Felixstowe Dock & Railway Company

Port of Felixstowe

Quality Report

Tomline House,
The Dock,
Felixstowe,
Suffolk
IP11 3SY
Tel: 01394 604500
Website: www.portoffelixstowe.co.uk

Date of inspection visit: 24/01/2017
Date of publication: 22/05/2017

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

Ratings

Overall rating for this ambulance location

Emergency and urgent care services	

Summary of findings

Letter from the Chief Inspector of Hospitals

Port of Felixstowe is an independent ambulance service operated by Felixstowe Port and Railway Company. The Port of Felixstowe provides emergency and urgent care to the staff and visitors within the docks.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on Tuesday 24 January 2017. We did not undertake an unannounced inspection of this provider.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005. We did not see staff deliver care during the inspection.

The service only provided urgent and emergency care.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- All staff had completed their required mandatory training, completed all competencies and participated in an appraisal between January and December 2016.
- Vehicles and equipment were maintained and serviced in line with legal and manufactures requirements.
- We found good oversight of controlled drug administration, storage and replenishment.
- The service had specific pathways of care for conditions requiring specialist intervention.
- We saw evidence in patient report forms and patient feedback data of staff considering the privacy and dignity of patients and their inclusion in decisions made about their care.
- Staff had a good understanding of the geographical location covered, including the time taken to respond to each area of the site.
- The service had a newly formed statement of purpose, vision and strategy, which was understood and promoted by staff.
- There was a newly established governance structure. The service appointed a medical director in April 2016. The role became substantive as of 17 January 2017 which provided some consistency..
- The service encouraged staff involvement in shaping the future of the service by participating with service delivery improvement.

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

- Documentation of when pain relief was offered or refused was not consistently recorded in the patient report forms
- Some audit tools used by the service did not reflect the work undertaken. For example, the service was auditing febrile convulsion outcomes despite never treating a child.
- The service did not have access to formal translation services which resulted in the use of internet translation sites when required.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. This included:

- The provider should review the process for accessing communication services for patients, including translation and facilities for those with a hearing impairment, and ensure that a robust and reliable system is in place.

Summary of findings

- The provider should review the process for auditing the completion of patient report forms to ensure it is robust and captures the required information to make improvements.

Ted Baker
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		Overall, we have not rated emergency and urgent care at Port of Felixstowe because we were not committed to rating independent providers of ambulance services at the time of this inspection. We found that: • Staffing across the service was good and consistently met the requirements of the service. • All staff had completed their required mandatory training in 2016. • We found good safeguarding policies and procedures, and staff were knowledgeable about safeguarding processes. • Competency training was delivered in line with current best practice and guidance. Policies and procedures also reflected current best practice. • Patient feedback and medical records showed staff provided care in a kind and compassionate way, considering the wishes of the patient during treatment. • Services met the needs of the population served, and staff routinely risk assessed all aspects of care deliver, for example undertaking rescues at height or within confined spaces. • The service had a process for identifying and managing risk, and this was done in line with current best practice and national guidance. • We found a culture of inclusion within the team and staff described the team as a “family”. However: • Staff did not consistently document some information, such as pain relief and discharge information, in patient records.

Summary of findings

- The service did not undertake targeted auditing of patient outcomes. Staff audited all national standards, which included areas not seen by the service (for example routine care of children and young people).
- The service did not have access to formal translation services for patients whose first language was not English.

Port of Felixstowe

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to Port of Felixstowe

Port of Felixstowe is operated by Felixstowe Port and Railway Company. The service opened in 1958. It is an independent ambulance service in Felixstowe, Suffolk. At the time of inspection, the service served the community within the port itself, including staff and visitors. It had previously been commissioned by an NHS provider to provide ambulance support in the surrounding areas local to the Port. However, this arrangement had discontinued in April 2016 but there were indications that a similar arrangement may be made in the future.

The service manager had been registered with the CQC, as registered manager, since 22 September 2015.

The service operates from one registered location, Port of Felixstowe, and we inspected this on 24 January 2017. We did not undertake an unannounced inspection.

Our inspection team

The team that inspected the service comprised a CQC Inspection Manager, a CQC lead inspector and a specialist advisor with expertise as a paramedic.

Facts and data about Port of Felixstowe

The service is registered to provide the following regulated activities:

- Treatment of disease, disorder and injury
- Transport service, triage and medical advice provided remotely
- Diagnostic and screening procedures

During the inspection, we visited the Port of Felixstowe fire and ambulance station. We spoke with eight staff including; registered paramedics, ambulance technicians and the senior management team, which included the medical director, CQC Registered Manager and the ports health and safety manager. During our inspection, we reviewed 20 sets of patient records.

There were no special reviews or investigations of the service on going by the CQC at any time during the 12 months before this inspection. The service was last inspected in November 2013 which found that the service was meeting all seven standards of quality and safety it was inspected against.

Activity (January 2016 to December 2016):

Detailed findings

- In the reporting period January 2016 to December 2016 there were 241 emergency and urgent care calls within the docks and a further 27 outside the docks supporting the local NHS ambulance trust.

The service employed five registered paramedics and 10 medical technicians. A doctor was contracted to undertake the role of medical director within the service and was the accountable office for controlled drugs.

Track record on safety:

- The service reported no never events during the reporting period.
- The service reported no clinical incidents and five non-clinical incidents within 2016.
- The service reported no serious injuries during the reporting period.
- No complaints had been received by the service during 2016.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Port of Felixstowe is operated by Felixstowe Port and Railway Company. The service opened in 1958. It is an independent ambulance service in Felixstowe, Suffolk. At the time of inspection, the service served the community within the port itself, including staff and visitors. It had previously been commissioned by an NHS provider to provide ambulance support in the surrounding areas local to the Port. However, this arrangement had discontinued in April 2016 but there were indications that a similar arrangement may be made in the future.

The service manager had been registered with the CQC, as registered manager, since 22 September 2015.

The service operates from one registered location, Port of Felixstowe, and we inspected this on 24 January 2017. We did not undertake an unannounced inspection.

Summary of findings

Overall, we have not rated emergency and urgent care at Port of Felixstowe because we were not committed to rating independent providers of ambulance services at the time of this inspection.

We found that:

- Staffing across the service was good and consistently met the requirements of the service.
- All staff had completed their required mandatory training in 2016.
- We found good safeguarding policies and procedures, and staff were knowledgeable about safeguarding processes.
- Competency training was delivered in line with current best practice and guidance. Policies and procedures also reflected current best practice.
- Patient feedback and medical records showed staff provided care in a kind and compassionate way, considering the wishes of the patient during treatment.
- Services met the needs of the population served, and staff routinely risk assessed all aspects of care deliver, for example undertaking rescues at height or within confined spaces.
- The service had a process for identifying and managing risk, and this was done in line with current best practice and national guidance.
- We found a culture of inclusion within the team and staff described the team as a “family”.

Emergency and urgent care services

However:

- Staff did not consistently document some information, such as pain relief and discharge information, in patient records.
- The service did not undertake targeted auditing of patient outcomes. Staff audited all national standards, which included areas not seen by the service (for example routine care of children and young people).
- The service did not have access to formal translation services for patients whose first language was not English.

Are emergency and urgent care services safe?

Incidents

- The service reported no never events or serious incidents in 2016. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Staff reported incidents through an electronic system. A team leader then investigated all reported incidents. The clinical governance group had incidents and complaints as standard agenda items in October, November and December 2016, despite staff reporting no incidents or receiving any complaints during these three months.
- We reviewed two of the five incident reports from March and April 2016.
- The incident dated 3 March 2016 was regarding a fault with the emergency telephone line to the fire station. The outcomes section of the report states that an email was sent to inform all port staff that the line was fixed. The report did state the mitigating actions implemented during the incident (the use of another telephone number) which ensured continuity of service provision.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify service users (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. As soon as reasonably practicable after becoming aware that a notifiable safety incident had occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- We asked two staff about duty of candour and both understood what it meant and how to apply it. The service had not had to use the duty of candour regulation due to the minimal amount of incidents.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- Formalised clinical dashboards were not in use at the service.

Cleanliness, infection control and hygiene

- The service had an established system for ensuring high standards of infection prevention and control. Both vehicles used for transporting patients were visibly clean throughout. Records for December 2016 and up to 23 January 2017 showed daily cleaning of both vehicles had taken place each day, and following each use.
- Staff had access to appropriate equipment to undertake cleaning, for example, separate colour coded clinical and non-clinical mops and buckets, and suitable cleaning substances for each area. Following a large contamination (for example from blood or other body fluids or suspected infectious material), staff cleaned vehicles with single use equipment and appropriate chemicals to ensure thorough decontamination of vehicles.
- We found the storage and use of cleaning materials was in line with the Control of Substance Hazardous to Health Regulation 2002. All chemicals were stored in designated cupboards and only accessible by ambulance and cleaning staff.
- Personal protective equipment (PPE) was available on each vehicle, including gloves, aprons, eye protection and helmets. Staff were aware of when and how to use and dispose of PPE appropriately.
- Team managers undertook hand hygiene audits every month. We reviewed compliance data between December 2016 and January 2017 and found full compliance. The clinical governance team reviewed audit results and action plans would be developed for non-compliance. Hand sanitiser was available in each vehicle for staff to use when out of the station.
- Staff were issued with uniforms which they were individually responsible for cleaning. The station held a stock of spare uniform for staff to use following

Environment and equipment

- The service operated two emergency ambulances and a rapid response car. Staff parked all vehicles in a purpose built garage, which adjoined the ambulance and fire station, when they were not in use on an emergency call. We saw MOT and servicing records for all three vehicles. The onsite engineer undertook ad hoc and emergency maintenance of vehicles between scheduled servicing to reduce any disruption to service delivery.
- Vehicle keys were stored within the control room. Only ambulance, fire and police staff had access to the building and control room. This ensured continuous safety and security of vehicle keys to prevent theft or damage occurring.
- There was an effective system in place to ensure vehicles were ready for use. Staff completed a daily checklist at the start of each shift, and following each emergency call. Checks included medical equipment, medication, engine and the vehicles' exterior (including emergency and non-emergency lights). We reviewed daily checks for December 2016 and up to 23 January 2017 and found these to be fully completed.
- There was appropriate clinical equipment for adults and children within each vehicle, for example resuscitation equipment. All equipment within vehicles was safely stored and secured when transported. For example, the defibrillator was securely fixed during vehicle movement and medical gas cylinders were securely stored in designated areas within the ambulance. This reduced the risk of injury to staff and patients and damage to equipment.
- Both emergency ambulances had standardised layouts and equipment bags. This ensured staff knew where equipment was, particularly in an emergency.
- During the inspection, we found the tail lifts on both vehicles had service stickers older than six months. We informed senior staff who were able to show us servicing documentation from November 2016 and informed us that the servicing stickers on the vehicles had not been changed accordingly. Servicing of specialist lifting equipment is required six monthly under the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998. All other lifting equipment had up to date servicing stickers and documentation, in line with LOLER 1998.
- The service used separate clinical and non-clinical waste bags and sharps bins for disposing of waste. Staff were aware of and recognised the requirements to segregate different waste. We observed the appropriate use of each waste disposal method during the inspection. Staff stored full waste bags and sharps bins securely inside the building and an external contractor collected this weekly.
- An external company maintained all medical, rescue and electrical equipment and we saw up to date records of ongoing maintenance and servicing.

Emergency and urgent care services

Medicines

- The service had an established process for medicine management. The medical director was the designated controlled drugs accountable officer for the organisation.
- We found secure storage of controlled drugs. Each registered member of staff had their own locker and key, and one senior paramedic had a master key. We checked all five controlled drugs registers and found they were accurate and up to date. Senior staff undertook monthly controlled drugs audits and reported to the clinical governance group. Staff had not raised any incidents in 2016 regarding controlled drugs or other medication.
- Medications, including intravenous fluids, were stored securely and safely on vehicles inside tagged response bags. The use of tagged response bags provided reassurance that no one had tampered with the equipment inside (inducing medication) following initial checks.
- An external company supplied medical gases to the service. The service did not store spare gas cylinders on site; however, this was mitigated as teams could restock at a local NHS ambulance station in an emergency or whilst awaiting delivery from the third party supplier. Each emergency ambulance carried two large oxygen cylinders, two portable oxygen cylinders and one portable nitrous oxide (pain relief) cylinder. We found all cylinders of medical gas in date, full and ready for use.

Records

- We reviewed 20 patient report forms (PRFs) during the inspection, and found them all to be legible and detailed, with the majority completed in full. However, staff did not always document when pain relief was offered or refused, or discharge information when patients did not go to hospital. We raised our concerns on site and the medical director assured us that this would be discussed at the next clinical governance meeting.
- Storage of records was in line with the Data Protection Act 1998. Within vehicles, staff kept records safe within a sealed envelope until depositing in a locked drop box inside the station. PRFs were kept securely at the station for 12 months before being archived for a further seven years.
- There was a process for reviewing and auditing patient report forms, which looked at completion, omission and accuracy of information and appropriateness of interventions. We saw evidence of this within the October 2016 governance meeting minutes.
- However, this was not fully effective, as the discrepancies found during inspection had not been identified as part of the audit process. We raised this on site and the medical director assured us the process would be reviewed and further training given to staff to ensure completion of PRFs improves.

Safeguarding

- The provider had an up to date safeguarding policy in place with detailed referral pathways for children and adults. The clinical governance group planned to review the policy yearly. Five staff we spoke with were aware of their responsibilities and could describe the escalation and referral process should they have safeguarding concerns. No safeguarding referrals had been made by the service in the last two years.
- All staff had been trained to safeguarding adults and children level two in 2016, and we saw records of this during the inspection. This was in line with the safeguarding Children and Young People: roles and competencies for health care staff 2014. Staff had access to a 24 hour telephone advice service staffed by medical consultants trained to children's safeguarding level three. This ensured staff had additional support in the event of a child safeguarding concern. The medical director also had level three children's safeguarding training.
- All staff asked were aware of the additional challenges faced by the service, for example illegal immigration and people trafficking. Staff worked in conjunction with the UK Boarder Agency, police and the local NHS Hazardous Area Response Team to ensure any people found within shipments were dealt with swiftly and safely.

Mandatory training

- We reviewed records for 2016 and found that all staff had completed their mandatory and essential training required for their role and as part of ongoing competency training. Mandatory training consisted of 23 modules including, but not limited to, intermediate and advanced life support, infection control, medical and trauma scenarios, and information governance.

Emergency and urgent care services

- The medical director or the senior paramedic, who both had previous experience of delivering clinical training, facilitated training sessions. Staff completed all mandatory training sessions face to face, with scenario based sessions incorporating multiple aspects of care and safety. For example, a trauma scenario could incorporate the trauma management, infection control, manual handling and scene safety.

Assessing and responding to patient risk

- Staff used the Joint Royal Collages Ambulance Liaison Committee (JRCALC) guidance to assess patients and we saw this documented on patient report forms. Up to date copies of JRCALC were available within the ambulance station. JRCALC is the nationally recognised standards of care for ambulance and pre-hospital staff.
- Medical advice was available via a 24 hour advice line staffed by senior doctors and staff knew how to access this.
- Staff assessed risks for patients in specific or high-risk environments, for example confined spaces, aboard a ship or at height.
- Staff were able to contact the local NHS ambulance service for additional resources and support, including the hazardous area response team (HART) and air ambulance.
- Port of Felixstowe had an up to date mental health policy (dated June 2016 and due for review June 2018) detailing the response to violent or aggressive patients. The policy includes details regarding the process for dealing with a patient that becomes violent or aggressive, including the use of minimal restraint and contacting the port police for assistance.
- The service adhered to the port wide health and safety procedures when working within dangerous or confined locations. Each action had a risk assessment and standard procedure that staff followed to ensure their safety and that of patients and bystanders. We reviewed the standard operating procedures for dealing with explosive items and working in confined spaces. All risk assessments looked at appeared fit for purpose and were reviewed regularly as required.

Staffing

- At the time of inspection (January 2017), the service employed five paramedics and 10 medical technicians, with a vacancy of one technician.
- Each shift consisted of four members of staff, with a minimum of one being a registered paramedic. We reviewed monthly rotas for December 2016 and January 2017 and found this to be consistently achieved.
- Staff worked a set shift pattern of two 12-hour day shifts, two 12-hour night shifts, followed by four days rest. This ensured staff could receive sufficient rest between shifts to reduce fatigue, maintaining safety whilst at work, and is in line with the Working Time Regulations 1998, which states a minimum of 11 hours rest period between shifts.
- An on call rota was in place and utilised when all four staff were dispatched to an emergency. There was a process in place to alert those on call and all staff asked were aware of this.
- There was no requirement to utilise bank or agency staff, as all shifts were covered internally. During periods of staff sickness, the on call staff would cover shifts.

Response to major incidents

- All staff were trained fire fighters and rescue specialists and were aware of their role within major incident scenarios.
- The service had protocols in place for handling explosive and radioactive material within the port. The service worked closely with the onsite police and security staff to prevent and contain a major incident. Senior staff explained the role of the service would be to contain the incident and request further assistance from offsite fire and rescue services.
- Major incident training formed part of the yearly competency updates for all staff. The training covered all aspects of the ports work, for example the handling of high-risk materials (chemicals, radioactive material and explosives), fire and major accidents involving ships and rescues from heights.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Evidence-based care and treatment

- We reviewed policies, procedures and clinical guidance used by the staff and found them all well referenced with current national guidance and best practice. For example, the mental health policy referenced the Mental

Health Act 1983 and 2007, the Mental Capacity Act 2005 and the Children's Act 1989. The discharging and non-conveyance policy referenced JRCALC Guidance 2006, the Department of Health National Stroke Strategy 2007 and the Resuscitation Council (UK) Resuscitation Guidelines 2010.

- The clinical governance group were beginning to review all policies and procedures on a yearly basis to ensure accuracy and validity. No policies had been reviewed at the time of the inspection as they were all implemented following the cessation of NHS work in April 2016.
- There was an established process in place for maintaining adherence to national guidance, policies and procedures. One senior manager collated updates and warnings from national bodies and disseminated them to staff through email and a shift handover book. For example, updates from Medicines and Healthcare products Regulatory Agency (MHRA), National Institute of Health and Care Excellence (NICE) and JRCALC.

Assessment and planning of care

- The service had recognised protocols in place for the transportation of patients to centres of specialty. For example, patients requiring percutaneous coronary intervention (PCI), a specialist technique to help patients suffering certain cardiac conditions, were taken to a specialist centre in Norfolk. Those patients requiring stroke care were taken to the local acute hospital, which is a stroke specialist centre.
- Each vehicle had the pathways for specific conditions set out for reference when on scene, which ensured staff had instant access to the most suitable pathways for patients.
- The service provided out of hours minor injuries and 'see and treat' care, usually provided by the onsite occupational health centre.
- There was an up to date discharging and non-conveyance policy in place for patients treated following an emergency call but not transported to hospital. Staff were aware of the policy and we saw evidence documented within patient report forms of the compliance with the policy. For example, documented advice to patient and the reasons for non-conveyance; however, this was inconsistent.
- The senior management team stated the service does not routinely treat children or young people, and the service had not treated anyone under the age of 18 years in the last five years. However, staff were trained in the treatment and assessment of patients, regardless of age, as part of their mandatory training programme.

Response times and patient outcomes

- The service provided care within the boundaries of the port and did not undertake any subcontracted work outside of that at the time of inspection.
- The service did not monitor response times, as all areas of the port were accessible within eight minutes. The senior management team told us they would be escalate any extended response times to the docks health and safety team for review.
- The service had implemented self-auditing against the national quality standards, for example return of spontaneous circulation (ROSC), febrile convulsion and stroke. The service had implemented self-auditing following the termination of its NHS contracts in April 2016. The service appeared to be undertaking audits that were not relevant to the service. However, the senior management team assured us that a review of the appropriateness of audits would be undertaken at the next clinical governance meeting.

Competent staff

- An external company undertook staff appraisals and all staff had received an appraisal in 2016. Line managers had oversight of staff development and personal targets and increased or decreased these accordingly throughout the year.
- We saw evidence of all 15 staff having yearly driving licence checks. All staff had undergone emergency driving training with the local NHS ambulance trust with three yearly updates. The provider had an up to date Driving Policy in place detailing the requirements of each member of staff in relation to driving and vehicle maintenance. Port of Felixstowe had secured driver training with the local statutory fire service delivered by registered and trained driving instructors.
- Senior staff undertook yearly registration checks for those staff registered with a professional body, for example the Health and Care Professions Council.
- Training records showed staff undertook yearly competencies, appropriate to their role. The medical director assessed the training lead, who in turn assessed all other staff. Staff had monthly training events to enhance their skills, particularly in areas less commonly

seen, for example, major incidents and children's resuscitation. The competencies and continued professional development updates contributed to registered staff meeting the requirements for reregistering with their professional bodies.
- The medical director stated that he was in negotiation with a local NHS trust to enable paramedics to attend theatre. This would enable supervised practice to maintain staff competence with intubation skills as the need for intubation did not occur frequently.
- New employees undertook a three day corporate induction programme within the port followed by a local induction to the fire station. All operational staff had completed the corporate induction programme.

Coordination with other providers

- Port of Felixstowe provided medical, fire and rescue services across the port and involved external providers in the event of a major incident or significant pressure.
- The service had a good working relationship with the onsite police force, which provided cover within the call centre when all crews were deployed to an incident. Although this was the agreed process for emergency cover, the service had no written standard operating procedure to ensure consistency in the event of an emergency.
- Staff liaised with the local NHS ambulance provider and could request the hazardous area response team (HART) and air ambulance support if required. Staff would provide immediate assistance, and then support the statutory fire and ambulance services who would take overall control of a major incident.
- Senior staff gave an example of illegal immigrants being found in a container. Staff would isolate the container and work with the police, Border Control and NHS HART teams to coordinate the safe release of those found.

Multi-disciplinary working

- Senior staff reported a good working relationship with the onsite occupational health centre (which was a nurse led service) who coordinated the care of all employees. The service provided out of hours 'see and treat' care, normally provided by the medical centre staff.
- There was a good relationship between the paramedics and the 24 hour clinical advice line staffed by doctors. Staff gave positive feedback about having access to specialist support whenever they needed it.
- We did not see any hospital handovers take place during our inspection; however, good working relationships had been previously established with local providers when Port of Felixstowe provided assistance to the NHS ambulance service, ceasing in April 2016.

Access to information

- Ambulance staff could access port workers occupational health records in order to update them following treatment and discharge for a minor illness or injury.
- For patients living within the UK but not employees, staff could, where appropriate and with consent, contact the NHS ambulance service or patients GP for information within surgery working hours.
- Both ambulances used for transporting patients had up to date satellite navigation systems to assist when transporting patients to hospital or a specialist centre. Staff asked knew how to use these.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw records confirming staff undertook Mental Capacity Act and Deprivation of Liberty Safeguards training yearly. All staff had received consent training within the last three years, as per the provider's requirements.
- The provider had an up to date mental health policy, covering the Mental Health Act (MHA) 1983 and 2007 and the Mental Capacity Act (MCA) 2005. The policy clearly set out the responsibilities under the MHA and MCA, including how to assess and establish capacity. The policy made clear the differences within the MHA Sections and how and when to implement these. The policy also made clear the use of "minimal restraint" when treating patients who lacked capacity. The policy stated that the onsite police service should be contacted to provide assistance where a patient cannot be safely cared for using "minimal restraint".
- When asked, five staff could explain capacity and showed a good understanding of when they would apply it within their role, for example if a patient was confused following a head injury.

Are emergency and urgent care services caring?

Compassionate care

- We did not witness any care delivery during the inspection, as the service received no emergency calls.
- The service gathered feedback from patients regarding their care using written feedback forms. The service reviewed each feedback individually and did not collate the data to provide an overview of the service.
- We reviewed five feedback forms and all patients when asked if staff treated them with dignity replied, "Yes definitely". All five patients also responded with "yes definitely" when asked if the ambulance crew respected their privacy during treatment.
- Staff told us that all patients would be treated with respect, dignity and compassion throughout their treatment. One paramedic told us of a recent death within the port and explained how a member of staff remained with the patient until it was safe to move them. This showed recognition by staff to the need for preserving dignity to deceased patients.

Understanding and involvement of patients and those close to them

- We saw evidence on patient report forms of staff and patients deciding on the best course of action together.
- For example, we saw one patient with a known long standing medical condition who did not want to go to hospital. Staff respected their decision and documented this on the patient report form.
- Through the feedback forms patients were asked if staff explained their care and treatment to them and four replied "definitely" with one "unable to say". Patients were also asked how involved they were in the decision about treatment and all five respondents answered "very involved".

Emotional support

- The port had its own on site counsellor for staff and visiting crews to access. Staff were encouraged to contact the service following difficult or traumatic jobs. As a team, staff 'debriefed' and supported each other when they had attended a difficult scene.
- Senior staff told us of a recent death within the port which was attended by the service. The crew of the ship involved did not speak English and were distressed. Staff told us that they provided reassurance and support to the crew. All staff involved were offered counselling and support following the incident.
- All staff and visiting crew on ships had access to a 24 hour support centre ran by volunteers. The support centre provided access to all faith leaders and areas for prayer. Staff gave an example of a patient from a foreign ship that became ill and was admitted to a local NHS hospital for a number of weeks. The crew were Catholic and the ambulance service arranged for and escorted a priest onto the ship to provide support to the crew.

Supporting people to manage their own health

- Due to the nature of the environment served, frequent or regular patients were not routinely seen. However, staff that did require regular treatment, for example for a long-term health condition, were referred to the occupational health department (which worked closely with the ambulance service) for further support and assessment.

Are emergency and urgent care services responsive to people's needs?

(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- There was an effective process in place to ensure senior staff planned and delivered services in line with requirements. An on call system was activated when all crews were attending a call out to ensure cover was provided across the port.
- A specific treatment room had been allocated within the fire station to facilitate the treatment of minor injuries and illness when the onsite medical centre was closed.
- The ambulance station was centrally located on the site and had easy access to all areas within the port.
- The service did not provide any services outside of the Port of Felixstowe site; however it was reviewing its contractual work with the local NHS provider with a view to begin supporting the NHS in the near future.

Meeting people's individual needs

- All staff had undertaken additional training in dementia and learning disabilities. Due to the nature of the site covered it was unlikely that staff would treat patients with dementia or severe learning disabilities. Senior staff could not recall a time when someone living with dementia or learning disability was treated by the

service. Senior staff identified these skills as a requirement for all staff as the service was looking to re-establish its contractual work with the local NHS Trust.

- Staff did not have access to a formal verbal or written translation service. The medical director told us that staff would use an internet based search engine to translate if needed. The port saw over 3000 ships in 2016 from 400 international ports. We raised concerns on site around the reliability and suitability of using an internet based translation service, when the service had no alternative source of translation (for example written or over the telephone).
- Both vehicles used for transporting patients had wheelchair accessible ramps and securing mechanisms, meaning patients could potentially travel in their own wheelchairs.
- The fire station and treatment room were not wheelchair accessible due to an outside step and small treatment area. This would make it difficult for 'see and treat' patients to access medical facilities when the occupational health centre was closed. However, staff could treat these patients within an ambulance if required and one was available.
- Neither ambulance nor treatment room had access to a hearing loop for those patients who had a hearing impairment. Combined with the lack of visual communication aids, this could affect the ability of staff to effectively assess patients and deliver information and care.

Access and flow

- During 2016, the service responded to 525 emergency calls, with 241 for an illness or accident on site. A further 27 calls were recorded for the local NHS trust, prior to the end of the contract in April 2016.
- The service operated 24 hours a day throughout the year. The Port of Felixstowe had two separate telephone numbers for the service, one for emergency calls and one for non-emergency calls. We saw these displayed around the site.
- During a major incident, for example a fire, anywhere on the site, automatic alarm systems trigger alerting staff within the control room. This reduced the reliance on employees to telephone for help and resources could be deployed with minimal delay. Emergency service personnel (police, fire or ambulance) could monitor incidents from the control room enabling timely deployment of further resources.
- The service gathered feedback from patients, including wait times for an ambulance. Four of the five feedback forms we looked at stated "very acceptable" for the wait time. The fifth patient responded with "unable to say".
- The service did not monitor response, on-scene or turnaround times at hospital at the time of inspection. The current service provision was such that these issues were not a risk to service delivery. However, should the service undertake further NHS work, this might affect service delivery, which senior staff recognised.
- Staff had a good working knowledge of the geography of the port, helping to reduce any possible delay in responding during an emergency.

Learning from complaints and concerns

- Senior staff told us that the Ports Corporate Affairs Department would deal with any complaints received and therefore the service had no separate complaint policy in place.
- The service had not received any complaints within the last year. Senior managers told us that complaints would be discussed at the monthly clinical governance and team leaders meetings. On review of clinical governance minutes from October, November and December 2016, we found that complaints were a routine item to be discussed.

Are emergency and urgent care services well-led?

Leadership / culture of service

- A senior management team (SMT) made up of the CQC registered manager, a senior paramedic and the medical director, managed the service. The SMT reported up to the port wide health and safety manager.
- The service consisted of four 'watches', or teams, each led by a watch manager.
- The senior management team demonstrated a good knowledge and understanding of the challenges and improvements required. The senior management team

showed a realistic approach to the service, demonstrating the limitation that the service had, for example, in the provision of care to the wider community and the maintenance of clinical skills.
- Staff gave a positive account of their local managers describing them as supportive and approachable. Good team moral and a culture of teamwork was evident throughout the inspection. The majority of staff had been in post for over 10 years and described the service as being like a second home and a family, and felt valued within their role.

Vision and strategy for this this core service

- The service had developed a detailed vision and strategy following the cessation of contractual work with the local NHS ambulance provider. The vision for the service was to provide the "right care, at the right time, in the right place".
- The services' strategy consisted of four strategic core aims, including: to have one point of access for all clinical policies, procedures and processes and to ensure the strategic aims are in line with regulatory requirements. The final points were to maintain a clear focus on clinical quality and develop the leadership and governance within the service.
- The service had a concurrent quality strategy that describes how the service "will meet or exceed the national quality standards set for our service".
- The Port of Felixstowe vision and strategy document details how the vision, four strategic aims and the quality strategy will be met and evaluated to ensure compliance and progress.

Governance, risk management and quality measurement

- Prior to April 2016, the service used the governance arrangements of the local NHS ambulance trust as it was providing support to them on a regular basis. From April onwards, the service had introduced its own structure and employed a medical director to oversee governance.
- The medical director, senior paramedic and CQC Registered Manager had monthly clinical governance meetings. The port's health and safety manager also attended the monthly governance meetings. This allowed active communication between the staff and executive team within the port and provided further challenge within the governance of the service.
- We reviewed governance meetings from October, November and December 2016. We found a clear structured framework to the meetings with set agenda items to review incidents, risk and quality monitoring within the service.
- The clinical governance group had oversight of performance and clinical audits, and this was discussed at each meeting. The service comprised four teams, and each team leader rotated the responsibility for the completion of audits on a monthly basis. This, along with the standardisation of evidence gathering tools and monthly oversight by the clinical governance group, provided assurance as to the accuracy of the data collected.
- Although there was no local risk register in place, senior staff had an understanding of the risks facing the service. The ports executive level health and safety team held and managed the corporate risks. However, we found staff identified and managed local risk well throughout the service. For example, the clinical governance team had identified competency shortfalls and a plan implemented for additional clinical supervision.
- The senior management team (SMT) were responsive to concerns raised by CQC throughout the inspection, and clarified or provided additional information to explain and reassure CQC after we raised concerns. This demonstrated the SMT were engaged in providing a safe, proactive service that used feedback to improve.
- We reviewed the 'confined space task' and 'national environmental' risk assessments. Both risk assessments were detailed and allowed for risk identification, impact of the activity and the implementation of control measures to reduce the risk.

Public and staff engagement

- Following treatment, patients were sent a form to gain feedback on treatment, staff and response times. The lead nurse at the onsite medical centre collated the feedback and fed back to the senior team monthly.
- A staff representative attended the monthly managers meeting to provide a voice for all staff. The role was rotated between all four teams to ensure all staff were represented fairly.
- Staff were encouraged to be involved and engaged in moving the service forward and changing working

practices. For example, two technicians had taken on lead roles for infection control, which involves reviewing and updating policies, educating colleagues and overseeing auditing of services.

Innovation, improvement and sustainability

- The senior management team had recognised that the maintenance of certain clinical skills was a challenge due to the nature of the patients treated. The medical director was in the process of securing 'theatre days' at a local NHS trust to maintain paramedic's intubation skills. Senior staff were also in talks with the local NHS ambulance service to initiate 'third crew' shifts, to enable all staff to reaffirm day to day skills less common within the port.
- The senior paramedic had recognised the need to individualise the training records of staff to better understand the gaps and requirements of technicians and paramedics and this was ongoing. A review of the delivery of training to make best use of time and resources was also being undertaken at the time of inspection, with the possibility of moving towards an e-learning package for some non-clinical training.
- The service had invested in an automated resuscitation machine as they had identified the challenges in transporting a patient in cardiac arrest to hospital.

Outstanding practice and areas for improvement

Outstanding practice

- The ability of the team to assess, manage and reflect on extreme situations showed an excellent resilience and culture amongst the staff to provide care that went beyond that expected of other paramedics and medical technicians.
- The ability of staff to respond to patients in any situation or location around the port site (including at height or on board ships) meant patients received safe, timely care regardless of the complexity of the environment they were in.

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should review the process for auditing the completion of patient report forms to ensure it is robust and captures the required information to make improvements.
- The provider should review the process for accessing communication services for patients, including translation.