Location Medical Services - Shepperton Studios Medical Centre

Quality Report

Shepperton Studios
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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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Location Medical Services is operated by Location Medical Services Limited. The service provides emergency and urgent care and transports patients from event sites to hospital emergency departments when necessary. The service also provides a paramedic home visiting service with a GP consortium.

We inspected this service using our comprehensive inspection methodology. We carried out this announced inspection on 19 December 2019. 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.

This is the first inspection to be rated. We rated it as **Good** overall.

- The service provided mandatory training in key skills to all staff and made sure everyone completed 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. Vehicles were deep cleaned and swabbed for the presence of microorganisms.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use vehicles. Staff managed clinical waste well.
- 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 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.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff assessed patients' food and drink requirements to meet their needs during a journey.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief advice in a timely way.
- The service monitored and met agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.
- The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles.
- 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.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.
- People could access the service when they needed it, in line with national standards, and received the right care in a timely way.
- 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.
- Leaders had the integrity, 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 staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of 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. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Nigel Acheson
Deputy Chief Inspector of Hospitals (South and London), 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
Urgent and emergency services	Good 	The main activity provided by this service was event medical cover. However, CQC do not currently regulate event medical cover. A small proportion of the service's activity was the urgent transfer of patients from events sites to hospital. This activity is regulated by us. We saw that the provider had made significant improvements since our last inspection. They had addressed all our concerns. We saw several areas of outstanding practice. This included their 'make ready' stores. The provider employed dedicated staff to manage their stock and equipment. Their paramedic primary care home visiting service, and their paediatric and adult critical care transfer. They had also developed a proposal with an NHS trust for a sepsis pathway. This would ensure immediate treatment of sepsis when a paramedic was first in attendance.

Summary of findings

Contents

Good

Location name here

Services we looked at

Urgent and emergency services

Summary of this inspection

Background to Location Medical Services - Shepperton Studios Medical Centre

Location Medical Services - Shepperton Studios Medical Centre is operated by Location Medical Services Limited. The service opened in 1997. It is an independent ambulance service in Shepperton, Middlesex. They primarily serve the communities of south east England.

The provider has had a registered manager in post since the service registered with us in June 2011.

Their main service was medical cover on event sites and film productions. The provider also had a small medical centre at the registered location. This provided basic first aid for contracted staff who worked in the film studios opposite.

In England, the law makes event organisers responsible for ensuring safety is maintained at events. This meant that the event medical cover came under the remit of the Health and Safety Executive. Therefore, we do not regulate services providing medical cover at events. However, the transport of patients from an event to hospital is a regulated activity.

The provider had five ambulances to carry out the regulated activity. They also had rapid response cars which they used for non-regulated activity. Therefore, we did not inspect their rapid response cars.

Our inspection team

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

Information about Location Medical Services - Shepperton Studios Medical Centre

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the registered location. We spoke with the registered manager, the clinical lead, the make ready manager, two paramedics and three patients who had used the service. We looked at their policies and procedures, seven patient care records, their risk register, incidents log, complaints log, patient and staff feedback

There were no special reviews or ongoing investigations of the service by us during the 12-months before this inspection. The service has been inspected three times before. The most recent inspection was in November 2017. We issued the provider with three requirement notices. This was because they were not meeting fundamental standards in clean premises and equipment, good governance, and they did not ensure all staff held up-to-date training in key areas. This is the first inspection to be rated.

They carried out 93 patient journeys from events to hospitals during the period 1 October 2018 to 31 September 2019. The provider did not complete any non-urgent patient journeys or repatriations during this period.

The provider had a database of 55 staff who could be allocated to regulated activity shifts. This included 28 paramedics, and 27 emergency technicians or emergency care assistants. They had additional first aiders and nurses who worked on event sites in any unregulated (non-ambulance) capacity. They would not normally be

Summary of this inspection

allocated to regulated elements of any events. One staff member was dual trained as a nurse and paramedic. They worked as a paramedic on regulated activity. The accountable officer for controlled drugs was the registered manager.

The provider had five ambulances and one four-wheel drive vehicle which were used for the regulated activity.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Urgent and emergency services

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

Are urgent and emergency services safe?

Good

This is the first inspection to be rated. We rated it as **Good** overall.

Mandatory training

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

We saw improvements in compliance with mandatory training. At the last inspection the provider assumed that staff working for an NHS trust had already completed mandatory training. However, they could not provide evidence of this. The provider relied on staff to communicate any training needs as part of their annual appraisal form, which they completed.

We saw that the clinical lead now took responsibility for ensuring that all staff were up-to-date with their mandatory training. The provider now subscribed to an external company which provided a training database and online training modules. This supported staff to upload training certificates which the clinical lead had oversight of. They were required to complete the training and pass an online assessment to be allocated work with the provider.

We saw the training database. The provider ensured staff had completed adult basic life support, training in being open, conflict resolution, consent, dementia awareness, equality and diversity, fire safety, infection control (clinical), information governance, moving and handling (clinical), safeguarding adults (level 2), safeguarding children (level 3). The database displayed when modules were completed, incomplete or had expired and when the module was in a reset period. This meant that staff could re-complete the module. We also saw that it included the date when staff completed training and the date training expired.

An external trainer ran face to face training on practical skills such as basic life support and advanced life support skills.

Staff were automatically recorded as 'unavailable' on the system until they successfully completed training. The administrator checked the training database before approving any shifts. This meant that the provider now ensured that all staff who completed regulated activity were up to-date with training that was necessary for their role(s).

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.

Relevant staff had all received safeguarding training level three for adults and children. This was in line with Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate Document (July 2018), and Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Intercollegiate Document (January 2019). This was an improvement since our last inspection. The provider had assured themselves that all staff that treated children had the correct level of training to support them to identify and respond to safeguarding concerns.

The medical director was the safeguarding lead. They had responsibility for notifying any safeguarding alerts to the Local Authority. They had safeguarding vulnerable adults and children level four training. This was in line with Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate Document (July 2018), and Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Intercollegiate Document (January 2019). The clinical lead was also trained in safeguarding to level four. This meant staff always had a point of contact with the right level of training if they had any safeguarding concerns or needed support or advice. They always had a duty manager on call. The registered manager or clinical lead acted as the duty manager. Staff could also contact the duty manager for advice and support.

We read their 'Safeguarding Policy' (January 2017). This confirmed different types of abuse and safeguarding concerns. There was a clearly defined referral process for reporting safeguarding referrals. Staff completed a safeguarding referral form. The policy also included a risk assessment form for people that were at risk of suicide or self-harm. There was information on how to recognise non-accidental injuries. For example, bruising to the soft part of the ear could be caused by slaps to the side of the head.

The referral had to be discussed with the duty manager on call (by telephone initially). Staff deposited the referral form on return to the medical site. It was posted into a safeguarding referral box.

The duty manager completed a separate safeguarding referral form. They checked the details and ensured the form was completed in full. This included information from third parties and the patient (when possible). They recorded any vulnerable patient concerns such as a patient who lived in a care home. The referrer documented any additional information. For example, if they notified the police. They recorded their details, mode of referral, time and date of referral before they scanned or faxed the referral to social services.

Managers told us that they reported safeguarding notifications to us, commissioners, providers and clinical commissioning groups. The provider had made no safeguarding referrals to the Local Authority since the last inspection in November 2017.

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 provider had improved their cleanliness of vehicles and equipment since our last inspection. At the last inspection vehicles and some equipment were visibly dirty. Following our feedback, the provider developed an audit tool to assess and monitor vehicle compliance with cleanliness.

We inspected two ambulances at the location. They were used to carry out regulated activity. The inside of both vehicles (including the cab areas), were visibly clean and tidy. Re-usable equipment such as blood pressure cuffs and slide sheets were visibly clean. The trollies were visibly clean, and the mattress coverings were clean and intact.

There were decontamination wipes available. Hand cleansing gel was available at the front and back of the vehicles. We saw personal protective equipment (PPE), such as gloves, overalls and helmets available on both vehicles that we inspected. However, we did not observe staff cleaning their hands or using PPE, as we were unable to observe any patient care during our inspection.

All five vehicles were deep cleaned every 12 weeks by an external company. We saw evidence of the deep clean schedule. We also saw an audit of the cleaning schedule and an audit of swab testing. This was swab testing of adenosine triphosphate (ATP) test. This was a process of quickly measuring the growth of microorganisms through detection of ATP. Swabs were taken pre and post cleaning to determine levels of bacterial contamination. The audit included suction units, windowsills, trolley beds, rear seats, grab rails, driver's inner door handles, inside cupboards, heater grills, carry chairs and steering wheels. Their results showed that the average percentage reduction of bacteria post cleaning. The results ranged between 91.8%-97.1% This provided further assurance to the provider that their cleaning of vehicles and equipment was effective.

The storeroom, stock and equipment were all visibly clean. We saw evidence of weekly checklists that were

completed to provide further assurance of compliance with their 'Infection and Prevention Policy' (January 2017). Staff ensured out-of-date and non-labelled food was removed from all fridges. The level of waste in bins was checked weekly and collection of waste was arranged as needed.

Their 'Infection Prevention and Control-People Policy' was written by the clinical lead and due for review in January 2019. The policy included clear guidance for staff to reduce the risk of infection by adhering to good practice. This included hand hygiene, the use of personal protective equipment, aseptic technique and working in the pre-hospital environment. We also saw their 'Hand Hygiene Policy.' This provided clear guidance for staff on indication for hand hygiene, types of cleansing agents and when to use them, hand hygiene technique and guidance for healthcare workers with direct patient contact.

The medical centre was visibly clean during our inspection. Dedicated hand basins were clean and accessible in the kitchen, clinical area and toilet. Liquid soap was available in wall mounted holder systems. There was wall mounted disposable paper towel dispensers. They contained absorbent disposable paper towels for hand drying and foot operated, lidded pedal bins positioned near the wash basin. This was all in line with their 'Hand Hygiene Policy'' (March 2018).

Environment and equipment

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 premises were secure. The provider's offices were located within a secure compound shared with other businesses. Visitors had to confirm who they were meeting before they were allowed through the barrier gates at the entrance. Then they had to report to reception staff and sign a 'visiting record'. Reception staff had to be aware of their arrival before they issued a visitors' pass. The provider kept its ambulances inside the secure compound between uses.

The storeroom was on the secure compound. It was separate building to the medical centre. The ambulances were parked outside. This meant it was easy to replace used equipment and stock on the vehicles.

The stock room was divided into five sections. This area was managed by a member of staff called make ready manager. They were responsible for the design and maintenance of the room. They used their IT system to manage the stock levels and expiry dates. This ensured there was enough stock. They used a barcode system to manage the stock. This was linked to an application on the manager's work phone. When they scanned the barcode, the phone displayed an image of the stock quantity and confirmation of what the item was. They also received confirmation of the stock quantity and the expiry date(s). The system generated an email to the make ready manager when any stock had an expiry date of four weeks. We checked a sample of five items and saw that they were all were all labelled correctly and in date.

Section one included the staff kitchen. This had a fridge, microwave, kettle and washbasin, table and chairs. There was a fire extinguisher which was in date. This was checked daily and maintained by studio staff.

Section two was a storeroom for consumables. They were kept in clear plastic containers, so they were easily visible. Each container was labelled. Information included the type of consumable, their size and expiry dates. They were organised so that the consumable with the oldest expiry date was the first in line to be used.

They kept the Control of Substances Hazardous to Health (COSHH), products in the storeroom. All COSHH products were stored in a locked cupboard. This is in line with COSHH regulations (2002) which is the law that requires employers to control the substances that are hazardous to health. This included signage in the area and related fact sheets to provide assurance that they would only be used in line with the regulations.

Section two also contained a computer. Section three was used to store medication which could be bought over the counter. For example, paracetamol. The area was locked, and the keys were carried and maintained by the make ready manager. The medication was also stored in clear plastic boxes which were labelled with information that included their expiry date. We checked a random selection of 15 boxes that contained medication. The boxes were all clearly labelled. They contained the medication that was recorded, and they were all in date.

Section four was a general storeroom for events equipment. The room was locked. Equipment was kept in plastic container boxes with lids. They were stored on shelves which were easily accessible, and they were all labelled.

Section five included the stock bags for the vehicles. The make ready manager was responsible for maintaining these. They used a checklist to ensure consistency when they re-stocked bags. They tagged and labelled them with stickers which included their expiry date. Bags that had been opened were stored on a specific shelf that was clearly marked.

We inspected two vehicles during this inspection. The outside lights and doors were working properly. They had handheld devices on the inside which were working. Sterile supplies such as dressings were stored securely with intact packaging and in date. We checked essential emergency equipment such as defibrillators and oxygen and they were all in good working order. There was evidence that the equipment was serviced, and potable appliance checks were completed. This provided assurance that they were compliant with the law which requires employers to maintain equipment to prevent danger.

The vehicles had age specific transport devices for babies and infants. They were safe, clean and lightweight. One type was for babies weighing under 9kgs. The other type was for infants up to 18kgs. They had adjustable five-point harnesses to secure children in their ambulances.

We saw evidence of their vehicle maintenance checks. The MOTs and servicing for all five vehicles were due to be completed in January 2020. The provider ensured they were all completed in January as this was their quietest month. None of the checks had expired before January 2020. They maintained a spreadsheet which included the vehicle model, the date it was purchased, date of service, MOT, mileage and details of any work that was completed. For example, one vehicle had brake tyres replaced and they were tracked and balanced to ensure they were safe to drive.

The provider's monthly checklists were fully completed for the period April 2018- March 2019. This included ensuring their stock levels were checked and any orders were placed. They ensured there were enough clean uniforms available. Staff said they were supplied with enough uniforms and a winter coat. They were not expected to pay for the uniforms.

The main clinical waste bin was stored outside with locks in place. Staff told us it was emptied when it was three quarters full and at least once a month (even if it was not three quarters full).

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 transported patients to the nearest NHS emergency department, as soon as they detected any signs of deterioration in a patient. They made the transfer under blue lights and pre-alerted the receiving hospital en route. They provided any necessary clinical information. For example, the nature of the patient's injury or illness, any known past medical history, their clinical observations and any care or intervention they had provided. This helped the receiving emergency department to prepare for the transfer. We were told that they would request an air ambulance service if this was the most appropriate mode for transport for the patient's needs. Staff could contact the duty manager at any time during the transfer for clinical advice and support.

They told us that the management of a patient that was deteriorating was part of their core practice, but how they managed it depended on the setting and the level of their concern. They planned for deteriorating patient activity based on the type of event. For example, they used 'the management of the collapsed for runner toolset' for a running event. They used individual care plans for contact sport events. Although we do not regulate this type of activity, this meant that they effectively planned for events and patients that could require emergency transfers form these events.

Management of the deteriorating patient was a core element of their in-house training. This included paediatric assessments, UK Sepsis trust updated toolset (2020), NEWS2, trauma management and managing a patient with deteriorating airway.

Staff had access to information that they would need if there was a major incident. A major incident is any occurrence that presents serious threat to the health of the community, or causes such numbers or types of casualties, as to require special arrangements to be implemented. They would be allocated a hospital by the medical controller with an external ambulance service if necessary. The information contained clear information about their role and responsibilities. It also confirmed information about actions to take if there was a hazardous substance attack. The provider had developed a business continuity plan since our last inspection. The Board of Directors for the provider and the compliance officer had approved the plan in April 2019. It included a clear plan so that work continued in the event of adverse conditions such as a storm, fire of crime. For example, they had a contingency plan so that calls were diverted from their base to managers (if needed). They had clear IT and information backup procedures and processes to follow if something unexpected happened such as fuel shortage or if they needed to close their office (temporarily). There were also clear emergency protocols for staff to use if there was an emergency such as a fire or bomb alert.

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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave all staff a full induction.

The service took account of relevant legislation, health and safety executive legislation, and the guidance provided in the Events Industry Forum's Purple Guide. They used this when they planned staffing numbers for a regulated activity. The Purple Guide provided national guidance to help services plan safe staffing for events. This helped to ensure there was enough staff, and the correct skill mix should the service need to transfer a patient to hospital and carry our regulated activity.

They had processes in place to ensure staff had the right qualifications, skills, training and experience to keep people safe and from avoidable harm. This also provided assurance that staff would be able to provide the right care and treatment. Staff were not allocated work until they had provided the information required

Managers told us that because events were planned, it was usually easy to allocate the right number of staff and skill mix to keep patients safe. The service had an online rota system. Staff could record their availability. Administration staff maintained a spreadsheet of staff details. This meant they could allocate staff to jobs according to their skills and qualifications. For example, for events where children may attend, managers allocated registered staff that treated children during their permanent job.

Managers told us they regularly reviewed the staff rota. They aimed to allocate staff who worked for them regularly. They removed staff from their rota if they had not completed any jobs for them in the previous 12 months.

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

We reviewed seven patient record forms. The provider had improved their documentation. They now maintained accurate, complete and contemporaneous records for each service user. This included a record of the care and treatment provided to the service user, and decisions taken in relation to that care.

Every patient record form had a unique number to help identify patients and match them to their health care records. Staff recorded the patients' name, date of birth, next of kin and address. We saw details of the time they were called, the time they arrived on the scene and the time that they arrived at the patient. They recorded baseline observations which they monitored according to their concerns. Some of these included temperatures, blood pressure, breathing rate, blood glucose level and level of alertness. They repeated sets of observations until handover. They recorded details of how the patient presented, their past medical history and the results of

their assessment. They recorded details of any medication, care or treatment they provided. Staff signed their name and time of handover. The receiving hospital staff also recorded their name.

They recorded the weight of babies, infant and children they transferred. This meant they could safely calculate the dose of any medications that may be needed. All records were fully completed.

When staff completed paper records, they returned them to the office/medical centre at the end of their shift. They put completed records into a marked wallet in a post box at the end of each vehicle shift. The post box was locked and emptied daily by administration staff. They scanned the records, so they were stored for archive and audit. The scanned paperwork was also sent to the reiving trust.

The registered manager or clinical lead reviewed the documentation and clinical information. They completed an audit of staff record keeping and emailed staff feedback following this. They did this immediately or as soon as possible. This was an ongoing process.

Medicines

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

The provider had updated their 'General Medicine Management Policy' in September 2019. This provided clear guidance for staff on the supply, administration, storage, disposal and adverse incident reporting of medicines. They employed a pharmacist on a job by job basis for specialist support and guidance. For example, regarding advice on the safe and secure handling of medicines and related policies and guidance.

The make ready manager had overall responsibility for ensuring all medicines were stored safely and securely in line with their policy. All medicines were store in locked areas within their stores. This area was not accessible to the public or unauthorised staff.

The policy provided clear directions on when medicines could be administered, by what route and the correct doses. Only staff that were employed directly by the provider and authorised to prescribe could prescribe. For example, a doctor.

They restocked medicine bags with non-controlled drugs ready for each shift. They tagged the bags to provide assurance to staff that the bags were stocked and ready to use. The medicine bags had to be signed in and out by staff. They checked the drugs bags at the start of each shift and signed the 'vehicle daily log' sheet to provide confirmation of each check.

Section five of the provider's storeroom was called the 'secure cage room.' This area stored their controlled drugs. Controlled Drugs (CDs) were stored and handled in line with CD legislation under the Misuse of Drugs Act 1971 and The Misuse of Drugs (Safe Custody) Regulations 1973. CDs are subject to strict legal controls and are closely regulated as they are susceptible to being misused or diverted and can cause harm. CDs were stored in a safe that could only be access by paramedics. Systems were in place to ensure the code to the safe was changed every month.

An access card was required to enter, and it was always locked. The room was temperature controlled to ensure medication that was required to be stored at room temperature (15-25 degrees Celsius), was stored safely. The make ready manager monitored the area. They used controlled circuit television.

Out-of-date medicines were returned to the medicine's stores. They were disposed of in their clinical waste bins within that storage area. They had a contract with a clinical waste provider who was responsible for collection and destruction of out of date medicines.

The oxygen cylinders were stored upright and securely outside. This was within a purpose-built cage that was locked. They were labelled correctly with signage that confirmed they were compressed gases and how to store and maintain them. The cage was divided in two. This ensured that empty and full cylinders were stored separately. This is in line with the Department of Health guidance set out in Medical Gases Health Technical Memorandum (2006).

Sharps bins were stored inside a designated area within the storeroom. This area was locked. This was in line with best practice guidelines.

Staff had to complete a knowledge test regarding medicine management. We did not ask to see evidence of this.

Incidents

Good

Urgent and emergency services

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. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service reported no never events in the 12 month period before our inspection. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by the healthcare service. Each never event has the potential to cause serious harm or death.

Staff had reported four incidents in the 12 months prior to the inspection. Incidents were logged onto an electronic spreadsheet. This was maintained by the registered manager and the clinical lead. They also led on the investigations. The incidents were all allocated an internal and client reference number. They recorded the type of incident, a brief description, and the investigator. There was a summary of the lessons learnt following completion of the investigation, and completed actions approved by the governance committee date. They recorded the date actions were completed, an explanation for any delays and when lessons learnt had been completed.

One incident was still under investigation. This involved a delay in one of their ambulance staff getting to the correct location when their staff had requested back up. The most recent incident logged involved a complaint by a female member of staff. They complained about a male colleague who had made 'inappropriate comments.' The investigator had discussed the matter with the staff member that the complaint related to. They completed an additional training module in harassment and were given a written warning. They apologised to the complainant. The provider felt that this was an isolated incident, so the learning was specific to the member of staff it related to. However, we reviewed the last eight incidents which dated back to October 2017. They were all investigated, and lessons learnt were share across the service.

We also read an example of lessons learnt following a debrief session. This was through a doctor who had attended a cardiac arrest with other staff. They had reflected on the management of the incident and implemented some changes from the lessons they had learnt. Staff were issued with name badges which included their clinical grade and skill level. This could help to allocate roles and tasks to match expertise more quickly in emergency situations. They also added 'post cardiac arrest sheets' in their advanced life support equipment bags to ensure best practice was maintained.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

This is the first inspection to be rated. We rated it 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.

We reviewed the provider's policies. All policies included details of the author, the date they had been approved and the date which they were due to be reviewed. They contained relevant, evidence-based information. For example, their 'Policy for the Supply, Administration, Safe Handling and Storage of Controlled Drugs' outlined their responsibilities and accountability, how controlled drugs would be purchased and stored, how their usage would be recorded and administered, how any discrepancies in numbers must be managed and their safe destruction.

Polices were based on the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance. JRCALC provides expert advice with practical guidance. They used their guidance to ensure staff were supported in their role and provide assurance that they had clear guidance on how to provide safe and effective care.

A pharmacist reviewed and updated their policies related to medicines. They were paid a retainer fee for this work. Polices were reviewed at clinical governance meetings to ensure they were up- to-date and reflected best practice.

The provider had introduced a regular audit programme which was monitored through their clinical governance. This was an improvement from the last inspection. They did not complete any audits to ensure staff complied with their policies when we previously inspected.

The provider told us that they submitted data every time they used Penthrox. This was to contribute to the knowledge and effectiveness of this medicine. Penthrox is a medicine that is used for the emergency relief of moderate-to severe pain in conscious adult patients with trauma and associated pain.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey. The service made adjustments for patients' religious, cultural and other needs.

Staff told us that adequate nutrition was a key aspect of patient safety. They provided drinking water for all patient transfers to hospitals. This was to maintain hydration and comfort. They explained that some patients could not take medication without water, so they ensured it was always available.

Staff assessed patients' nutrition and hydration needs during their paramedic primary care home visiting service. A patient told us that staff explained the importance of drinking plenty of fluids. Staff told us they referred to other services when they identified issues. For example, they could refer obese patients or patients with significant weight loss to the community dietician service.

Pain relief

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

The service monitored and managed patients' pain in line with the Joint Royal Colleges Ambulance Liaison Committee guidance. They recorded pain scores before and after pain relief to monitor the effectiveness of pain relief and the patients' condition. They used a numerical score of one to ten to assess and record patients' pain in adults. They used a scoring system to assess and monitor pain in children. The scale showed a series of faces ranging from a happy face at 0, or "no hurt", to a crying face at 10, which represents "hurts like the worst pain imaginable". We saw pain relief was managed and monitored using pain scores in patient care records.

Response times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

The ambulances had tracking devices that linked to their monitoring system. This enabled them to monitor when a vehicle left and arrived at the planned location. The service monitored this in real time. The provider recorded, tracked and audited response times and used the data to make improvements.

This system allowed them to monitor urgent transport of patients to emergency services. This included the drivers' speed. The monitoring provided them with further assurance that staff drove safely under blue light circumstances.

Some event organisers set specific response times for ambulance staff to reach patients. The response time was measured from the time the call went out to the arrival time of the crew. The tracking system supported the provider to monitor and report this data.

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The provider collected data on its services. They reviewed this at various committees to monitor the effectiveness of their services and make improvements. For example, they collected data on their paramedic primary care home visiting service. This included the number of home visits the paramedics completed, the reason for the visit and the outcome. Outcomes included GP follow- up home visits, follow-up visits by the paramedic team, hospital admissions and emergency admissions. They monitored the most common conditions that the paramedics were

called to and successful referral pathways that were a result of their home visit. These included referrals to cancer speciality nurses, talking therapies, the falls rapid response team and drug and alcohol services.

They compared the results of patient outcomes who had received a home visit from their GP between March 2017 to January 2018. The paramedic service had resulted in a 20% reduction of patients requiring hospital admissions. This was because they were able to attend early. This meant patients did not incur delays in care and treatment because they were unable to attend a GP practice for an appointment or because they could not get a timely appointment. This also meant that it freed up GPs to deliver other services such as providing end of life care to their patients.

Competent staff

The service made sure staff were competent for their roles. Managers provided clinical supervision to provide support and development.

The service carried out pre-employment checks to assess the safety and suitability of staff in advance of offering them work. We reviewed five staff files. They completed Disclosure and Barring Service (DBS) checks before employing staff. The DBS check is the service provided by the Disclosure and Barring Service at the Home Office. The purpose of the DBS is to help employers make safe recruitment appointments to protect children and vulnerable adults.

We saw evidence that staff qualifications were checked. Staff were required to have two reference checks to be offered work. However, one out of the five members of staff did not have any reference checks in their file. The provider told us that this member of staff had worked for them for 10 years and that their references where on their ''older system.'' We did not ask to see evidence of this. The other four staff all had two reference checks. This meant the provider had assurance that staff had the right qualifications and experience before they offered them work.

Staff did not routinely receive appraisals using a formal appraisal process. This was also highlighted during our last inspection in 2017. However, the provider told us that their event clinical lead or duty manager worked alongside staff several times a year. We were told that clinical supervision was used to assess and develop competencies.

However, we were not shown any documented evidence of clinical supervision during the inspection and there was no documented evidence on staff files.

Staff that were employed as part of their paramedic primary care home visiting scheme and their paediatric and adult critical care transfer received additional training and supervision from the clinical lead.

Staff had to complete mandatory training modules to be 'live' on their database and available to be allocated work. New starters had to attend a one-day induction programme and an annual refresher training every year. They were paid to attend this. It included how to use their equipment and the process for booking controlled drugs. All staff were given a staff handbook as part of their induction. This included information on their terms and conditions, conduct, equal opportunities, equality and diversity, their role and responsibilities and their responsibility to read all the company policies and procedure. Staff had to sign to confirm they had received the handbook and sought clarification of anything they did not understand.

Bespoke training was sometimes scheduled. For example, if new equipment was introduced, staff had to attend training to be trained to use it.

Staff told us they accessed the service's policies and procedures via an online application. They could access them 24-hours a day. They received an alert when a policy or procedure was updated. Managers also received an alert that confirmed when they had read the updated information. Some polices had mandatory assessments attached to them. Staff were required to complete the assessments after reading these polices. This was to assess their understanding of the policy. They had to get 80% of the questions correct to upload their certificate onto the training matrix. This gave the provider assurance that staff had received and read all the updated information.

Multidisciplinary working

Good

Urgent and emergency services

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.

Staff coordinated with doctors that were on site at events. We were given examples of when this had happened. For example, if someone attending the event had an accident or a heart attack.

There was a team briefing at the start of every event. The team leader led this. They ensured staff had all the relevant information for their shift. For example, contact details, chain of command.

The team leader facilitated simulation training at events. The team practised their clinical skills and used equipment that might be needed. The team leader assessed the effectiveness of clinical skills and team working. They fed back immediately to ensure the team practised in a safe and controlled environment.

Staff handed over all clinical information to hospital staff when they transferred the patient. They told us they had a good rapport with hospital staff, there was mutual respect and they worked together well at handovers. We were not able to observe any handovers during the inspection.

Staff carried smartphones which they used to contact the duty manager for support and advice. We were given examples of when the duty manager had organised back up support and staff told us they worked well as a team.

We were told that the paramedic primary care home visit service was well managed from an operation perspective, between the 9am to 5pm. However, staff could not always speak with the patients' GP. This was due to their other commitments or because it was out of hours. In these situations, the provider had an escalation process. They would call the clinical lead initially. They worked two days per week for the NHS. However, they had an arrangement that they could have one hour protected time during each shift. This time was protected to take clinical calls from staff for this type of situation. They could also escalate clinical calls to their medical director.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The paramedic primary care home visiting service offered advice to promote and maintain health and wellbeing. They liaised with the patient's GP and could refer to specialist services.

Staff gave us examples of how they encouraged patients to adopt healthy lifestyles. For example, raising awareness about the dangers of smoking, identifying patients who were willing to engage with local drug and alcohol services and directly referring patients to talking therapies with their informed consent. They gave patients advice about immunisations when patients sustained open wounds.

A patient who had used the paramedic service told us they were given advice about healthy eating and support services to avoid social isolation. Staff had explained the importance of good mental health.

The provider had included health promotion as part of their unregulated activity. They encouraged staff to have wellbeing checks which included blood pressure and body mass index checks and they raised awareness of mental health and mindfulness. Although this fell out of our scope of regulation it showed that the service was committed to supporting people to improve their overall health and wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

All staff that completed regulated activity were required to undertake adult and children safeguarding training. They also had to complete a competency assessment through their external training platform. The Royal College of General Practitioners accredited this.

Registered staff carried out capacity assessments when there were concerns about mental capacity. A capacity assessment allowed healthcare professionals to identify patients who lacked capacity to make decisions about their care and treatment. This is in line with the Mental Capacity Act (MCA) 2005.

Good

Urgent and emergency services

The provider told us only a very small proportion of their work involved providing care and treatment to children. Parents accompanied children under the age of 16 years and were able to provide consent if needed.

We were told that only registered staff assessed Gillick Competence in children under the age of 16 years.Gillick Competence was the statutory process for assessing that children under the age of 16 years were competent to make decisions about their own care and treatment. They were not allowed to work if they had not completed it. This meant the provider had assurance that staff had the training to support them to assess Gillick Competency and ensure they obtained consent in line with current legislation. This was an improvement since the last inspection.

Are urgent and emergency services caring?

Good

This is the first inspection to be rated. We rated it as **good.**

Compassionate care

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

Staff told us they maintained patients' privacy and dignity by using screens at events and closing ambulance doors when they completed assessments or provided care in ambulances that were stationary. They told us they asked patients how they liked to be addressed, kept them covered up as much as possible and spoke to them discreetly when other members of the public were nearby.

We read many examples of positive feedback that had been recently received. This was feedback from clients on behalf of staff and patients. Some feedback was from GPs, medical staff from an NHS trust and direct patient feedback. One patient who had received care wrote to the provide and praised their ''caring attitude, empathy and understanding''. Another patient wrote about a paramedic, 'this person was highly knowledgeable and certainly had a way of dealing with patients that was very impressive. I am grateful for your caring response''. Some of the feedback we read did not fall within the scope of regulated activity. However, it still demonstrated that staff provided compassionate care to patients.

We spoke with an elderly patient who had used the paramedic primary care home visiting service. They lived on their own. They told us they felt completely comfortable with the paramedic. They said, ''they covered me up and made sure I was warm''. They only exposed the part of my leg that was the problem. They chatted to me and explained everything. I didn't want them to go because they were so helpful, kind and caring.''

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff told us about times they had provided emotional support to patients and their families. One paramedic had used a teddy with an anxious child on an ambulance transfer. They had used the teddy to demonstrate how they would be strapped and transferred on the ambulance. They called the teddy ''teddy mate'' and used it to demonstrate procedures such as taking a temperature. This had effectively reduced the child's anxiety. Following this, they agreed it would be beneficial for all young children that required emergency transfers. They had contacted a national children's charity to request their support to fund this. The charity had approved the proposal. All children received a ''teddy mate'' that was compliant with infection prevention standards.

We spoke with the parent of a young baby who had been transported by the provider. They told us that the staff were caring, explained everything in full, encouraged them to ask questions and talk about their concerns. They encouraged the parent to maintain close contact during the transfer, which helped to minimise their distress. They told us, ''they ensured they had the right equipment to transfer our baby and they were so gentle and caring. They made sure she was totally protected and comfortable on the stretcher. They were professional, but at the same time very kind and compassionate and even managed to make us smile.''

Understanding and involvement of patients' and those close to them

Good

Urgent and emergency services

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

We read positive feedback from family because ''everything had been explained'' and ''they were inclusive''. We read some feedback from a patient's wife. The patient had received a home visit from the paramedic home visiting service. Their wife had commented that the service was very thorough and helpful, and they were ''extremely happy with the service''.

We spoke with the family of a patient who had used the paramedic home visiting service. Staff had visited their elderly parent at home. They recommended the patient was transferred to hospital after they completed an assessment. Although the patient had wanted to avoid going into hospital, they consented. They explained why it is was necessary to their family. The staff also explained everything to their family, encouraged them to ask questions and gave them information about relevant support services. A member of the family described them as ''marvellous.''

We saw posters that the provider displayed to communicate patients' rights about advice or treatment they may be offered. This included the right to have treatment fully explained by their staff, the right to have their privacy and dignity and cultural and religious beliefs respected, the right to refuse any treatment, assessment or examination and the right to have the consequence explained to them.

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

(for example, to feedback?)

Good

This is the first inspection to be rated. We rated it 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. It also worked with others in the wider system and local organisations to plan care.

Clients who were event organisers and production companies, funded all the work that the provider carried out. The provider had enough time to plan for events as most events were planned well in advance. This helped them to ensure they had the right number of vehicles, equipment and staff to effectively plan to keep people safe.

The provider met with clients in advance of events to help them plan effectively and to meet the expectations of the client. They requested that clients gave feedback following events or the transportation of patients to hospitals. We saw evidence of feedback and the provider monitored and acted on this.

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 provider ensured that all staff completed mandatory training in dementia awareness and equality and diversity. This was an improvement since our last inspection. This provided assurances that staff were aware of the importance of meeting individual needs.

The provider told us they rarely needed to use translation services. However, they also told us they could use other solutions such as translation applications on mobile telephones. They had access to an external translation service when they carried out regulated activity, such as the adult and paramedic transfer service. This was part of their contract with the NHS trust.

They encouraged independence and mobility to patients that had incontinence. The paramedic primary care home visiting service offered advice, support and referred to specialist services with consent. They provided specific aids and equipment to help reduce their risk of falls and maintain their independence and wellbeing.

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 the service at any time while at an event. The service had specific response times for geographically larger events such as music festivals. The

service monitored response times using their tracking devices and they monitored journey times to hospitals. They also used the tracking devices to identify where vehicles were at larger events, so they were able to allocate vehicles nearest to the point of need. This provided assurance to the provider that they could attend to patients as quickly as possible.

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 provider encouraged patients and clients to provide feedback after they had used their service. They had an email address on their website for patients to register a complaint. They also encouraged all patients to complete online feedback and they requested feedback from their clients. Negative online feedback, such as 'not satisfied', generated an automatic alert to management. This meant they were able to identify any themes and they used it to improve their service.

The provider told us that they displayed posters at events which displayed details of how to log a complaint. However, we were unable to review this as care and treatment provided on an event does not fall within the scope of our regulation.

They aimed to resolve complaints as quickly as possible. They took negative feedback very seriously and aimed to address this as soon as possible.

We saw a complaint that a client had emailed to the registered manager. This was related to the attitude of a member of staff. The registered manager had met with the individual and discussed the concerns raised. They had reflected on their behaviour; they had acknowledged why it had caused concern and they wrote an apology to the client.

We saw another example of an internal complaint. The complaint was related to offensive remarks. The registered manager had met with the individual who had made the remarks. The staff member had reflected on their behaviour and made an apology to the complainant. They had attended additional training in harassment and received a written warning. These complaints were managed in line with their 'Complaint Policy' (August 2017).

The provider emailed negative feedback to staff that it was related to. They told us they asked to meet individuals and discussed feedback face to face and agreed how to resolve the matter, any development needs and related learning.

Are urgent and emergency services well-led?

Good

This is the first inspection to be rated. We rated it as **good.**

Leadership

Leaders had the integrity, 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 staff. They supported staff to develop their skills and take on more senior roles.

The managing director was also the registered manager. The clinical lead was an advanced clinical practitioner who worked for the provider three days per week and in an NHS emergency department two days per week. They had worked for the provider for 11 years. The service had a fleet and equipment manager and an operations manager who both reported to the managing director. Staff also included a senior clinical advisor who reported to the medical director, a training team who reported to the clinical lead, a manager responsible for all the stock and stores who reported to the fleet and equipment manager, and the operational staff who reported to the operations manager.

Managers told us their biggest asset was their staff. They told us they had an open-door policy and an emphasis on engaging with staff. Operational staff knew who the managers were and told us they were visible and available. They were described as ''approachable'', ''fair'', ''caring'', ''easy to get on with'' and ''they listen.''

Staff felt well supported and were clear about the management structure. They reported seeing their managers most days and that they were visible and approachable. We were given several examples of issues staff had raised with the managing director. Staff had felt listened to, advised they were impartial and that their concerns had been dealt with.

Staff were always offered a de-brief session following an incident. They received a wellbeing call or face to face contact on the same day of the incident and additional support was available. This included time off, and lighter duties. We were given several examples of when this had been applied. The duty officer was present for all events. If an incident occurred during an event, they were offered a debrief at the scene. This was to ensure staff welfare. They also enquired about the performance of equipment and checked on other staff that had supported the incident. The duty officer requested permission for a clinical follow-up at the hospital the patient was transferred to. They shared the information with the crew involved and completed an audit of their documentation and care. This meant that they reviewed their care to provide assurance that it was in line with best practice, lessons were learnt, and they constantly improved. Lessons learnt were shared.

The provider collected staff feedback to identify any themes related to concerns or areas for improvement. Staff felt able to contribute ideas and raise concerns. We were given several examples of changes that had been made in response to staff feedback.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

We read their vision and strategy which included an overview of their services and objectives targeted for the end of March 2020 and objectives to be achieved between March 2020 to March 2021. Their document included strategies they had identified to meet their vision, and actions that needed to be completed to achieve the objectives.

For example, an immediate objective was maintaining the stability of the company as a member of the management team was about to retire. They planned to recruit someone to fill this vacancy. An action linked to this was to develop the job description and selection criteria. They also identified that they needed to produce a more comprehensive list of staff requirements to support effective job matching. This included the distance staff were prepared to travel for jobs and work they would not consider, rather than ask staff their preferred type of work.

Culture

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

Staff told us the culture was open and honest. The provider ensured they had the right training, skills and equipment necessary to complete their work. They told us they were supplied with enough uniforms, free training and equipment such as smartphones to support them to work efficiently.

Staff told us they felt able to raise concerns. Their 'Whistleblowing Policy' was written in March 2018. This included how whistleblowers' could notify us and other external agencies of their concerns, or if they were dissatisfied with the outcome of their investigation. They highlighted that any victimisation or attempt to deter a whistleblower would be a disciplinary offence.

We read their 'Duty of Candour and Being Open Policy' written in September 2019. The policy outlined what duty of candour (DoC), was and what being open meant. DoC is a legal duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. There was a clear process for staff and management to follow. We also saw that all staff were required to complete mandatory training in being open and in obtaining consent. This provided assurance that staff had the necessary knowledge to support them to apply this legal requirement

Staff told us the company was inclusive. We read their 'Code of Conduct Policy'. This was due for review on 1 July 2020. This provided guidance on personal and professional conduct that was expected at and away from the workplace. The policy was inclusive. Staff had to notify any clothing requirements to managers immediately. For example, if their faith required them cover certain parts of their body. The policy also stated that staff must respect each other, and they could take disciplinary action if they dressed in a way to cause offensive

Staff were always offered a de-brief session following an incident. They received a wellbeing call or face to face contact on the same day of the incident, and additional support was available. This included time off, and lighter duties. We were given several examples of when this had been applied.

One member of staff told us they received some bad news during a shift. They had recently joined the company and told us management were very supportive and understanding. They encouraged them to go home but checked on their wellbeing later that day. They were encouraged to take as much time off as needed. They told us ''everyone is treated as equals'' and ''there is no pulling of ranks''.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The medical director was the service's governance lead. The clinical lead was an advanced clinical practitioner. The provider had implemented processes that supported governance of the service. This was an improvement since the last inspection. We saw evidence of regular governance meetings, minutes of meetings that reviewed their projects such as the paramedic home visiting service and they had set up a risk register. This was regularly reviewed as part of the clinical governance meetings.

There were governance meetings with clear records which showed they reviewed the minutes of previous meetings and provided an update on agreed actions. For example, in the meeting held on 3 June 2019 they had visited the updated development of their make ready stores, they had reviewed the CCTV within the sores and checked the electronic access to controlled drugs were all completed. They had agreed for the make ready stores to be operational following completion of related training. This provided assurance that staff could manage the stores, medication and controlled drugs safely and efficiently.

We saw that incidents and any safeguarding reporting were standard agenda items at the meetings. They had also discussed a recent event and the contents and purpose of the 'advanced care bags' which were used at trauma events and major incidents.

They discussed the benefit of sharing information of their paramedic home visiting service at the local ambulance depot.

We saw that policies were a regular agenda item on the clinical governance meetings. They agreed policy review dates. However, they updated them sooner if there was national guidance related to best practice or legislation. They also reviewed any patient group directives (PGDs). PGDs allow certain healthcare professionals to supply and administer prescription-only medicines without an individual prescription. PGDs were signed off by the medical director, clinical lead, managing director and a pharmacist that they sub-contracted.

At the last inspection the provider did not complete any audits to monitor the quality of their service. However, they had developed several audit tools and audited practice such as vehicle cleanliness, documentation audits, response times and fridge temperature control to ensure certain medication was stored at the correct temperature.

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. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk lead was the medical director. They had established a risk register since our last inspection. There was a risk register for regulated activity. This was last updated in March 2018. It included the date the risk was identified, the objectives or priorities that were affected, a description of the risk and the controls they had been implemented to manage it. Leads were also allocated to the risk and to the controls. For example, they identified that a potential risk was inability of back up support by an NHS ambulance trust when unplanned support was required. The clinical lead had oversight of this risk. The managing director lead on the control identified to mitigate the risk. They sent a plan to any NHS ambulance trust who could be called on to support activity at an event. They planned for additional resources if they anticipated capacity issues.

The service required that all staff who drove their ambulances had completed an accredited driving qualification. This included training in driving under blue lights. We saw evidence of driving qualifications and copies of driving licences in the staff files we reviewed.

Their tracking system allowed them to monitor urgent transport of patients to emergency services. This included the drivers' speed. The monitoring provided them with further reassurances that staff drove safely under blue light circumstances.

Staff who completed the paediatric and adult transfers and the paramedic home visiting service under NHS contracts, did not attend homes that were flagged as ''high risk'' without police support.

They had a clear process when an incident occurred. Staff that we spoke with knew how to report an incident and who to report it to. The operation manager recorded all incidents on an incident reporting log. The process outlined how they should consider the duty of candour for all incidents and what they should do.

They had a clear process for investigating incidents and what to do if it was their fault. We spoke to a manager who was able to tell us what they should report to us. They told us they would develop an action plan following the completion of an investigation. The clinical director and managing director took responsibility for ensuring they were completed.

Information management

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

The information systems were integrated and secure.

Their policies gave clear guidance on data or notifications that were required to be submitted to external organisations.

The provider monitored, managed and reported on its quality and performance to key stakeholders. It captured real time information. All information surrounding performance such as response times were completed based on their central data sources.

All staff completed Information governance training to be eligible to complete work for the company. Information governance provides a way for employees to deal consistently with the many different rules about how information is handled, including those set out in the Data Protection Act 2018.

Public and staff engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The leadership team arranged social events which enabled staff to share ideas for innovation and improvement. Staff were encouraged to share their ideas of how to improve the service as well as raise their concerns. We were given examples of ideas that had been implemented. They collected feedback from staff through online questionnaires.

Staff gave us examples of positive feedback they had received from the managing director. We saw evidence that they disseminated it to individuals, and they told us they shared it more widely across their communication channels. The provider had an internal online site that was used as a communication channel. There was also an electronic communication group to enable team

discussions. They were used to ask questions, share ideas and best practice. A manager told us they monitored both. This was to identify and monitor any themes such as staff concerns.

We were given several examples of how the provider engaged with other services to raise awareness of their services, improve communication, joint working and care. For example, one of their paramedics had recently given a presentation on a GP educational day. They used a clinical scenario where multi-disciplinary working had not been effective. They explained what should have happened, how they had managed this, lessons learnt and how they could work effectively to improve care together.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

The provider had made significant improvements since our last inspection. They had addressed all of the issues that we raised at the last inspection. There was an emphasis on continually improving. They encouraged innovation and recognised that staff were their biggest asset. They wanted to know their staff well and maintain a pool of regular staff. They organised social events and training. They believed it was important to value staff and invest in them because ‘’we want them to come back’’.

Outstanding practice and areas for improvement

Outstanding practice

We found the following areas of outstanding practice:

- The provider had established a contact with a GP consortium to deliver a paramedic home visit service. The team provided a home visiting service to patients that needed an assessment. For example, when the GP could not visit due to their workload or a patient could not get to the practice because they were frail. The service also freed up GP time to complete their full range of duties.
- We were given an example of how this worked. If a patient rang the practice because they were unwell, a GP triaged the patient to determine if they needed a home visit and met the criteria for a paramedic home visit. A paramedic was dispatched to complete an assessment of the patient in their home. Once they had completed the assessment, they uploaded the details onto their NHS device. They called or sent an instant message to the GP to confirm it had been completed. The GP reviewed the assessment and discussed the management with the paramedic whilst they were with the patient. For example, they could advise that the patient needed a course of antibiotics. This meant patients were seen promptly, in the comfort of their home. It avoided delays in diagnosis and treatment and reduced unnecessary hospital admissions.
- The provider had secured a six-month trial of this service with another GP consortium. This was due to the success of their other service. A manager told us this was a personalised, efficient service. They had seen a reduction in unnecessary hospital admissions and waiting times for appointments. We read positive feedback from related GPs and patients who had used the service.
- The provider had also established another project. This was a paediatric and adult critical care transfer. Another ambulance provider were the lead for this project. The provider was working in partnership with them and a local NHS trust. We saw the framework for the project. This clearly outlined what type of patients could be transferred by their paramedics, which required a nurse or doctor, and which had to have the approval of a consultant to transfer the patient.
- They agreed that they would transfer adult patients that required emergency transfers to another hospital if there were no paediatric transfers ongoing or planned. This meant they used their resources efficiently. It also freed up the other ambulance provider to respond to 999 calls.
- Their 'make ready' stores were a highly efficient service that was run by a dedicated manager. This ensured equipment and stock that staff needed was prepared in advance and to an agreed standard. This also meant that other staff were available for treating patients.
- The provider had developed a pathway with an NHS trust regarding immediate treatment of sepsis. They had received an NHS innovation award for this project. Their pathway focused on commencing treatment by a paramedic, as soon as the diagnosis was made. This was when a paramedic was first in attendance. This avoided critical delays in commencing treatment due to traffic and particularly when there was adverse weather.

Areas for improvement