Ambulance & Medical Support Services - Ambulance Station Sandhurst

Quality Report

Unit 22
Vulcan Way
Sandhurst
Berkshire
GU47 9DB
Tel: 07767 215186

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Not sufficient evidence to rate
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Ambulance & Medical Support Services – Ambulance Station Sandhurst is operated by Ambulance & Medical Support Services Ltd. The service provides an emergency and urgent care ambulance service by conveying patients from event sites to the local acute NHS trusts.

Ambulance & Medical Support Services - Ambulance Station Sandhurst is not commissioned by other organisations to deliver services on a regular basis. Work was undertaken for event organisers on an ad hoc basis and there was no formal contract issued. The service had three emergency ambulances it used to carry out the regulatory activity.

We previously inspected the service on 1st May 2019, following which the service was placed in special measures and rated as inadequate. We took urgent action and served a notice of decision to ensure only medicines listed in Schedule 17 Part 3 'Exemptions from the Restriction on Administration of Prescription Only Medicines' and Schedule 19 'Medicinal Products for Parenteral Administration in an Emergency' of the Human Medicines Regulations 2012 were administered to any patients.

We carried out a comprehensive follow-up inspection on 7th January 2020 to assess whether the provider had made sufficient changes to the service to lessen the risk to people using the service. We gave the service 48 hours' notice of the inspection to ensure everyone we needed to speak with was available.

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

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We found the following areas of improved practice:

- Processes had been introduced to make sure all staff working for the service had the qualifications, competence, skills and experience necessary for the work to be performed and had completed appropriate mandatory and safeguarding training for their role to deliver safe care and treatment.
- Infection prevention and control processes had been put in place to reduce the risk to patients and staff of cross-infection.
- Processes had been put in place to ensure the safe management of medicines which complied with national guidelines and legislation.
- The service had developed systems to manage patient safety incidents and respond to patient complaints.
- Senior staff had acknowledged they lacked the necessary skills, knowledge or experience to effectively manage and develop the service. They had taken the necessary steps to get support and bridge the gap whilst they developed their own skills.
- The service had developed a governance process to support systematic improvement of service quality and safeguard high standards of care. Although, the processes and systems were in their infancy and still needed to be developed and embedded into the service.

However:

- Even though the service had reviewed and updated the policies and procedures, they were still not always relevant to the service or reflective of current working practice.

Summary of findings

- The service did not always keep the premises clutter-free. There were no fire safety and environmental risk assessments completed to make sure people were kept safe and free from harm.

  Our rating of this service improved. We rated it as **Requires improvement** overall.

  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 two requirement notices, the details are at the end of the report.

  Nigel Acheson

  Deputy Chief Inspector of Hospitals (London and South), on behalf of the Chief Inspector of Hospitals

Overall summary

We found the following issues that the service provider needs to improve:

The premises were not clutter-free and there had been no fire safety or environmental assessment completed for the premises.

Information contained in the service policies and procedures did not always match current working practices.

There were gaps in the service's systems and processes that supported staff in assessing if a patient had the capacity to make decisions about their care.

The governance framework was still in its infancy, some aspects required further development and change needed to be embedded into the service.

However, we found the following areas of good practice:

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

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

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

The service had suitable premises and equipment and mostly looked after them well. Staff managed clinical waste well.

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment for events it was contracted to provide medical assistance for.

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

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

The service was beginning to manage patient safety incidents. Staff recognised incidents and near misses and were being encouraged to report them appropriately. Managers investigated incidents and shared lessons learned with the whole team. There was a Duty of Candour policy to follow if things went wrong.

The service provided care and treatment based on national guidance.

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief advice in a timely way.

The service had started to monitor response times with the intention to use the findings to make improvements.

The service was putting in processes to monitor the effectiveness of care and treatment, with the intention of using the findings to make improvements and achieve good outcomes for patients.

Summary of findings

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Due to the nature of the service there was limited opportunities for staff to work with doctors, nurses and other healthcare professionals and support each other to provide good care.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

The service planned and provided services in a way that met the needs of the event they were attending.

The service took account of patients' individual needs.

People could access the service when they needed it and receive care in a timely way.

The service had systems and process in place for patients to give feedback and raise concerns about the care received. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Although the manager at the service had the right qualifications to run a service, they had acknowledged they lacked the necessary skills, knowledge or experience to effectively manage and develop a service. They had taken the necessary steps to get support and bridge the gap whilst they developed their own skills. The manager was visible and approachable in the service for staff.

The service had a vision for what it wanted to achieve. The vision and strategy were focused on developing the quality and sustainability of the service and having the formal strategy to turn it into action.

There were indications that the service promoted a positive culture that supported and valued staff and were focused on the needs of the patients receiving care.

Systems and processes were being developed to operate an effective governance framework and to improve service quality and safeguard high standards of care.

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had started to collect, analyse and use information to support activities.

The service was taking steps to improve engagement with patients, staff and the public.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Requires improvement 	The service provides medical cover at events such as boxing (in support of army medical staff), motocross and equine events for adults and children. The service conveyed patients from event sites to the local acute NHS trusts. We rated this service as good for safe and responsive and requires improvement for effective and well-led. We did not rate caring as we did not have enough evidence to make a judgement. Improvements had been made to the service since we last inspected. Where knowledge and skills had been lacking in the service, advice and support had been sought and listened to. This had helped the service develop processes and systems to help improve service quality and keep patients safe from harm. However, change was in its infancy, some aspects required further development and changes needed to be embedded into the service.

Summary of findings

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Ambulance & medical Support Services - Ambulance Station Sandhurst

Services we looked at

Emergency and urgent care

Summary of this inspection

Background to Ambulance & Medical Support Services - Ambulance Station Sandhurst

Ambulance & Medical Support Services – Ambulance Station Sandhurst is operated by Ambulance & Medical Support Services Ltd. The service was registered with the Care Quality Commission (CQC) in May 2011. It is an independent ambulance service based in Sandhurst, Berkshire. The service primarily serves the communities of Berkshire and Hampshire but covers army boxing events in other counties.

Ambulance & Medical Support Services- Ambulance Station Sandhurst is not commissioned by other organisations to deliver services on a regular basis. Work was undertaken for event organisers and included conveying patients from event sites to NHS hospitals on an ad hoc basis. The service had three ambulances and five rapid response vehicles. We have only reported on the three ambulances as these were the vehicles used for the regulated activity.

The service for this location has had a registered manager in post since 08 September 2012. A registered manager is a person who has registered with CQC to manage a service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an inspection manager, a CQC pharmacist specialist and a specialist advisor with expertise in paramedic services. The inspection team was overseen by Cath Campbell, Head of Hospital Inspection.

Information about Ambulance & Medical Support Services - Ambulance Station Sandhurst

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the ambulance station at the registered services address. The ambulances used for the regulated activity and associated equipment were kept here. The service employed two members of staff, the registered manager, who was a paramedic, and an administrator on a permanent basis. The service recruited and kept a bank of paramedics and technicians who had substantive contracts with the NHS or Ministry of Defence. These staff would be used as and when needed to deliver the service at events which included conveying patients to the local acute hospital if required. At the time of the inspection the service had access to 11 emergency medical technicians/combat medical technicians and four registered paramedics. We spoke with the registered manager and two of the service's bank staff. In addition, we spoke with the external consultant the service had enlisted to assist the

Summary of this inspection

registered manager make improvements to the service. We were not able to observe any care being delivered to patients or speak with them as no one was receiving care during our inspection.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Requires improvement	Not rated	Good	Requires improvement	Requires improvement
Overall	Good	Requires improvement	Not rated	Good	Requires improvement	Requires improvement

Requires improvement

Emergency and urgent care

Safe	Good
Effective	Requires improvement
Caring	Not sufficient evidence to rate
Responsive	Good
Well-led	Requires improvement

Are emergency and urgent care services safe?

Good

Our rating of safe improved. We rated it as **good**.

Mandatory training

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

Since the last inspection in 2019 the service had reviewed mandatory training and had developed a system which meant they could be assured of their staff's relevant training needed to work in the service.

There was now a training matrix which listed the mandatory training needed before staff could work in the service and a way to track when training was going out of date and needed to be renewed.

As found at the previous inspection, staff undertook their mandatory training through their substantive employer. However, staff were now required to provide evidence to Ambulance & Medical Support Services Ltd (AMS Service Ltd) that mandatory training had been completed. We saw evidence mandatory training was recorded in detail on the mandatory training spreadsheet and a copy of the staff's training certificates keep in their staff file. Where staff had not completed the required mandatory training at their substantive post employer, the provider would provide the training either via an online or face-to-face training module.

The service was in the process of transferring the paper system onto a computerised spreadsheet. This would mean mandatory training could be monitored through a dashboard and colour coded. This would help them to maintain oversight of in date and expired training at a glance.

Safeguarding

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

Since the last inspection the service had reviewed and rewritten their safeguarding policy. The policy was now one single document which covered both adults and children. It detailed the different types of abuse, including information on prevent the radicalisation of vulnerable people, how to recognise them and the procedures required to report a safeguarding concern, as well as details of the safeguarding lead and their responsibilities.

The registered manager was the adult and child safeguarding lead for the service and had completed level 2 adult and child safeguarding training and could demonstrate knowledge of the correct way to report an adult or child safeguarding concern. At the time of the inspection the registered manager was organising his level 3 safeguarding training.

We saw evidence operational staff were trained to level 2 adult and children safeguarding in their substantive role, which was now required as part of the AMS mandatory training. In addition, a paramedic that worked as a clinical lead for AMS had safeguarding training level 3 and could be called upon if safeguarding advice was needed.

The registered manager told us that if a safeguarding concern was identified during an event the staff would contact the safeguarding lead and completed the new AMS Service Ltd safeguarding incident report form. Blank forms were kept in the vehicle folders that were on each ambulance. The ASM Service Ltd safeguarding lead would then make the necessary referral as needed. Staff we spoke with could tell us about the procedure but had not needed to raise a safeguarding concern.

Staff completed a daily log sheet for each job they completed and a patient record form (PRF) for each patient treated. On these forms was a tick box to fill out if there had been any safeguarding issues. We reviewed three daily log sheets and patient record forms, all forms were filled out and indicated there had been no issues. This showed that safeguarding issues were being considered when staff were at events.

We saw evidence all staff had an in-date Disclosure and Barring Service (DBS) check which was reviewed during the recruitment process. This protected patients from receiving care and treatment from unsuitable staff.

Cleanliness, infection control and hygiene

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

The service had a cleanliness and infection control policy which had been reviewed and updated since our last inspection. However, there were still incidents where the policy did not match current practice. For example, the policy stated vehicle interiors would be cleaned daily whereas they were cleaned when used and deep cleans would happen monthly when in practice they were occurring every six weeks. The cleanliness and infection control policy also included guidance on hand hygiene and the use of personal protective equipment.

The service employed the services of an external contractor to give advice on infection prevention control best practice and to supply the cleaning and hygiene chemicals and ancillary products needed. We saw evidence the service was following the instructions as detailed in the contractor's manual. For example, using the correct cleaning solutions and equipment for vehicle and premises cleaning. Cleaning chemicals were stored in a dedicated metal storage cupboard with signage on the door highlighting the 10 golden rules for the control of substances hazardous to health. However, while product information sheets were available, there was no list of chemicals contained in the cupboard and the service had yet to complete the control of substances hazardous to health 2002 (COSHH) assessments[MS1]. COSHH assessments can prevent or reduce workers exposure to hazardous substances.

The shared kitchen and sluice area had been turned into a cleaning station and new industrial sinks fitted. This area housed dedicated cleaning equipment such as specialised cleaning mops and brushes. There was a separate staff toilet with hand-washing facilities which had its own cleaning materials. The service now had a separate area where staff could make hot drinks. Disposable paper cups were used that did not require washing up. The measures the service had taken had reduced the likelihood of cross-infection.

We reviewed two ambulances used by the service to convey patients to hospital. They were visibly clean internally and externally. Reusable equipment such as splints and monitors were visibly clean. All trolleys were clean and disposable clean linen was available.

Personal protective equipment (PPE) such as gloves and aprons were available in the station and on the vehicles. Since our last inspection, body fluid spillage kits had been purchased and were now on the ambulances. Hand sanitising gel dispensers for hand disinfection were seen in the station and on the vehicles.

The service had changed its documentation relating to the cleaning of the vehicles. There was an ambulance cleaning standard guide on each vehicle which listed what needed to be cleaned and the cleaning products that needed to be used. Staff signed and dated the daily log sheet to evidence the task had been completed. We reviewed the AMS vehicle cleaning log which showed vehicles used for the regulated activity were being deep cleaned every six weeks and listed when the next deep clean was scheduled for.

The practice of removing sterile single use items from the manufacturer's packaging for ease of access in an emergency, making them no longer sterile, had been stopped.

Requires improvement

Emergency and urgent care

Environment and equipment

The service had suitable premises and equipment and mostly looked after them well. However, there had been no fire safety or environment risk assessments completed for the premises. Staff managed clinical waste well.

The service had a security policy which had been reviewed and updated since our last inspection. Included in this policy were details of who was responsible for security, which was the registered manager, areas certain staff had access to and how often key pad codes should be changed.

The ambulance station had a forecourt where the ambulances used for regulated purposes were parked. This area was used for cleaning and restocking the vehicles. There was a garage that was used for internal deep cleaning of the vehicles and a secure room for the storage of consumable items and medicines. This secure room was only accessible to certain members of staff who required access to the space. The garage had CCTV cameras which monitored the front door and the medicines room. In addition, the medicine cabinet had anti-theft detectors on it which would alert the registered manager if unauthorised access to the cabinet was taking place.

Since our last inspection the ambulance station had been decluttered, although some areas were still partially restricted by the storage of equipment, such as the corridor to the training room. The staircase up to the office on the mezzanine floor had no hand rail and there was equipment stored on the staircase landing which could be a fire hazard. The training room had been cleared and staff teaching sessions were now taking place in this area. There was no signage to show the evacuation route from this area in the event of a fire.

We asked to review the environmental and fire risk assessments for the station, but were told none had been completed. Post inspection, we were told the registered manager and members of the team had carried out the risk assessment of the premises as per guidance from the health and safety executive and government public sector information website[MS2] after our visit. The service provided the completed forms to us. However, from the documentation we could not see if the risks identified at the time of the inspection, had been rectified or mitigated against.

Equipment was stored relatively neatly throughout the station. The service had a medical device servicing log which included a list of all equipment held by the provider and the last date it had been serviced. Annually, they used an external company to service and test electrical appliances for safety. Records confirmed this had last been undertaken in January 2019 and we were told by the registered manager this had been booked for January 2020.

On the ambulances used for the regulated activity, there was equipment suitable for adults and children. This included paediatric oxygen masks and nebuliser masks. Each ambulance had relevant emergency equipment available for both adults and children, such as defibrillators, airway management equipment and transport boards. There were five-point harness for the stretchers. Five-point harnesses minimise the risk of injury to patients and staff if the ambulance was involved in a collision.

We observed that there were fire extinguishers throughout the station and on the ambulances. One extinguisher in the station was past its service date which we flagged to the registered manager during the inspection. There was no fire extinguisher in the office which again we pointed out at the time of inspection[MS3].

Consumables were stored neatly in racking and off the floor in a locked room. Consumables we checked were in date. At the last inspection in 2109, the service kept out of date consumables in an unlabelled box in the station, which meant there was a risk they could be re-introduced into the service. Out of date consumables were now discarded immediately when out-of-date therefore eliminating this risk.

All keys to the vehicles were now stored securely when outside of the driver's possession which meant the vehicles could not be used without authorisation. Keys were kept in a locked cupboard which was accessed using a key from a code controlled key safe.

Records showed all vehicles used for the regulated activity were compliant with Ministry of Transport (MOT)

testing and the vehicles were regularly serviced. There were appropriate records of insurance and road tax. The service had vehicle breakdown cover for emergency assistance should the vehicle develop a fault.

There was a wipeboard in the station which was used for vehicle fleet management. This board listed the vehicle, its call sign, MOT due date, service date, information on deep clean and whether it was operational.

Each vehicle was fitted with a satellite navigation and tracking system. This system also sent a message to the registered manager if the blue lights were activated which indicated a patient was being conveyed to hospital on blue lights.

The service used radios to link between the operational crew and the on-call support. This meant there was 24/7 clinical support for the teams when they were out in the field. When not in use the radios were stored in the station on charge.

For each vehicle there was a folder, collected by the crew at the start of their shift, which contained information they would require. This included, patient report forms, cleaning standards for the ambulance, AMS service Ltd vehicle breakdown procedure and the vehicle fuel card. Also, within the folder was the allocated vehicle's satellite navigation system. This was a system which used a combination of satellites and mapping software to determine the vehicle's position and plan the best route to a chosen destination.

The daily log was used by staff to confirm the ambulance kit, such as the suction unit and defibrillator, and the vehicle daily inspection checks had been completed. The daily log required the crew member to tick and sign to say checks had been completed but was not a detailed list of individual checks. Since our last inspection, a standardised load list (a list of consumables and equipment each ambulance should carry) had been developed as a reference. This was used by crew to make sure they knew what individual items should be present on the vehicle. However, we did not see a vehicle checklist, for example, checking tyre pressures and screen wash, for staff to reference against when carrying out the vehicle checks prior to taking the vehicle out. This meant vehicle checking relied on staff remembering what was required. [MS4]

On the date of the inspection two ambulances were on site. We checked both vehicles which appeared to be in good working order. There was no visible body work damage and doors and lights were working properly.

Cupboards on the ambulances were standardised and labelled correctly. This meant the cupboard's contents now corresponded with the cupboard's labelling. This meant equipment and consumables could be found in a timely manner if needed in an emergency.

Lifting equipment for patient transport was stored, clean and accessible on the vehicles. This included spinal boards, carry chairs and stretchers. This meant equipment could be easily used if needed by the ambulance crews.

The service had reviewed and updated the waste policy. This policy included explanation of types of waste and how waste should be segregated and disposed of. During the inspection we observed that waste was disposed of in accordance with the policy. Each ambulance had a container for the disposal of clinical waste and a sharps bin. There was an accessible lockable yellow bin at the station where clinical waste was stored until collected for disposal by a specialist company.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

AMS Service Ltd did not use The Purple Guide, which is a guide written by the Events Industry Forum in consultation with the events industry to help event organisers manage health and safety at events. The registered manager told us risk assessments were completed prior to the crew being sent to any public event. Risk assessments considered; how many people were at the event, what was the risk and the number of paramedics and vehicles required. This assessment was based on organising previous similar events and requirements booked by the event organisers. Most events had an event doctor in attendance, employed by the event and not the service, which formed part of the risk assessment.

Staff told us whilst at events, they could contact the event's doctor for immediate advice regarding escalation if patients were deteriorating. They could also contact the registered manager for advice at any time.

Assessment for patients were carried out and recorded on patient report forms (PRFs). The documentation assisted staff in undertaking a rapid assessment and making the decision to convey to hospital or contact the NHS ambulance trust to request an ambulance to convey the patient. The forms were detailed and included, a record of the incident; assessments including vital signs and consciousness; and any medicine innervations. The PRF had a carbon copy, meaning that one copy could be left with the patient once they had arrived at the hospital. The registered manager told us they had been given compliments by the local trust on the completeness of information supplied to the trust when they handed patients over to them.

Patients were monitored to identify early detection of deterioration whilst in the care of the service. This information was recorded on the PRF. In addition, information for staff kept on the ambulance, included guides on the national early warning score (NEWS2), a system used to standardise the assessment and response to acute illness, and a guide to the detection of sepsis, a potentially life-threatening condition caused by the body's response to an infection.

We reviewed eight PRFs for patients that were conveyed to hospital. The records showed initial assessments were carried out in a timely fashion, patients were continuously monitored and forms were fully completed by the staff.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment for events it was contracted to provide medical assistance for.

The service employed two members of staff, the registered manager, who was a paramedic, and an administrator on a permanent basis. Other staff who worked for the service had substantive contracts as paramedics or technicians with the NHS or Ministry of Defence and were contracted to work on an ad hoc basis when required. The medical director for the service was a private GP based in central London, he undertook this role on a voluntary basis.

Since the last inspection the service had reviewed who was registered to work with the company. Only staff with the documented qualifications, skills, training and experience were now registered. The service at the time of the inspection had 11 ambulance technicians and 4 registered paramedics registered as being available to work on regulated and non-regulated work.

Some staff took on additional responsibilities at the service, for example operational and clinical leads. However, there were no formal role descriptions for these posts. Therefore, it was unclear if staff who were in these positions were aware of the scope, responsibility or accountability of their role.

All events were risk assessed for staffing needs by the registered manager and the administrator would contact staff to see who was available to work. The registered manager told us the service had access to enough staff to ensure there was the correct number of staff, at the right level, working at events.

Records

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

The service had patient report forms (PRFs) which staff completed following their assessment and treatment of patients. The service used two versions of the form, a short form for non-regulated activities and a longer form for regulated activities. The longer form was more detailed and included conveying information such as which hospital patients were taken to.

The PRF had a carbon copy, with the top part being retained by the service for their records and the bottom copy being left with the patient at the hospital for their records. There was a folder on the ambulance for storage of PRFs at the event site and a secure box at the station for crews to place their completed PRFs generated after an event. The registered manager was responsible for collecting, reviewing and filing the PRFs.

We were told if an electrocardiogram (ECG) recording had been carried out on the patient a copy of the ECG record would be printed and left with the patient at the hospital. The service was considering making a second recording and keeping that with the patients' notes at the service for completeness. However, this practice had not commenced at the time of the inspection.

We saw that PRFs were filed in a locked cabinet in a secure office. We reviewed the eight PRFs for patients conveyed to hospital from an event during the period June 2019 to December 2019. We found most forms to be legible and completed in full.

The registered manager completed monthly PRF audits and spoke to staff if documentation needed to be improved. We reviewed June 2019 to December 2019 audits and action plans. These showed minor documentation errors and documented that the staff members had been spoken with.

Medicines

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

There was an up to date medicines management procedure for staff to follow for the order, receipt, storage, administration and disposal of medicines. There was a separate procedure for controlled drugs (CD). Both documents had recently been reviewed and kept up to date.

A Home Office Controlled Drug Licence was issued in accordance with the Misuse of Drugs Act 1971 which meant the service could hold stocks of certain CD medicines for use by paramedics on behalf of the company. CDs were stored correctly at the station and on the ambulances. A random check of CD medicines showed quantities were accurately recorded and checked at signing in and signing out by two members of staff. Clear audit trails could be followed to ensure that CDs were monitored to prevent discrepancies or identify any issues.

Patient Group Directions (PGD's) were available which gave the required authorisation for paramedics to administer certain additional medicines. A PGD is legally required if the medicine is administered from the service's own stock to a patient. A PGD allows healthcare professionals to supply and administer medicines to pre-defined groups of patients, without a prescription, ensuring patients had speedy access to medicines they needed during treatment. However, we found that ambulance technicians were also included in making the decision to treat patients with certain non-parenteral prescription only medicines. Whilst this practice is not supported by current legislation, we were assured that an appropriate governance process was in place to assess and manage ongoing risk. Staff had undertaken appropriate training, assessed as competent and could contact the duty clinician to discuss the clinical need to treat the patient. This ensured people had timely access to safe treatment.

Following the previous inspection's findings, the service had removed one medicine, midazolam, from use. It would no longer be ordered, stored or supplied by the service. A second medicine, tranexamic acid, was not currently available for use by the service. However, the service wished this drug to be available for paramedic use. The service had following its medicine management policy and procedures and developed an authorised PGD, which required signing off by the medical director, a pharmacist and the responsible person. Staff would receive training in the medicine before it was introduced into the service. The service were aware new medicines could not be introduced into the service until conditions placed on their registration of the regulated activated by the CQC had been lifted.

Medicines were stored safely and securely at the location with access only by authorised members of staff. Since the last inspection, temperature monitoring for medicines was now undertaken to ensure they were stored within the safe storage temperature range required. Stock rotation was undertaken to ensure medicines did not go out of date.

Medicine bags were prepared separately for technicians and paramedics. We saw medicine bags with green tags and an expiry date which indicated they were ready for use. We reviewed three bags containing medicines and all medicines were in date. A checklist including a photograph of the layout of the medicines were also included in each bag.

Although there was no formal written procedure available there were arrangements in place to track and audit medicines from receipt to administration or destruction. Any medicines used were recorded and tracked against

the Patient Report Form (PRF). The medicine bag number, batch numbers of each medicine including their expiry date was electronically recorded. This ensured that stock levels were monitored and the reason for its administration could be audited. A sign in and a sign out register was kept ensuring that each medicine bag could be tracked. Any medicines that required to be removed and destroyed were recorded and two staff witnessed the destruction.

During the inspection we bought to the attention of the operational manager and registered manager there was no formal written procedures regarding the tracking and auditing of medication. A written procedure was immediately drafted, and we were told would be reviewed at the next monthly managers meeting.

During our announced inspection we found medical gases were stored securely on vehicles in a locked cupboard to prevent the risk of injury to staff and patients. Medical gas cylinders were also stored safely and securely at the service location, with appropriate hazard warning stickers prohibiting smoking and naked lights visible on the outside of the building. Cylinders were stored in a dedicated secure area that was clean, dry and well ventilated. They were stored on wooden racks which ensured segregation between empty and full cylinders.

Incidents

The service was beginning to manage patient safety incidents. Staff recognised incidents and near misses and were being encouraged to report them appropriately. Managers investigated incidents and shared lessons learned with the whole team. There was a Duty of Candour policy to follow if things went wrong.

The adverse incident reporting and investigation policy had been reviewed and updated following our last inspection. This policy included information relating to the incident reporting procedure, such as; definitions of relevant terms including, adverse incident, hazard, risk and near miss; the adverse incident reporting procedure; how to grade an incident and how to investigate an incident.

Previously the policy was not relevant to the service as it referenced staff roles and teams that did not exist in the company. The updated policy had removed the majority of these references. However, there was still some areas where it was unclear if this was the practice actually being carried out by the service. For example, the policy referred to the AMS Service Review Group who would review incidents but currently incidents would be reviewed at the monthly management meeting. The policy also referenced key performance indicators that currently where not being used to measure performance.

The service had retrained staff on incident reporting, had made sure incident reports forms were available to staff and were actively encouraging staff to report incidents and near misses. We saw reference to this in the staff newsletter. We were told by staff members that if an incident or near miss occurred they would fill out an incident report form, which was found on the ambulance and at the ambulance station, and alert the registered manager.

Incident reporting was a standing agenda item at the monthly managements meeting, which had started since the last inspection. The service had reported three incidents since the incident reporting system had been brought in August 2019. One of these incidents related to the regulated activity. We reviewed the significant event audit or serious incident form that had been completed for the incident. All information relating to the incident was completed thoroughly including a description of the incident and immediate actions taken. The form also included the learning and action points and how this was communicated to the team. This showed incidents were now being reported, discussed and acted upon. On the reporting form the incident had been classified as a significant event audit (SEA). However, the Adverse incident Reporting Investigation Policy Version 1.3 made no reference to SEAs, did not give a definition of a SEA or how they should be reported. Therefore, it was unclear if the policy was the practice the service used when reporting incidents.

The service had not reported any Duty of Candour concerns between January 2019 to December 2019. Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Requires improvement

Emergency and urgent care

The registered manager understood and could recognise when an incident required Duty of Candour and their responsibilities in relation to Duty of Candour.

The adverse incident reporting and investigation policy referred to the Duty of Candour. However, since the last inspection the service had also written a separate Duty of Candour policy.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Requires improvement

Our rating of effective stayed the same. We rated it as **requires improvement.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance. However, information contained in the service policies did not always match current working practices.

Since the last inspection in 2019, the service had reviewed the majority of their policies and procedures. References to other organisations, roles and departments that did not exist at AMS Service Ltd had mostly been removed. Dates to review the policies and procedures had been added. This meant there was now a timeframe to review documents to ensure updated guidance and working practices occurred.

However, when we reviewed the policies we found not all policies and procedures matched the current working practices of the service. For example, the latex policy states there is a database of all approved latex free equipment, the service does not have one; the cleanliness and infection control policy states a different cleaning schedule than current followed; and the adverse incident reporting and investigation policy, talked about a review group and quarterly management review meeting that currently do not exist. This meant staff could not always follow the information and processes provided in the polices.

Since the last inspection the registered manager had started receiving and reviewing National Institute for Health and Care Excellence (NICE) guidance to ensure practice and policies reflected best practice. For example, the registered manager explained the changes which had been made to the safeguarding policy after the NICE guidance had been read.

The registered manager told us all staff provided care and treatment to patients in line with the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) clinical practice guidelines and this would reflect current professional and best practice guidelines. We saw copies of the JRCALC guidelines at the station and staff had access to either hardcopies of the guidelines or via a JRCALC mobile phone application.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief advice in a timely way.

We were told staff followed guidance provided in the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) guidelines to support them with their assessment of patients, and the type of pain they may be experiencing.

Patients' pain levels were recorded on the patient report forms (PRF). Adult patients rated their current pain level between zero and 10 with zero being no pain and 10 being the worse pain a patient has ever experienced. Paediatric patients used a similar scale but from zero to four. The PRFs we reviewed showed that patients' pain levels were being assessed regularly and medication given if required.

Registered paramedics and technicians could administer analgesia, as analgesia was contained within the medicine packs taken to events. Nitrous oxide, an inhaled analgesic gas, was also available on the ambulances used to convey patients to hospital.

Response times

The service had started to monitor response times with the intention to use the findings to make improvements.

AMS service Ltd did not provide a service that had response time standards. However, since the last inspection the patient record forms (PRFs) had been

updated so certain parameters could be recorded by the crew. For example, time of patient presentation, time at scene, time to transfer to hospital from the event site and handover time at the hospital emergency department.

From the PRFs we reviewed we saw this information was being captured by the crews. The registered manager told us this information was being collected with the intention to monitor and discusses findings at the monthly management meetings as a way of reviewing performance and to help improve the quality of the service.

Patient outcomes

The service was putting in processes to monitor the effectiveness of care and treatment, with the intention of using the findings to make improvements and achieve good outcomes for patients.

The service was developing its audit schedule to support the delivery of safe and effective care. The service had started some monthly audits, for example medicine management, patient report forms, cleanliness and the completion of the daily logs. At present there was no framework which showed a complete list of audits or their agreed frequency.

The registered manager or designated individual would complete the audits and the results discussed at the monthly management meeting. Any resulting actions needed would then be put in place. We could see from documentation we reviewed during the inspection, this was beginning to happen. However, the audit process was still in its infancy and needed to be fully developed and embedded into the service.

All the patient record forms we reviewed showed staff had administered timely treatment and had a clear explanation for why patients were transferred to hospital. Where service users were transferred a formal handover was provided. To ensure full handover of care the hospital was provided with a copy of the patient report from (PRF) with all details of care which had been provided by AMS Service Ltd. Hospital staff receiving the patient were asked to sign the PRF to show a formal handover had occurred.

It was reported by the registered manager that once the patient was handed over to the hospital the service received limited patient feedback as it was not normal practice for NHS trusts to give patient outcomes to independent ambulance providers. However, with limited feedback provided, the service had no information or data to demonstrate that the treatment the service had administered had been effective once the patient had left their care.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service had reviewed and updated how staff were assessed as being competent for their roles. This meant there was assurance staff had the necessary qualifications, skills and experience to fulfil the role they were employed to carry out.

The staff induction policy had been reviewed and updated. This policy detailed the induction process for new staff and covered site-specific health and safety information for the ambulance station. This included, information management, start and end of shift procedures, patient handling, waste disposal, infection control, manual handling and vehicle cleaning.

Prior to the working at the service new starters were required to produce documented evidence of their qualifications, professional registration, mandatory training, Disclosure and Barring service (DBS) number, along with the date the DSB was completed, their driving licence so Driver and Vehicle Licensing Agency (DVLA) checks could be completed and details of blue light training, if required for their role. They also received an orientation of the ambulance station, which included demonstration of equipment, manual handling training and an introduction to policies and procedures.

A checklist was completed for each member of staff when induction and induction training had been completed. The checklist would be returned to the administrator to update the personnel file and for the new member of staff to be issued with a pin number. This pin number was used on the service's forms to identify members of staff completing the documentation.

The registered manager or clinical lead would accompany the new member of staff on their first

operational shift to make sure they were competent in their role and worked according to the service values. The member of staff would then be 'signed off' to work for the company.

Since the last inspection in 2019, staff files had been made for each member of staff. We received these files and saw the necessary documentation was included to evidence staff were competent for the roles they undertook for the service.

The service offered training opportunities to the staff and ran training days at least three times a year. These training sessions were continuing professional development (CPD) accredited which meant they went towards individuals CPD obligations for their professional body or association registration. Members of staff we spoke with where signed up to attend the next training session where ECG interpretation was to be covered.

The service had no formal job descriptions or identified roles and responsibilities, for example, the clinical leads. Therefore, it was unclear if staff who were in these positions were aware of the scope, responsibility or accountability of their role.

The service had introduced an appraisal process for staff. This involved a formal discussion between the registered manager and the member of staff. This conversation was documented and included details on performance, training required and resulting actions from the appraisal. The registered manager had set themselves a measured approach to completing staff appraisal, completing as a minimum, two per month. At the time of the inspection the registered manager had completed 33% of the staff appraisals and was ahead of the agreed timelines to get them completed.

Multidisciplinary working

Due to the nature of the service there was limited opportunities for staff to work with doctors, nurses and other healthcare professionals and support each other to provide good care.

The registered manager told us they worked well with event organisers and other services that supported events, such as security teams and Ministry of Defence doctors. This meant there was good communication and team working between all the parties who were involved with patient care at events.

If required, patients were taken to the emergency department for continuation of their care. The registered manager told us they received good feedback about the effectiveness of their handovers and handover paperwork. However, there had been no formal feedback between trust's and the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, there were gaps in the service's systems and processes that supported staff in these decisions.

The service had a patient consent policy dated January 2018 which had not been reviewed or updated since the last inspection. The policy included information on the types of consent and guidance on gaining consent from adults, children and patients who lacked capacity. The policy also contained information on the Mental Capacity Act 2005.

However, the policy had not been personalised to the service and included staff roles and departments which did not exist in the company, such as the patient experience department and the clinical support desk. The policy also referenced the patient capacity assessment guide form that staff were told to follow to assess capacity. We could not find this form, in the information folders that were keep on the vehicles, of the ambulances we inspected. This meant staff could not accurately follow all the information and directions in the policy.

The Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) was part of the mandatory training staff needed to have completed before commencing their employment with the service.

The patient report form (PRF) form prompted staff to assess patients' mental capacity before assessment and treatment took place. The PRFs we reviewed showed this had taken place for the eight patients the service had conveyed between since the last inspection in May 2019 and December 2019.

Discussion with the registered manager and the member of staff showed they was a good understanding about consent and their responsibilities.

Requires improvement

Emergency and urgent care

Are emergency and urgent care services caring?

Not sufficient evidence to rate

We were not able to inspect this domain as at the time of our inspection we did not observe care being delivered.

The service had conveyed eight patients from June 2019 to December 2019. Although the service collected some patient details on their patient report forms (PRF) we had not gained the consent to contact these individuals to ask about the care they had received from the service.

Are emergency and urgent care services responsive to people's needs? (for example, to feedback?)

Good

Our rating of responsive improved. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of the event they were attending.

The service was not commissioned by any NHS or private health organisations to provide an ambulance service.

The service covered a range of events held mainly in Berkshire and Hampshire regions these included religious and sporting events. The service also covered Ministry of Defence army boxing events in these and other counties. If required, the service would convey patients from events to local acute NHS hospitals.

Work was mainly undertaken for event organisers on an ad hoc basis and there was no formal contract issued. For certain events the service used a memorandum of understanding(MOU). A MOU is a formal agreement between two or more parties and they are used to establish official partnerships. MOUs are not legally binding but carry a degree of seriousness and mutual respect and state what is expected of each party.

The registered manager planned staff numbers and skill mix to meet the needs of the event. This included having capacity to convey patients to the local NHS hospital, if necessary, from the events they were providing a service for.

The registered manager told us a post event briefing was held with the organisers and staff to review the service provision at these events. This included whether people's needs were met and areas for improvement at future events. These meetings were not minuted therefore we had no evidence they occurred or what was discussed and if any improvements had been suggested. However, we did see correspondence from event organisers thanking AMS Service Ltd for their work at the events.

Meeting people's individual needs

The service took account of patient's individual needs.

Each vehicle was equipped with a translation card for multiple languages and sign language for deaf people. This enabled staff to show or use common phrases to find out what problems the patient was experiencing.

The patient consent policy stated it was not appropriate to use children to interpret for family members who do not speak English or for an adult family member to interpret for a child who does not speak English, which is good practice. We were told by the registered manager that some of the events they regularly covered employed doctors who had the relevant language skills to talk to patients in their native language. Staff told us if needed they could use an online translation service through their mobile telephones.

The vehicle had different points for entry, which included tailgate lift, so people who were mobile or in wheelchairs could enter the vehicle safely. This took account of people's individual needs.

The service did not have equipment to support conveyance of bariatric patients. We were told the local NHS ambulance service was used if a patient was assessed as needing bariatric equipment to be conveyed safely.

The registered manager told us if patients were violent or aggressive the support of the police or event security would be sought. The service did not convey patients experiencing a mental health crisis who were agitated or

refused conveyance. The service would seek the support of the police services to ensure these patients were safely conveyed to the local NHS acute hospital or mental health services by the local NHS ambulance trust.

Access and flow

People could access the service when they needed it and receive care in a timely way.

The service only worked at events for which they had been booked to provide a medical or first aid service. People could access the service at any time whilst at an event. Patients would be assessed by the crew and the event doctor, if there was one present, and a decision made if the patient could be treated and discharged at the event, or if they needed conveying to hospital.

Since May 2019 and December 2019 eight patients had been transferred using AMS Service Ltd ambulances to the local NHS hospital's emergency department.

The service had introduced documentation to monitor how long it took for crews to treat, or transfer patient care and treatment over to the local acute NHS trust. The service planned to use this data to assess the quality of patient care and if patients received the appropriate care in a timely way.

Learning from complaints and concerns

The service had systems and process in place for patient to give feedback and raise concerns about the care received. The serious treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The service had a complaints handling policy which had been reviewed and updated since the last inspection. The policy set out how to rate complaints, actions required and by whom and the timescales for investigating and responding to complaints. Although the policy was now more relevant to the service provided, it still referenced areas that the service did not have. For example, roles not currently found or defined in the service (the complaints champion and the board); documentation not seen during the inspection (a feedback investigate report (FIR), the complaints log reference sheet and patient client detail form); and the complaints governance (a complaints report would be presented to the board biannually).

There was information on the ambulances which gave patients and their relatives access to an email address, address and telephone number so they could contact the service regarding comments, concerns and feedback. The service had also introduced patient feedback forms which was another way for service users to express their views.

We saw in the new monthly management meetings that complaints were part of the standard agenda. Complaints would be discussed, themes and trends looked for, and any learning from comments highlighted. It also included what information or training, if needed, would be given to staff.

However, there had been no complaints made to the service since the last inspection. This meant the changes in practice and the revised complaints handling policy had yet to be followed to see if they were fit for purpose.

Are emergency and urgent care services well-led?

Requires improvement

Our rating of well-led improved. We rated it as **requires improvement.**

Leadership

The manager at the service had the right qualifications to run a service. They had acknowledged they lacked the necessary skills, knowledge or experience to effectively manage and develop a service. They had taken the necessary steps to get support and bridge the gap whilst they developed own skills. The manager was visible and approachable in the service for staff.

The registered manager, a registered paramedic was also the director of the company and had responsibility for the premises, equipment and staff. Since the last inspection

they had recognised they lacked the skills needed, in certain areas, to effectively manage and develop the service, and had taken the steps needed to address these issues.

The service had sought the services of an external consultant to offer support, advice and challenge to the registered manager. Where the registered manager was lacking knowledge, they had used the knowledge and skills of staff working in the service to delegate to. For example, reviewing and updating the medicine management system, updating the staff record system and the review of policies. The registered manager had also brought in the services of an infection control company to give infection control support and advice.

Since the last inspection the registered manager had more engagement with the medical director, who undertook the role on a voluntary basis. There were now more frequent meetings between the two. Although there were still no formal minutes from these conversations, the registered manager did document their conversations so there was a record of what was discussed. The medical director had been actively involved in changes to the service and working practices since the last inspection. They had also started to call into the monthly meeting which gave them greater clinical oversight of the service. However, there was still no role description for the medical director's post. Therefore, their role and responsibilities within the service remained unclear.

Prior to the inspection we had received the organisational chart for the company. This indicated there were operational supervisors and clinical leads working in the service. During the inspection the registered manager referred to staff in these roles. However, there were no formal role descriptions for these posts. Therefore, it was unclear if staff who were in these positions were aware of the scope, responsibility or accountability of their role.

The registered manager told us they were frequently part of the allocated staff at events, giving them visibility both to staff working for the service and event organisers. We were told by a member of staff that the registered manager, if not working with them, was always available via the telephone for advice and guidance.

There was no nominated deputy to cover for the registered manager in the event of their unavailability such as sickness and holidays. This meant there was a weakness in the service as the service did not have a documented plan should the registered manager be unavailable.

Vision and strategy

The service had a vision for what it wanted to achieve. The vision and strategy were focused on developing the quality and sustainability of the service and having the formal strategy to turn it into action.

The provider's vision for the service was 'to deliver world class patient services through a skilled and committed workforce". The service had four strategic objectives to deliver this vision by 1) meeting NHS, industry and CQC standards in quality and performance, 2) ensure sound financial management, 3) deliver the recommendations from regulatory and professional associations and 4) work towards expansion and development of the service provided.

The service had recognised where it needed to focus to develop the quality and sustainability of the service. Through seeking support and advice, the service had worked out an action plan on how to raise the standards of the service. The action plan was reviewed monthly to monitor process against the plan, to make sure quality improvements and hence sustainability of the service occurred.

Culture

There were indications that the service promoted a positive culture that supported and valued staff and were focused on the needs of the patients receiving care.

We spoke with two members of the team during the inspection. They told us the registered manager promoted a caring and positive culture for staff and they were visible and approachable to staff. We were told the registered manager or clinical lead cared about their safety and well-being and could always be contacted whilst they were on a job to provide support and guidance. We were given examples of this from the staff. We were told the team were like a family with many staff having worked in the service for many years.

The registered manager was well liked amongst the team and the staff were keen to provide assistance and support to drive forward the improvements and changes in working practices that had occurred since the last inspection. Staff told us they welcomed being included more in how the service was being run and how the registered manager had started to delegate tasks to the team.

Staff we met during the inspection were focused on making improvements to the service so they could provide the best care to their patients in a safe and effective way.

Since the last inspection the whistle blowing policy had been reviewed and updated and was now relevant to the service. By having a whistle blowing policy indicated the service encouraged an environment where staff would feel comfortable and there was a framework to raise concerns.

Governance

Systems and processes were being developed to operate an effective governance framework and to improve service quality and safeguard high standards of care. However, they were still in their infancy, some still needed to be developed and embedded into the service.

At the last inspection we found that governance arrangements were not operating effectively to ensure that all quality, performance and risks were understood and managed. At this inspection we found governance arrangements had improved.

The service had employed an external consultant to help improve the governance framework and develop systems and processes to make sure there was assurance and oversight of the service.

Policies and procedures had been reviewed and updated. However, not all policies had clear processes with some not reflecting current practices. This meant performance could not always be measured against the policy. [MS1]

The service was developing its audit schedule to support the delivery of safe and effective care. The service had started some monthly audits, for example medicine management, patient report forms, cleanliness and the completion of the daily logs. At present there was no framework which showed a complete list of audits or their agreed frequency[MS2].

The service had improved how checks were made to ensure staff who worked for the service had the necessary skills and competencies to carry out their role. There was now a documented process, with the recording of information, that could effectively demonstrate staff had the necessary, skills, knowledge to carry out their roles.

The service had implemented a monthly management meeting. This meeting covered governance, performance and risk management. The meeting had a set agenda and were minuted. We reviewed the three meetings that had occurred since implementation and saw information such as, incident reporting, medicine management, infection prevention and control, and clinical update where discussed. At the time of inspection, the meeting was attended by the registered manager, the external consultant and the medical director. It was hoped as the service developed other members of the team with additional responsibilities, such as the clinical leads or operational managers might start attending the meetings. These meetings gave assurance that the management team had begun to have oversight of the service.

Actions from the management meetings were cascaded down to the team via emails, a social media forum and a newly developed monthly staff newsletter.

Management of risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Types of risk to the service were covered in the adverse incident reporting and investigation policy, this included clinical, operational and financial risks.

The service had updated its risk register. The register now contained information on when the risk was raised, date of review, category of risk, risk score which was rag rated, who owned the risk and any mitigation of risk.

When we reviewed the risk register, there were 10 current open and ongoing risks. We saw areas of concern that had been highlighted in the last report, for example, lack of oversight of staff qualifications and training data, had been added to the risk register.

We saw evidence the risk register was reviewed and updated at the monthly management meeting. At this meeting risks were identified and discussed, and a plan put in place to eliminate or reduce them.

The service used an event risk assessment. This assessment was used to assess the potential risks of activities undertaken, the event and the workplace. The assessment reviewed hazards, those at risk were identified, what the existing control measures were, the level of risk as defined by the risk management framework and if there were any additional control measures.

The registered manager gave us the example of driving the ambulance around the event and transporting the patient or returning to the event. The risk identified was the entry and exit of the vehicle from the event site, which would put the patient and staff at risk. To mitigate the risk staff needed to plan where best to position the vehicle to allow easy exit from the event via arranged routes.

Information management

The service had started to collect, analyse and use information to support activities.

The service had started to collect data so it could monitor its performance and drive improvement. For example, response time to transfer from event site.

Access to electronically held records and information was password protected. This meant only authorised members of staff had access to the information. We saw that computers were locked when left unattended.

The service had started to use information technology systems to improve on patient care. For example, medicine management was monitored through an electronic system and the staff's mandatory training and qualifications was being transferred from a paper system to an electronic system which would flag when updates in training was required.

Policies and procedures included information when data or notifications needed to be submitted to external organisations as required. The registered manager told us he had not needed to notify any external bodies of any issues.

Public and staff engagement

The service was taking steps to improve engagement with patients, staff and the public.

The service continued to find it challenging to capture patient feedback, given the transient nature of the service. The service had introduced patient feedback forms which were held on ambulances and staff were encouraged to share these with patients. However, patient feedback was minimal.

There was a box in the ambulance station where staff could leave feedback for the registered manager. The registered manager told us there had been no feedback from staff using the box. We were told staff would feedback verbally whilst working alongside the registered manager or via the telephone. However, there was no record of these conversations or evidence of changes made as a result of staff feedback.

Therefore, since the last inspection, more formal staff engagement had been introduced. The service had introduced a staff newsletter. The newsletter we reviewed included an introduction paragraph from the registered manager, an update on governance issues from the external consultant, information from the management meetings including any changes in policies, procedures or practices, encouraging staff to report incidents and near misses, a 'hot topic' of the month. As the newsletter was new, there was a section asking staff for feedback and what would they like covered in future newsletters.

Staff we spoke with during the inspection, told us since the last inspection the registered manager was more approachable and open to suggestions about how the service could be improved.

Innovation, improvement and sustainability

The service was concentrating on improving the quality of the service and bringing the service up to the standards required to carry out a regulated activity.

Requires improvement

Emergency and urgent care

The registered manager told us the service and staff were committed to providing a safe, effective, caring, responsive and well-led service for their patients.

The company measured success and sustainability by being recommissioned by event organisers.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure fire safety and environmental risk assessments are carried out and regularly reviewed.
- The service must ensure fire extinguishers are serviced and operational.
- The service must ensure the premises are kept free from clutter that could pose a trip hazard and prevent safe evacuation from the building.
- The service must ensure all policies and procedures are relevant to the service and reflect current practice.
- The service must ensure there is an effective audit framework which can identity where quality and safety are compromised.

Action the provider SHOULD take to improve

- The service should complete its own control of substances hazardous to health 2002 (COSHH) assessment and list the chemicals contained in the cleaning cupboard
- The service should consider developing a checklist for staff to reference against when carrying out vehicle checks.
- The service should consider creating role descriptions for specialist positions, such as the medical director, clinical leads and operational manager. These should identify scope, responsibility and accountability of the role.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15(1)(c)(e) All premises and equipment used by the service provider must be** **c) suitable for the purpose for which they are being used.** **e) properly maintained** • The service must ensure fire safety and environmental risk assessments are carried out, action taken to mitigate the risk and assessments regularly reviewed. • The service must ensure fire extinguishers are serviced and operational. • The service must ensure the premises are kept free from clutter that could pose a trip hazard and prevent safe evacuation from the building.

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 **Regulation 17(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);** • The service must ensure all policies and procedures are relevant to the service and reflect current practice. • The service must ensure there is an effective audit framework which can identity where quality and safety are compromised