Ambulance Station

Quality Report

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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Ambulance Station is operated by Central Medical Services, East Midlands. The service provides emergency and urgent care and a patient transport service.

We inspected this service using our comprehensive inspection methodology. We gave the service 48 hours' notice of our inspection to ensure everyone we needed to speak with was available. We carried out the inspection on 18 and 26 February 2020.

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.

The services provided by this service patient transport services with emergency and urgent care transport from events and carrying out 999 calls for NHS trusts. On this inspection we inspected both core services.

Where our findings on patient transport services – for example, management arrangements – also apply to other services, we do not repeat the information but refer the reader to the patient transport core service.

We rated it as **Good** overall.

We found the following areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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

- The service did not comply with Duty of Candour regulation.
- Staff completion of information governance and prevent training was below 70%.
- The safeguarding adults policy did not reference modern slavery.

Summary of findings

Following this inspection, we told the provider that it must and should make some 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 emergency and urgent care. Details are at the end of the report. Although a breach of a regulation normally limits the rating of that key question to requires improvement as this breach relates to one incident, we have over ruled that principle and the rating for safe for emergency and urgent care has therefore been rated as good.

Heidi Smoult
Deputy Chief Inspector of Hospitals (Acute Hospitals South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Good	The main service provided was emergency and urgent care. This included care at events and conveying patients to hospital services when required. The service transported high dependency patients for NHS trusts. The service carried out emergency ambulance work, for example, responding to 999 calls. We have rated safe, effective, caring, responsive and well-led as good. We rated safe as requires improvement. Overall, we rated the service as good because it had enough competent staff with the appropriate level of qualifications and training. The service maintained standards of vehicles and equipment and followed infection control practices. Staff followed best practice and completed risk assessments and records appropriately. The service worked well with partner organisations and continuously tried to learn and innovate. The service treated patients with kindness and dignity at all times. However, the service did not fully comply with Duty of Candour regulation.
Patient transport services	Good	Patient transport services was a regulated activity provided by the service. A different group of staff provided this service to the staff that provided emergency and urgent care. We have rated safe, effective, responsive and well-led as good. We did not see any patient care in patient transport services, so we were unable to rate the caring domain. Overall, we rated the service as good for the same reasons as emergency and urgent care. Staff responded appropriately if a patient became unwell when being transported. staff stored patients own medication appropriately and staff monitored the arrival and departure times of patients.

Summary of findings

Contents

Good

Ambulance Station

Services we looked at:
Emergency and urgent care; Patient transport services

Summary of this inspection

Background to Ambulance Station

Ambulance Station is operated by Central Medical Services, East Midlands. The service was registered at this location on 2 May 2017. It is an independent ambulance service based in Linby, Nottinghamshire. The service primarily served the communities of the East Midlands.

The service has had a registered manager in post since the service registered.

The service provided pre-planned patient transport services, for all age groups from birth. Journeys included discharges from hospitals, transfers for specialist treatment, transport to and between care homes and repatriation of patients from within the UK and Europe.

The main service provided was emergency and urgent care. The service provided medical cover for events which included conveyancing to hospitals. The events themselves were not a regulated activity but the conveyancing to hospital was. The service also provided emergency transfers to hospitals, including responding to 999 calls. The service also transported high dependency patients for NHS trusts.

The service had a total of 42 vehicles. The service had 27 ambulances for the provision of urgent and emergency care, five rapid response vehicles and a specialist quad bike for events. The service also had two ambulances for patient transport use only. The service also had three secure cell ambulances, a make ready van, a driver training ambulance and two other specialist vehicles.

The service was yet to be inspected at this location.

We inspected this service using our comprehensive inspection methodology. We gave the service 48 hours' notice of our inspection to ensure everyone we needed to speak with was available. We carried out the inspection on 18 and 26 February 2020.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in ambulance services. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Ambulance Station

The service provides patient transport to NHS and privately funded patients for admission to, or discharge from hospital, attending outpatient appointments and airport repatriations with medical escorts. The service also provides repatriation within the UK and Europe, events work with conveyancing to hospitals and emergency transfers including 999 calls. Staff carry out some clinical interventions including administration of oxygen and nitrous oxide, cardiac monitoring and suction. The service offers transport and urgent and emergency services 24 hours a day, seven days a week.

Most of the work carried out by the service was contracted by the local NHS trusts and some work was carried out by private booking arrangements.

At the time of our inspection the service was registered to provide the following regulated activities:

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

During the inspection we spoke with nine members of staff including the registered manager, director of

Summary of this inspection

operations, HR director, lead nurse, two paramedics, one ambulance technician and two emergency care assistants. We spoke with four patients and relatives during our inspection. We also reviewed 10 patient feedback cards and they were all complimentary about the service the staff provided. During our inspection, we reviewed 20 sets of patient records. We reviewed vehicle checklists and records. We reviewed eight staff files.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has not been inspected previously.

The service had a total of 42 vehicles. The vehicles were parked overnight on the site.

Activity (1 January 2019 to 31 December 2019)

In the reporting period there were 35 emergency and urgent care patient journeys undertaken from events, 14500 high dependency transfers and 13085 emergency patients attended to.

There were 8250 patient transport journeys undertaken for the NHS, five private transfers and 88 were from air ambulances to other departments.

The service held controlled drugs (CDs). Patients would also carry their own medication in their personal belongings on discharge.

Track record on safety

- No never events
- 35 incidents
- One serious injury

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	Good	Good	Good	Good	Good
Patient transport services	Good	Good	Not rated	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Emergency and urgent care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The service conveyed patients to hospital services from events which meant they were providing emergency and urgent care regulated activities. From 1 January 2019 to 31 December 2019, the service transferred 35 patients to hospital from events. The service also transferred 14,500 high dependency patients during this timeframe.

The service also carried out emergency ambulance calls for NHS providers. From February 2019 to January 2020, the service carried out 13,085 patient transfers to hospital.

The service carried out 88 patient transfer journeys from the local air ambulance to another location.

The service provided emergency and urgent care at events however, CQC does not currently have the power to regulate this activity.

The service employed 210 members of staff, of which 199 were frontline staff. All of the frontline these staff carried out urgent and emergency work, patient transport journeys and event work.

Summary of findings

We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff mostly made sure everyone completed it. The service had enough staff with the right qualifications skills training and experience to keep patients safe from avoidable harm and provide the right care and treatment. The service made sure staff were competent for their roles.
- Staff understood how to protect patients from abuse. 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 controlled infection risk well. They kept equipment, vehicles and premises visibly clean. The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service provided care and treatment based on national guidance and evidence-based practice. Staff kept detailed records of patients' care and treatment. Staff assessed and monitored patients' pain.

Good

Emergency and urgent care

- The service monitored and met key performance indicators so that they could facilitate good outcomes for patients. The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- All those responsible for delivering care worked together as a team to benefit patients. Staff supported patients to make informed decisions about their care and treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support and involved patients, families and carers.
- The service planned and provided care in a way that met the needs of local people and could access the service when they needed it.
- The service was inclusive and took account of patients' individual needs and preferences and it was easy for people to give feedback and raise concerns about care received.
- Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care
- The service had a vision for what it wanted to achieve. Leaders and staff understood and knew how to apply the vision.
- Leaders operated good governance processes, throughout the service. 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 collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats.
- Leaders and staff openly engaged with staff, patients and the public to plan and manage services. All staff were committed to continually learning and improving services.

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

- The service did not comply with Duty of Candour regulation.
- The mandatory training levels for information governance and Prevent training were below 70%.
- The safeguarding policy did not reference modern slavery in line with best practice.

Good

Emergency and urgent care

Are emergency and urgent care services safe?

Good

We rated safe as good.

Mandatory training

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

The service had set guidelines on what mandatory training was required based on the clinical or non-clinical grade of staff members. The service provided training on recruitment and then annually. Overall the compliance rate for mandatory training as of 31 December 2019 was 82%. The service had planned mandatory training in for all staff who required it.

The service had two training modules where training completion was below 70%. Training levels for information governance was at 60% and trainings levels for PREVENT were at 59%. PREVENT training is meant to alert people to the possibilities of "non-violent extremism".

All staff had training in basic life support (BLS) as a minimum level of life support training, although most had advanced life support training (ALS). Training completion rate for ALS was 96%.

Mandatory training modules included equality and diversity, health and safety, conflict resolution, fire safety, infection prevention and control, moving and handling, safeguarding adults (including Mental Capacity Act 2005 and Deprivation of Liberty Safeguards), safeguarding children, resuscitation of adults and children (matched to each clinical grade appropriately – e.g. first aiders, cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED), paramedics completed full ALS training), information governance, PREVENT training, consent and capacity, learning disability awareness, mental health awareness, dementia awareness, medicines management and administration, customer care, professionalism, major incident and advanced driving.

The service had a training manager and were clear which staff needed to complete training, this would be booked and the staff would be contacted. The registered manager monitored this through the training matrix which indicated who needed to do which training. The registered manager showed us the training matrix which indicated staff training levels.

Staff told us that they received emails that they were due to renew training and could access this via online courses as requested by the registered manager. The service also provided several training courses face to face.

Staff who required advanced life support training to carry out urgent and emergency care work received the appropriate training.

Safeguarding

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

The service had a named safeguarding lead and a safeguarding adults and children policies that included guidelines and training requirements for the staff. The policy contained references to female genital mutilation (FGM) guidelines. The policy did not contain any reference to modern slavery guidance in line with best practice.

The safeguarding lead had safeguarding level four training. The service also had another staff member who had level four safeguarding training who acted as the safeguarding lead if the safeguarding lead was not at work. Staff told us they were aware of the named safeguarding lead and would contact them with any queries.

Safeguarding training provided by the service met national guidance. All staff had training in level three safeguarding children and level two safeguarding for adults as part of the mandatory training programme. The service provided online training as a refresher for staff who had already undertook safeguarding training however, if the staff member was new to healthcare they had face to face training.

The registered manager told us the service identified any potential safeguarding issues at the time of booking or from staff on collection or handover at the start or end of journeys.

The safeguarding lead reported they shared safeguarding incidents with the hospitals and ambulance organisations they provided a service to. The service worked with a variety of NHS trusts who had individual reporting systems, the service followed the appropriate pathway for reporting safeguarding depending on the NHS trust.

If a patient was identified as having a protection plan in place it would be conveyed to the ambulance crew who were carrying out the patient journey.

The service recognised and acted on safeguarding concerns. The service had safeguarding folders for each of the services. We reviewed the reported safeguarding incidents that staff had reported in one of the folders and saw appropriate reporting based on concerns identified during patient care. These included reporting for poor home conditions, poor care of relatives and unstable living situations.

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.

Staff had training in infection control procedures as part of the mandatory training programme. Records showed 94% of staff had undertaken infection prevention control training. The service had an appropriate infection control policy in place. The service had a lead nurse who also acted as the infection control lead for the service.

The service cleaned ambulances daily and between each patient. Staff recorded this on each of the patient transfer records. We reviewed 10 records and the box which showed that the vehicle had been cleaned had been checked on 10 occasions. Whilst on inspection we saw three patient journeys, the trolley was cleaned and the linen was swapped on each occasion.

The registered manager told us that they completed a deep clean after transporting a patient with an infectious condition or as a minimum, every six weeks. The service had a contract with a cleaning company that provided regular deep cleaning and was also available 24 hours a day seven days a week to provide emergency deep cleaning.

The registered manager told us if the service transported a patient with a known infection this would be recorded on the booking sheet or confirmed on collection and the vehicle would then be removed from service to be cleaned. The staff told us that where possible that journey would be booked as the last journey of that shift to clean the equipment and not disrupt other bookings. Appropriate decontamination cleaning products were available on all ambulances as part of the infection control pack.

We saw all sterile supplies including single use dressings, were stored correctly, packaging was intact, and they were all in date.

All reusable equipment was visibly clean and stored safely. We saw that the stretcher trolley, carry chair and seats were clean and surfaces intact. Blankets and pillows were clean and stored tidily. Staff told us they would collect a new blanket and pillowcase from the hospital after each journey if they were leaving one with the patient.

On this inspection we saw staff in visibly clean uniforms. Staffs arms were bare below the elbows. Staff were responsible for cleaning their own uniforms. However, the service had a contract with a laundry company who would clean uniforms if required.

Gloves, personal protective equipment (PPE) and hand cleansing gel were available for use in all vehicles. During observation we saw staff use PPE and hand cleansing gel appropriately, staff also washed their hands in the hospitals in between patients.

The service carried regular infection control audits. The service audited the cleanliness of both its ambulances and its base. Between October 2019 and December 2019 the average monthly audit scores for the vehicles was 96.5% and for the base room it was 100%.

Environment and equipment

Good

Emergency and urgent care

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

The service had their own workshops near to their office. The service had a team who looked after equipment and the vehicles. All vehicles had valid insurance, road tax and annual safety checks. The registered manager told us that all vehicles are serviced and have an annual safety check at the same time and the company is signed up to the annual safety check alert service. All vehicles had breakdown cover with the same company.

The service had a paper-based system of vehicle folders but was moving over to an electronic system. Staff showed us logs to report any defects or concerns with the vehicles. These were shared with the registered manager. The electronic system would track reported faults and provide reminders for annual safety checks ahead of time. The system would also track mileage so vehicles could be serviced at the appropriate time.

The service had suitable equipment that was tested and ready for use. Medical devices were calibrated and serviced by qualified staff and were accurate and safe for use. This included stretchers, carry chairs, suction units, electrocardiogram (ECG) machines and automatic external defibrillator unit (AEDs). We inspected five vehicles and they all had appropriate medical devices which were serviced appropriately.

We saw an asset register for the equipment used by the service. This included equipment that had been sold or decommissioned but was kept on record to ensure there was an audit trail of its disposal. We were told that any equipment recorded as out of service would be serviced and used if required. Any equipment that was not in use was clearly marked so that staff would not use it.

Staff t transferred patients in a safe and secure manner using seat belts, child car seats with belts or harnesses on the stretcher.

Staff transferred some patients and only transferred patients up to the weight limit of their equipment. If they were unable to do so safely, they would decline the booking or call for additional help if it was an emergency. The majority of stretchers at the service were bariatric stretchers.

There were seat belts for all seats and a two-point harness on the stretcher.

Clinical waste bags and sharps bins were available on the ambulance. Staff told us these were emptied after use and collected for disposal by a specialist company which provided a lockable yellow wheelie bin which was emptied weekly. The sharps bin had just been removed and was being replaced. We were shown body fluid spillage kits.

Assessing and responding to patient risk

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

Staff made clinical assessments of patients. The service used national early warning scores (NEWS2). We saw evidence that patients had primary and secondary assessments completed. The individual clinician treating the patient was trained to make clinical decisions and decided if the patient should be taken to hospital. The registered manager told us that if any drugs carried by paramedics or interventions had been carried out, the paramedic would also accompany the patient. All staff always had access to senior paramedic clinical advice.

The service followed National Institute for Health and Care Excellence (NICE) guidelines. Staff followed NICE guideline NG51 the recognition, diagnosis and any management of sepsis. Staff used a recognised sepsis screening tool which provided a flowchart for staff to identify and provide emergency treatment for patients with sepsis. Staff we spoke with had a good understanding of sepsis and knew how to use the sepsis tool.

The service provided advanced resuscitation equipment such as airway management equipment and this would be used, if required, to provide clinical intervention for patients who were being transferred.

Staff told us they were able to contact a senior clinical advisor from within the service for advice if it was not deemed to be an emergency. The senior clinical managers included the registered manager, director of

operations and lead nurse. The service also had a consultant doctor contact if it was needed. Staff told us this would then be documented in the patient transport record.

The service prepared an event medical plan for all events. This included the location of emergency hospital services in case a patient needed conveying to hospital.

The staff had a clear criteria of who they could transfer as part of a high dependency transfer. High dependency patients required a higher level of input and had more potential issues than a standard patient transfer.

Staffing

The service had enough staff with the right qualifications skills training and experience to keep patients safe from avoidable harm and provide the right care and treatment.

The service had 210 members of staff, of which 199 were frontline staff. The service had 69 paramedics, 54 ambulance technicians, 36 emergency care assistants, 32 first aid trained staff and eight registered nurses. These frontline staff provided may be required to convey a patient off-site from events, provide the high dependency patient transfers and undertake emergency medical care, including responding to 999 calls.

The service had a rota system for its regular staff. Staff would also be contacted to cover any absences through sickness. The service had both full-time staff and staff who were independent contractors. They service had two staff members on each ambulance and operated as many as ambulance as were required based on the needs of the service. Staff would not be expected to take on additional work they could not carry out.

Staff had the appropriate training and qualifications for the roles they undertook. This included mandatory training on the training matrix. We also saw evidence of qualifications reflecting the job role they carried out in place in all eight staff files we reviewed whilst on site.

All patient transport staff had recruitment checks including a passport check, the right to work in the UK, employment histories, references and a disclosure and barring service (DBS) checks in line with national regulations. We saw evidence of this in employee files we reviewed on site.

The service had 2% staff turnover and 1.25% staff sickness in the last 12 months. If staff were sick the registered manager told us they would rearrange the shifts or bookings.

Records

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

The service had a variety of booking forms and systems which were used for emergency and urgent care. When transferring high dependency patients within the NHS service they would receive a reference number when transferring patients and would make records during the patient journey. When responding to 999 calls the service received information from the call centre and kept records during patient treatment.

Staff used a patient report form to document the care and treatment of patients conveyed off-site during an event and for patients who were treated on site.

Whilst undertaking emergency call work patient report forms (PRFs) were filled in by the crew to record any details of the journey. This included a description of the manual handling required or incidents. Forms were then sent to the appropriate NHS trust to which the work was subcontracted after they were reviewed by the lead nurse.

We reviewed 20 PRFs whilst on inspection, 10 of which were for patients who required care after an emergency call out work and 10 for patients who required care whilst at events. We found all the required information had been completed and all the text boxes were filled appropriately. We saw the primary and secondary assessment was completed on all patients if required. All the patient records we reviewed were clear and fully complete with a signature of the staff member. Records also indicated if a patient had the presence of a do not attempt cardio-pulmonary resuscitation order (DNACPR).

The lead nurse audited every tenth record and used an online auditing tool to monitor the results. The audit checked records included appropriate recording of medicines, safeguarding, consent and capacity, patient treatment and patient assessment. In the three months prior to inspection the service averaged 98.69% compliance.

Staff ensured patient records were available to hospital staff. The registered manager told us that patient records were photocopied if the patient was taken to hospital, so staff had a record of care and treatment provided.

Staff reported that they could store paperwork securely on the ambulances. Records were stored in a lockable glovebox of the ambulance and handed in at the end of each shift before being sent to the appropriate NHS trust or stored on a weekly basis.

All computers at the service were secure and needed a password to logon. The service ensured staff changed their logins on a regular basis in line with information security standards.

The service had recently gained compliance with the data space transfer governance (DSTP) information governance for the NHS and were permitted to use NHS logins for their emails.

Medicines

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

The service had a medicines management policy in place. The policy contained information on storage of medicines, controlled drugs and administering medication.

The service stored medicines centrally and the lead nurse was responsible for this process. Medicines bags were prepared for staff to take to events or when carrying out emergency medical care. Staff picked up a medicine bags before each shift.

Medicines used for conveying patients from events and when attending emergency calls were taken from the medication storage on the site prior to staff attending the event. The registered manager told us medicines were held in medicine bags with the clinician when in use. Individual paramedics were responsible for the storage and control of the medicines allocated to them for the event or when on emergency calls. The registered manager told us the contents and quantities of medicines for each paramedic were listed and amended as they were used. All medicines administered was also recorded on the patient treatment form. The following their shift, staff would then store medicines and they would be checked into the medicines storage room on site.

The service used controlled drugs and had the required controlled drugs licence. Whilst on inspection we checked the controlled drugs book and found that the records were accurate.

Staff at the service carried out room temperature and fridge temperature check we saw the checks had been carried out daily.

Medical gases including nitrous oxide and oxygen were always stored securely on the ambulance. Medical gases were secured to the vehicle wall and were in date. Staff told us the vehicle was kept locked when not in use.

The service had a formal contract with an external provider for oxygen and nitrous oxide cylinder supply and removal.

Staff had training in the use of medical gases. Competence had been assessed on different courses and the registered manger shared the syllabus with us to show the topics included.

Staff told us they referred to Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines when they required further guidance on the use of medication and medical gases. These were updated as new advice or guidance was published and were available on all vehicles.

The service had resuscitation policy which clearly stated the procedure for administering emergency medicines such as oxygen and intravenous fluids. This was line with Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.

Incidents

The service did not fully comply with Duty of Candour legislation. However, the service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service reviewed and followed up incidents. The service reported 35 incidents from January 2019 to December 2019. Of these incidents none were never events and one was a serious incident. Never events are

defined as 'adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability'. The service had a policy document that included how and when to report incidents. This included near misses, moderate harm and information governance.

The records showed that incidents were reviewed and acted on. The registered manager gathered witness statements from staff to investigate the incident and staff told us learning was shared with them. The service had separate incident files for serious incidents, each NHS provider and for other incidents.

The service learned lessons and made changes following incidents. The service had a serious incident which resulted in harm to a patient due to staff not following the correct procedure when clamping a wheelchair into the back of an ambulance resulting in a patient falling. Whilst on inspection we saw that the service had notices on staff boards reminding staff if the correct procedure.

The service completed incident forms for other organisations when they were not responsible for the issue. For example, when they were not given correct information about the patient and this affected the transport or delivery of service.

The registered manager monitored incident themes and trends, however there weren't any identified themes.

The registered manager shared learning with the staff members involved as part of the investigation process. Any learning that was identified was shared with staff on staff boards. We saw an example of this where there was learning related to wheelchair clamps highlighted on the staff board after a serious incident had occurred.

The service had a Duty of Candour Policy in place. Duty of candour requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide support to that person. The policy contained suitable references to regulations and highlighted the steps that needed to be undertaken following a serious incident. However, some actions were attributed to specific roles which were not relevant in the organisation for example, a senior clinical counsellor so we were not assured the policy was tailored to the organisational structure. The policy was due for review at the time of our inspection.

Where serious incidents had occurred, there was a robust approach taken to investigation and actions were fully implemented. Staff had suitably followed some aspects of the duty of candour however did not follow the Duty of Candour policy fully to comply with all the Duty of Candour regulations. Staff had notified relevant persons promptly were open and honest when an incident occurred and demonstrated they apologised and made initial contact with the relevant person over email. However, they did not offer or send copies of the incident reports and actions to the relevant person and meetings to discuss incidents were not routinely offered. The service also did not provide appropriate feedback and outlined the measures taken to prevent re-occurrence with the relevant person following on from a serious incident. The service's Duty of Candour policy in section explained the necessary steps which should be undertaken in notifying the relevant person following a serious incident, but these were not always followed.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Good

We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff had used updated and new guidance as it was made available to them. New medical guidance was shared by the service and then shared with staff. Staff told us they had access to Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. The registered manager told us staff had access to sepsis and Advanced Life Support flowcharts as in the National Institute for Health and Care Excellence (NICE) guidelines.

All staff could access the on-line staff portal where they could read policies. We were told that any alert to changes to policies or urgent information sharing was done through a staff bulletin or staff electronic communication application.

Policies and procedures reflected national guidelines. For example, the resuscitation policy included clear guidance for staff from the United Kingdom Resuscitation Council (UKRC) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC). This included guidelines on how to manage a cardiac arrest, post resuscitation care and hypothermia.

The registered manager told us the service followed the unified do not attempt cardio-pulmonary resuscitation orders (DNACPR) from the hospital wards. The service only used original copies of DNACPR paperwork when transporting patients who had them in place.

Staff told us if a patient dies whilst on board the ambulance and the team were aware of a do not attempt cardio-pulmonary resuscitation order (DNACPR) or the patient was nearing the end of their life, they told us they would continue to the destination and inform the appropriate authorities.

At the time of inspection staff did not undertake secure mental health transfers. Staff had training in mental health awareness as part of the mandatory training programme.

Pain relief

Staff assessed and monitored patients' pain.

Staff assessed patients pain using a verbal 0-10 pain score and recorded this on the patient treatment record. There was also a visual pain scale for children or adults who were unable to communicate their pain verbally.

Whilst on inspection we saw staff ask about pain levels of patients and record the pain score.

Staff had access to pain relief medication if it was required. All staff were able to administer pain relief.

Response times

The service monitored and met key performance indicators so that they could facilitate good outcomes for patients. They used the findings to make improvements.

The service monitored key performance indicators (KPIs) against targets set by the three NHS organisations they had urgent and emergency contracts with. Response times overall were monitored by the trusts that the service had contracts with. The performance of this service would form part of that, so there is not a specific response time which was monitored.

The service was performing well with the majority of its KPIs. We reviewed the KPIs of the NHS contracts and could see that the service was performing well within what it could control. When the service operated on behalf of NHS trusts they had a number of KPI's in relation to service provision; including areas such as shifts cancelled after being confirmed, booking on the shift within five minutes of start time, post hospital turn around and hospital handover. In the last ten months the service had achieved amber (on target) times and green (exceeding target) five times.

The service looked into poor performance areas within the KPIs to see if it could improve. For example, since June 2019 the services performance in clinical handover times had dropped. This was due to the service expanding the emergency departments it serviced. The service had delays in clinical handovers at some emergency departments due to the high levels of capacity of those emergency departments.

The service was performing well with its air ambulance targets. The service had a 100% response rate within two hours to emergency air ambulance patient transfer to hospital requests for the trust it had a contract with.

Patient outcomes

The service monitored the effectiveness of care and treatment.

In the 20 patient records that we reviewed showed staff had administered timely treatment and had a clear explanation for why patients were transferred to hospital.

The lead nurse audited every tenth patient treatment record in order to check the effectiveness of the care and treatment provided and ensured that they had positive outcomes where possible. The audit checked records included appropriate recording of medicines, safeguarding, consent and capacity, patient treatment and patient assessment. In the three months prior to inspection the service averaged 98.69% compliance.

The service did not necessarily identify any overall changes that needed making but it did highlight individual practice mistakes which were corrected through conversation and supervision of staff.

Competent staff

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

The service had an appraisal system that met the needs of the staff and the business. Team leaders carried appraisals for the staff in their teams. The registered manager and staff told us these identified staff members specialist strengths, development or training needs and how they would be achieved. As of December 2019. the appraisal rate was 98%.

We saw evidence of staff appraisals in all the records we reviewed, and staff told us they had annual appraisals.

The service had an induction policy in place to ensure that all new staff received consistent and appropriate introduction. This policy applied to all permanent or temporary staff. The service had an induction checklist which staff would complete. The induction checklist included; infection prevention, safeguarding, resuscitation, vehicles and equipment, healthcare pathways, medicines management, uniform and personal protective equipment, risk, event medicine, clinical assessment, major incidents and duty of candour.

The service had an online system that automatically checked staffs driving licences on a six- monthly basis. The system sends automatic alerts if it finds issues. Staff members have their driving license physically checked on recruitment prior to employment. We saw in all staff records we reviewed that staff had driving licence checks upon recruitment.

All members of staff that carried out driving duties including emergency driving had evidence of additional driver training. The service had emergency driving instructors who held an advanced driving qualification and assessed all new staff members. Drivers were re-assessed every three years if they drove regularly and yearly if they weren't regular drivers. We also saw evidence of drivers being re-assessed appropriately following incidents.

The registered manager told us they checked the paramedic registration details on the Health and Care Professions Council (HCPC) website. This registration required paramedics to demonstrate every yearly they are trained and competent to work as a paramedic.

The service employed eight nurses in total. The service ensured nurses had undergone re-validation.

Staff worked in a crew of two or more and there was no lone working.

Multi-disciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

The service worked with other organisations and professionals to ensure the safety of patients. The service had contract with three NHS providers and the registered manager attended regular meetings with these organisations.

The staff told us they had regular contact with medical staff at hospitals and other units when carrying out urgent and emergency work and patient transports. The service had several examples of positive feedback from other organisations.

Staff worked with the local authority and NHS organisations when raising safeguarding concerns about patients.

Staff liaised with the local emergency departments and hospital wards about specific patients' care. When they conveyed an acutely unwell patient to an emergency department or hospital ward, they alerted the hospital to ensure the department was ready to receive the patient.

Consent, Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

All staff had received training in consent. If the patient lacked capacity or was confused staff demonstrated a good understanding and reported, they would remain

calm and compassionate. If the patient had capacity but was unable to talk, staff told us they would try to obtain consent non-verbally. The service had a consent and capacity policy in place. The Mental Health and Mental Capacity policy on the staff portal provided guidance on consent, how to establish capacity and how to record it in the patient record.

Staff had training in mental health awareness. The service could transport patients with mental health conditions with or without escorts as part of the urgent and emergency work. At the time of inspection, the service did not transport patients who were sectioned under the Mental Health Act.

The service did not use restraint methods for patient transfers. Staff told us they did not use restraint if a patient had challenging behaviour. Staff would try to de-escalate the situation, talk to health care professionals who knew the patient and call the police if the situation was not manageable. Some staff had training in conflict management.

Staff told us when a patient declined to be transported it was documented on the patient transport form (PTR). The registered manager told us that some staff had conflict resolution training and skills, but that staff were able to risk assess the situation at the time. Staff were able to refuse to take a patient if they deemed the patient or staff would be unsafe. For example, if a patient was aggressive or at risk of harming themselves or others.

Staff told us they would always seek consent from the patient to transfer them to hospital and this would be recorded in the comment box of the patient treatment record. On all patient treatment records we reviewed the consent section was filled in appropriately. If the patient declined transfer, staff recorded this on the record and the patient was asked to sign. We did not see any records where the patient had declined transfer to hospital.

Staff demonstrated they had a good understanding of the Mental Capacity Act. Staff were able to recognise situations where consent was impaired, for example if the patient was unconscious or confused. If a patient was unconscious and needed emergency medical treatment at the hospital, staff told us they would work in the patient's best interests and transfer to hospital.

Staff told us if a patient was confused, they would carry out a capacity assessment. If the assessment showed the patient lacked capacity to make the decision, they would discuss it with the police, explain the rationale for the decision and request assistance.

Are emergency and urgent care services caring?

Good

We rated safe as good.

Compassionate care

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

During the inspection we observed three patient journeys. We observed one high dependency transfer and two emergency calls, Staff always treated patients with kindness and compassion during these journeys.

Staff always respected patients' privacy and dignity. During the patient journeys we observed staff were always conscious of patients' privacy and dignity. Staff ensured that curtains were closed in patients' homes when carrying out examinations on them. Staff ensured that curtains were drawn in hospitals when transferring patients from the bed to the stretcher.

Staff took account of patients' individual needs. Staff tried to follow patient's wishes on where they would receive treatment on the patient journeys we observed.

We looked at ten patient feedback cards during the inspection. Patient feedback cards were all positive. Patients said, "staff were comforting and attentive" and "staff were extremely friendly, professional and made me feel at ease."

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Good

Emergency and urgent care

Staff showed emotional support to patients. We saw staff have conversations with their patients about their wellbeing and regularly checked on them. Staff also spoke with the relatives of two patients to see how they were doing.

We looked at several patient feedback cards during the inspection. Patients provided feedback on emotional support. One patient said, "staff made sure I was OK when I was upset and couldn't do anymore for me."

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff showed understanding to patients and to those close to them. We saw staff explain the situation to patients and try and carry out the treatment the patient required. Staff phoned the hospital ward directly to attempt to get the patient immediate access which they asked for to reduce the patients anxiety of having to wait. Staff also spoke to those close to the patients to see if they wanted to accompany the patient in the ambulance.

We looked at several patient feedback cards during the inspection. Patients provided feedback on understanding and being involved in patient care. One patient said, "the crew always explained everything to me as they went along."

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

(for example, to feedback?)

Good

We rated responsive as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

The service had contracts with three NHS providers. The service responded to urgent emergencies for two of the providers and carried out high dependency patient transfers for the other service. The emergency and urgent care service provided emergency care and treatment for patient who required it.

The emergency and urgent care service provided transport to hospital for patients from events, providing prompt access to treatment was needed.

The service provided free support to assist vulnerable patients repatriate. Staff had transported a victim of a terrorist attack. The service transferred a patient back to another country following an attack in the UK. Staff also transferred a patient for free who called for a transfer but couldn't afford the fees.

The service covered events and only worked at events where they conveyed patients who needed it to hospital.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

The staff told us they rarely transported patients who required an interpreter, but they would ask about any requirements at the point of booking if the journey was pre planned. If the patient was accompanied by a family member or carer, they would ask for their assistance in translating. Staff would only use family members in emergency situations until an appropriate translator could be arranged. Staff understood the risks involved with having family members translate for patients. Staff also had emergency communication booklets with common emergency phrases in 18 different languages. Staff told us there was a telephone translator service they could call on their mobile phones if required. The service also had posters in the six most common languages. The service had communication aids if they were required for patients with learning disabilities.

Staff had mental health awareness training. Mental health awareness also formed part of the induction process.

The registered manager told us that booking information was taken that reflected the cultural, religious or preference needs of the patient. For example, female only crews were available if requested. This would not always be possible in an urgent or emergency situation.

Good

Emergency and urgent care

Staff had training in dementia awareness, and it formed part of the staff induction process. The registered manager told us that staff used their training or experience of working with patients. The service had dementia friendly distraction aids which could be used to comfort patients living with dementia.

All ambulances were equipped to transport patients who required assistance with getting in and out of the ambulance or who used wheelchairs or other walking aids. There was a child harness available for use with the stretcher on the ambulance.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

The service operated 24 hours a day, seven days a week.

Patients accessed the service via emergency calls to receive emergency care when it was required. The service also provided high dependency transfers for patients.

Patients accessed the service for transfer to hospital from events by presenting at the onsite medical centre and being assessed by staff.

At events that required patients being transferred to hospital the registered manager told us there was always a vehicle available for this.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

The service had a complaints policy which told patients, their family, carers and other professionals how to make a complaint. Staff told us they were aware of the complaints process. The policy stated that complaints were accepted verbally or in writing. The complaint was considered formal if the person making the complaint requested it and the details of the complaint were provided. The policy outlined the responsibilities, duty of candour and the complaints process.

Complaints were acknowledged within three working days and a complete written response sent within 25 working days. If the complaint was more complex and took longer to investigate, the policy stated that the complainant would be kept informed. If the complaint involved other providers, the service shared the complaint, with consent, and requested they responded separately.

In 2019 the service had eight patient complaints all related to the urgent and emergency care service. Three were due to clinical disagreements, two complaints were due to lost/broken property, one was the crew attending an incorrect address, one was for faulty equipment and one was due to poor staff attitude.

We reviewed three patient complaints and found that the service had responded appropriately and in a timely manner on each of the occasions.

The registered manager did not identify any particular themes of trends from their complaints.

The registered manager used team meetings and the staff message board to share any lessons learnt from complaints if it was needed.

Are emergency and urgent care services well-led?

Good

We rated well-led as good.

Leadership of service

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

The senior management team comprised of; the registered manager, head of operations, clinical director, lead nurse, head of human resources, finance manager, training and compliance manager and the head of events and business development.

The registered manager had overall responsibility for the running of the company. The registered manager also worked alongside the staff on patient transport journeys when needed. They carried out appraisals and provided training as required.

The organisation was a nationally recognised accredited teacher of first aid. The service was also accredited to teach advanced ambulance practitioner and emergency blue light ambulance driving both of which were nationally accredited and used by the NHS ambulance trusts as recognised courses.

The senior management team was also responsible for the management of risk, complaints and incident investigation and governance of the service. They had developed new processes and use of electronic systems to provide clear oversight of the service.

The clinical director acted as senior clinical advisor and was available for staff to contact for clinical advice. They were responsible for updating staff on clinical guidelines and overseeing the clinical support of the team. The registered manager told us they would meet with the clinical director regularly or when needed.

Staff told us that managers were visible and approachable.

Staff told us that communication with the leadership team was very good. We saw evidence of this communication on communication boards on the inspection site.

We found the leadership team were very responsive. The registered manager provided us with information promptly.

Vision and strategy for this service

The service had a vision for what it wanted to achieve. Leaders and staff understood and knew how to apply the vision.

The service had a vision that stated it, 'aims to be the outstanding provider of quality ambulance provision with the highest level of trained staff from our own in-house training academy supporting a vibrant and growing economy'. Its mission was to, 'Work with employers and employees to deliver high quality patient care and offer life changing employment opportunities whilst providing outstanding teaching and learning'. Staff were aware of the services vision and mission.

The registered manager told us his continuing vision and strategy would be to focus on growth whilst maintaining quality.

Staff and registered manager told us there were plans to develop the business and expand to do more events work.

The service was also developing its training facilities and had recently purchased a new building with a focus on policies and training for in house staff and staff from outside the company.

Culture within the service

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

Staff demonstrated throughout the inspection that they placed a high priority on ensuring a good standard of patient centred care. Staff said they were proud of their commitment to patient care.

Staff told us they were proud to treat patients and carers with compassion and kindness. They aimed to provide emotional support to patients, families and carers.

Staff told us they felt respected, supported and valued by the leadership of the service.

Staff told us the registered manager was visible and approachable for all staff and staff could raise concerns without fear.

Staff told us they were able to raise concerns without fear of victimisation. The service had a recognised person responsible for staff feedback, including whistleblowing and complaints. Staff were actively encouraged to give both positive and negative feedback.

Staff were able to access training online or face to face. Staff told us if there was other training, they wished to do

they could discuss this with the registered manager. The service had good training facilities on site. The service had developed a team leader role for staff members who wanted to advance.

Managers took account of staff members emotional well-being. A senior member of staff held debriefs with staff members if there was a traumatic incident. A senior member of staff held a debrief after each event which included reflecting on any patient care.

Governance

Leaders operated good governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had opportunities learn from the performance of the service.

The registered manager was responsible for all governance arrangements. The senior management team included the registered manager, head of operations, clinical director, lead nurse, head of human resources, finance manager, training and compliance manager and the head of events and business development. There was a clear organisational and reporting structure which staff were aware of and understood what they were responsible for.

Staff at the service had a regular weekly team meeting where staff were updated. If staff could not attend this meeting they could be updated on incidents, complaints and other feedback using either the staff communication board, and electronic app or via email. These meeting were minuted so staff could access the information if needed.

The service held regular meetings whenever they were required for incidents or any other issues. These meeting were always minuted. We reviewed four sets of meeting minutes which included meetings for; scope of practice for staff, contact meetings, employee relations and recruitment. The minutes for the meetings were clear and concise. There were clear actions and responsible staff members with timeframes for each of the actions.

Management of risk, 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.

The service had a risk management framework in place. The policy outlined the responsibilities of different staff and staff in terms of risk management. It also highlighted the management of the risk register and explained the risk management training on offer to the relevant staff members.

The service had a risk register in place. At the time of inspection, the risk register was being reviewed by an external contractor. The service sent us the risk register following the inspection. The risks on the register was rated, 'low, moderate and high', using a scale on both likelihood of the risk occurring and the severity of the consequences if it did. The risk register stated who had ownership of the risks so it was clear who was responsible and the assurance plans in place.

The service had several 'high' risks on the risk register, which had current positions and assurance plans in place. One example was the risk, 'Harm to staff or visitors and negative impact on company reputation due to poor health & safety or unkempt premises. To counter this risk staff did regular health and safety checks of the premises and had a single point of contact for maintenance and security issues. The service also did a report of premises to board meetings and monitored incidents daily using an incidents log.

The registered manager told us one of the main risks at the time of inspection was non-payment for services delivered within a reasonable time frame. The registered manager had bought in a finance director who had improved the timeliness of payment.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to a password protected electronic staff application where they could read policies and access other forms.

Staff could access and provide a variety of performance data relating to their urgent and emergency care work broken down by each provider.

Confidential information was stored on secure electronic systems. Paperwork with confidential patient information was stored in a locked cupboard and shredded when not needed.

The registered manager submitted notifications to the CQC following safeguarding alerts or serious incidents. They had also completed safeguarding alerts to the local authorities and hospitals.

The registered manager was responsive to requests for data and additional information as requested following this inspection.

Public and staff engagement

Leaders and staff openly engaged with staff, patients and the public to plan and manage services.

Leaders encouraged staff engagement and ensured they were available to staff. Staff were able to comment on policies and procedures through staff meetings or talking directly to one of the senior management team. All staff were members of a closed staff electronic communication group that was also used to share feedback and other information. Staff can also leave feedback through an online questionnaire.

Patients were able to leave feedback easily. We saw a feedback poster and cards on the ambulance. These could be completed by patients, families and carers and placed in a secure post box fixed to the internal wall of the vehicle. The service also used information from internet-based feedback, complaints and compliments. The service told us, and from what we saw, patient feedback was generally positive but there was a low response.

The service engaged with its partners and the wider healthcare economy. The service provided a link on the invoices it sent to private companies. The service had regular meetings with the NHS trusts it worked with and were inspected by these trusts on a regular basis.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services.

The service was investing in new facilities in order to improve learning opportunities for its own staff and healthcare staff from other organisations. The service was increasing the training facilities it had in order expand that side of its business as well as improve the training on offer for its own staff.

The service worked prior to some events to research recovery from potential drug related illness. This helped the service make clinical decisions about whether or not a patient who came in whilst unwell needed conveying to hospital. The service looked on internet forums prior to events to research the drugs that were commonly in circulation and look at side effects. Staff then looked at drug amnesty bins and at drugs taken by patients during events in order to help staff working at events have a knowledge of the strength and side effects of the drugs at the festival. This was also used to help staff at future events.

The service worked with local schools in order to try and prevent injuries to children. The service sent a paramedic to a school following an incident when a child was injured during a fight. The paramedic explained the impact the injuries could have on the person involved in order to try and prevent this from happening again.

Good

Patient transport services

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

Information about the service

Ambulance Station is operated by Central Medical Services, East Midlands. The service was registered at this location on 5 May 2017. It is an independent ambulance service in Linby, Nottinghamshire. The service primarily serves the communities of the East Midlands.

The service had two patient transfer specific ambulances. The vehicles were parked on site overnight.

Activity (1 January 2019 to 31 December 2019)

There were 8,250 patient transfers for NHS trusts. The service carried out five private patient transfer journeys. The service carried out 88 patient transfer journeys from air ambulance to another location.

The service employed 210 members of staff, of which 199 were frontline staff. All of the frontline these staff could work in patient transport services.

Where our findings on patient transport services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the emergency and urgent care section above.

Summary of findings

We found the following areas of good practice:

- The service maintained its vehicles used in patient transport services.
- Staff responded appropriately if a patient became unwell when being transported.
- The service staffed patient transport journeys appropriately.
- Staff kept detailed records of patients' care and treatment during patient transports.
- The service stored patients own medication appropriately.
- The service monitored arrival and departure times for journeys.
- The service planned and provided care in a way that met the needs of local people and the communities served.
- People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Good

Patient transport services

Are patient transport services safe?

Good

We rated safe as good.

Mandatory training

The management and completion of mandatory training across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care section of this report is also relevant to the emergency and urgent care service and therefore we have used this to rate this service.

Safeguarding

The management of safeguarding across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care section of this report is also relevant to the patient transfer services and therefore has been used to rate the service.

Cleanliness, infection control and hygiene

The management of cleanliness, infection control and hygiene across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Environment and equipment

The service maintained its vehicles used in patient transport services.

We reviewed one of the two patient transport vehicles whilst on inspection. The vehicle was in good condition and contained appropriate serviced and calibrated equipment.

The rest of the management of the environment and equipment across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Assessing and responding to patient risk

Staff responded appropriately if a patient became unwell when being transported.

Staff responded to patients who became unwell while with the service. The registered manager and staff told us that if a patient's health deteriorated while being transported the team would review their condition and drive to the nearest emergency department. Staff told us, if possible, they would call ahead or contact 999 for urgent assistance.

The service had defibrillators on patient transport vehicles, but they did not contain all the patients monitoring equipment they had on urgent and emergency vehicles.

The rest of assessing and responding to patient risk across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Staffing

The service staffed patient transport journeys appropriately.

Staff were allocated to regular patient transport shifts the service did for an NHS trust. The service would also staff any ad hoc private patient journeys if they were booked.

The registered manger and staff told us that if a booking was for a long-distance journey three crew would be allocated. This meant one to drive, one to remain with the patient and one to sleep. Or if the patient was self-caring, they would provide a two person crew.

The rest of staffing across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Records

Good

Patient transport services

Staff kept detailed records of patients' care and treatment during patient transports.

Bookings were received electronically or over the phone. On this inspection there was an electronic booking system and electronic patient transport forms.

We reviewed the booking system and were told that the staff member taking the booking was responsible for completing the form. Information required included the patient details, the collection address, destination and reason for journey. We were told that on booking staff would request clinical details, diagnosis, infections or mental health needs, the presence of a do not attempt cardio-pulmonary resuscitation order (DNACPR) and any escorts to accompany the patient.

The rest of the management of records the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Medicines

The service stored patients own medication appropriately.

The service did not store drugs on patient transport vehicles. Patients own medication was kept with their belongings. Medicines to be taken home from hospital were placed in the patients' bags by staff at the hospital.

The rest of the management of medicines across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Incidents

The management of incidents across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

This service did not have any incidents reaching the threshold for duty of candour.

Are patient transport services effective?
(for example, treatment is effective)

Good

We rated effective as good.

Evidence-based care and treatment

The management of evidence-based care and treatment across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Response times

The service monitored arrival and departure times for journeys. The service did not have waiting time targets in the patient transport service, patients were assigned by the trust for transfer when they were not able to do so.

Competent staff

The management of competent staff across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Multi-disciplinary working

The management of multi-disciplinary working across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The management of consent, mental capacity act and deprivation of liberty safeguards across the service was the same for both the emergency and urgent care service and

Good

Patient transport services

the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Are patient transport services caring?

Not sufficient evidence to rate

During the inspection we did not observe any direct patient care and were unable to talk to or contact patients, families or carers. Therefore, we were unable to rate caring. However, we read compliments received by the service that showed compassion and kindness shown by staff to patients, friends and staff from other organisations.

Compassionate care

The management of compassionate care across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Emotional support

The management of emotional support across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Understanding and involvement of patients and those close to them

The management of understanding and involvement of patients and those close to them across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Are patient transport services responsive to people's needs?
(for example, to feedback?)

Good

We rated responsive as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

The service held a regular patient transport service contract with one NHS provider and would also provide patient transport for this service on an ad hoc basis.

The service would also carry out some privately paid transfers for patients. They also sometimes provided occasional free transfers for a variety of patients dependent on individual circumstances.

The service provided free patient transfers for a local hospice. Staff had taken different patients to various destinations including football matches.

Meeting people's individual needs

The service did not carry out transfers for patients from secure mental health facilities.

The management of meeting people's individual needs across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Patients could access patient transport services through the regular or ad hoc contract with an NHS provider, this would be arranged by the hospital.

Private patient transport bookings were booked on the day of travel or in advance. Staff assessed the resource requirements and capacity on an individual basis. The

operations manager and registered manager were responsible for taking patient transport bookings. The service advertised a contact number for bookings which were linked to mobile phones if the office was unattended.

The service could collect patients who needed to be repatriated to other areas of the country. The registered manager told us that the service had collected one patient from Europe and returned them to the UK following surgery. The patient was clinically well and required transport to return home.

Learning from complaints and concerns

The service had no complaints related to its patient transport services.

The management of learning from complaints and concerns across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Are patient transport services well-led?

Good

We rated well-led as good.

Leadership of service

The management of leadership of the service across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Vision and strategy for this service

The management of vision and strategy for this service across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Culture within the service

The management of culture within the service across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Governance

The management of governance across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Management of risk, issues and performance

The management of risk, issues and performance across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Information Management

The management of information management across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Public and staff engagement

The management of public and staff engagement across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Innovation, improvement and sustainability

The management of innovation, improvement and sustainability across the service was the same for both the emergency and urgent care service and the patient

Good

Patient transport services

transport service. The evidence detailed in the emergency and urgent care service section of this report is also relevant to the patient transport service and therefore has been used to rate the service.

Outstanding practice and areas for improvement

Outstanding practice

The service provided free patient transfers for a local hospice and other patients who may needed them.

The service worked with events to try and research drug related illness. The service looked in drug amnesty bins and looked on internet forums to research the drugs that were commonly in circulation ad look at side effects in order to help staff working at events as well as staff at future events.

The service worked with local schools in order to try and prevent injuries to children. The service sent a paramedic to a school following an incident when a child was injured during a fight. The paramedic explained the impact that the injuries could have on the person involved in order to try and prevent this from happening again.

Areas for improvement

Action the provider MUST take to improve

- The service must ensure it complies fully with Duty of Candour regulations following serious incidents. This was a breach of regulation 20 – Duty of Candour.

Action the provider SHOULD take to improve

- The provider should ensure that staff complete information governance and prevent training.
- The provider should ensure that the safeguarding adults policy references modern slavery.

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
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **The service did not fully comply with Duty of Candour legislation** **This was a breach of Regulation 20 (3) (4)**