southern Medical Rescue as well.

Managers investigated complaints and identified themes. Both the contracted to NHS trust and senior managers investigated all complaints and relied on various sources of information; for example, statements from staff involved, reviews of the complainant's information, ambulance dispatch notes, and clinical records. The service kept track of complaints through use of a tracking document. This included the date of complaint or concern, a brief description and outcome or any actions taken or outstanding. The log categorised concerns, complaints for example, crews' attitudes or clinical decisions, such as from GPs or hospital departments.

We reviewed the Southern Medical Rescue complaints, which was clear in how a complaint would be handled and by whom. The policy did not contain any complaint response times or timescales of the complaints process. It provided an email address for external complainants to use but it was not clear how external complainants would access that email address. There was a contact form on the providers website, but no information about how to make a complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Southern Medical Rescue's investigation log showed that staff feedback sessions were part of their action plans following investigations.

Are Emergency and urgent care well-led?

Good

The service did not have a previous rating. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The leadership team consisted of a director, managing director, director of operations, and a medical director. The director was responsible for health and safety, vehicle fleet and training and education. The managing director was responsible for finance and human resources. The operations director was responsible for planning and make ready. The medical director oversaw the clinical lead who had responsibility for clinical team leaders and clinical mentors.

The leadership team had clinical and military backgrounds and some also were training to be paramedics.

Leaders provided good communication with and to their staff and provided good operational support for crews on the road. We viewed communications with staff, and saw messages to alert them to operational changes within NHS trusts such as divert requirements, whereby ambulances may be required to convey patients to a different hospital than the one planned, or operations pressure escalation levels (OPEL) set by NHS trusts regarding their capacity and resource escalation action plan (REAP) from NHS ambulance trusts.

Good

Emergency and urgent care

Leaders understood the priorities of the service and engaged with NHS trusts and other stakeholders to work together to address concerns or issues. Leaders felt that at times their service was not always used as effectively as possible and they provided feedback of this to the trust.

Staff we spoke with said they knew who their leaders were and were approachable, visible and accessible. Both the director and managing director go out with crews on shifts on occasion. Managers told us they had an 'open door policy' and encouraged staff to contact them directly with any queries or concerns.

Leaders used a mentoring scheme for staff to ensure they are addressing any staff training needs and to encourage staff development.

Vision and Strategy

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

Leaders said they had a vision to progress the company carefully and in a considered way, preferring to get things right and not grow too quickly as they felt this could impact on the quality of their service.

Leaders had plans to progress the expansion of training provisions and to develop "home grown" staff as part of the plan.

Leaders told us they wanted to expand into other types of services such as secure mental health transportation but were planning this with consideration. Leaders told us they were collaborating with external partners to identify and align to the wider needs of the population and local areas.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Senior managers we spoke with were very friendly and welcoming with our inspectors. This was reflected in the way we saw them communicate with their staff. It was clear staff felt comfortable with the senior team. Staff we spoke with said they enjoyed working there and felt the leadership team were open, honest and caring. Leaders said they hoped staff felt communication was good and they were like family, as that's how leaders viewed their staff. Leaders said staff do come and chat to leaders to discuss or raise any issues. Leaders said they would consider a staff satisfaction survey in the future but had not yet carried one out.

The welfare of staff members was a priority for senior managers. Staff accessed help and support from Trauma Risk Management Practitioners (TRiM - a trauma-focused peer support system designed to help people who have experienced a traumatic event). Staff could be referred into the TRiM service from either Southern Medical Rescue, the contracted to NHS trust, or could self refer. Posters in staff areas provided them with information of support and health and wellbeing services they could access.

Crews we observed showed care and compassion towards patients and their families.

Good

Emergency and urgent care

The CQC has not received any concerns, complaints or whistleblowing concerns relating to any workplace culture concerns at Southern Medical Rescue.

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.

Leaders told us they had internal clinical review meetings and operational meetings and external governance and performance meetings with their contracted to NHS trust. We requested meeting minutes from these meetings but did not receive them, therefore we cannot be assured of the frequency, content or outcomes of these meetings. Leaders told us they had a good open working relationship with the NHS trust and were able to discuss any operational or performance issues openly and honestly with them. Evidence from the investigations logs indicated communication with the NHS ambulance trust staff was effective.

Leaders worked with the NHS trust to ensure their requirements were coordinated to Southern Medical Rescue staff. This would involve direct meetings with the trusts private providers operational manager and ambulance control staff. Operational updates were issued through secure social media applications to all staff to ensure staff were aware of NHS trust requirements and changes.

Leaders told us they did not have regular staff meetings and did not produce meeting minutes from any informal staff meetings. Leaders told us they would try to coordinate staff meetings alongside CPD training days and staff would have the opportunity to raise or discuss issues then. CPD training days were currently held approximately quarterly. The lack of staff meetings and meeting minutes did not ensure staff had regular opportunities to raise issues, concerns or learning opportunities and leaders did not have the regular opportunity to provide feedback on operational or other issues. However, staff and managers did engage through social media applications to communicate issues or concerns as they arose.

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.

Operational and performance data captured by the NHS trust was shared with Southern Medical rescue leaders. This enabled them to monitor their key performance indicators. Data from Southern Medical Rescue run sheets were also fed into that data to provide correlation of data. The service had created their own custom dashboard which showed live data of performance which enabled the service to identify issues quickly and address any themes or trends.

Managers monitored the quality of the service continuously and had systems in place to help with this. This included, for example, monitoring the service's performance and KPIs, reporting and investigation of incidents, internal and external feedback, risks, and staffing.

The service had a risk register that used a matrix score system to identify and score possible risks to the service provision. It included areas as, adverse weather, vehicle and premises loss, staff loss, equipment loss, lone working and possible foreseeable events such as supplier issues and business resilience. The risk register included planned and possible mitigating actions to reduce or remove risks.

Operational issues were escalated by leaders to the NHS trust and any outcomes communicated to staff via telephone or secure social media applications. Leaders told us they audited patient care records to identify any skills gaps in staff. Leaders told us that if staff had identified skills gaps, then the service had a mentor scheme which could support staff in addressing skills gaps. Mentors could join staff on shifts to observe their skills in practice and support with any improvements required.

The service had a staff information page within a web based communications package. Staff were able to access information such as who to contact for specific issues, any staff events they could attend.

The service did not provide a service for major incidents.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service received data from the NHS trust they were contracted to and used this to inform them of their key performance indicators. We reviewed the limited evidence provided to us and saw that a missed KPI (key performance indicator) had resulted in a financial penalty. There was no system in place to make staff aware of the financial implications of performance.

Data captured by crews was entered and stored securely on electronic tablets which were password protected. If any paper documentation was used, this would be taken to a secure NHS ambulance trust location to be processed and stored onsite securely. Any paperwork that may have been brought back to the ambulance base, was stored in a locked cupboard and the keys stored in a key safe behind locked doors, which were also covered by CCTV.

The service had developed a custom IT dashboard and leaders told us it met the same security level as the NHS and had been approved by the NHS ambulance trust they were contracted to.

It was not clear how the information gathered and monitored was then communicated to staff to ensure all staff had a holistic understanding of the correlations and possible impacts of performance on the service. It was also not clear how staff would be able to raise issues or concerns related to the monitoring data that had been captured.

Engagement

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

As Southern Medical Rescue received undertook work for an NHS trust, it was the trust that provided the majority of public engagement and improvement of services, with Southern Medical Rescue addressing their services own engagement and improvement needs.

Good

Emergency and urgent care

Leaders engaged with their contracted NHS trust and other stakeholders to work together to address concerns or issues. We saw evidence that Southern Medical Rescue were able to assist with the transport needs of a bariatric patient when the NHS e trust were not able to and to resolve issues of challenging situations for the staff whilst on shift.

Leaders told us they had open and constructive meetings with the NHS trust We saw feedback from the trust complimenting the service on the provision of staff for the trust during a pressured time within the NHS.

Leaders told us they had engaged with the local authority to offer free first aid training to new parents in the local area. The service also provided free medic services for Remembrance Sunday in the local area.

The service had a staff information page within a web based communications package. Staff were able to access information such as who to contact for specific issues, any staff events they can attend. Staff were able to contact a duty member of the leadership team on a 24 hour 7 day a week basis. The service also had a number of IT programmes that staff could receive and send communications to leaders and use secure social media applications to contact leaders and other staff members. Notice bards were present in staff rest areas at the ambulance station. These had general information posters such as wellbeing and health support, along with clinical messages for staff to read. Staff were all contactable through telephones.

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.

Leaders told us staff had given feedback verbally to them with regards to patient care areas that they felt they required additional or refresher training. The service had planned for future continuous professional development days (CPD) to take into account any staff feedback regarding areas they wish to seek improvement in. Previous CPD days included discussions on new types of new drug bags and safeguarding training.

We reviewed evidence from investigations and saw that staff would receive feedback sessions following investigations but did not see any evidence that this had been shared and received by staff.

The service had created a bespoke IT system which managed stock items, performance data, had links to staff ID cards to log shift starts and shift ends, shifts worked which enabled staff to download invoices easily and audits.

Leaders told us they had plans to create a learning academy and were registered with Qualsafe to carry out training (Qualsafe are an Ofqual recognised Awarding Organisations who create recognised training in subjects such as pre hospital care and first aid). Leaders told us they were also registered with Outreach Rescue Medical Service (ORMS) who provide medical rescue and safety services.

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
Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure that staff have dedicated hand hygiene facilities that meet guidance The service must ensure the proper and safe management of medicines