Phoenix Response Services Limited

Thame Ambulance Station - Main Hub

Inspection report

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

Ratings

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

Summary of findings

Overall summary

This was the first time the service had been inspected. 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. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment and gave patients pain relief when they needed it. The service met agreed response times. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Leaders did not have reliable systems and processes in place for them to have a good oversight on safeguarding referrals.
- Not all staff had received clinical appraisals of their work, so managers could not be assured that they were competent. Supervision was not available to all staff.
- Feedback from service users was not being collected and collated effectively.
- Systems for assessing, monitoring and improving the quality of the service were not effectively and robustly integrated.

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 Thame Ambulance Station - Main Hub

Thame Ambulance Station – Main Hub is operated by Phoenix Response Services Limited and is an independent ambulance service. The service provides an Emergency and Urgent Care (EUC) service 24 hours a day, 7 days a week.

The service first registered with Care Quality Commission (CQC) in 2021. Thame Ambulance Station – Main Hub became a registered location with CQC in September 2022 but had been in operation from 2021 as a satellite location. The location is registered with CQC to provide the following regulated activities:

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

The service has 2 ambulance stations, one based in Thame, Oxfordshire and another based in Rainham, Kent. At the time of the inspection, the service had a contract to provide 9 shifts per day with 1 NHS ambulance trust from the Thame ambulance station. The Rainham location was used as a head office. The service was in tender with another trust and planned to provide Emergency and Urgent Care (EUC) services from the Rainham location in the future.

The service has 16 frontline ambulances, 2 blue light training vehicles and 1 car which is used by mangers to commute between the 2 locations. The service does not have specialist vehicles, such as bariatric vehicles or high dependency vehicles. The service only provides a EUC service and does not provide any medical support to events or a Patient Transport Service.

The service has had a registered manager since it first registered with CQC in 2021. A registered manager is a person who has registered with CQC to manage the service. They have a legal responsibility for meeting the requirements set out in the Health and Social Care Act 2008.

This was the first time the service had been inspected.

How we carried out this inspection

During the inspection visit, the inspection team:

- Visited the Thame Ambulance Station – Main Hub.
- Spoke with 5 staff members, including paramedics, associate ambulance practitioners, emergency care assistants and technicians.
- Spoke with 3 members of the management team, including the registered manager and chief executive officer, the head of resources, and the infection protection and control (IPC) lead and equipment manager.
- Inspected 3 ambulances.
- Looked at the management of medicines.

After the inspection visit, the inspection team looked at a range of policies, procedures and other documents relating to the running of the service.

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.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- The service was in the process of supporting Irish paramedics with Irish qualification conversion courses to give them opportunity to work in the UK, to boost their employed workforce.

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 robust systems and processes are operated effectively to assess, monitor and improve the quality and safety of the service provided (Regulation 17(2)(b)).
- The service must ensure statutory notifications are submitted to the Care Quality Commission as required by Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Action the service SHOULD take to improve:

- The service should ensure that all staff receive regular appraisals and clinical supervision of their work. (Regulation 18).
- The service should ensure that feedback from service users is collected and collated effectively. (Regulation 16).

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Emergency and urgent care

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

Are Emergency and urgent care safe?

Good

This was the first time the service had been rated. We rated it as good.

Mandatory training

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

All emergency and urgent care (EUC) staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Training included, but was not limited to, conflict resolution, equality and diversity, fire safety, health and safety, infection protection and control (IPC), information governance and manual handling. Mandatory training followed the Core Skills Framework which sets out 11 mandatory training topics for all staff working in a health and social care setting.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. They had also received training on the Mental Health Act 2007.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff would not be deployed for service if they had outstanding mandatory training. We saw the training records of 55 members of staff, which listed the completion date and the expiry date of each mandatory training module. All were up to date, with some of the training completed before the staff members had joined the service. Staff told us that they received email reminders from the online training company when renewal of training was due.

We saw a presentation from a contract review meeting that was held with the Trust in September 2022. This showed the service had 56 members of staff and 54 out of 56 had completed training in manual handling and were up to date with their blue light training.

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, managers did not always have good oversight on safeguarding referrals made.

Staff received training specific for their role on how to recognise and report abuse. All crew members deployed for service had received level 3 safeguarding training in both adults and children. Level 3 training is required for all staff who have an active role in any safeguarding situation and require the knowledge to shape the safeguarding policies of their workplace.

The registered manager was the safeguarding lead for the service. It is expected that the service has access to a safeguarding lead trained to level 4, as they would be responsible for the governance around safeguarding. The registered manager reported they completed level 4 safeguarding training within their previous role before 2021 but were unable to provide evidence of completion. They were due to complete safeguarding training to level 4 in December.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff who we spoke with had a good understanding of signs of abuse and gave examples of safeguarding referrals they had made.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They had received training in domestic violence and recognising abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Five crew members told us what they would do if they needed to raise concerns about safeguarding. Safeguarding referrals were made directly via the trust, through Electronic Patient Care Reporting (EPCR) tablets. Crews could get safeguarding advice from the trust's clinical advisors, available 24 hours a day. However, staff told us that they did not receive feedback on any safeguarding referrals and 3 staff members did not know who the safeguarding lead was for the service.

Managers told us that they received some feedback on safeguarding referrals through monthly governance meetings with the trust. We saw evidence of spreadsheets which were shared by the trust, which indicated which crew member had submitted each safeguarding referral, on what date it was submitted and on what date it was actioned. Each referral included the patient record form (PRF) number. Between 1 October 2022 and 7 November 2022, there had been 44 safeguarding referrals made. Managers did not have a good oversight on the nature of the safeguarding referrals made by their staff members. They told us they would only hear back if further information was required about the referral. This meant that the service could not effectively monitor safeguarding referrals, and any learning around safeguarding incidents could not take place.

One staff member told us that they had completed a safeguarding referral for one service user multiple times. There were concerns over how cluttered the service user's home was, and this posed a falls risk and a fire risk. The staff member reported being called out to the same service user several times, and each time they did not see an improvement. The crew member escalated this to the safeguarding team at the trust and took additional steps themselves to ensure that changes were made, including notifying the service user's GP.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained in line with the National Standards of Healthcare Cleanliness 2021 and the Health and Safety at Work Act 1974. The ambulance station had cleaning materials and equipment which were colour coded according to the National Colour Coding Scheme. This

scheme reduced the risk of cross contamination between different areas. We saw different areas clearly marked to demonstrate which colour coded equipment to use, for example, the kitchen area was a green cleaning area. Mop heads were changed daily. The service followed the Control of Substances Hazardous to Health (COSHH) regulations and staff had received COSHH training.

The intention was for a make ready team to be responsible for cleaning the ambulances. A team of 4 make ready staff were due to start the month after the inspection.

The management team, including the registered manager and the infection protection and control (IPC) lead were carrying out the make ready duties, alongside an apprentice paramedic. Cleaning of the ambulances included the use of a fogging machine. The fogging machine produced a fine spray of micro-droplets containing a cleaning solution, which reached hard to reach places. The exterior of the ambulances were cleaned inside the station by hand. We inspected 3 vehicles, and all were visibly clean and well maintained. The make ready process had been developed and written by the registered manager of the service, and staff members we spoke to were complementary about how well the vehicles were cleaned, stocked and maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw scheduled deep clean reports and check lists for 10 vehicles which took place throughout October 2022. One vehicle received a deep clean twice within this period as it had been contaminated. All equipment was removed from the vehicle and the process took an average of 3 hours 35 minutes to complete. Areas to be cleaned were outlined on the check list and included ceilings, walls, work surfaces, waste receptacles and oxygen areas.

Eleven deep clean audits occurred between March 2022 and October 2022. These looked at the vehicle exterior, vehicle cab interior, vehicle saloon interior and equipment within the ambulance to see if they were visibly clean. No areas of concerns had been identified.

Staff followed infection control principles including the use of personal protective equipment (PPE). All ambulances held level 2 and level 3 PPE. Level 2 PPE included disposable aprons, fluid resistant surgical masks, eye protection and disposable gloves. Level 3 PPE included fluid repellent coveralls and FFP3 face masks. Level 3 PPE was required to be used on calls where the patient was highly contagious, such as possible COVID-19 infection or infection with Monkey Pox. All staff had been fit tested for the FFP3 masks, which meant that the service could be assured that the facemasks were providing adequate protection.

Staff were observed to be bare below the elbow, which improves the effectiveness of hand hygiene. Hand gel was available on all ambulances and staff told us that they washed their hands when in hospitals. The station had a sink specifically used for handwashing, and a poster demonstrating effective hand washing techniques was above the sink.

We saw evidence of 16 uniform audits which had been completed between August and October 2022. The audits looked at uniform standards, a demonstration of good hand hygiene procedures, access to non-alcohol hand gel on staff belts, and presence of an identification badge. All audits showed that staff were compliant. The audit forms had a comments box at the bottom to highlight any actions taken if audits showed non-compliance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Antibacterial wipes were available on each ambulance, which were used to wipe down stretchers and surfaces in between patients. If an ambulance became contaminated during a shift, the crew returned the ambulance back to the station. The station

had 2 spare ambulances. We saw one vehicle during our inspection clearly marked with vehicle off road (V.O.R) signs in the windscreen, stating it was in quarantine and required an enhanced clean. The quarantine V.O.R sign informed staff not to access this vehicle without PPE. This vehicle had been contaminated with vomit during a call and required an enhanced clean.

Once a vehicle was cleaned and ready to use, the make ready team displayed a 'made ready' sign in the windscreen.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. Fire escapes were clearly marked, and fire extinguishers were available in prominent positions throughout the station. The service secured fire extinguishers to the wall and they were marked with servicing dates. This was in line with the Regulatory Reform (Fire Safety) Order 2005.

The ambulance station was spacious, clean and tidy. Vehicles could easily access and exit the station through electric shutter doors. The station had ample space for 11 ambulances, and the service planned to increase capacity by bringing another ambulance from Rainham.

The ambulances were converted box vans under the government's Individual Vehicle Approval scheme, which was required for modified goods vehicles. Managers told us they were keen to use box vans as these were known to have less motion in the back which reduced the likelihood of motion sickness. The ambulances were compliant with the National Ambulance Vehicle Specification, which was based on the British and European Standard (BS EN 1789). Satellite Navigation systems were available onboard each vehicle.

CCTV was present within the ambulance station and within the medicine's storeroom.

The station had a kitchen, sluice room, toilet facilities and a shower, a secure medicine storeroom, a quarantine room for faulty equipment and an upstairs office space/training room.

Staff carried out daily safety checks of specialist equipment. Crew members were required to complete a vehicle damage report (VDR) at the start of each shift. This included an inspection of the vehicle and an inspection of equipment. We looked at 10 VDR checklists which confirmed they were being used by crews.

At the end of the shift, crews were required to complete a daily vehicle stock usage sheet. Crews noted all equipment used during the shift and if there had been any damage to equipment on this sheet.

The service had a report of medical devices defect policy, which stated that it was the responsibility of all staff to ensure that medical devices were operating correctly. Any defects were reported on a medical devices defect form and handed to the relevant manager. If managers were notified verbally, it needed to be followed up with a written report.

We saw evidence of faulty brakes on a stretcher being reported on the medical device defect report. The report outlined the checks carried out and actions taken.

Good

Emergency and urgent care

The service had purchased all vehicles in 2021 and all were still under a 3 year warranty. This meant all servicing and maintenance was carried out by the manufacturer. In the event of a breakdown whilst on the road, a breakdown service was included in its warranty. Managers told us they would look at other breakdown cover for the vehicles once warranty lapsed.

All keys for the ambulances were kept secure within a safe.

The service had contracts with external companies to service its equipment, carry out the required portable appliance testing (PAT) and calibrate the equipment. Calibrating equipment ensures a maintenance of accuracy and repeatability. We saw certification of calibration for 2 different sets of equipment and servicing and maintenance schedules for spinal boards and carry chairs.

The service's IPC lead had received certified training from 2 manufacturers. They were accredited to service ambulance trolleys, compact chairs, scoops and boards, so servicing of this equipment could be carried out internally.

The service had enough suitable equipment to help them to safely care for patients. The service had a total of 16 frontline ambulances within its fleet. Eleven of these vehicles were kept at the Thame ambulance station and used for the 9 shifts per day that the service was contracted to fulfil with the trust. Having an excess of vehicles meant that the service could provide additional shifts when required and had spare vehicles to use if a vehicle was off road. The remaining 5 ambulances were located at the head office and were to be used if other contracts with other trusts came to tender.

The ambulances were loaded with equipment according to a loading list. The ambulances we inspected were all stocked accordingly. Managers told us that the load sheets were over the expected requirements from the trust and gave sufficient equipment for the crews to attend 3 complex jobs, such as cardiac arrests. As the trust covered a large geographical area, this reduced the likelihood of crews needing to return to the base ambulance station to restock on equipment mid-shift.

Faulty equipment was marked with a red quarantine sticker and placed in the quarantine room, and this was recorded on the daily vehicle stock usage sheet.

The service had suitable facilities to meet the needs of patients' families. Each ambulance had a 5 point harness used to transport children or crews used a child's own car seat.

The service did not have specialist vehicles, such as bariatric vehicles or secure mental health vehicles.

Staff recorded what equipment had been used on the trust's electronic patient record forms (PRFs) which were accessed on electronic patient care record (EPCR) tablets.

Staff disposed of clinical waste safely. Clinical waste bins and sharps bins were stored correctly and securely on each ambulance we inspected. Clinical waste bins were locked and stored within the ambulance station. A general waste bin was locked and stored externally. The service had a contract with a waste management company to collect the clinical waste. The waste management company complied with Section 34 of the Environmental Protection Act 1990 and took infectious clinical waste for treatment, infectious sharps waste for incineration and feminine hygiene waste.

Staff told us that they would dispose of the clinical waste back at the ambulance station or within the hospitals that they visited. One crew member told us that when they deal with a complex case, such as a cardiac arrest, this can generate a lot of clinical waste. Therefore, they would dispose of the clinical waste from that job within the hospital when they had transferred the patient.

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 used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Score (NEWS) tool, when prompted to on the electronic PRFs. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration on adult patients. Training records showed that staff had received training in NEWS2 and training on identifying sepsis.

Staff had 24-hour access to the clinical support desks of the trust if they needed specialist clinical advice on scene. If required, staff told us that they would pre-alert the nearest hospital to inform them that they were arriving with a seriously unwell patient.

Staff knew about and dealt with any specific risk issues. The service communicated any updates from the trust to all staff through emails. Important documents and policies were stored on an online storage drive, which staff members accessed on their mobile phones. The most recent communication was regarding the increased incidence of monkey pox infection within the UK. We saw posters in the ambulance station which gave information on monkey pox. Managers told us urgent communications were emailed to all staff, stored on the online storage drive, displayed on station walls and in the cabs of the ambulances, ensuring the information was disseminated to all.

Staff were able to access pathways documents which were stored on an internet storage drive on their mobile telephones. The pathways documents gave crews advice on urgent care pathways and community pathways. One crew member told us how useful the pathways documents were, especially when not conveying patients to hospital. We saw different pathways documents relating to falls, head injury, surgical referrals and GP services.

The service had 24-hour access to mental health liaison and specialist mental health support. They accessed support from the trust's clinical support desk. Staff told us when accessing this support, they had found it helpful.

Staff shared key information to keep patients safe when handing over their care to others. They communicated key information on history, treatment and medicines administered to the patient when handing over care to Hospital Ambulance Liaison Officers (HALOs).

Staff told us of occasions when they had communicated with service users' GPs when they had not needed to be conveyed to hospital. GP details could be found on the EPCR tablets.

Staffing

The service had enough staff to fulfil contracted shifts. Staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Good

Emergency and urgent care

The service had enough staff to fulfil all shifts. The service had 20 employed staff members, 32 subcontracted staff members and 3 staff members on a zero hours contract. There were 11 subcontracted paramedics at the time of the inspection. Managers told us the 'ideal' number of employed paramedics would be a minimum of 12. This would increase if the service was successful in tendering new contracts with other trusts.

The service was contracted to provide 9 shifts per day for the existing contract. Managers told us that the service was able to offer more shifts, as they had an excess of ambulances. They had completed 11 shifts on some days in the month prior to the inspection.

Subcontracted staff were required to notify the service on what shifts they could cover a month in advance. Managers told us that their aim was to have more employed staff providing them with more consistency. The service had experienced delays in subcontracted staff notifying them of their availability for the following month, which meant that they could not offer more shifts until they had confirmation from subcontracted staff which shifts they could cover.

We saw meeting minutes from a contract review meeting which was held with the trust in June 2022. The service had informed the trust about its plans to increase the capacity of the staff by sponsoring paramedics from Ireland through conversion courses. The service was also interviewing a further 6 UK paramedics at the time of the meeting.

Managers accurately calculated and reviewed the number and grade of staff members needed for each shift in accordance with national guidance. The trust determined the skill mix on each shift. For newly qualified paramedics or new staff, the service aimed for 3 people to be on these shifts to give additional support.

Managers limited their use of bank and agency staff and used staff familiar with the service. They made sure all staff had a full induction and understood the service. They used a bank of subcontracted staff who notified the service of what shifts they could cover a month.

Records

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

Patient notes were comprehensive and crews could access them easily. Staff used the NHS ambulance service's electronic patient record forms (PRFs) which were accessed on electronic patient care reporting (EPCR) tablets.

All sections of the electronic PRFs were accessed from a main menu, and as each section was filled in, the data was updated to a secure portal. The electronic PRF was designed to be familiar to those staff members who used paper PRFs and included sections for a description of the incident, observations, patient consent, assessments, notes and supporting forms. The coloured dials on the menu changed colour to green once the section had been completed and stayed red if no information had been recorded in that section.

Once all the relevant sections of the PRFs had been completed, crews submitted the records. Records could be edited after they had been submitted as complete, but an audit log was kept of any changes made.

The service had completed an audit of 24 records, while these were generally positive there were some areas where improvements were required. These included detailing patient ethnicity and time of hand over. The NHS trust for whom the service worked also undertook records audit and shared the outcomes with the management team. We were told that any concerns were raised with the staff member directly.

Records were stored securely on a digital platform by the trust.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The service stored and managed all medicines safely. We saw evidence of systems and processes in place for the management of medicines. The medicines management policy stated that the service was committed to the safe and secure management of medicines. Audits were carried out weekly and staff members were required to sign when they took medicines out on their shifts.

Medicines for each grade of staff were stored in tagged bags. The tags were colour coded to show if the bags needed to be refilled with red, green and blue tags. We inspected a paramedic bag and a technician bag against the logbook and saw all medicines were in date and correct according to the log.

All vehicles carried medical oxygen and nitrous oxide and oxygen. We saw that these medical gases were stored correctly both in the station and on the ambulances.

The service had a Home Office licence to store controlled drugs (CDs). The licence had expired on the 23 August 2022. However, a new application had been requested on 6 July 2022. The service had been inspected by the Home Office on the 5 July 2022 in respect to the previous year's licence. The controlled drugs accountable officer was the registered manager. They had the responsibility to ensure the safe and effective management of CDs within the service.

CDs were stored securely in a safe which was double locked. The medicines room was alarmed and was covered by CCTV. The room was temperature controlled and a log was evident which recorded the temperatures daily. The service stored one medicine in a fridge. This was located upstairs in the office area. Managers told us that they had moved the fridge out of the medicines room as it was making the room too hot. The fridge was locked, the temperature of the fridge was displayed and within the expected temperature range.

Vehicles had a secure drugs safe which were used to store controlled drugs. Keys to the safe were stored with the vehicle keys. If the crew on that vehicle were a mixed crew of paramedic and technician, the paramedic would remove the safe key from the vehicle keys and attach them to their belt with a carabiner clip. On mixed crews, technicians would be allocated to drive. Only paramedics were able to administer CDs.

Correct systems and processes were in place for the safe disposal of medicines. Records tracked the medicine from expiry and removal from use to disposal.

Staff followed systems and processes to prescribe and administer medicines safely. Staff followed patient group directives (PGDs) when administering medicines. PGDs are written instructions outlining who can administer medicines and are written by a multi-disciplinary group including a doctor and a pharmacist. The PGDs outlined the clinical condition for which each PGD applied, the criteria for when the medicine should be used or not used, (for example, for children under 16) and any cautions that should be observed. Staff could access the PGDs on the online storage drive. We saw PGDs for 16 different medicines and all were within date and signed by the medical director of the service, a senior pharmacist and the registered manager of the service. Members of staff were required to sign a registered health professional authorisation sheet to confirm that they agreed to work within the PGD and only within the bounds of their own competencies and professional code of conduct.

Staff completed medicines records accurately and kept them up-to-date. Staff recorded what medicines had been administered to service users on electronic PRFs. Medicines were selected from a list, which included the required dosage for each medicine. Staff had the option to select 'medicines supplied' when patients were given the medicine to administer themselves.

Incidents

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

Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with trust policy. They would report incidents on an incident reporting form either directly to the service or through the trust. They gave examples of incidents that they had reported. One staff member told us that they had reported a fault on the emergency button within the ambulance to the trust.

The service had reported 26 incidents to the trust in the 12 months prior to the inspection. We saw evidence of investigation into 2 of these incidents.

Staff informed managers that they had reported incidents to the trust on daily run sheets. The daily run sheets were completed by crew members for each shift and included details of all calls that they had attended and if the vehicle was taken off road. We saw a log sheet which indicated an incident was reported when a member of public had attacked the ambulance. This meant that the service was kept informed of any incidents that had been reported directly to the trust.

Staff did not have access to airwave radios through this trust. Staff were required to dial 999 if they were in a dangerous situation when outside of their vehicle. Staff told us that they had refused to attend to a patient who was threatening to kill, as they did not have access to airwave radio and police back up was not available. Managers at the service fully supported the decision made by the crew.

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 spoke with 5 members of staff who had good knowledge and understanding of duty of candour. The service's duty of candour policy stated it aimed to promote a culture of openness, which it saw as a prerequisite to improving safety and quality of a patient's experience. Training in duty of candour was completed by all staff during induction.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Managers discussed incidents within the monthly governance meetings that they had with the trust. However, 3 staff members told us that they had not received feedback on any incidents that they had reported. One member of staff described how managers had positively supported them following an incident.

Staff received feedback and looked at improvements to patient care. Communications of feedback and changes were communicated through email and on the online storage drive due to staff working at different shift times.

Good

Emergency and urgent care

There was evidence that changes had been made as a result of feedback. One incident was reported to the trust regarding a service user who had taken an overdose and was known to be violent. Crew members raised concerns and following an investigation into the incident, an alert warning was added to the online system, which would help crews if a similar occurrence were to happen again. This was communicated to the service through an e-mail.

Are Emergency and urgent care effective?

Good

This was the first time the service had been inspected. 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 protected the rights of patients subject to the Mental Health Act 1983.

Staff followed the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) national guidelines. JRCALC combines expert advice with practical guidance to help paramedic crews in providing safe and high-quality patient care. Staff accessed the JRCALC guidelines from an app on their mobile telephones and the trust's EPCR tablets. Staff told us that they also followed National Institute of Clinical Excellence (NICE) guidance, and the British National Formulary (BNF) for guidance on prescribing medicines.

Staff followed up-to-date policies and pathways to plan and deliver high quality care according to best practice and national guidance. They accessed the trust's policies and pathways on the online storage drive and through the EPCR tablets. These included, but were not limited to, clinical pathways, urgent care pathways, operation policy and procedures and clinical directives. Staff also were able to access the current Resource Escalation Action Plan (REAP) levels, which indicated operation pressures, medicines memos, drug alerts and any 'hot news' topics, so they were fully informed.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. This was covered in detail in the capacity to consent policy which was issued to all staff on the online storage drive and was also covered in induction training. Staff who we spoke with had sound knowledge of the Mental Health Act.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff were prompted to obtain a pain score within the observations section of the electronic PRF. Staff told us that they would ask patients to score their pain on a level of 1 to 10. They told us that they sometimes used a pain rating tool, which showed a variety of facial expressions and allowed service users to indicate the level of pain they were experiencing by pointing to the one that resembled their level of pain.

Staff administered and recorded pain relief accurately. Staff had access to a variety of pain relief medicines on all ambulances. This included paracetamol, nitrous oxide and oxygen (gas and air), and morphine. All pain relief medicines were in date and stored correctly. Staff recorded the pain relief given on the electronic PRF, including who administered it.

Response times

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

Staff completed daily run sheets during each shift, which reflected calls attended, and time spent. The run sheets gave the following information:

- The original call time, crew call time and location when the call was received
- Mobile time, the time it took to get to the patient
- Patient pick up location, time arrived on scene and time left scene
- Patient drop off location, time arrived at drop off locations, handover time and time of clearing the hospital and available for the next call.

The trust monitored the same parameters through the information they received from the EPCR tablets and compared them to Key Performance Indicators (KPIs). They looked at parameters such as on scene duration when patients were not conveyed to hospital, time taken to get from on-scene to hospital, and clear up time at the hospital (handover of the patient and being back on the road and available for another call).

We saw evidence of an evaluation of the KPIs from a presentation from the trust in September 2022. During the month of August 2022, staff from the service had been called to 1279 calls. Of the 1279 calls:

- 928 were active mobile calls, which meant that they were not stood down
- It took an average time of 15 minutes and 25 seconds to arrive on scene to these calls
- 465 calls were not conveyed to hospital, and these calls took an average time of 1 hour, 7 minutes and 34 seconds
- 476 calls were conveyed to hospital, with on scene durations averaging at 45 minutes and 36 seconds
- It took an average of 23 minutes and 51 seconds to convey patients to hospital
- Clear up duration times were an average of 16 minutes and 50 seconds.

The KPI performance was compared to other Independent Ambulance Providers and to the performance of the trusts own staff. However, this was not a fair comparison compared to other services, as it did not give a reflection of how many calls the other independent ambulance providers had attended. The data showed that staff from Phoenix Response Services had been improving in meeting the KPI targets, and minutes from a contract review meeting which took place in June 2022 showed that the service had achieved a 3 and a half minute improvement in times of conveyed patients compared to the previous quarter. (The KPI for time on scene for patients who are conveyed to hospital was a target of below 40 minutes). The KPI target for time on scene with patients who were not conveyed to hospital was below 1 hour. The meeting minutes from June 2022 showed that the service had achieved a reduction by 9 minutes compared to the previous quarter in terms of time on scene with patients who were not conveyed to hospital and were showing an improving trend and continuous improvement in terms of clear up times from hospitals.

The meeting minutes from June 2022 showed that there had been a reduction in overall job cycle times of 5 and a half minutes compared to the previous quarter. The Trust commended the service for this improvement.

Good

Emergency and urgent care

Patient outcomes

The Trust monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The trust monitored key performance indicators (KPIs) and shared a report of these with the service each month. These reports looked at how long it took crews from the service to arrive at different categories of calls. Category 1 calls are for people with life threatening injuries and illnesses, and the aim is to be on scene within 8 minutes. We saw that from 32 category 1 arrest or peri-arrest calls, 24 were under 8 minutes and a further 4 were just over 8 minutes. The service was not in control of where their crews were dispatched, and therefore could not always impact on the response times. The report also looked at time on scene and clear up time (which is the time for crews to be back on the road after a handover of a patient, which aims to be under 15 minutes).

Managers and staff used the results to improve patients' outcomes. We saw evidence from meeting minutes with the trust that the service was showing consistent improvements on the KPIs each quarter. Improvements were checked and monitored.

Managers planned to carry out a comprehensive programme of repeated audits to check improvement over time. Auditing of IPC was embedded, with the IPC lead conducting audits of the cleanliness of the vehicles, and uniform and hand washing audits of staff. The head of governance had been employed to conduct audits of records but was not fully embedded into their role. We saw 1 audit of records which had been completed in September 2022. It was not clear what other parameters they were going to audit.

It was not clear if managers used information from the audits to improve care and treatment. We did not see evidence of any action taken documented on the audits. Managers told us that concerns raised from audits of records would be raised directly with the staff members involved.

Competent staff

The service made sure staff were competent for their roles. Clinical appraisals took place for staffing training. However, annual staff appraisals and supervision meetings to provide support and development were yet to start. were yet to start.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff consisted of assistant ambulance practitioners, emergency care assistants, ambulance technicians and paramedics. Staff were either employed or subcontracted to the service. The trust would not deploy the staff member if they did not have evidence of completion of all mandatory training.

EUC staff who were responsible for driving ambulances had ‘blue light’ training, which gave them the skills, knowledge and understanding that is required to drive a vehicle using blue lights and sirens.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us that they had received induction training. They completed a new starter corporate, equipment and site induction document. They were required to sign off each induction activity when they had completed it. Both the new starter and the line manager signed the induction form, to confirm that they had received the necessary training listed in the document.

The trust provided the service with a local induction checklist, which outlined induction training that they required new staff to complete. This included training in reporting incidents, IPC, confirming an understanding of key policies and issue of a PIN number which would enable the member of staff to work for the trust.

Managers had not yet supported all staff to develop through constructive appraisals of their work. The service had provided us with an appraisal programme which it intended to use for all employed staff. It was the service's intention to carry out yearly appraisals on all employed staff. Clinical appraisals were completed for apprentices and staff who were training.

At the time of the inspection, the service had not completed any staff appraisals. The service informed us that this was because the first employed member of staff was employed in November 2021. This was confirmed when we looked at the staff register, which listed staff grades, employment status and the starting date.

The service had employed a new head of governance in February 2022, who would be responsible for completing staff appraisals and clinical appraisals. We saw evidence of 4 clinical appraisal documents which had been completed between August and September 2022 for 2 trainee emergency care assistants, 1 trainee assistant ambulance practitioner and 1 trainee paramedic. The clinical appraisals looked at a variety of tasks, which included but was not limited to; if consent was gained, if allergies were documented, if drug administration was counter checked and administered as per guidelines and if a minimum of 3 sets of observations had been carried out. The clinical appraisal documents included a recommended action plan, but none of the documents we saw had any actions recommended. Clinical appraisals were repeated every 3 months for staff who were training.

Staff had the opportunity to discuss training needs with their line manager. The head of governance was the designated paramedic mentor and clinical lead for the service and their role included identifying and supporting staff to undertake further training.

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 with Hospital Ambulance Liaison Officers (HALOs) within emergency departments, to hand over patient care. Managers told us that the aim was to handover care of service users within a 15 minute time frame of arriving at the hospital. HALOs work at acute hospital trusts to prevent lengthy delays when the ambulances reach the emergency department, meaning that crews are freed up more quickly to be allocated to other jobs.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service worked with the trust to deliver Same Day Emergency Care (SDEC) and Urgent Community Response (UCR) pathways to patients. The SDEC service was in operation for 12 hours per day at the time of the inspection. Ambulance clinicians could refer service users to SDEC clinicians via a telephone call. Staff told us that they could access contact with service users GPs and other health professionals through the EPCR tablets.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. They could access 24 hour support from the trusts clinical support team or refer service users experiencing a mental health crisis for urgent treatment through the UCR pathway. The crisis response was co-ordinated through a local single point of access, with assessment and care aimed to be started in under 2 hours of the referral.

Health Promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. It was not always feasible for staff to give service users advice on leading healthier lifestyles, especially in an emergency. However, staff gave examples when they had given smoking cessation advice to a service user who had Chronic Obstructive Pulmonary Disease (COPD).

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. 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 capacity to consent Policy, which was available to all staff on the online storage drive. The policy outlined what consent was, the two stage test of capacity, acting in the best interests of the patients and assessing capacity.

Staff used a mental capacity assessment functional test tool, by following the prompts on the electronic PRF. This included prompts on whether the service user could understand the information, retain the information and if the service user could communicate their decision back to the crew. If staff required the assistance from police when assessing the capacity of a patient, the PRF prompted staff to include the police identification number in the record.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Staff recorded consent on the electronic PRFs. Patients provided their consent by pressing 2 buttons on the electronic device.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff followed the service's capacity to consent policy which stated, 'if a person has been assessed as lacking capacity, then any action taken or decision made for, or on behalf of that person, must be made in their best interests'. The policy gave guidelines on respecting service users decisions on advance decisions. An advanced decision is where a person aged 18 or over has set out what particular types of treatment they would not want to have and in what circumstances, should they lack the capacity to refuse consent themselves in the future.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. They understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Guidelines were clearly and thoroughly documented in the capacity to consent policy, which was accessed by staff on an online storage platform.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw evidence of staff training on consent, the Mental Capacity Act 2005 including Deprivation of Liberty Safeguards and reducing restraints in health and social care. Staff told us that they would always use the least restrictive options first and would take advice from the trust's clinical advisors.

Good

Emergency and urgent care

Are Emergency and urgent care caring?

Insufficient evidence to rate

This was the first time the service had been inspected.

We did not have enough evidence to rate caring.

Compassionate care

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

The service displayed posters which asked staff members, 'How much do you care?' The posters reminded staff that 'when attending patients, everything you do matters!' and to 'be proud of being the best you can be'. We spoke with 5 members who displayed the values outlined in the poster.

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. The 'How much do you care?' poster advised staff members to ensure that they listened to the patient, relative or representative. One staff member told us that talking with patients in a caring and compassionate manner can make a huge difference to a situation.

Patients said staff treated them well and with kindness. We saw evidence of a thank you card which had been posted to a crew member. It said, 'Thank you so much for coming to help us, you made a sorry situation less scary.'

Staff followed policy to keep patient care and treatment confidential. They followed the service's confidentiality policy and procedure which was available to them on the service's online storage drive.

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. The 'How Much Do You Care?' poster instructed staff to make sure that patient's choices were discussed and taken into account. One staff member told us that it was imperative that patients should be involved in their treatment as a patient who has been listened to will be happier and more trusting.

Patients and their families could not easily give feedback on the service and their treatment. At the time of the inspection, the service did not collect feedback directly from service users. Managers told us that they were due to implement a feedback form, which would be stored on the ambulances. Staff told us they had verbally signposted service users to give feedback through the Trust.

Are Emergency and urgent care responsive?

Good

Emergency and urgent care

Good

This was the first time the service had been inspected. 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 planned and organised services, so they met the needs of the local population. The service was provided through a contract with a trust and was not directly responsible for planning the service. The service had agreed to provide 9 shifts per day through the contract. but had capacity to provide up to 11 shifts per day if there was demand. Managers planned to tender contracts with other trusts and to expand the business.

Facilities and premises were appropriate for the services being delivered. The ambulance station in Thame, Oxfordshire was well placed to cover the wide geographical area covered by the trust. All ambulances were in excellent working condition, and the service prided itself on the quality of its fleet. The service had identified a need for more employed staff, so they could consistently fulfil the shift requirements they had contracts for, and were in the process of employing a further 20 paramedics

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 through the trust's clinical advisors. The service did not have specialist mental health vehicles but would contact the trust if they needed assistance with a service user experiencing a mental health crisis. Staff could refer service users experiencing a mental health crisis to the UCR pathway.

The service had systems to help care for patients in need of additional support or specialist intervention. The electronic PRFs guided staff members when completing JRCALC suicide risk assessments, falls risk assessments and safeguarding assessments. Staff followed the service's safe holding policy, which gave staff advice for when they required to restrain a service user. The policy stated that restraint should only occur in emergency situations and only used as a last resort. This policy designed to be read in conjunction with the service's safeguarding policy, airways management policy, resuscitation policy and management of cardiac chest pain procedure.

The service relieved pressure on hospitals by using the SDEC and UCR pathways. Staff told us that they had used these pathways and also contacted service users GPs to get help for patients, so they did not need to be conveyed to hospital.

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 mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff received mandatory training in dementia and learning disabilities. Staff told us that they could access support from the trust's clinical advisors when dealing with patients experiencing a mental health crisis or refer them to the UCR pathway, which aimed to get support to patients experiencing a mental health crisis within 2 hours.

Good

Emergency and urgent care

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The on scene conveyance and referral procedure policy stated that efforts should be made to ensure that communication is tailored to suit the needs of patients and they should be given time and support to understand the information. Staff were able to access the 'Big World' translation service or use carers or family members as interpreters when required. Staff were advised that discretion should be used, and consideration should be given to the patient's rights to confidentiality.

Managers made sure staff, and patients, and carers could get help from interpreters when needed. Staff had access to a translation service 24 hours a day and used this to communicate with patients when English was not their first language.

The service did not have information leaflets available in other languages spoken by the patients and local community.

Staff had access to communication aids to help patients become partners in their care and treatment. One staff member told us that they had communication picture aids stored on their mobile phone, which could be used with children or with people who struggled to communicate. Patients were able to point to the relevant picture to explain how they were feeling.

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.

Staff supported patients when they were transferred between services. Staff followed the service's on scene conveyance and referral procedure policy, which was created in line with local and national guidelines and the UK Ambulance Service Clinical Practice Guidelines. Staff also adhered to the trust's procedures.

Staff had access to tools and algorithms on their EPCR tablets and mobile phones which assisted them in their clinical decision making and gave advice on the appropriate emergency and urgent care pathways to follow. These were provided by the JRCALC app. Outcomes after following these guidelines could include transporting the patient to an urgent care centre, advising the patient to convey themselves to an urgent care centre if appropriate, or leaving the patient at scene for a visit by another clinician, such as the patient's GP. Staff who were ambulance technicians would need to get support from the trust's clinical advisors to confirm that non-conveyance to hospital was appropriate, only paramedics could make this decision independently.

Emergency and urgent care pathways would be followed, especially in cases requiring specialist care such as major trauma, stroke, heart attack and vascular services. Staff could also refer service users using the SDEC and UCR pathways.

Staff followed guidelines from The Royal College of Paediatrics and Child Health, which recommended that all children under the age of 2 must be conveyed to an appropriate A&E department following a 999 call.

For seriously unwell patients, a rapid response vehicle may be required. Phoenix Response Services did not have rapid response vehicles within its fleet. The Trust would supply these when appropriate.

Learning from complaints and concerns

Good

Emergency and urgent care

It was not easy for people to give feedback and raise concerns about care received directly to the service. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

The service did not clearly display information about how to raise a concern. This meant that service users did not always know how to give complaints, complements or feedback directly to the service. Managers told us that they planned to start using feedback leaflets shortly after the inspection. The service's complaints policy stated that complaints could be communicated verbally or in writing and may be addressed to any level of the organisation. The policy stated that all complaints would be recorded and logged by the head of resources.

Managers told us that the service had received some thank you cards directly from service users. The service's complaints policy stated that if a staff member received any compliments, letters of thanks or positive feedback, the service would write a note of thanks to the individual crew members involved. However, we did not see any evidence of this taking place.

Staff understood the policy on complaints and knew how to handle them. The complaints policy was available to all staff on the online storage drive. The policy stated that all complaints would aim to be acknowledged within 5 working days, and a full response provided in 21 working days.

Managers investigated complaints and identified themes. Managers discussed feedback with the trust during contract review meetings. Any complaints raised about the service's staff were investigated by managers of the service and the results of the investigation were fed back to the trust. The contractual arrangements were that investigation returns should be in 14 days, but the return times for the service were often in excess of 30 days. Managers told us that there was sometimes a delay in receiving the complaint from the trust, which impacted on their ability to fully investigate and respond within the timeframe. Data from the trust showed that the service had received 8 complaints in the third quarter of the year 2022. Three of these complaints were upheld and 4 were partially upheld after investigation from the service. The trust compared this to other independent ambulance providers but did not give the numbers of complaints received or the number of shifts carried out by the other independent ambulance services, so it was not a fair comparison. The trust had asked the service to focus on improving the return times for investigation reports and look at identifying causes for a higher than expected level of upheld complaints.

We saw evidence of investigations into 6 complaints. Investigation into complaints included witness statements, a review of records, and a complaint summary. The results of the investigations were shared with the trust and any actions which had been taken were included. Actions taken included sharing of memos to all staff and advising further training when required.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers from the service investigated complaints raised through the trust. The trust would then feedback the results of the investigation to the complainant.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw evidence of learning opportunities identified following the investigation of complaints and incidents, which was fed back to staff members. This included a recommendation from the trust for staff to familiarise themselves with the procedures around back up requests and a reminder for staff members to fully check patient details when collecting a patient for transport to a different hospital.

Good

Emergency and urgent care

Staff could give examples of how they used feedback to improve daily practice. The service was committed to learn from any complaints raised. We saw evidence of further training in trauma care and a continued professional development session being organised for all staff following a complaint regarding how a crew member handled a potential neck injury.

Are Emergency and urgent care well-led?

Requires Improvement

This was the first time the service had been inspected. We rated well led as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Most of the leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had been 'hand-picked' by the service's CEO and registered manager, to build a team with combined experience and knowledge. The registered manager had worked alongside the IPC lead and the head of resources in previous roles in other independent ambulance services. The fleet manager had started working in patient transport services (PTS) and used their skills to expand and train in vehicles management, stores and fleet. The director of finance was a shareholder in the business and the finance and governance support manager had a background in the ambulance industry.

The head of clinical governance had joined the service in February 2022, although due to other volunteering commitments, staff told us that they had not been visible in the service. The head of clinical governance was responsible for managing audits, complaints and incidents of a clinical nature and staff appraisals.

The service had appointed a medical director who was responsible for authorising the purchase of medicine for the service within the remit of the written PGDs, which had been approved by a pharmacist. The medical director gave advice to the clinical director and to paramedics and ambulance technicians around clinical scenarios.

All leaders and staff were appointed following a robust recruitment procedure. Staff had enhanced Disclosing and Barring Service (DBS) checks.

The registered manager had a network of contacts within the ambulance industry as they had worked in the industry for a long time.

The registered manager and the head of resources were both qualified trauma risk management (TRiM) practitioners. TRiM practitioners are trained to recognise operational stress in their colleagues and staff, and signpost them to find the early help they need. The head of resources had a Business and Technology Education Council (BTEC) level 5 Professional Award Supporting Trauma Risk Management qualification. The head of resources was planning to train and qualify as an ambulance technician, in order to provide peer review ride-alongs and staff appraisals.

Leaders used a UK based investigative skills and healthcare training company to identify courses to benefit themselves and the service. Through this company the registered manager had completed Controlled Drug Accountable Officer Training and fire risk assessment courses. The head of clinical governance had completed teacher training courses.

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.

Phoenix Response Services was founded with the mission to provide excellent pre-hospital healthcare services of proven quality and to ensure the highest standards of patient safety and welfare whilst delivering the best possible clinical care.

The aim of the service was to provide a safe response to the trust's needs, ensuring high quality care while listening to and involving patients with their treatment or pathway. They wanted to provide a service with patients at the heart of the service delivery.

The service's vision was to offer a high end, professional emergency response service, with high quality ambulances which were staffed by nationally recognised trained and prepared health care professionals.

Managers told us that they aimed to be 'the best out there' and wanted 'to be the biggest by being the best'. The registered manager told us that their aim was to make the independent ambulance sector look better and give commissioners confidence in what they do. They told us that their strategy was to treat people how they wished to be treated, and they aimed to be loyal and supportive to their staff.

The values of the service were discussed with staff at interview and at induction. The values included:

- To focus on people in every aspect of the service through a 'patient first' approach
- To place the quality of care provided to their patients as the highest priority within the organisation
- To ensure all practices within the company were regulated and governed ensuring a quality service to customers.
- To develop staff and ensure they understand the accountability for the roles in which they worked.

Managers set the service up in the middle of the COVID-19 pandemic. They had challenges on the way, as they lost 3 sets of investors, but were keen to fulfil their aims. The immediate aim was to tender a new contract with another trust. In addition to the 16 vehicles, the service could access another 3 ambulances if required which were a different model to the rest of the fleet. Managers preferred to keep a standardised fleet. The service had ordered a further 6 vehicles, but there were ongoing delays with getting new ambulances due delays in the supply of component parts.

The service had 2 older vehicles suitable to use for driver training. Managers were planning on recruiting 2 driving instructors to the service, to deliver blue light driver training both internally and external to the service. Managers believed that this would provide a much needed service and help to recruit more staff.

Managers were conscious of the need to manage the business responsibly. They acknowledged they were a small independent ambulance provider and did not have access to vast resources. To implement changes, managers would construct a business case to see if it was viable.

Good

Emergency and urgent care

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Managers had developed the service themselves, writing policies and procedures to reflect the values of the service.

We saw managers working in make-ready roles on the day of the inspection. Managers knew the make-ready system, as they had developed it for the service themselves, so were able to backfill when required. Staff were complementary about the managers and told us that they could contact the head of resources 24 hours a day if they had any issues. However, the head of clinical governance had not been visible, and none of the staff with who we spoke with had received an appraisal. Managers told us that the head of clinical governance had not been working to full capacity as they had pre-arranged commitments, but were 'the right person for the job and was worth waiting for.'

The welfare of staff was a priority for managers. The service had 2 TRiM practitioners who identified and supported staff who may be struggling. The TRiM practitioners would offer support and welfare checks for those who needed it and could refer staff on for counselling and occupational health support. The service was affiliated with a charity which offered free support for former military or 999 responder staff who were suffering with post traumatic stress disorder (PTSD). The charity offered a free confidential helpline which staff could use if they did not feel able to approach the TRiM practitioners. The service had 2 freedom to speak up guardians. Freedom to speak up guardians help staff to speak up when they feel that they are unable to in other ways.

Staff who worked over Christmas 2021 received double-time pay, despite the trust only offering time-and-a-half for these shifts. Managers of the service told us that they wanted to show their appreciation to their staff for their hard work over the previous year.

Governance

Leaders operated a combination of formal and informal governance processes, throughout the service and with partner organisations. It was not possible to assess the effectiveness of the informal, internal processes. Staff at all levels were clear about their roles and accountabilities.

The executive management committee for the service consisted of the chief executive officer, the head of resources, head of clinical governance, fleet manager, finance and governance support manager and the IPC and equipment manager. The executive management committee took advice from a medical director and a director of finance, who was a shareholder in the service.

Members of the executive management team oversaw operational team leaders and clinical team leaders, who in turn oversaw the work of the A&E operational crews and the make-ready operatives.

Leaders had developed a comprehensive list of 88 policies, listed on a register in the service's policies and procedures document. The documents included a review date. All policies were in date. Staff had access to the relevant clinical policies on the service's internet storage drive. In addition to this, the service had a list of 59 standards operating procedures, which included using a stretcher procedure, cleaning bodily fluid spillages procedure, linen disposal procedure and a complaints reporting procedure.

The service's governance framework policy outlined the essential skills expected of leaders. The policy stated that 'all meetings of the governance committee will be recorded and reviewed, ensuring that all actions are followed up on and completed effectively.' The service's executive management committee procedure stated that meetings of the executive management team would be held monthly or depending on operational demand. It stated, 'meeting dates will be diarised and extraordinary meetings may be called between regular meetings to discuss and resolve any critical issues arising' and 'the committee will be responsible for ensuring the necessary meetings are scheduled for those reporting the required information to the committee, ensuring that these are formal meetings with minutes recorded.' We did not see any evidence of any formal meetings being held since August 2021.

Managers told us that day to day issues were dealt with on an informal basis, as they worked together closely, and they wanted to react as issues arose. Formal meetings that were minuted would only be arranged if there was a bigger issue or if the executive management committee were reviewing policies and procedures for the service. We saw evidence of meeting minutes from 5 executive management committee meetings which took place between 3 February 2020 and 16 August 2021. These meetings were reviewing policies and procedures relevant to the service, such as reviewing the access arrangements to the quarantine room in the ambulance station and safe storage of the EPCR tablets. We did not see any meeting minutes from any meetings that had taken place in the year preceding the inspection.

Managers from the service met with the trust on a monthly and quarterly basis. We saw evidence of meeting minutes from 2 of the contract review meetings and data of safeguarding referrals made for quarter 1, quarter 2 and quarter 3 of 2022. The contract review meetings were attended by representatives from the trust and the director of finance and the head of resources from the service. Actions were raised during these meetings, which were noted on the meeting minutes and indicated who would be responsible for completing the action. Managers told us that the outcomes from these meetings would be discussed in person, and the meeting minutes shared with other relevant members of the executive management committee by email. We did not see any evidence of outcomes from these meetings being shared with other staff.

Management of risk, issues and performance

Leaders and teams used some 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.

The service had a risk register and had identified the main 3 risks as staffing, payment issues from the trust and cost of consumables and fuel. The service had 28 items listed on its risk register. The register was version controlled with evidence of review. The risk register highlighted possible consequences from the risk, and mitigating actions that were put in place to reduce the risk. Each risk was allocated to a responsible manager, and the risk register suggested how often the risk should be reviewed. It was unclear if these risks were discussed by the management team as there were no meeting minutes or notes.

Staffing had been identified as one of the top 3 risks for the service. To manage the risk posed from staffing levels, managers told us that they were on a constant recruitment drive. The service had employed 9 apprentice emergency care assistants in 2021 and were supporting them to develop and train up to become paramedics. The service had 8 apprentices working at the time of inspection. In addition to this, the service was recruiting 20 paramedics using an Irish training conversion course. Normally, paramedics trained in Ireland can only work as technicians in England. This initiative had started in October 2022 and had a cohort of 20 paramedics.

Staff had told us that they sometimes did not feel safe on certain jobs as they were not provided with airwave radios from the Trust. The provision of airwave radios was not on the risk register, but managers told us that it should be and were going to add it as a risk.

While some audits were undertaken and feedback meetings were undertaken with the trust where performance and quality monitoring indicators were discussed, it was unclear from the evidence provided how this information was used to gain assurance about the quality of the service and help drive improvement.

The service's business continuity management programme followed the NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response, 2013, and the International Standards Organisation (ISO): 22301: 2012. The ISO 22301:2012 specified requirements to plan, establish, implement, operate and continually improve a documented management system to protect against and reduce the likelihood of impact from disruptive incidents when they occur. The service was no longer accredited with ISO 2012, but still followed its principles.

The service had developed a clinical improvement strategy, which had the purpose of improving the care and treatment provided to patients. It stated that the service had a database which was populated with all incidents and which would be used to identify patterns and trends. For any shortfalls identified on the database, such as equipment faults, action plans would be devised and the service would adopt a 'lessons learnt' approach, disseminating the lessons to staff to reduce the chance of re-occurrence.

We did not see evidence of a database which listed incidents.

The service had developed a major incident plan which outlined the response which would be implemented during a major incident.

Information Management

The service did not always collect reliable data and did not always analyse it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were not consistently submitted to external organisations as required.

The service did not collect feedback directly from service users at the time of inspection. Feedback was communicated to managers from the Trust during monthly and quarterly meetings. The service planned to start using feedback forms which would encourage feedback directly to the service. A feedback form had been developed and the service had discussed the use of the feedback forms with the trust.

Staff were able to access policies specific to the service, and policies from the trust on an internet storage drive. This included accessing the JRCALC guidelines, clinical pathways documents and PGDs for medicine management.

Managers told us how they had communicated a change to all staff regarding the withdrawal of one of the medicines used by staff. Firstly, an email was sent to all staff and the update was uploaded onto the internet storage drive. A poster was displayed in the medicines room to make sure that all staff were aware of the communication.

Managers occasionally had to remind staff about parking issues outside the ambulance station. Crews who were working on one shift were required to both park in one bay. Emails were sent and a reminder was posted on the internet storage drive.

The service used the trust's IT systems to create patient care records, raise incidents or safeguarding referrals. This meant that the service did not hold patient's health records permanently, but the service's information governance policy stated that the service still followed the necessary legislation for the management of information for short term handling of patient health records. The service followed guidance from the Data Protection Act 1998, the General Data Protection Regulation (GDPR) 2016 and The Freedom of Information act 2000. If paper based patient records were created (if the electronic system had a fault or when working for other Trusts), the health records would be transported to the designated points in a secure manner, as directed by the relevant trust, at the agreed timeframe and to the agreed locations.

The trust shared spreadsheets on a quarterly basis which outlined the safeguarding referrals made by staff from the service. The spreadsheets gave the service information on the number of safeguarding referrals made, the date they were made and the date the referral was actioned, together with the call sign of the crew member. However, managers did not have good oversight on the referrals. Managers could not be assured that all safeguarding referrals made had been received and recorded. There was no information on the nature or a description of the referral, meaning the service was unable to monitor trends and themes. Nor could the service identify learning requirements from the data.

Under regulation 18 of the Care Quality Commission (Registration) Regulations 2009, the service was required to submit notifications of safeguarding referrals relating to abuse or allegations of abuse to CQC. The service had a policy for the procedure for making of statutory notifications. The policy stated that it was a legal requirement of the Health and Social Care Act 2014, that registered providers should make statutory notifications to CQC in the event of certain incidents and circumstances. At the time of inspection, no such notifications from the service had been received, although it was clear that staff members were reporting safeguarding issues.

The service did not have an audit tracker. The head of clinical governance had been appointed to complete regular clinical audits. At the time of the inspection, the service audited how visibly clean the vehicles were and carried out a monthly uniform audit, which included looking at hand washing techniques, completed by the IPC lead. Additionally, there was a robust auditing system of medicines carried out by the head of resources which was completed weekly.

The head of clinical governance had completed 1 audit of records in September 2022.

Engagement

The service did not always actively and openly engage with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service did not collect feedback directly from patients at the time of the inspection. This meant complaints, complements or feedback were not easily given directly to the service. Managers told us that they planned to start using feedback leaflets shortly after the inspection.

Staff were able to raise concerns and feedback with managers through a clinical services email address. The registered manager and the head of resources were visible within the ambulance station, and staff told us that they felt comfortable approaching them to discuss concerns. Managers encouraged input from staff members, with one member of staff requesting if a certain type of pain medicine could be used. Managers discussed the idea and fed back to the member of staff that this was not possible as the trust dictated which medicines were used on the contract. Another member of staff suggested carrying more quantities of a certain medicine, as they were frequently requiring to restock mid-shift. The service considered this suggestion, and implemented the change, as the trust policy stated that a minimum amount should be carried, not a maximum level.

Good

Emergency and urgent care

The service had developed a staff survey which asked staff how valued they felt, how satisfied they were with their working life and whether they would recommend working with Phoenix Response Services to their friends and family. However, at the time of the inspection, the service had not implemented the staff survey and therefore did not have any results to evidence the satisfaction of their staff.

Managers of the service met with representatives from the trust to discuss KPIs, staffing levels, audits of patient records, incidents, complaints and plans for the future on a monthly and quarterly basis.

Learning, continuous improvement and innovation

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

The service did not participate in any national audits or quality improvement measures.

The IPC lead for the service had trialled the use of new cleaning equipment and built in fogging machines on each ambulance. To monitor the effectiveness of these new initiatives, the IPC lead used an Adenosine Tri-Phosphate swabbing kit which was used to swab certain points within the ambulance before and after using the new cleaning products. This was compared to swabbing points on ambulance where the normal cleaning products were used, the results were analysed, and a decision was made if it was worth swapping over to the new products. The ATP swabbing kit was not used as a routine audit tool as the swabbing tips were expensive, at approximately 12 pounds each tip. It was not cost effective.

The service had started with 9 apprentice ambulance technicians, and at the time of inspection had 8 apprentices. The service was supporting the apprentices to develop and progress and at the time of the inspection, 1 apprentice was completing a technician's course and another one was booked to start the course in the following year. The service could not support all the apprentices to complete their training at the same time, as they needed staff on the ground. Apprentices were required to have reviews every 12 weeks and clinical appraisals every 6 months and the results of these were to be communicated to the trust.

Managers told us of an incident where one of their employees could not complete their driver training, as the driving training company could not insure the individual on their vehicles due to their age. The registered manager took insurance out for the individual, at monetary cost, but they wanted to support the employee to complete this training.

The clinical governance lead was arranging for a mental health nurse to provide continued professional development to staff around mental health.