Sharp-Fire and Rescue Limited

Sharp Medical Services - Dorset 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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

We have not previously rated this service.

We rated Sharp Medical Services inadequate because:

- There were not accurate records of the numbers of staff working for the organisation to provide assurance all staff were recruitment checked and received the appropriate level of training. The service did not control infection risk well with no regular record of cleaning or ongoing audit. The service did not store oxygen and control of substances hazardous to health safely and securely. Staff did not complete risk assessments ahead of and during the transfer of patients. Staff did not keep detailed records of patients care and treatment. There was no system to ensure medicines were stored at the correct temperature and medication audits were not routinely carried out. Staff did not always report incidents, incident investigations were not thorough, and lessons learned were not shared.
- Care and treatment was not being provided based on national guidance and evidence based practice. Staff were not trained to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Response times and quality outcomes were reported but not always used to facilitate good outcomes for patients and make improvements. It was not clear how competency was assured for all staff. The effectiveness of multidisciplinary working was not regularly reviewed.
- The service was not inclusive to take account of patients' individual needs and preferences. It was not easy for people to give feedback and raise concerns about care received.
- The delivery of high-quality care was not assured by the leadership. Effective governance processes were not being operated and risks, issues and performance were not well managed, identified and mitigated. There were no processes for monitoring and improving the quality of the service. Staff were not provided with opportunities to meet, discuss and learn from the performance of the service. Staff did not always feel respected, supported and valued or supported to raise their concerns.

However:

- Staff understood how to safeguard and protect patients from abuse with relevant training provided. There was enough suitable equipment and clinical waste was managed well.
- Staff worked together and with the local trust to deliver a service to transfer patients. Staff followed national guidance to gain patient's consent.
- The service was planned and provided to meet the needs of the contract to deliver transport services to patients. Patients overall received their transport in a timely way.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to Sharp Medical Services - Dorset Hub

Sharp Medical Services is a subgroup of Sharp Fire and Rescue, which was first registered on 28 July 2021.

The service provides staff and vehicles for non-emergency patient transport services, high dependency ambulance transport services, intensive care / critical care ambulance transport services and neonatal or paediatric specialist ambulance transport services. The provider was contracted to supply services to the local ambulance trust.

The provider also provides non-regulated activity which are out of scope of registration and therefore not included as part of our inspection. These include event medical care and treatment, long distance repatriations, aeromedical road transport, social care, and specialist and resilience inclement weather and rough terrain transport.

Sharp Medical Services has three patient transport service (PTS) transports, three first line vehicles, one high dependency vehicle, one vehicle with all terrain capability and three cars.

We were informed the provider employs 50 staff, to include 11 full time, five part time, and 34 bank staff. Bank staff include one doctor, five paramedics, and five ambulance technicians.

The provider undertakes 95% of its work with the local trust. The remaining five percent is described as event work which is not covered in our current scope of registration and therefore did not form part of our inspection. The provider's quality report for December 2021 to February 2022 stated the service carried out 2,917 patient journeys, and for March 2022 to May 2022 1,948 patient journeys. Senior leaders told us they do not, currently, provide an emergency service.

The Regulated Activities for this service are.

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

This is the first time the service has been inspected.

How we carried out this inspection

The team that inspected the service comprised of a CQC lead inspector, an inspection manager and a specialist advisor with experience in emergency and urgent care. The inspection was overseen by Catherine Campbell, Head of Hospital Inspection.

This inspection took place on 7 September 2022 and was unannounced. We spoke with six members of staff and looked at five staff files. The provider did not keep patient files. After the inspection, we requested and reviewed further information.

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

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider 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.

Should the provider have not de registered we would have taken the following actions.

Action the service MUST take to improve:

- The service must ensure medicines are managed safely and in line with guidance. They must introduce systems to conduct comprehensive medicines audits, store medicines in compliance with manufacturers recommendations, record fridge and room temperatures consistently and develop a procedure to alert staff if temperatures are exceeded. (Regulation 12(g)).
- The service must ensure systems or processes are established and operated effectively to assess, monitor and mitigate risks. The risk register did not accurately detail the risks faced by the organisation and the actions planned to mitigate risks. The business continuity plan was not up to date and there was no evidence staff had been trained in their roles and responsibilities (Regulation,17(1)).
- The service must undertake an infection control audit in line with guidance from Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. The service must ensure it has ongoing systems and processes, including regular audits, to identify, monitor, escalate and mitigate infection control risk. (Regulation 15(2)) (Regulation 17(2)(a)).
- The service must ensure it has systems and processes to assess, monitor and drive improvement for the quality of the service. This includes undertaking regular health and safety audits and producing an action plan to address shortfalls. This ensures that staff are made aware of lessons learnt from incident investigations and know how to escalate risks to a relevant external body as appropriate. (Regulation 17(b)).
- The service must ensure it undertakes risk assessments and provides training to comply with the mental health act code of practice for the transportation of detained patients. (Regulation 12(1)).
- The service must ensure that it keeps accurate records of the numbers of staff working for the organisation and that all staff are recruitment checked and receive the appropriate level of training (Regulation 18(1))
- The service must record, maintain and store its own patient records and risk assessments for the provision of regulated activity. (Regulation,17(1)).

Action the service SHOULD take to improve:

- The service should consider introducing training evaluation forms to monitor the quality of the training provided.
- The provider should ensure that the manual handling training for staff includes the subject of controversial techniques and why they should not be used in manually handling a patient.
- The service should store oxygen safely and continually risk assess the storage arrangements.
- The service should store control of substances hazardous to health securely and in line with regulations.
- The service should ensure information about how to make a complaint is readily accessible in different formats to meet the needs of all patients.
- The service should ensure staff receive training on the Mental Health Act 1983 and the accompanying code of practice.
- Review how to obtain regular patient feedback to enable improvements made to the service to be reflective of the local population and meet patient needs.

Summary of this inspection

- The Service should ensure that staff have access to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inadequate

Emergency and urgent care

Safe	Inadequate
Effective	Inadequate
Caring	Insufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate

Are Emergency and urgent care safe?

Inadequate

This was the first time we rated this service. We rated it as inadequate.

This is because there is limited assurance about safety.

Mandatory training

The service provided mandatory training, but we could not be assured records covered all staff to evidence they had appropriate, completed and up to date training.

Managers monitored mandatory training for 50 of the staff and alerted staff when they needed to update their training. However, we were not assured training records covered all staff who worked for the provider due to conflicting staff numbers provided to us during our inspection.

Most staff received and kept up to date with their mandatory training. Training records showed 100% compliance for 50 employed staff. We looked at 50 staff training records, all staff were recorded as having completed an induction. The service provided training in dementia awareness, and mental health awareness, however we did not see evidence training in supporting people with learning disabilities or autism was provided.

There were no processes to monitor the quality and effectiveness of training. A senior member of staff recently recruited to the organisation told us they had a very good induction including a good level of training in manual handling. However, we spoke with three members of staff who told us training in manual handling was not comprehensive, they received one session and were expected to learn on the job and did not feel the training was enough. There were no training evaluation records for the manual handling, this meant the provider was not aware staff were unhappy with the level of training provided. We reviewed the induction programme, which included a description of the techniques taught in manual handling. This did not detail the use of controversial techniques, techniques that while not illegal, should not be used due to risk to the patient and should be included in the training of staff.

Safeguarding

Inadequate

Emergency and urgent care

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. We saw training records for 50 staff which showed 100% safeguarding training compliance. The registered manager was the safeguarding lead and we saw evidence they had appropriate training to level three in child and adult safeguarding. Clinicians were trained in safeguarding to level three children and level three adults, and patient transport services staff were trained to level two adults and level two children, this is in line with the intercollegiate guidance on children and adult safeguarding 2018 and 2019 respectively.

Staff knew how to identify adults and children at risk of or suffering significant harm and followed processes to report abuse. The provider's safeguarding policy was last updated in November 2021.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Control measures were not followed to protect patients, staff and others from infection. Equipment, vehicles and the premises were observed to be visibly clean.

The provider had policies and staff were trained in infection control. The provider's infection prevention and control policy were reviewed annually and last updated in October 2021. We saw the training records for 50 staff which showed 100% of staff had completed infection control training.

Areas were observed to be clean and well maintained. The vehicles and premises looked visibly clean during our inspection visit.

Cleaning records were not up to date to demonstrate all areas were cleaned regularly. We were not assured vehicles were being cleaned regularly and in line with provider policy. We saw deep clean records for 11 vehicle and were told by a senior member of staff the deep cleaning of vehicles was based on a six-weekly cycle, with interim deep cleans when necessary. For example, following bodily fluids spill, or risk of other cross contamination. Of the vehicle records seen only 10 vehicles had been recorded as having been deep cleaned on one occasion between September 2021 and December 2021, and one vehicle as having undergone a deep clean in June 2022. There was no evidence to show vehicles were being deep cleaned regularly. We reviewed the daily cleaning records for all vehicles and found only seven out of 11 vehicles had been cleaned between August 2022 and September 2022. Following inspection, we were provided with the cleaning schedule for these dates and observed records completed on only 19 occasions, with ten recorded after our inspection date.

Staff followed infection control principles including the use of personal protective equipment. Senior leaders told us they carry out hand hygiene audits, we requested copies of these, but the provider did not send them to us. We saw evidence that 42% of staff had not completed an assessment of their hand hygiene knowledge and technique.

There was no infection control audit to identify, monitor, escalate and mitigate infection control risk. We looked at the environmental audit of the premises which had been carried out by the registered manager on 13 September 2022, this audit covered several environmental items but did not incorporate an infection control assessment.

Environment and equipment

Inadequate

Emergency and urgent care

The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people safe.

The provider had enough suitable equipment to help them to safely care for patients. We saw records showing staff carried out daily safety checks of specialist equipment. We were shown evidence portable appliance testing (ensuring electrical equipment is maintained in order to prevent danger) had been completed recently, several appliances were marked as having failed the test. Safety labels had been appropriately attached to the equipment and it had been taken out of use.

Vehicles were suitable and well maintained. We inspected six ambulances all of which appeared in good external condition, and all interiors were visibly clean. However, one vehicle had ripped seats with padding exposed, which could provide an increased risk of infection to service users.

Medical equipment was not always stored safely. Oxygen cylinders were not stored safely and there was no risk assessment for their safe storage. The cylinders were surrounded by flammable materials and there was a lack of hazard warning signage for the storage of oxygen. We raised this concern during our inspection and the provider resolved this problem straight away. We also found an unsecured medical gas cannister in one vehicle and an unsecured sharps waste container in a second vehicle.

The control of substances hazardous to health (COSHH) were not secure. The COSHH cabinet, was situated in the disabled toilet and was accessible by both staff and visitors and unlocked. This was not compliant with the COSHH Regulations (Control of Substances Hazardous to Health regulations 2002 (as amended)). We raised this concern during our inspection and were given assurance by a senior manager that these issues would be addressed that day.

Staff disposed of clinical waste safely, and we saw a service level agreement from May 2022 with a clinical waste disposal company for disposal of sharps, pharmaceuticals, and hazardous clinical waste.

During our onsite inspection we were not assured restraint for transporting children was available and appropriately used. We found the vehicles used for this purpose did not contain child safety seats, or child harnesses. We expressed concerns over the welfare of children being transported by the service and the use of seat belts and child harnesses. The provider confirmed they had the appropriate equipment available. We were subsequently provided with photographic evidence of staff with bags labelled as containing child restraints and three pictures of seats with harness seatbelts fitted and three seats with what appeared to be, a booster attachment.

We were also provided with copies of a template of an induction workbook on transporting paediatric patients in an ambulance. This included a section on a child restraint system and a section for staff to record competency with identifying the child safety restraint, and checking, fitting, storing the product, and knowledge of the procedure to follow if the equipment failed its checks.

Assessing and responding to patient risk

Staff did not complete and update risk assessments for each patient to remove or minimise risks. It was unclear how staff identified and acted upon patients at risk of deterioration.

Staff did not complete risk assessments for each patient. We saw no evidence that patients had undergone a risk assessment prior to transport. There was no evidence key information to keep patients safe was handed over when the transport was arranged. We looked at governance meeting minutes for June 2022. They referred to an incident of unintentional self-harm by a patient. No evidence was submitted by the provider that staff had completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

We were not assured staff had clear processes to promptly respond if a patient's health was to suddenly deteriorate. The service was not an emergency service and therefore in an emergency when transporting patients would be required to contact the local ambulance service. We reviewed the course induction which referred to the 'patient deterioration procedure'. The June 2022 governance meeting minutes referred to an incident reporting a patient deteriorating however there was no further detail on these. We did not see a copy of the deteriorating patient policy or protocol.

No process to monitor the deteriorating patient The National Early Warning Score (NEWS) is a nationally recognised tool, used in acute and ambulance settings, to improve the detection and response to the clinical deterioration in patients. We were given a copy of a National Early Warning Scores (NEWS) poster; however, we found no evidence of sepsis or NEWS documentation in the ambulances we inspected. We were shown copies of staff competency records and saw they did not include information about the National Early Warning Score (NEWS) or the management of sepsis.

Staff did not have access to guidance to safely manage patients We were not shown evidence of use of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance being used or an audit of JRCALC guidance being undertaken. We found there was no reference made to the guidance in the induction and job role competency documentation.

There was no evidence staff had been trained in how to support patient with mental health needs, to assess and respond to risk. The provider submitted as evidence an induction programme overview document, however we found this made no reference to the transportation of patients with mental health needs or those detained under the Mental Health Act 1983. A review of memos and standard operational procedures on the staff portal found no reference to conveying patients who were being detained under a section of the Mental Health Act 1983 or their responsibilities under the accompanying Mental Health Act Code of Practice.

There was no evidence of ongoing assessments of patients during transport, particularly following an incident. We reviewed an incident from March 2022 when a patient who had not been safely restrained by a seatbelt fell from a wheelchair after the ambulance was reported as braking unexpectedly. The statement from the Sharp Medical Services employee described the patient as being in pain. The member of staff confirmed they did not summon assistance, and we found there was no patient record. The staff members statement made no reference to physical observations being undertaken or reference to checking for injuries.

Staffing

The service provided enough staff when transferring patients, but we were not assured all staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

There was conflicting information for the number of staff employed. From our review of staffing we saw a discrepancy in the figures given for the number of staff employed by the service to include full time, part time and bank staff. Training records indicated 50 staff as having received training, and a list of staff provided by the service for this inspection stated

there was 50 staff employed. A review of the roster for the period March to September 2022 showed 63 staff employed who had undertaken work during this period with several shifts when sub-contractors were used. A discussion with the staff member with responsibility for human resources found that approximately 75 staff were employed. We can therefore not be assured all staff are being recruited appropriately and have the correct qualification, skills and training.

The provider recognised staff files were not all completed. We were shown an audit of personnel files dated March 2022 which covered 41 human resource actions and found several areas for improvement, including interview notes, contracts of employment, and driving assessments missing from staff files. The service had corrected some of these however the action plan indicated that five areas of actions were still to be completed at time of the inspection. We reviewed four staff employment records that included all evidence and documentation required for employment checks, including evidence of disclosure barring service checks being undertaken and recorded.

There appeared to be enough staff to carry out the journeys that were undertaken. The provider would not accept a patient transfer if they were unable to staff the transfer safely. However, it was reported concerns over the provider's staff resilience levels which had resulted in shifts being dropped at short notice. The local trust contracting the work had been working with the provider to address these. We were shown a copy of the provider's operations report submitted for July 2022 which referred to an increase in sickness levels and the use of a human resources toolkit to monitor sickness and absenteeism levels. A senior manager showed us the electronic rostering system and we were told by the administrator the registered manager held weekly recruitment meetings which included the administrator who had responsibility for human resources.

We were not assured the provider was monitoring hours worked and that breaks were taken by staff. Under the Working Time Regulations 1998 staff cannot work more than 48 hours a week averaged over 17 weeks, unless the work has an opt out agreement. Workers are entitled to a 20-minute break if working more than six hours and that a worker is entitled to 11 consecutive hours rest in each 24-hour period during which he works for his employer. We spoke with three employees who stated they felt pressurised by managers to work excessive hours to cover shifts. The service monitors staffing hours by utilizing an electronic timesheet system. We were shown copies of rotas and the schedule time sheet. Staff work a range of hours from two to 21-hour shifts recorded. In the period March to September 2022 there were 78 occasions when staff worked in excess of 12 hours, 17 of these were for the local trust and of the eight occasion when this was in excess of 15 hours four of these were also for the local trust.

Records

Staff did not keep detailed records of patients' care and treatment.

The provider did not keep patient records and staff could not access information for patients. There was a risk patient information was not shared and risks were not appropriately assessed, mitigated and managed for the safety of both patients and staff. We were informed the service supplied patient transport services only for the local ambulance trust. A senior manager informed us the service does not keep patient records, as these were provided and retained by the local trust providing the contracted work. ,

The provider confirmed patient records were held for their event work, this is not a regulated activity and therefore was not reviewed as part of this inspection.

Medicines

The service did not follow best practice when storing medicines.

Medication was stored securely but not always in line with best practice. We were shown medications were kept in a secure cupboard within a secure room. We found the room temperature where medication stored was not recorded, and fridge temperatures were not consistently recorded. The provider was unable to ensure that medication was being stored in accordance with manufacturer's recommendation. Following the inspection, we were provided with photographs of refrigerator temperature records. These showed several gaps in recording and the medication policy did not detail the action to be taken should the room temperature increase or in the case of a fridge malfunction. We asked for, but did not receive, a medication audit but were given a stock audit that had been undertaken by the registered manager. We found the stock audits reported on quantity of medications and were not an audit of medication policy compliance.

From the records submitted we found medication management was not a part of mandatory training and was not covered in qualified staff competency booklet.

We were informed by a senior staff member the medication bags are checked by the registered manager, and the registered manager informed us records were kept in exercise books, which were then scanned once full, and uploaded on a server. Ambulances we saw were equipped with lock cubebins used for the storage of medication.

Incidents

The service did not manage patient safety incidents well. Staff did not always report incidents. Incident investigations were not thorough, and lessons learnt were not shared.

We were not assured staff were always reporting incidents and appropriate learning identified and shared. We saw one example where a staff member involved in an incident had failed to report the incident. On following this up the information supplied to us did not contain an incident investigation report, lessons learnt or how these would be disseminated to the staff and senior managers.

The incident log did not cover the duration of the provider's registration and there was no learning from incidents. We were shown an incident log which commenced on 6 January 2022, over four months after registering with the CQC. From 6 January 2022 to 7 September 2022 there were 24 incidents recorded. These included five falls, three patient inappropriate or challenging behaviour, and three described as 'running call'(at first contact with a patient there is limited or no information from which to derive a code to categorise). We were unable to identify learning from these incidents.

We reviewed two sets of governance minutes and these did not provide a comprehensive narrative of the investigations, outcomes and actions or how these were to be disseminated to the staff as learning points.

When incidents were reported that included a description of the use of a manual handling controversial technique, the technique was not subsequently investigated by the provider. We reviewed two examples of incidents where a controversial lifting technique was possibly used by a member of staff.

We looked at incidents that would suggest the ambulance staff had conveyed patients with a mental health difficulty. The minutes of the June 2022 governance meeting referred to a patient detained under section two of the Mental Health Act being transported inappropriately. Further to this the records showed two incidents of concern, one of challenging behaviour and a second of a patient smoking 'illicit drugs prior to collection'. We were told by a senior manager that all incidents were reviewed by the governance committee. We found the minutes did not record lessons to be learnt or the implementation of an action plan by the provider.

Inadequate

Emergency and urgent care

We found there was no evidence in the governance minutes or staff meeting minutes that managers shared learning with their staff about incidents or never events that had happened elsewhere.

Are Emergency and urgent care effective?

Inadequate

This was the first time we rated this service We rated it as inadequate.

Evidence-based care and treatment

Care and treatment was not provided based on national guidance and evidence based practice. Managers did not check to make sure staff followed guidance. Staff were not trained to protect the rights of patients subject to the Mental Health Act 1983. There were no patient records or risk assessments undertaken. Therefore, there was no evidence patient's physical, mental health and social needs had been assessed or their care and support had been delivered in line with legislation, standards and evidence based guidance.

There were policies and procedures but no mechanism for monitoring compliance with these. Managers regularly reviewed policies and procedures but did not ensure staff applied these in practice.

Staff had not received training on the Mental Health Act 1983 and its accompanying Code of Practice to ensure that patients detained under a section of the Mental Health Act were being provided with the appropriate care and support.

Nutrition and Hydration

Staff assessed patients' food and drink requirement to meet their needs during a journey.

Staff made sure patients had enough to eat and drink.

Pain relief

Staff did not keep a record to show they assessed and monitored patients regularly to see if they were in pain.

We were not provided with evidence that patients pain was assessed using a recognised tool. There were no patient records to review this. We were shown a poster of a pain assessment tool. During one incident, described earlier in the report, where a patient fell from their wheelchair, there was no record of their pain being assessed. There is no reference to pain models or tools as part of the induction programme or the operational staff induction skills package.

Response times

Response times and quality outcomes were reported, but they were not always used to facilitate good outcomes for patients and make improvements.

Quality outcomes were reported and sent to the local ambulance trust to monitor performance as part of the contract. These indicators included the number of journeys undertaken, those completed within the time frame agreed by the trust, and the number and timings of the transport of patients to renal appointments.

The trust private provider operational meeting minutes of June 2022 referenced some areas in the quality data that would require improvement and the report included a summary of the discussion of the key performance indicators presented by the provider. No actions were noted.

We did not see evidence this report was used by the provider when we reviewed the operations report, operational minutes or clinical governance meeting minutes. We reviewed a copy of the quality outcomes and there was no narrative or action plan supporting the data.

Competent staff

There were processes to appraise staff work performance and provide observations for support and development. However, it was not clear how this was maintained for all staff to ensure ongoing competency.

Staff completed an induction when commencing employment with the provider and had probational reviews. The staff files we saw did had details of induction and probationary reviews recorded.

There was a process for annual appraisals to provide support and development to staff. Most staff had been employed for less than one year so were yet to have an appraisal. The appraisal policy dated October 2020 referred to the participation in the appraisal process being optional for those members of staff employed on a zero hours contract and working less than 16 hours a week, self-employed or where the provider is not their primary workplace. It was unclear how the provider was assured these staff maintained their competency.

The registered manager stated most the staff were employed on a bank basis and were expected to make a point of contact with their supervisor at a minimum of twice a year. If bank staff were employed by the trust, and undergoing the trusts appraisal and supervision framework, they could 'opt out', of this arrangement. We did not see any method for being aware of concern or support needs for staff. .

We were informed that each member of staff must have a minimum of two clinical direct observations per year comprised of both announced and unannounced observations. The June 2022 governance minutes stated the two team leaders would be responsible for carrying out five of these observations a month. We did not see evidence this benchmark had been met and the minutes did not provide a narrative on what percentage of staff had undergone this process.

As the majority of staff are employed on a bank / part time basis the registered manager explained that regular supervision can present a challenge to organise therefore the provider had adopted a two point of contact rule to ensure staff undertake supervision for their role. A memo dated September 2022 informed staff of the introduction of the policy of two points of contact requirement for staff, following completion of their probationary period.

We found the provider did not have a designated person with responsibility for training.

We did not see evidence of continuing professional development recorded in the four files seen.

Inadequate

Emergency and urgent care

Managers did not make sure staff meetings were regularly available. We were shown minutes of staff meetings that were held in July 2022, we were informed by the registered manager meetings had not been held regularly prior to that. Staff had access to the full notes if they could not attend. We saw the minutes of the meetings were placed on the staff portal.

Multidisciplinary working

Staff worked together and with the local trust to deliver services to transfer patients. However, the effectiveness of this was not reviewed and information was not effectively shared.

Staff did not have regular multidisciplinary team meetings. This meant there was not regular discussions on how staff felt they were providing effective care or where improvements could be made.

The provider worked with the local trust to deliver services to patients through arranging appropriate transfers and aiming to meet response times. However, it was not clear how the provider was made aware of important information to care for the patient as there was no record held.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff followed national guidance to gain patient's consent. Staff were not trained to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff received training in consent and would gain verbal consent from patients. In the absence of patient records we were unable to confirm this was being recorded. We were shown training records for 50 staff which showed 100% of staff had undertaken training in consent.

Staff were not trained in the Mental Capacity Act and Deprivation of Liberty safeguards. We were informed by the registered manager staff were provided with information cards with brief notes on the Mental Capacity Act. There was no evidence of documentation relating to the deprivation of liberty safeguards and the use of seatbelts/restraints in the vehicles. Reviewing incidents it was evident restraint was not always recognised, or less restrictive options used where possible.

There was no evidence to show the managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Are Emergency and urgent care responsive?

Inadequate

This was the first time we rated this service, we rated it as inadequate

Service delivery to meet the needs of local people

The service was planned and provided to meet the needs of the contract to deliver transport services to patients.

Inadequate

Emergency and urgent care

Sharp Medical Service provided patient transport contracted by a local trust. The service was organised to deliver services in line with the contract.

Meeting people's individual needs

The service was not inclusive to take account of patients' individual needs and preferences. There was some flexibility to take account of individual needs as they arise.

Staff were not supported to ensure they were able to meet the needs of patients living with mental health problems, learning disabilities and dementia and ensure they receive the necessary care to meet all their needs. There was no evidence that staff supported patients living with dementia and learning disabilities by using the 'This is me' documents and patient passports.

There was no evidence people were supported to communicate. The provider did not have information leaflets available in languages other than English. There was no evidence of access to interpreters and signers when needed.

In the six vehicles inspected by us we found that there were no communication aids in the vehicles to help patients become partners in their care and treatment.

Access and flow

People accessed the service when they needed it and overall received their transport in a timely way.

Access was controlled through a booking service managed by the patient transport services dispatch team of the local trust. The service did not monitor in detail the journeys completed to review patient experience for example timeliness of journeys, disruptions or cancellations.

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received.

There was a process and policy for complaints. There had been no complaints received since the provider registered with the CQC.

The service did not clearly display information about how to raise a concern. We were informed by the registered manager that information on how to complain was placed in every vehicle, however, we inspected six vehicles and did not see information posters or leaflets for patients and their relatives and carers on how to complain or raise concerns.

Are Emergency and urgent care well-led?

Inadequate

This was the first time we rated this service We rated it as inadequate.

We found that the delivery of high-quality care is not assured by the leadership, governance or culture.

Inadequate

Emergency and urgent care

Leadership

The delivery of high-quality care was not assured by the leadership. Leaders were not always aware of the risks, issues and challenges in the service. Leaders were not always clear about their roles and their accountability for quality.

Our review of the risk register and incident investigation found insufficient evidence to suggest that the leadership were aware of the risks and challenges in their service. The review of the governance structure found that the provider was not monitoring the quality of their service effectively.

The structure included two operation leads, one operations lead had been recently appointed. We were informed clinical oversight was provided by a medical director employed on a sessional basis. We saw no record of these sessions taking place.

The registered manager informed us that staff are kept informed and engaged through the website portal. Three of the staff spoken with stated that the registered manager was visible and approachable.

We did not see evidence of a leadership strategy or developmental programme which included succession planning.

Vision and Strategy

Progress against delivery of the strategy and plans was not consistently or effectively monitored or reviewed and there was no evidence of progress

We saw a copy of the provider's vision statement, mission and core values, but did not find evidence this had been developed in collaboration with staff and people who use the services and external partners.

The registered manager told us the vision statement was developed around statement of purpose and experience of the work over the last few years. We were told these had been communicated to staff during induction, via memos, and that the staff portal contains information for the staff.

Culture

Staff did not always feel respected, supported and valued. They were not supported to raise their concerns.

There was a varied response when we asked about the culture. The senior staff we spoke with described a positive culture. However, some staff described a culture of bullying and coercion to undertake additional shifts. Comments from staff included that shifts are allocated on an ad hoc basis and staff must eat in the ambulances for their break when they are unable to return to base. Staff stated they were not listened to and training was inadequate for the role.

The registered manager and team leaders were described by all the staff we spoke to as approachable however we did receive comments that when under scheduling pressure from the local ambulance trust they were described as becoming less approachable and dismissive and that staff did not feel supported by senior management.

Staff complained of feeling unsafe at night on returning to the premises. We were shown training records that recorded a conflict resolution module that had been undertaken by 50 staff and we saw that a lone working procedure was

accessible on the portal and was also covered on the induction course. We were informed by the registered manager that all staff had access to a personal alarm system and that the provider operated an out of hours on call system. The provider had a lone working risk assessment, updated February 2022, with a risk rating of 'low'. This was dated as being communicated to staff in February 2022.

There appeared to be no clear process for staff to be supported in raising concerns. There were not regular staff meetings or individual meetings with staff.

Governance

Leaders did not operate effective governance processes. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service. There had been no recent review of the governance arrangements, the strategy, or plans.

Governance meetings were not being held regularly or used effectively to identify and share learning. The providers governance policy was updated in November 2020 and two governance meetings had been held in March and June 2022. The governance policy was not prescriptive over the numbers and frequency that meetings would be held. There was no evidence of how the minutes of these meetings were distributed or how the provider was assuring itself that lessons learnt had been passed on to staff. On review on the staff portal there was no evidence of minutes or sharing of information.

The minutes of the June 2022 governance meeting described how most incidents are for information only, and the provider had introduced a general log form for staff to complete. The minutes stated this would be reviewed by the 'on call', who would decide whether an incident form was required and who would then contact the staff involved. We found that at this meeting a total of 16 incidents were reported of which eight directly impacted on the patient's condition, five related to operational challenges and three had insufficient information.

Management of risk, issues and performance

Leaders did not manage risk, issues and performance effectively. Risks were recorded but actions were not identified to reduce their impact. There were no processes for monitoring and improving the quality of the service.

There were no systems or processes to assess, monitor and drive improvement for the quality of the service. We were informed that the provider did not have a schedule of audits. The audit policy dated 2020 refers to two audits, a patient clinical record audit and a clinical observation audit. The provider keeps patient records for its event work only and therefore this audit falls outside the scope of registration and could not be checked as part of this inspection. A second audit listed was of clinical observations for which each member of staff was required to have a minimum of two direct observations a year. No results of audits were made available, and clinical governance meeting minutes seen did not have results of audits undertaken in detail with no action plans to address any short falls.

There were not processes to effectively assess, monitor and mitigate risk. The risk register contained several identified risks, including recruitment, infectious diseases, fleet and reliability. There were no details in respect to risk controls that were in place, the register was undated, had no review dates and no evidence of review by the senior management team.

The provider had a business continuity plan which was undated and referred to annual review. There was no evidence from minutes seen of review by senior management having taken place. We found the document referred to the roles staff would be allocated in the event of a business crisis, but there was no evidence staff had received relevant training in preparation for this.

We were provided with an invoice dated March 2022 for the retention of a medical director who was employed to offer advice for the purpose of annual clinical governance., The provider could not provide evidence of patient case reviews and no contribution to discussions were noted in the two sets of clinical governance minutes provided.

We were shown a health and safety inspection report dated May 2022. This report identified three areas of concern, slip trip or striking hazards, electrical hazards and fire hazards. However, there were no explanatory comments in the document to describe what these concerns were. The accompanying action plan referred to continuous monitoring to ensure walkway is maintained, this risk was reported as 'medium'. We found no reference to this report had been made in the July 2022 operations report, the clinical governance minutes of June 2022, or referenced in the provider's risk register. Despite requesting sight of the service regulatory reform (fire safety) order 2005 we were not shown this risk assessment.

The governance minutes, together with the operations meeting minutes of March 2022, and the operations report of July 2022 referred to external partners, however these are brief mentions. There were no updates on meetings or review of the key performance indicators and service level agreements with external partners.

Information Management

Information is used mainly for assurance and rarely for improvement.

Staff had access to the staff portal on the providers website which provides access to shift rostering, policies and procedures, staff meeting minutes and memos. Memos seen by us included directions on loading and unloading patients, use of carry chair and lifting limits and heatwave guidance. There were no minutes of governance meeting, action plans, or evidence of shared learning on portal.

Information governance was included in the mandatory training and records and 50 staff had undertaken the module with a reported 100% compliance. A data breach notification policy, dated November 2020, can be accessed through the portal on the website, this policy refers to the operations manager having the responsibility for the carrying out of an investigation into any breech to determine whether it is required to make a report to the Information Commissioner.

The registered manager informed us that the provider had not completed an information governance audit.

Engagement

There is a limited approach to sharing information with and obtaining the views of staff, people who use services, external partners and other stakeholders.

We were informed by the registered manager that the service did not undertake patient satisfaction surveys, and this was the responsibility of the local ambulance trust. The local trust confirmed this and states that they have not received any feedback about the service.

Inadequate

Emergency and urgent care

The provider has held staff meetings on 22 and 24 July 2022 and minutes refer to discussion with staff about recent memos, standard operating procedures, and the introduction of a staff questionnaire. We were informed that meetings had not been held regularly prior to these dates.

Learning, continuous improvement and innovation

There was limited evidence the service was continually learning and making improvements.

There was limited understanding of quality improvement methods to support and encourage innovation and service development.

Learning was not being shared to enable the development of the service. The minutes of the operations and governance meetings or action plans were not shared with the staff.

There was no evidence of networking or involvement in national peer frameworks.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service should consider introducing training evaluation forms to monitor the quality of the training provided. • The provider should ensure that the manual handling training for staff includes the subject of controversial techniques and why they should not be used in manually handling a patient. • The service should store oxygen safely and continually risk assess the storage arrangements. • The service should store control of substances hazardous to health securely and in line with regulations. • The service should ensure information about how to make a complaint is readily accessible in different formats to meet the needs of all patients. • The service should ensure staff receive training on the Mental Health Act 1983 and the accompanying code of practice. • Review how to obtain regular patient feedback to enable improvements made to the service to be reflective of the local population and meet patient needs. • The Service should ensure that staff have access to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure systems or processes are established and operated effectively to assess, monitor and mitigate risks. The risk register did not accurately detail the risks faced by the organisation and the actions planned to mitigate risks. The business continuity plan was not up to date and there was no evidence staff had been trained in their roles and responsibilities (Regulation,17(1)). • The service must undertake an infection control audit in line with guidance from Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. The service must ensure it has ongoing systems and processes, including regular audits, to identify, monitor, escalate and mitigate infection control risk. (Regulation 15(2)) (Regulation 17(2)(a)). • The service must ensure it has systems and processes to assess, monitor and drive improvement for the quality of the service. This includes undertaking regular health and safety audits and producing an action plan to address shortfalls. This ensures that staff are made aware of lessons learnt from incident investigations and know how to escalate risks to a relevant external body as appropriate. (Regulation 17(b)). • The service must record, maintain and store its own patient records and risk assessments for the provision of regulated activity. (Regulation,17(1)).

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

- The service must ensure that it keeps accurate records of the numbers of staff working for the organisation and that all staff are recruitment checked and receive the appropriate level of training (Regulation 18(1))

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure medicines are managed safely and in line with guidance. They must introduce systems to conduct comprehensive medicines audits, store medicines in compliance with manufacturers recommendations, record fridge and room temperatures consistently and develop a procedure to alert staff if temperatures are exceeded. (Regulation 12(g)). • The service must ensure it undertakes risk assessments and provides training to comply with the mental health act code of practice for the transportation of detained patients. (Regulation 12(1)).