The Risk Practice Ltd

ShowMed

Quality Report

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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 known to CQC and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

ShowMed is operated by The Risk Practice Ltd. ShowMed supplies doctors, nurses, paramedics, emergency medical technicians, emergency care assistants and first aiders to organised sporting and public events.

The main service provided by this service which falls under the scope of CQC regulation was patient transport.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 27 and 28 of February 2018.

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.

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:

- There was a robust electronic staff booking system, overseen by a workforce planning co-ordinator. This enabled the service to utilise the right levels of skilled staff and resources to meet the needs of the service safely.
- The service had comprehensive policies and processes to identify, assess and monitor risks and to improve quality and safety. Staff were knowledgeable about how to record incidents and had ready access to incident reporting forms. We saw evidence and examples of incident reporting, reviews and learning from incidents to drive improvements.
- The service had developed an effective recruitment system. This ensured the service had sufficient numbers of suitably skilled staff and accurately monitored whether all staff had the qualifications and skills needed to provide safe and high quality care. The service carried out skills assessments, qualifications checks and ensured the suitability of staff by conducting Disclosure and Barring Service (DBS) background checks.
- There were comprehensive systems in place to facilitate multidisciplinary and multiagency working. A collaborative approach was evident in the pre-planning for events and in the delivery of a safe urgent patient transport service.
- The feedback from staff was overwhelmingly positive. They spoke with enthusiasm and passion about the service and its culture. They described management as being visible and approachable. Staff also spoke of a commitment to providing the best possible care and treatment to patients.
- The leaders of the service had a clear vision and strategy, which underpinned their desire to provide high quality health care and to be seen as 'the caring face of events.' The management appeared open and inclusive. This was evident in the morale of the staff and in their comments.
- The service was excellent at finding ways to engage with their staff and in providing information to a workforce that was casual by nature. They had sought numerous ways to do this to ensure that information was readily accessible at all times, including the use of a duty emergency point of contact.
- We saw evidence that showed the service were actively seeking to improve their services, such as considering the introduction of BS 76000, a management standard that provides a framework for organisations to value people.

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

Summary of findings

- Staff completed training in safeguarding children and adults; however this was not always to a sufficiently high and skilled level for their roles.
- The service performed and documented regular monthly deep cleaning of their ambulances. However, they did not have a robust system to identify that vehicles had been cleaned prior to transportation, in between conveyances, or as and when required. Since routine cleaning was not recorded there was no means to identify if vehicles had been cleaned and were ready for use.
- There was no formalised process for checking the contents of paramedic bags and for the service ensuring that the correct items, such as blood glucose meters were present, correct and in date. The paramedic bags were also not identifiable as being ready for use or requiring restocking.
- The systems for managing equipment and medical gases were not robust. We found that oxygen cylinders were not stored appropriately and there was no means to identify and segregate full, part used and empty cylinders. The service used a vehicle equipment checklist, which did not include checks for expiry date or function. This meant that the service could not ensure itself that medical gases and other equipment on the ambulance were in date and functioning before the point of use.
- The completion of the patient report forms were not always to a sufficiently high standard particularly with the lack of documenting and witnessing consent.
- The service was registered to provide urgent transport services to the whole population; however we did not see specific policies, equipment, skills assessments or competencies relating to the needs of children and young people.
- The service did not currently check that relevant staff had been vaccinated for infectious diseases such as Hepatitis B and that they had achieved immune status, which may be appropriate for their role.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected patient transport services. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals.

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		The main service provided was urgent patient transport. Therefore we have reported findings in the patient transport section. We do not currently have a legal duty to rate independent ambulance services, but we highlight good practice and issues that service providers need to improve. The leaders of the service had a clear vision and strategy. Management appeared open and inclusive. This was evident in the morale of the staff and in their comments, which were overwhelmingly positive. They spoke with enthusiasm and passion about the service and its culture. Staff also spoke of a commitment to providing the best possible care and treatment to patients. A collaborative multi agency approach was evident in the pre-planning for urgent patient transport services during events. Pre-planning incorporated risk assessments and addressed relevant patient safety issues. The service had developed numerous ways to engage with their staff and provide information to a workforce that was casual by nature. They had also invested in new team management software. We found the online staff booking system to be effective. This enabled the service to utilise the right levels of skilled staff and resources to meet the needs of the urgent patient transfer service safely. The service had established policies and processes to identify, assess and monitor risks and to improve quality and safety. Staff knew how to record incidents and had ready access to incident reporting forms. We saw evidence and examples of incident reporting, reviews. We found that the service had an effective recruitment system. Skills assessments, qualification and Disclosure and Barring Service (DBS) checks were performed. This

Summary of findings

ensured that they had sufficient numbers of suitably skilled staff and accurately monitored whether all staff had the qualifications and skills needed to provide safe and high quality care.

The service worked hard to establish a good relationship with its existing and potential clients. We spoke to one client who was very satisfied with the service and described how they always met their expectations and requirements.

We found evidence of service innovation, improvement and sustainability. The service was developing a clinical competency framework for staff to ensure that they were working within the boundaries of their role. A new alternative to controlled drugs for pain relief was introduced into the medicines formulary. The service had in place a business continuity policy.

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

The service did not have effective systems in place to ensure that medical gases were available in the necessary quantities and at all times. We found that oxygen cylinders had not been stored appropriately and there was no system in place to identify and segregate full, part used and empty cylinders.

The service could not ensure itself that medical gases and other equipment on the ambulance were in date and functioning before the point of use.

There was no formal process for checking that the contents of paramedic bags were correct and in date. The paramedic bags were also not identifiable as being ready for use or requiring restocking.

The service did not have a robust system to identify that ambulance vehicles had been cleaned prior to transportation, in between conveyances, or as and when required. Since routine cleaning was not recorded there was no means to identify if vehicles had been cleaned and were ready for use.

The service had performed audits which highlighted issues with completion of the patient report forms. Information was not always recorded to a sufficiently high standard, particularly surrounding the lack of documenting and witnessing consent.

Summary of findings

Staff had completed mandatory training in safeguarding children and adults; however this was not always to a sufficiently high and skilled level for their roles.

The service was registered to provide urgent patient transport services from events to the whole population; however we did not see specific policies, skills assessments, competencies or equipment relating to the needs of children and young people. We were not assured that staff had the right competencies and training to provide urgent transport services to this population group.

The service did not currently check that relevant staff had been vaccinated for infectious diseases such as Hepatitis B and that they had achieved immune status.

ShowMed

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Detailed findings

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Background to ShowMed

ShowMed is operated by The Risk Practice Ltd. The service opened in 1999. It is an independent ambulance service located in Bury, Greater Manchester with further bases in the Midlands and the South of England. The service provides doctors, nurses, paramedics, emergency care technicians, emergency care assistants and first aiders to organised sporting and public events nationwide.

The service had 10 permanent staff, with defined roles and responsibilities and 212 staff working for them on a casual basis. Staff referred to throughout the report included those employed on a permanent and on a casual basis. Staff were deployed to events based on an electronic booking system overseen by a dedicated workforce planning co-ordinator. Permanent members of staff included the registered manager who was the director of clinical care and training, a workforce director and a managing director.

The service supported a range of venues and events varying in size and location, for example, sporting arenas, race courses, cycling centres, concerts, filming locations, and historic buildings amongst others. The service had a member of staff responsible for major events planning, where large crowds were expected to attend. The service provided medical management, safety, event first aid and a patient transport service to its clients. We regulate the part of this independent ambulance service related to the urgent transfer of patients and their care and treatment during their transfer.

Between February 2017 and February 2018 the service transferred six patients from an event site via ambulance to local urgent and emergency centres.

At the time of our inspection, we inspected one high dependency level ambulance. The service had another ambulance of the same specification based in Coventry, to enable them to provide cover to the Central and Southern regions. Ambulances were relocated between the sites depending on the location and scope of the events being covered.

The service is registered to provide the following regulated activities:

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

The Bury location for this service was registered by CQC on 12 June 2017, the service had previously operated from a number of different locations. New services are assessed to check they are likely to be safe, effective, caring, responsive and well-led. This is the first inspection under this registration.

The service has had the current registered manager in post since 2017.

Detailed findings

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection (North West).

Facts and data about ShowMed

ShowMed was established in 1999 and incorporated in 2000 by the current managing director. The service operates from a number of locations. Bury is the registered location for the service. This is an operations base for the organisation. Their human resources and staff fulfilment functions are located in Bury and the premises also house their main storage area. There is also a head office in Northampton for financial and administration functions as well as housing their training centre. Major events planning is co-ordinated from an office based in London.

The management had indicated that the majority of their work does not involve the use of their ambulance vehicles for transfer and that they would call upon the relevant local NHS Ambulance service to support the transfer when necessary. Where the service does transfer to NHS facilities, they provide an equipped and staffed ambulance to carry out this activity. The times the service conveys patients are at large crowd events, such as sporting events and large concerts where they have the provision to do this.

The managing director and workforce director led the service with the support of a clinical care and training director and a financial director. The service utilised a casual work force of 12 doctors, 10 nurses, 48 registered paramedics, 15 emergency care technicians, 11 emergency care assistants and 116 first aiders. The staff accessed the service website internal portal to review the events available and then book themselves for a given event. The workforce planning co-ordinator then ensured appropriately trained staff were deployed to specific events based on the event risk assessment, and reviewing the staffing requirements.

During the inspection, we visited ShowMed which is located in Bury, Greater Manchester. One ambulance was securely garaged at this location. The service has another ambulance based in Coventry, to enable them to provide cover to the central and Southern regions. We did not examine the ambulance based in Coventry during our inspection.

We spoke with eight staff, the registered manager and director of clinical care and training, two further directors of the service, the workforce planning co-ordinator, the human resources co-ordinator, the clinical advisor and with clinical delivery staff including a paramedic and an emergency medical technician. We received comments on the service from three members of staff via the CQC feedback system. We spoke with one patient who had given us their contact details and had been transported from an event to an NHS Trust between February 2017 and February 2018. We also spoke to the safety officer at a venue which was a long standing client of the service.

During our inspection we reviewed six sets of patient records. The records related to patients who had been transported from an event to a local NHS facility. We looked at one High Dependency Unit (HDU) ambulance and the facilities at the registered location. We reviewed other documentation including policies, staff records, training records, risk assessments and planning and briefing packs.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC.

Activity (February 2017 – February 2018):

The service made six patient transport journeys from organised events to local NHS facilities between February 2017 and February 2018. All these transfers were of adults, no children were transferred during the reporting period however the service is registered to transport the whole population.

Detailed findings

Track record on safety within the last twelve months:

- There had been no never events reported by the organisation.
- There were no serious clinical incidents or serious injuries reported by the service.
- There had been no complaints relating to the urgent patient transfer service.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Urgent patient transport services were provided by this ambulance service. Please see the information about location section for full information on this service.

Summary of findings

We found the following areas of good practice:

- There was a robust electronic staff booking system, overseen by a workforce planning co-ordinator. This enabled the service to utilise the right levels of skilled staff and resources to meet the needs of the service safely.
- The service had comprehensive policies and processes to identify, assess and monitor risks and to improve quality and safety. Staff were knowledgeable about how to record incidents and had ready access to incident reporting forms. We saw evidence and examples of incident reporting, reviews and learning from incidents to drive improvements.
- The service had developed an effective recruitment system. This ensured the service had sufficient numbers of suitably skilled staff and accurately monitored whether all staff had the qualifications and skills needed to provide safe and high quality care. The service carried out skills assessments, qualifications checks and ensured the suitability of staff by conducting Disclosure and Barring Service (DBS) background checks.
- There were comprehensive systems in place to facilitate multidisciplinary and multiagency working. A collaborative approach was evident in the pre-planning for events and in the delivery of a safe urgent patient transport service.
- The feedback from staff was overwhelmingly positive. They spoke with enthusiasm and passion

Patient transport services (PTS)

about the service and its culture. They described management as being visible and approachable. Staff also spoke of a commitment to providing the best possible care and treatment to patients.

- The leaders of the service had a clear vision and strategy, which underpinned their desire to provide high quality health care and to be seen as 'the caring face of events.' The management appeared open and inclusive. This was evident in the morale of the staff and in their comments.
- The service was excellent at finding ways to engage with their staff and in providing information to a workforce that was casual by nature. They had sought numerous ways to do this to ensure that information was readily accessible at all times, including the use of a duty emergency point of contact.
- We saw evidence that showed the service were actively seeking to improve their services, such as considering the introduction of BS 76000, a management standard that provides a framework for organisations to value people.

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

- Staff completed training in safeguarding children and adults; however this was not always to a sufficiently high and skilled level for their roles.
- The service performed and documented regular monthly deep cleaning of their ambulances. However, they did not have a robust system to identify that vehicles had been cleaned prior to transportation, in between conveyances, or as and when required. Since routine cleaning was not recorded there was no means to identify if vehicles had been cleaned and were ready for use.
- There was no formalised process for checking the contents of paramedic bags and for the service ensuring that the correct items, such as blood glucose meters were present, correct and in date. The paramedic bags were also not identifiable as being ready for use or requiring restocking.
- The systems for managing equipment and medical gases were not robust. We found that oxygen cylinders were not stored appropriately and there was no means to identify and segregate full, part used and empty cylinders. The service used a vehicle equipment checklist, which did not include checks for expiry date or function. This meant that the service could not ensure itself that medical gases and other equipment on the ambulance were in date and functioning before the point of use.
- The completion of the patient report forms were not always to a sufficiently high standard particularly with the lack of documenting and witnessing consent.
- The service was registered to provide urgent transport services to the whole population; however we did not see specific policies, equipment, skills assessments or competencies relating to the needs of children and young people.
- The service did not currently check that relevant staff had been vaccinated for infectious diseases such as Hepatitis B and that they had achieved immune status, which may be appropriate for their role.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- The service had an incident reporting policy and an incident reporting standard operating procedure that was available to all staff. Incidents were risk assessed into numerical categories to identify them as low, medium and high risk and recorded on an incident dashboard. The incident reporting standard operating procedure clearly outlined the incident reporting steps that staff should take when reporting an incident.
- Staff could report incidents using a paper or online incident reporting form. The ambulance we inspected had a folder containing incident reporting forms for completion at events. Staff we spoke with were able to give examples of what constituted an incident and were aware of the incident reporting process. They were able to locate incident report forms and knew how to complete and submit them.
- The service had an effective system to review incidents. Incidents were monitored and investigated by the director of clinical care and training, who demonstrated that each incident was risk assessed and prioritised for investigation. A database of investigations was maintained with incidents categorised by severity and by type of incident which enabled the collection of data to be analysed for trends.
- We saw that incident reporting form completion had been highlighted in the staff newsletter, to ensure that staff were aware of the location of the online form, what constituted an incident and to whom the completed forms should be sent.
- There was one incident relating to the urgent patient transfer service between February 2017 and February 2018. We reviewed the corresponding incident reporting form. We saw evidence which showed the incident was investigated and the learning shared with staff. This incident was categorised as a near miss.
- Following the incident surrounding the lack of equipment on a vehicle, the service introduced a policy to ensure that ambulances were not emptied and remained fully kitted between events. The policy also incorporated a vehicle equipment check list; however, this did not include checks for expiry dates or function. This meant that the service had learned lessons from this incident, however they had not learned fully.
- We looked at all incidents between February 2017 and February 2018 and saw that actions were taken for each of the incidents reviewed and that they had resulted in changes in policies and processes. However, we did not see any evidence that actions identified as being required in the investigation and their implementation had been documented in the central incident folder.
- The registered manager discussed incidents with staff, when appropriate, and provided feedback on incidents either verbally or by more formal processes.
- The service had not reported any serious incidents between February 2017 and February 2018.
- Staff covering the patient transfer from events service had access to paper and online reporting forms via the services online system. Staff could also speak with the duty emergency point of contact person covering the event and knew that the emergency point of contact telephone number was available on the services website, on their phones and in the event brief.
- Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.
- The service had a comprehensive duty of candour policy which clearly outlined the roles and responsibilities under this legislation. Staff understood their responsibilities under this policy in reporting incidents and in being open and honest when notifiable incidents occur. Staff described this policy as being “ingrained,” within the service.
- The management staff told us that there had been no notifiable incidents between February 2017 and February 2018 that would have triggered the duty of candour process.

Mandatory training

- Mandatory training was delivered by a combination of e-learning and face to face training. Mandatory training

consisted of consent, handling medication and avoiding drug errors, equality diversity and human rights, fire safety, handling violence and aggression, infection prevention and control, lone worker, manual handling, preventing radicalisation, safeguarding adults and safeguarding children.

- Records indicated that 87% of staff were up to date with their mandatory training. These figures had increased monthly from the information available relating to February 2017 to February 2018. A large proportion of the service's staff were employed within NHS settings and undertook annual and three-yearly mandatory training as part of their NHS roles. We checked the records of ten staff who had conveyed or who had the potential to convey patients from an event. We found all the mandatory training records examined, including that of a paramedic who had transferred patients between February 2017 and February 2018 to be completed and in date.
- The service had a human resources co-ordinator who had access to statistical information on the mandatory training compliance rates of staff. Staff were asked to submit supporting documents relating to their mandatory training from their permanent jobs. The human resources co-ordinator had oversight of mandatory training compliance to ensure that suitably trained staff were allocated to jobs. Emailed reminders were sent to staff to indicate training needed to be completed or was overdue.
- The service had put mandatory training onto its key objectives list for 2018 and aimed to ensure all grades of staff received mandatory and CPD training opportunities.
- The service had a driving standards policy. The staff we spoke with had completed ambulance driver training, including blue light training, but that had been completed with their permanent employers and not with this service. Driver training had been placed on the service's risk register and identified as 'significant.' The service has addressed this risk by appointing a driving standards consultant to provide refresher training in blue light standards and to roll out drive outs for non NHS employed staff. Familiarisation training on the ambulances was also to be rolled out together with an assessment, by the end of April 2018.

Safeguarding

- The provider had a joint policy for safeguarding children and adults. This policy clearly stated the responsibilities for staff and how to report safeguarding concerns. The director of clinical care and training, who was also the registered manager, was the national safeguarding lead. The managing director was the deputy safeguarding lead with the workforce director also having a role in safeguarding.
- All staff that we spoke with had a good understanding of safeguarding, all knew how to report a safeguarding concern and who to contact if they received a disclosure. Staff were able to describe the signs of abuse and were aware of specific safeguarding issues such as female genital mutilation and the PREVENT strategy for identifying and preventing radicalisation.
- Staff that covered urgent transportation from events, had access to an incident reporting form and the emergency point of contact telephone number. Staff could seek guidance from the emergency point of contact and were given the appropriate contact details for the relevant local authority safeguarding teams. Staff were then expected to make the referral to the local authority themselves and provide feedback to the emergency point of contact. The safeguarding referrals were then passed to the national safeguarding lead to oversee.
- The service had an internal safeguarding training compliance rate of 88% and figures had demonstrated an upward monthly trend over the previous 12 months. The service reviewed staff qualifications, training and skills, including those with their existing employer, to ensure that their training was up to date.
- Mandatory training delivered by the service included safeguarding for adults and children at level two. At the time of the inspection the provider was unsure whether their paramedics would have level two or three safeguarding through their permanent employment training.
- Three out of the four designated staff that were on the emergency point of contact rota had level three safeguarding for adults and children.
- At the time of the inspection there were no plans in place for the registered manager who was the national

named safeguarding lead to complete additional level four safeguarding training. Therefore, not all staff had access to a member of management with suitable levels of skills and training in line with national guidance. This issue was highlighted to senior management and they addressed this issue by booking additional level four safeguarding training to be completed in May 2018.

- The service had not reported any safeguarding incidents between February 2017 and February 2018.

Cleanliness, infection control and hygiene

- We inspected one ambulance and found cleanliness and infection control to be of an acceptable standard.
- The service had an infection prevention and control policy that was available for all staff. The registered manager had overall responsibility for compliance with the infection control protocol. Guidance on communicable and infectious diseases was also available online to aid staff.
- All new employees of the service had infection control training including hand hygiene as part of their initial period of employment and annual updates included as part of mandatory training. This training was reviewed annually by the Infection Control Lead, who was also the registered manager.
- The staff that we spoke with had a good awareness of infection prevention and control and could describe how they would deal with a vehicle that was contaminated during a patient transfer. Staff would refer to the emergency point of contact for advice and support in infection control matters.
- Advice and guidance was available for operational staff on disease specific precautions and the use of appropriate personal protective equipment.
- On the ambulance that we examined we found that personal protective equipment was available for staff to access; this included disposable clinical gloves, aprons and face masks.
- The service used disposable linen such as blankets, sheets and pillowcases which were single use only and were changed after each use and disposed of.
- Staff had access to hand-cleansing gel on the vehicle, in hand pumps and on a dispenser on the wall of the vehicle. The service has completed an infection control and the use of hand gels audit in September 2017. No issues were identified in this audit. The registered manager explained how the service planned to roll out future audits at more venues and events in 2018.
- A spill kit was available on the vehicle to manage any small spillages and reduce the infection and hygiene risk to other patients. In addition disinfectant wipes were available to clean reusable equipment such as blood pressure cuffs and stretchers after each use.
- The safe disposal of clinical waste was detailed in the infection prevention and control policy. A service level agreement was in place with a waste contractor for safe disposal. We observed that the service had a large clinical waste container and a supply of clinical waste bags and sharp bins, all of which were empty at the time of the inspection. The waste containers were held in a secured area within the ambulance base.
- The protocol for 'safe disposal of clinical waste generated during the transfer of a patient from an event,' outlined that clinical waste bags were placed in a clinical waste bin at the receiving NHS facility. Where this was not possible they were disposed of at the end of a shift into the appropriate clinical waste container at the ambulance base.
- All ambulance interiors were subjected to a comprehensive deep clean on a monthly basis. We saw completed records of the last nine deep cleans for the vehicle at the Bury location, which detailed the date of completion, the detailed tasks performed and the signatures of responsible staff. This process was overseen by the major events planning and South area manager.
- Cleaning instructions for the vehicle were available for reference on the ambulance and displayed clearly above the cleaning equipment at the ambulance station, to support staff in identifying the correct equipment to use. A colour coding system was in place, which identified equipment such as mops and buckets that were used in different areas of the vehicle, for example in clinical and non-clinical areas.
- There was no process in place to record or check that vehicles were cleaned weekly or regularly as referred to in the infection prevention and control policy. Documented cleaning tasks were identified in this policy

to ensure that vehicles were clean prior to an event and after each patient journey. Since these tasks were not recorded there was no means to identify if vehicles had been cleaned and were ready for use.

Environment and equipment

- We inspected one ambulance held in the ambulance station at the service's Bury location, this vehicle was in a good condition with no visible defects. The service had another ambulance based in Coventry, which we did not examine during this inspection.
- The premises were clean and tidy with adequate space inside and outside to safely store the vehicles. There was clear signage throughout the building to indicate the presence of compressed gas and signage to say that eye protection must be worn. The station was a shared unit; however it provided a suitable environment for the service with adequate office space, facilities for staff, cleaning and separate storage areas. A room was available and identified for future training purposes.
- Ambulances were locked when not in use and the keys were held in a locked drawer in the station office.
- Staff locked the ambulance station shutters when not in use and the station was on a secure site. All interior doors leading to storage areas within the station had key code entry with access to the code limited to senior staff. Patients' records were stored in locked filing cabinets.
- We reviewed the fire extinguishers within the ambulance station and found that they had not been serviced within the required dates. The managing director took immediate action to phone the landlord of the premises to ensure that this issue was addressed.
- The service segregated and effectively managed clinical waste, non-clinical waste and confidential waste. The service had a service level agreement for the safe disposal of clinical waste.
- Consumable stocks were stored on shelves and pallets in an access coded store room. The level of stock was managed by the management team. A staff member dedicated time each week to maintain the storeroom. The staff we spoke with told us there were never any problems with replacing used consumables.
- We examined the contents of the one paramedic grab bag that was available for inspection. There was a list available of items that should be present in the bag. Upon inspection we found that the bag contained a blood glucose meter that was no longer used by the service. This item was removed and replaced with the correct in use blood glucose meter. We also found a number of items that were near to their expiry date. The registered manager informed us that bags should be checked before they go out and that they do carry out some random checks. Documented bag checks were not performed, leaving the potential for equipment to be unavailable in the event of an emergency.
- The service indicated that they planned to have the paramedic grab bags tagged and to have a database highlighting the contents and expiry dates. They also were considering formalising the bag checking procedure. Internal tagging of paramedic bags had been placed onto the services risk register in April 2017 to address a different issue relating to the potential tampering with bags in between events. The service was developing a new system for bag tagging and the issue was being progressed through operational meetings.
- The service used equipment tracking to record equipment going out to and returning from events. This system was overseen to ensure compliance.
- All essential equipment in the vehicles was visibly clean and had been serviced, checked and calibrated in February 2018. Equipment had stickers which clearly highlighted when the next date for checks were due. We reviewed the equipment service records for 2017 and 2018 and found them to be completed fully.
- All sterile supplies were stored appropriately in the vehicle and we found no evidence of out of date stock during our inspection.
- A vehicle checklist was available for completion prior to the ambulance attending an event. We checked six pre-journey vehicle checklists and found that five out of six had been completed fully. There was also a vehicle defect form to highlight vehicle deficiencies for the attention of relevant staff.
- In addition a vehicle equipment check list was available and completed prior to the ambulance attending an event. This was a detailed list covering items such as: required paperwork, equipment, kits, gases, cleaning

equipment, airways, bedding and consumables. The check list referred to the number of items required but did not include checks for expiry date or function, for example suction and defibrillator function checks. The registered manager indicated that equipment would not be used without testing it first. This meant that there was a risk that faulty equipment could go undetected until the point of use.

- We checked the heart start defibrillator on one ambulance and found this serviced, powered, and fit for use.
- We checked for documentation relating to registration, vehicle breakdown cover and Ministry of Transport (M.O.T) safety test certificates for the two ambulances. Both vehicles were registered less than one year ago and therefore did not require an M.O.T. Each vehicle had adequate breakdown cover and the service had a vehicle servicing schedule which outlined when the next service and M.O.T dates were due.
- Both vehicles' registration documentation indicated that they met the weight threshold of up to 3.5 tonnes for a category B licence when fully stocked. Records showed that drivers had the correct licence category for the weight of the ambulance vehicles.
- The ambulances were high dependency level specification. Relevant equipment was available for both adults and some for children. An extra safety strap was available for transporting children. However, a specific child safety harness was not available. This issue was raised with the managing director and they indicated that they would consider obtaining harnesses for children. The service had not undertaken any urgent conveyancing of children from events in the previous twelve months; however they have the potential to do so.

Medicines

- The service had a medicine management and administration policy relating to the safe and secure handling of medicines with the exclusion of controlled drugs. This document served as a reference for staff and laid out comprehensive standard operating procedures for medicine management. The policy set out safe systems for procuring, requisitioning, handling, storing, transporting, administering, the reporting of incidents and disposing of medicines.
- The policy indicated that a range of medicines were stocked suitable to the needs of patients. The policy also highlighted the need to report adverse drug reactions and defective medicines. The ambulance staff that we spoke to were aware that medicines given were recorded on the patient report form.
- A comprehensive framework was in place to manage medicine usage and replenishment effectively such as, a drugs sign out and tally sheet, a drug bag inspection sheet and a medicines request form. The registered manager oversaw this process.

  We reviewed one of the medication grab bags. It was visibly clean with no leakages, medicines were in date and stored appropriately. The bag was appropriately date tagged and sealed ready for use, the date tags were tracked on a spreadsheet by the registered manager, which also showed when medicines were due to go out of date or needed replenishment. We checked the corresponding sheet from the paramedic medicines database and found all items checked were documented correctly.
- The service did not stock any controlled drugs. For disposal of other medications the service followed the same guidance for the disposal of clinical waste / sharps and utilised sharps bins.
- We spoke with a clinical advisor who attended the service's Patient Safety Committee (PSC) meetings. They were responsible for, alongside other members of the management team, the development, implementation and performance management of policies and procedures, including the provision of expert advice on the management of medicines within the service. Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were also brought to the attention of this committee.
- Medicines at the station were stored securely in a locked cupboard in a coded entry store room and were tagged. Access to medicines was controlled. Only the registered manager and operational leads had access. Medicines on the ambulance were stored securely in a locked safe and were within a locked cupboard. The medicines bag was also sealed with a tag.

- The service had a service level agreement with an NHS pharmacy which supplied a good range of medicines and a lead time for stock replenishment of less than 48 hours. This ensured the system was resilient.
- We looked at the systems for managing medical gases. At the station oxygen was stored in a locked cupboard in a carry bag. Upon inspection the oxygen cylinder within the bag was found to be empty. Reference was made to: The British Compressed Gas Association code of practise 44 - The Storage of Gas Cylinders. This guidance indicated that the oxygen cylinders should be stored in a well ventilated area and secured upright vertically or secured horizontally for round bottomed containers. Full (including part-used) and empty cylinders should be segregated within the store, the areas being identified by signage.
- On the ambulance oxygen and entonox cylinders were stored securely and had adequate volumes of gas. Upon inspection we found a large F sized oxygen container secured on the rear of the ambulance which was full but had expired by 10 days.
- The service did not have a robust system for monitoring the expiry dates, stock deficiencies and storage of medical gases. We escalated this to the service at the time of the inspection and they took immediate action to address this by removing and replacing the expired oxygen container.

Records

- The service had a records management policy in place. Staff were reminded of the importance of completing patient report forms professionally and fully in this policy and in staff communication aids such as the service newsletter and on event briefing documentation**.**
- A supply of patient report forms was kept on each ambulance for completion by staff. Once completed the forms were placed in a confidential sealed envelope, labelled with the date and event details and then deposited into secure confidential locked post boxes for collection. These boxes were emptied by team leaders and transported to the nearest office. There was a documented guide for records collection for staff to follow.
- The patient report forms were collected on a fortnightly or monthly basis from venues or events. The service had a process for reviewing these forms to collate trends, ensure staff had completed these appropriately and to highlight good practice.
- Completed records were stored securely in locked filing cabinets within a coded locked storage area in the ambulance station. To aid record retrieval, review and completion; the registered manager was considering developing separate patient record forms to cover activity related to patient transfer and non-patient transfer. More information was required on the form when completing a patient transfer and removing unnecessary sections would aid completion.
- The service ensured that the patient report form information detailing the care given to the patient during the transfer was passed to the receiving NHS facility. The receiving NHS facility photocopied the original record and the ambulance service retained the original. Carbon copied reports were not used by the service.
- We reviewed six patient report forms which were completed when transferring patients urgently from events to an NHS facility between February 2017 and February 2018. We found that staff had completed two to an acceptable standard. Examination of the four incomplete forms showed the biggest gaps were for patient consent to treatment and the witnessing of consent. This issue was highlighted to the registered manager who indicated that he was building on his audit programme for patient report forms and advice on this issue had gone out to staff.
- The service has sent out some guidance to staff following an audit which was undertaken in January 2017 and completed in August 2017. This highlighted the need to improve completing witness signature, pain assessment and follow on advice. We did not see any further evidence produced to indicate whether this advice had improved staff completion of the patient report form.

Assessing and responding to patient risk

- The service had an event venues' risk assessment and a 'Medical Management Plan,' that was completed prior to an event. This document identified the nature of the event or venue and considered the expected

attendance figures, demographics and the likely risks posed to the public. This guided the deployment of the right levels of appropriately trained staff to address those expected risks. The plan was circulated to the local authority and NHS ambulance service for inspection and sign off.

- All planned events had a dedicated risk assessment based on the likely incidents that may occur and a multiagency approach was taken with the relevant local authorities in the planning for risks associated with transportation from event sites.
- The event briefing document highlighted an alert system for managing medical emergencies. There was also a casualty transport flow process for patients that required hospital admission. Staffing at major events ensured that there was a doctor onsite. The service had the right people, right place, and right team approach to staffing. There was also a crash team protocol.
- The staff we spoke with all knew how to deal with a deteriorating patient and how to escalate their concerns. They clearly understood the escalation process and described the actions they would take including getting support at the event, calling the emergency services and pre-alerting the appropriate NHS facility.
- The ambulances used for patient transport services were equipped with automatic external defibrillators (AEDs) and oxygen that could be used in the event of an emergency.
- Staff covered 'Handling Violence and Aggression,' in their mandatory training. The service also provided some conflict resolution training to paramedics.

Staffing

- The service had a number of permanent staff consisting of directors, managers and office workers, with defined roles and responsibilities. There were 212 staff working for the service on a casual basis, 12 doctors, 10 nurses, 48 registered paramedics, 15 emergency care technicians, 11 emergency care assistants and 116 first aiders. There were also staff providing a consultancy service and a clinical advisor.
- The service asked for and checked the supporting documentation of staff, to ensure that they have the right training and competencies for their roles. All potential new recruits completed a basic life support assessment and an interview as part of the recruitment process.
- There was a tracker system for new starters which the human resources co-ordinator shared with the workforce planning co-ordinator prior to booking their first shift.
- All staff were given a 'welcome pack,' on induction with their uniform, an induction booklet, an identity card and a welcome letter. An online link was provided with instructions and details of their first shift arrangements. There was an induction checklist available for new staff; we examined ten checklists which we found had been fully completed.
- New staff were given a buddy to support them through their first few shifts. Staff told us that new staff would not be left to work alone until assessed to be competent.
- The workforce planning co-ordinator reviewed all requests for work by staff and deployed them to cover urgent patient transport services during the event based on their individual skills, training, and competence. Live jobs were released in advance, staff could book themselves on via the services internal web portal, and there was also a 'whats app' page for staff to book onto and view events requiring urgent patient transport provision.
- If the service could not fill an event with the required levels and grades of staff, they increased their required skill levels with more paramedics and technicians than identified as being required. The emergency point of contact was informed when there were capacity issues relating to the provision of an urgent transport service for events and the event informed if required.
- To ensure that the service had the right number of ambulance vehicles and skill mix of staff to provide an urgent patient transport service from events, they attend 'Safety Advisory Group,' meetings. At the meetings resources required were discussed with the event holder, police, local NHS ambulance service and other relevant parties. The service utilised a major event planning tool and risk assessed events with the aim of maintaining safe care and treatment at all times.

- Medical management plans, which included staffing levels and ambulance vehicle requirements for patient transport, were signed off prior to the event by the local authority and the local NHS ambulance service.
- Staff were not allowed to work more than fourteen hours per shift as part of the working time directive. The staff we spoke with said that they managed to get adequate breaks and periods of downtime and they were aware of the working time directive. The service did not monitor the time off that staff had between shifts undertaken with them and their permanent jobs, but expected their staff, as health care professionals to act with integrity. There had not been any issues reported by the service with this system.
- Staff could remove themselves from the rota for up to 48 hours prior to the start of the event. After this they would have to liaise with the workforce planning co-ordinator to be able to do this. Staff who habitually cancelled were not asked to cover further shifts to help ensure events were staffed appropriately.
- Out of office hours staff were supported by the emergency point of contact system. All staff were given their contact details to access clinical advice, for operational issues, sickness and significant equipment issues.

Anticipated resource and capacity risks

- The service has completed a business continuity impact analysis; there was also a business continuity policy. This policy covered the priority functions and key services which must be maintained in order for the service to continue providing delivery of an emergency pre- hospital medical service to a contracted event.
- The main objectives outlined in the business continuity policy were to ensure service provision in periods of disruption, to reduce periods of disruption, their likelihood and to improve resilience.
- The service anticipated resource and capacity risks through the use of a risk register. This identified issues with staffing relating to staff dropping off rotas at short notice and due to increased demand. The service put an action plan in place with a new recruitment strategy.
- The service had also placed the introduction of a new drug into the medicines formulary for pain relief onto the risk register. We saw evidence of potential risks associated with changes to service provision being addressed. The registered manager attended a train the trainer course to enable roll out of training to paramedics and safe implementation of this new drug. The service also planned to evaluate its effect on patient care.

Response to major incidents

- There was a major incident plan in place. This document clearly outlined the steps to take in preparing for an incident such as the use of major incident aide memoirs, action cards, knowing their individual roles and attending training sessions. The steps to follow if a major incident occurred were also outlined. It also documented the need for an initial risk assessment and first actions required at the scene.
- The service aimed to provide an initial response to a major incident until stood down by the local NHS ambulance service. They stated a need to rapidly identify and declare a major incident so that the NHS ambulance service can mobilise their major incident plan and mobilise and co-ordinate as early as possible to the incident.
- The service had a major incident box located on a trolley for ease of movement. This box was taken to any major event and contained triage cards, log sheets and equipment such as basic airways. This resource was available to aid in categorising patients.
- The registered manager was a major incident medical management and support instructor. They had plans to provide scenario training to staff as the major incident policy had only recently been updated. This would include co-ordinating the urgent patient transport of patients and liaising with the local NHS ambulance service.

Are patient transport services effective?

Evidence-based care and treatment

- The service had a number of evidence based policies and procedures in place. This ensured that staff had documentation to reference and follow and for tasks to be completed in the correct manner. Policies included,

major incidents, complaints, medicine management and administration and the duty of candour. Policies were readily available to staff as hardcopies in the ambulance station and via the services online portal.

- Policies and procedures referred to advice and guidance from the General Medical Council (GMC), Nursing and Midwifery Council (NMC), the National Institute for Clinical Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. Policies were discussed at the Patient Safety Committee and reviewed by relevant staff.
- We saw evidence of information and guidance that was made available for staff providing an urgent patient transfer service during an event. Documentation included a poster with operational information, guidance for needle stick injury, vehicle enquiry, equipment enquiry, complaints and guidance for staff on safe discharge of those under the influence of alcohol and drugs.
- Further guidance on the treatment of conditions were available for staff, for example head injuries, hyperventilation, faint & collapse and strains and sprains.
- The service had conducted a number of audits and had identified future audits that it planned to undertake. Planned audits included; handwashing – use of hand gel, drugs bags, patient report forms and safe discharge by first aiders. The service planned to build on their audits by including independent audits in their audit programme.
- We saw evidence of actions taken following the patient report form audit, where a number of issues were identified such as the lack of documenting consent to treatment. These issues were highlighted to urgent patient transport staff via the services newsletter, team briefings and also in a pre-event briefing document.
- Staff received updates on policies and procedures in a number of ways such as the services online portal and the regular newsletter which was emailed to all staff. Both members of staff that we spoke to could recall reading numerous policies and receiving regular updates.
- There were no specific policies and guidance relating to children and young people in use within the service. This issue was highlighted to senior staff.

Assessment and planning of care

- The majority of the service's work did not involve the use of their ambulances for urgent patient transfer from events and that the service called upon the relevant local NHS Ambulance service to support their transfers when necessary. They conveyed patients from large crowd events such as sporting arenas and large concerts where they had the provision to do this.
- The service had an 'event venues risk assessment' and a 'medical management plan,' that was completed in conjunction with other relevant parties prior to an event. This document identified the nature of the event or venue and considered the expected attendance figures, demographics and the likely risks posed to the public. This allowed the deployment of the right numbers of ambulance vehicles and levels of appropriately trained patient transport staff, to address those anticipated risks. The plan was circulated to the local authority and ambulance service for inspection and sign off.
- Urgent patient transport staff were given important contact details via the induction booklet and the emailed newsletter. Contacts included those for compliance and recruitment issues, major events planning and those for out of hours clinical advice, operational issues and significant equipment issues.
- One member of staff explained that in planning where to transfer a patient that they were made aware of the receiving NHS facilities criteria to ensure that patients are taken directly to the most appropriate NHS facility.

Response times and patient outcomes

- The service did not routinely measure response times as its urgent patient transport provision was on event sites only. The service stated that their response times were hard to measure.
- Hospital handover times for ambulances were being looked at and discussed. The time taken to transfer patients into NHS facilities was not measured. This issue had been placed on the services 'risk register,' as low risk in April 2017 and progress was being monitored through management meetings.

Patient transport services (PTS)

- We examined three sets of patient feedback forms collected by the service between February 2017 and February 2018. We noted that one patient had left feedback on their ongoing care needs and the service had played a positive role in highlighting the patients' health condition.
- We spoke to one of the services clients who indicated that the service has always met their requirements and that the urgent patient transport service provided was "quick and efficient" and "transport off-site had all gone to plan, in liaison with the NHS."

Competent staff

- The service had a recruitment ethos which enabled them to form links with higher education establishments and to recruit suitable candidates, such as student paramedics and medical students.
- Interviews were performed face to face and also consisted of a basic life support assessment. This assessment included the operation of automatic external defibrillators and the provision of cardiopulmonary resuscitation (CPR). The interview was recorded and the practical assessment was documented on a dedicated recruitment form. Following the inspection we spoke with the managing director who confirmed that the assessment of skills at recruitment covered adult basic life support and paediatric life support.
- At recruitment events the service gave out new starter clinical medical questionnaires that must be completed as part of the recruitment process.
- The human resources co-ordinator ensured that staff had the appropriate skills and knowledge for their role. All staff at recruitment were asked to submit supporting documentation in relation to their roles, including evidence of training completed.
- The service had standardised its application requirements for staff of all grades which included: a curriculum vitae (CV), a disclosure and barring service check (DBS), a qualification check, a right to work check, a basic life support check and evidence of mandatory training compliance in the last 12 months.
- The service had not always performed reference checks. The current human resources co-ordinator was addressing this issue by performing retrospective reference checks.
- Disclosure and barring service checks were performed during recruitment and then reviewed every two years. Staff were expected to renew their disclosure and barring check every three years.
- We reviewed ten sets of staff records to evidence the completion of pre-employment checks and ongoing training as required. Staff files were completed to a good standard with the exception of Hepatitis B vaccination documentation.
- Staff completed a clinical medical questionnaire in relation to their physical health during the recruitment process. However, the service did not currently check that staff, such as paramedics, who were employed by the NHS, had been vaccinated for infectious diseases such as Hepatitis B, or check their immune status. The human resource staff member was in the process of requesting this information from all staff.
- The service were developing a competency framework on its online website outlining what was expected for the staff members' role. This clarified which duties that they could and could not undertake and acted as a reference for staff that were unsure. It was unclear whether this competency framework related to the needs of children and young people.
- Information held on newly recruited staff was shared with the workforce and planning co-ordinator prior to them being eligible to book onto their first shift.
- Checks were performed via an on-line human resources portal, to ensure that staff were appropriately trained. This included checking staff records for qualifications, Health and Care Professions Council (HCPC) registration, driving licence checks and blue light training.
- If records were not completed appropriately then steps were taken including, talking to the member of staff, referral to their professional body, or an inability to work for the service.
- Team leaders assigned to events were responsible for ensuring that staff could perform their duties relating to urgent patient transport competently and report any concerns.

- Driving licences were rechecked every six months. The staff that we spoke to had a category B1 UK driving licence appropriate for the B1 weight category of the two ambulances that the service utilised.
- Following a revision of the services driving standards policy, the service had appointed a driving standards specialist to provide refresher training in blue light standards. The service had introduced this new training after identifying that some staff may not be reassessed within their permanent employment. The service has also documented that they were going to provide drive outs for staff with an instructor to familiarise themselves with the ambulances utilised by the service.
- All new staff received a welcome pack as part of their induction containing information about the service and details of their first shift. All new staff received peer support provided through a buddy system, until deemed competent to work unsupervised. We also saw evidence of job descriptions for staff.
- To support the ongoing training of staff and the need for relevant staff to complete their mandatory training every year, the service had a contract with a dedicated supplier of healthcare mandatory training.
- The service had recently introduced an 'Appraisal and Development Review and Planning Policy and Guidance document,' for staff. The service did not complete staff appraisals but had developed a new appraisal system for roll out to staff beginning in March 2018.
- The development and implementation of a staff appraisal system for health care professionals was included in the services key objectives for 2018.The service outlined that newly recruited staff would be appraised every six months and then every 12 months for all staff.
- The managing director acknowledged that appraising a casual workforce was challenging and that they were considering different options to achieve this.

Coordination with other providers and multi-disciplinary working

- We spoke with one client who had worked with the service over a number of years. They were very satisfied with the service and described how it always met their expectations and requirements, "they were experienced and met all the criteria that they were looking for in a non NHS provider."
- The client explained that the service provided them with medical services plans which outlined their requirements for urgent patient transport provision and that met NHS approval. The managing director and the workforce director had regular meetings with the client and were described as being "quick and efficient" and "obliging, polite and professional."
- We saw evidence of a multi-agency approach to the planning of urgent patient transport services from an event. Staff liaised with the local police force and were included in local NHS ambulance service plans.
- Senior managers attended 'Safety Advisory Group' meetings along with representatives of the fire brigade, police, local NHS ambulance services and the local authority. The group discussed the anticipated risks associated with urgent patient transport provision from the event. The group also performed risk assessments, which enabled them to agree the resources required in conjunction with the client.
- Staff ensured that the patient report form was made available when handing over patients taken via ambulance to a receiving NHS facility. The staff that we spoke with indicated that they would pre-alert the receiving facility and liaise with the local NHS ambulance service to provide support during the transfer.

Access to information

- Staff could access information relating to patient transport services required at a specific event, once the event had been booked and the details released onto the services website. This enabled staff to familiarise themselves with the information required relating to urgent patient transport provision prior to the event itself.
- Staff allocated to the urgent patient transport service at events had access to policies, guides, clinical advice and information relating to that specific event and patient transport provision. Information could be accessed

remotely via the services on-line portal and the emailed newsletter sent out to all staff. Each member of staff also had a copy of the event briefing document and there was an information folder in each ambulance.

- Staff providing urgent patient transport cover had access to clinical advice at the event as there was a doctor on site covering major events. Staff could also contact the emergency point of contact, the local NHS ambulance service and the receiving NHS facility.
- Staff had access to a satellite navigation system in the ambulance. The necessity for this system was lessened as the events covered by the urgent patient transport service, were located at fixed sites. The potential receiving NHS facilities were also local to the event and highlighted in the pre-event briefings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The two staff that we spoke with had good knowledge of the Mental Capacity Act (MCA), the Deprivation of Liberty Safeguards (DOLS) and their application.
- The service included 'consent,' in their mandatory training and staff were aware of the term 'best interest decisions,' relating to patients care and treatment. The service had an internal consent training compliance rate of 88%. However we found gaps in documenting patient consent to treatment and the witnessing of consent on patient report forms.
- The patient report form had a section outlining capacity and consent and listed the key information that staff followed in assessing whether a patient may lack capacity.

Are patient transport services caring?

Compassionate care

- The service emphasised their desire to be known as the 'caring face of events.' All of the staff that we spoke with during the inspection showed a commitment to providing the best possible care.
- We were unable to observe care given directly to patients during an urgent ambulance transfer, as there were no events held during the inspection. This was also due to the limited number of times that patients were transferred urgently from an event site to a local NHS facility.
- We sent out comment cards for patient feedback prior to the inspection; however no urgent patient transfers occurred during this time period. We spoke with one patient who had been transferred from an event between February 2017 and February 2018.
- The patient that we spoke with told us that staff were very kind, gave them a chair and also offered them a blanket to keep them warm and preserve their dignity. Staff also took the necessary time to engage and made them feel calmer by having a conversation with them. The patient felt that staff went out of their way to make them feel better.
- We reviewed three sets of patient feedback forms collected by the service between February 2017 and February 2018, one comment stated that, "everyone helped my mum and went over and above our expectations."

Understanding and involvement of patients and those close to them

- Staff we spoke with explained that they would regularly check the needs of the patient and their families. A staff member told us they would also see if patients understood their care and treatment during transfer.

Emotional support

- Comments from patient feedback included thanking the service for all their help and in signposting them to other health care services. Another comments' card described the support that the service gave to their relative and for keeping them safe and reassured.
- Staff understood the need to support the patient and their families whilst a patient was receiving care and treatment and should their condition deteriorate during transfer. Staff explained how they tried to support the emotional wellbeing of patients and their families by offering reassurance or trying to calm them, depending on whether they were anxious, upset or agitated.

Patient transport services (PTS)

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- A medical management plan was completed prior to events, which was shared with the local authority and the local NHS ambulance service for approval and sign off. This included staffing levels for the urgent patient transport service, a major incident plan, the names of receiving hospitals and operational procedures.
- The service carried out risk assessments in conjunction with clients to determine the number of ambulance vehicles required for the event. These risk assessments were also used to determine the scope of medical provision required, for example the number of field hospitals, treatment centres, or first aid rooms where patients could be seen by medical staff to prepare them for transport off site as and when required.
- We saw evidence of the service effectively providing an urgent patient transport service to large events at short notice. One client that we spoke with said that the service were always able to meet their requirements in this respect. The service stated that they had regular contact with their clients in order to build strong working relationships.
- The service attended safety advisory team meetings along with other services such as the fire brigade, police, NHS ambulance and also the client. The service worked side by side other agencies in planning for major events and to ensure that they have the right number of ambulances and the right staff levels and skill mix to provide safe urgent patient transport cover for the event.

Meeting people's individual needs

- The service had a bariatric stretcher on one of its ambulances to aid in the transfer of patients who exceeded a certain weight. There was an additional safety strap on the ambulance to aid in the transport of children. However, the service did not have a specific child safety harness.
- Ambulances carried an acid kit containing equipment such as visors, shields, gauntlets and aprons. This enabled staff to treat people who may have been affected by acid burns.
- The ambulance information folder contained an emergency multilingual phrasebook. In addition staff told us that they had access to a telephone interpreter service. To access this service staff would contact their emergency point of contact.
- We saw in the ambulance a pictorial communication book, which aided staff interactions with patients that had communication difficulties. This guided staff in understanding the needs and preferences of patients with additional needs such as a translator or other communication aids.
- Staff had a guide to follow on the patient report form detailing the signs to indicate that a patient may lack the capacity to consent to treatment such as, being able to communicate their wishes and the risks attached with refusal of care, treatment, transfer and advice.

Access and flow

- To book onto an event the workforce accessed the services website portal to see which events were available for them to work and to nominate themselves for urgent patient transport provision during the given event. The size and nature of the event helped in determining the number of staff and physical resources required to meet the anticipated urgent transport provision needs of the attending population.
- The workforce planning co-ordinator reviewed all requests for work by staff and deployed them to cover urgent patient transport services during the event based on their individual skills, training, and competence. Live jobs were released in advance, staff could book themselves on via the services internal web portal, and there was also a 'whats app' page for staff to book onto and view events requiring urgent patient transport provision.
- The service used a status update system at events to prioritise care and treatment for patients with the most urgent needs They also had a crash team protocol and doctors on site. This system allowed for patients requiring urgent transport to local NHS facilities to be treated promptly and prioritised for transfer.

Patient transport services (PTS)

- Patients could access their care and treatment in a timely way. The urgent patient transfer service was able to ensure that the right staff and equipment were where they needed to be at the time required. They used a traffic light system to highlight the number of patients that were requiring assessment, treatment or transfer and to identify when extra resources were required.
- The service used a demand feedback system which showed when they were under severe pressure and were reaching capacity additional aid would be sought from local health care services. The use of a casualty transport flow aided in identifying patients with conditions requiring immediate transfer offsite and local NHS facility admission. Additional ambulances were hired if required to provide adequate urgent patient transport services at larger events. Ambulances were hired empty and then fully equipped by the service. We saw evidence where the service risk assessed their capacity for providing this service at events. The service also advised clients in advance when they did not feel they had enough resources to safely provide urgent patient transfer cover.

Learning from complaints and concerns

- The service had a complaints policy, which included details on how to make a complaint, their responsibilities, the need for openness and support, staff training and learning from the management of complaints. The complaints process was overseen by the director of clinical care and training.
- The service had received no complaints relating to their urgent patient transfer service between February 2017 and February 2018.
- We found that all complaints relating to regulated and non-regulated activities had been investigated to see if any changes were required to improve the patient's experience. Complaints were discussed at board level and fed back to staff.We saw evidence of support being offered to staff and to the affected family. There was clear evidence of learning from complaints. The staff involved were offered refresher training and advised to make the public that they were treating aware of their skill set.
- The service had a system for handling and logging complaints received in writing, via email, via telephone or face to face. Complaints were acknowledged within five working days and after investigation a written response communicating the outcome was sent to the complainant.
- Feedback leaflets for patients who wished to make a complaint were available in the ambulance information folder, which was kept on the vehicle. These leaflets had an embedded QR barcode which could be scanned, enabling complaints to be made directly online.
- The staff that we spoke with were aware of the services system for handling, managing and monitoring complaints and concerns.
- Changes in policies and processes relating to complaints were fed back regularly to all staff groups.

Are patient transport services well-led?

Leadership

- We saw that the leadership team had clearly identified roles and responsibilities. The management team described how they strived to be professional, open and inclusive.
- We received feedback directly from three members of staff via our pre-inspection invitation for feedback. Comments received included: "I have seen the company grow and flourish." "Senior Management and supporting networks have also been made available to staff." "Staff are continually learning with training sessions being provided to advance learning while working."
- Further comments from staff included, "this kind of working environment means that people are not afraid to raise any concerns they may have either about their own capabilities or any issue that may arise." "Risk averse [sic] and will not cut corners or sacrifice safety for the sake of profit." "Very caring team both to patients and to staff." "Always willing to take on board views of staff in order to drive standards up."

Culture

- One member of staff that we spoke with during the inspection described the organisation as having a "no

blame culture" and that people were "invited to speak out." They felt that the registered manager had "brought momentum" to the service and "pushed for improvement."

- Further comments from staff described the management team as "visible, open, friendly and approachable." They felt supported and were able to give examples where they had raised issues and the managers had actioned it promptly.

Vision and strategy for this core service

- The vision for this service was clearly laid out in their statement of purpose. "At ShowMed we aim to provide high-quality medical support in a flexible and imaginative way to meet the needs of both event organisers and participants."
- The service aimed to deliver this vision for example by 'ensuring that medical treatment is immediately available and is provided to the highest possible standard, in line with current available guidelines for best practise.'The services statement of purpose outlined their desire to respond positively to any complaints or criticisms of their service and to use these to improve the urgent patient transport service that they offer at future events.
- In addition the service highlighted their desire to be known as 'the caring face of events.'
- The management team and the staff that we spoke with were passionate about delivering a high quality urgent patient transport service to their patients and event organisers. They also aimed to work in a manner which minimised the burden placed on the local health economy.
- The service outlined their yearly objectives to ensure that they had a credible strategy in delivering the key elements outlined in their statement of purpose. Objectives for 2018 included, ensuring that they seek feedback from their service users at every opportunity and the development of an online and accessible competency framework.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The service had a governance framework in place. The managing director and the workforce director led the service with the support of the director of clinical care and training (who was also the registered manager) and the finance director. They were supported by managers, office staff, consultant advisors, clinical advisors and clinical delivery staff.
- The service were considering introducing BS 76000, a management standard that provides a framework for organisations to value people, for the mutual benefit of both parties.
- All staff that we spoke with were aware of their roles and responsibilities and how they contributed to the service. They also knew who the different leads were and what they were responsible for. Under their governance framework the service had developed a number of policies and protocols to aid service delivery, however there were no specific policies relating to children and young people in use within the service.
- A file was placed at each venue containing the latest clinical evidence for conveying staff to use for reference. For example, the use of the 'green whistle' for pain relief, tourniquets and a sports concussion assessment tool. This evidence was taken to the 'Patient Safety Committee' and incorporated into existing policies if needed.
- The service had a number of systems in place to review their processes, address issues and to make improvements. We saw evidence of this in the minutes of the 'Patient Safety Committee' meetings. A group representing different elements of the business including a clinical advisor discussed such issues as the services risk register, incidents, audits and proposals and any patient safety issues.
- Incidents, themes and trends were discussed by the patient safety committee for greater understanding / resolution. A cross-section of staff with all skills/grades within the organisation attended to encourage learning and prevent the possibility of a recurrence.
- In addition a number of forums contributed to the services overall quality and performance including, operational meetings, human resources meetings, multiagency 'Safety Advisory Group' and briefing meetings.

Patient transport services (PTS)

- The service had an incident reporting system to monitor quality and take action to improve performance. Incidents were categorised for risk and collated for trends. There was evidence of actions taken to mitigate risks. However, the learning from incidents did not always assure us that lessons were learnt fully.
- A feedback system for patients and staff was in place to measure and monitor quality. Through this engagement the service analysed feedback, whether positive or negative to drive service improvements. The service stated that "patient feedback was hard to find."
- We looked at the services' risk register which categorised risks by department, initial risk level, ongoing risk level and who was responsible for actions required to mitigate those risks. A progress report was included for each risk with ongoing actions time lined. We also looked at a risk and compliance tracker, this was completed at 'Risk and Compliance' meetings to record and discuss action points and to highlight progress on the completion of those actions.
- The service had established links with other services and clients and attended multiagency meetings and briefings during the course of preplanning for urgent patient transfer provision during events.
- There was a policy in place for risk management and the service had a risk management consultant on board to oversee this process. We saw copies of organisational risk assessments such as 'ShowMed event venues,' 'medication storage Bury office' and operational risk assessments such as the 'risk assessment guide for selection of protective equipment based on risk of exposure to blood or body fluid.'

Public and staff engagement (local and service level if this is the main core service)

- Staff we spoke with described how management were more than happy to listen when they had a question, issue or concern. Staff had access to a person in the management team out of hours via the emergency point of contact telephone number.
- Staff feedback was delivered in a number of ways including via the staff feedback page, newsletters, emails, the staff on-line system, the briefing document and face to face by the recent introduction of team leaders and team meetings.
- The service had developed new ways to engage with their staff. They had invested in new team management software, to provide agile working for all managers and staff for collaboration and communication.
- Regular contact was maintained between the service and their existing clients. One client that we spoke to described the development of a long term professional relationship with the northern hub of the business. There was a system for feedback between them however the client stated that they had "no complaints only praise."
- The service had its own website accessible to the public which described the service and its background, as well as its statement of purpose, events where it provided urgent patient transport services, projects, contact details and a link to a feedback form. The service posted information for staff and the public on their face book page. The public could provide feedback via a dedicated leaflet which was located in the ambulance information folder.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The service had sought an alternative medicine for pain relief due to issues surrounding the governance of controlled drugs. They had introduced an innovative drug) in the form of an inhalation 'green whistle,' as an alternative, which they assessed to be very safe and effective. The service had introduced training for this new medicine and saw it as an effective alternative to controlled drugs.
- Most of the services contracts rolled from year to year. Managers were able to describe their plans for sustainability and this included contracts that had recently been renewed and contracts that they were tendering for.
- The service had an ongoing recruitment strategy. This included hosting recruitment events where the service delivered presentations and establishing links with higher education establishments.
- The service were working on an induction video to give an overview of the whole company to newly recruited staff, who would then send an online acknowledgement to show that they had seen it.

Patient transport services (PTS)

- The service were developing a clinical competency framework to cover all staff grades and outline duties what they can and cannot perform to ensure that they were working to and within the boundaries of their role. It was unclear whether this competency framework related to the needs of children and young people.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that robust systems are in place for checking and monitoring the contents of paramedic bags, equipment and for the management of medical gases. These systems must include a check for expiry dates and for function. Processes must also ensure the correct storage and the clear segregation of full (part used) and empty medical gas cylinders.
- The provider must introduce a system to assure itself that regular cleaning of ambulances is documented and to identify the vehicles as being cleaned and ready for use.
- The service must assure itself that an effective system is in place that addresses any highlighted deficiencies in record completion.
- The service must introduce specific policies, equipment, skills assessments and competencies relating to the needs of children and young people.

Action the hospital SHOULD take to improve

- The provider should ensure that all levels of staff have suitable safeguarding children and adults skills, including training in line with best practice.
- The provider should mitigate the potential risks posed to staff by infectious diseases by checking their vaccination records.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** · The provider must operate effective systems and processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. · The provider did not have effective systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users that arise from the carrying on of the regulated activity. · The provider did not maintain a complete and contemporaneous record of the care and treatment provided to each service user. This is a breach of Regulation 17 (1) (2) (a) (b) (c)