Ise Vale Medical Services Ltd

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Quality Report

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

Ratings

Overall rating for this ambulance location	Good
Emergency and urgent care services	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Ise Vale Medical Services Ltd is an independent ambulance service located in Leeds, West Yorkshire. The service assesses and provides emergency medical treatment mainly to participating visitors and staff at public events. The service has three emergency ambulance vehicles to allow for the transfer of patients to hospital.

We inspected this service using our comprehensive inspection methodology. We carried out a short noticed announced inspection on 25 January 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? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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 main service provided by this service was emergency and urgent care through the provision of first aid and medical cover for events, which was not within our scope of registration. The service also transports patients from event sites to hospital in the event of a medical emergency which does fall under the scope of regulation.

Services we rate

Our rating of this service was Good overall.

We found the following areas of good practice:

- The stated aim of the service was that the patient always came first and staff were very caring in all aspects of their practice.
- Staff worked in a culture that was friendly and supportive.
- The service was planned in advance to meet the needs of visitors and participants at events.
- Patients could access the service in a timely and efficient manner with rapid on scene arrival times.
- The service had systems and processes in place to handle and respond to complaints.
- Leadership operated through direct and open communication with staff.

However, we identified some areas that the service provider needed to improve:

- No clear safeguarding lead or defined safeguarding procedure was in place. We found a lack of evidence of safeguarding training being completed both for staff and the safeguarding lead.
- The medicines management policy did not fully describe the provider's intention to procure and administer patient group direction medicines in line with legislation and guidance.
- Paediatric monitoring equipment including basic life support equipment, paediatric defibrillation and paediatric safety restraints for use during patient journeys was deficient or absent from vehicles.
- Managing and controlling risks appropriately, for example those associated with cleanliness of vehicles and infection prevention and control.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Good 	The main service provided was first aid and medical cover for public events; however, this was not within our scope of registration. On occasions, the service transports patients from the event site to hospital in the event of emergency treatment being required. This falls under the scope of regulation.

Good

Ise Vale Medical Services Ltd

Detailed findings

Services we looked at
Emergency and urgent care;

Detailed findings

Contents

Background to Ise Vale Medical Services Ltd

Ise Vale Medical Services Ltd is operated by Ise Vale Medical Services Ltd. The service has been registered with CQC at its present address since October 2017. It is an independent ambulance service based in Leeds. The service assesses and provides emergency medical treatment to visitors and staff at public and private events. It has three emergency ambulances to allow for the transfer of patients to hospital.

Our inspection team

The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection. The team that inspected the service consisted of a CQC lead inspector a specialist advisor, and a member of CQC staff as an observer.

Facts and data about Ise Vale Medical Services Ltd

Ise Vale Medical Services Ltd operates from a single location based at The Training Centre, New Princess Street, Leeds, LS11 9BA which is used as an administrative base for operational staff and storage of vehicles and equipment. The service employs 15 full-time and part-time staff.

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the ambulance station and administrative headquarters in Leeds and inspected vehicles and equipment. We spoke with nine members of staff including the registered manager. We were unable to speak with patients or relatives or to observe the delivery of care. During our inspection, we reviewed 10 sets of medical records, applicable to patients who had been transported to hospital for further care.

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 had not been inspected previously.

Track record on safety

- No recorded never events
- Clinical incidents zero no harm, no low harm, no moderate harm, no severe harm, no death

Detailed findings

- No serious injuries

The service had received no complaints from January to December 2018.

Our ratings for this service

Our ratings for this service are:

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

Emergency and urgent care services

Safe	Requires improvement
Effective	Good
Caring	
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Summary of findings

Emergency and urgent care services

Are emergency and urgent care services safe?

Requires improvement

We rated emergency and urgent care as Requires Improvement for safety.

Incidents

- **Processes were in place to support the formal recording and reporting of incidents.**
- The incident reporting policy was revised in January 2019 and included the requirement to report certain types of incidents to the Care Quality Commission. The incident reporting policy was held electronically and available to staff on-line.
- Processes were in place to support the formal recording and reporting of incidents which included a standard incident form. Staff we spoke with were aware of what constituted an incident and of how these were reported. Arrangements were in place for the sharing of learning from incidents with staff.
- No incidents had been reported in the 12 months prior to the inspection (January to December 2018).
- No never events were reported in the 12 months prior to the inspection (January to December 2018). Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic barriers are available at a national level, and should have been implemented by all healthcare providers.
- The provider's duty of candour policy was revised in January 2019. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. However, staff we spoke with were not entirely clear in their understanding of duty of candour. Duty of candour was included in statutory training for staff due to be implemented in the first quarter of 2019.

Mandatory training

- **The service was in the process of reviewing its mandatory training arrangements.**
- The service had systems in place to oversee and monitor staff participation in mandatory and statutory training.
- We reviewed the records of mandatory training undertaken by staff recorded in a workforce management system widely used in the independent ambulance sector for arranging staff work schedules and planning rosters.
- Staff attended induction training prior to working with the service. We reviewed evidence of the training materials used for staff induction. Staff we spoke with confirmed details of the mandatory training they had undertaken and where training was planned.
- The service informed us it followed the Skills for Health: Core Skills Framework for the standards relating to mandatory and statutory training. Staff completed an annual work book and signed a declaration confirming their understanding. The service had adopted a policy that it was mandatory for all staff to complete statutory training, including staff in administrative and support roles. At the time of inspection the service was in the process of implementing statutory training in the first quarter of 2019.

Safeguarding

- **Managers and staff were unclear as to the designation of the safeguarding lead and as to the safeguarding procedures followed. We found a lack of evidence of safeguarding training being completed.**
- The safeguarding policy was revised in January 2019 and included arrangements for liaison with the relevant local authority and the police.
- The safeguarding policy described the role and functions of the designated safeguarding lead. The provider confirmed ahead of the inspection that the operations manager was the safeguarding lead. However, staff we spoke with were unclear as to the designation of the safeguarding lead.
- The provider informed us that as part of planning for events where it provided services, safeguarding protection pathways were put in place with other agencies including the police service. However, at our inspection we found staff we spoke with were unclear as to the safeguarding procedures followed.

- The provider informed us that all staff received training in dealing with safeguarding protection issues which arose at event sites. However, we found a lack of evidence of safeguarding training being completed.
- Level three safeguarding training (level three) is required for paramedic staff that have contact with children, as specified in the safeguarding intercollegiate document. The designated lead for safeguarding, should have completed safeguarding training at level three or above. We did not review evidence that safeguarding training of the appropriate level had been completed.
- The service informed us that until now, the need had not arisen to raise any safeguarding concerns for either an adult or a child.

Cleanliness, infection control and hygiene

- **We were not assured that the cleanliness of vehicles was consistently maintained to a high standard or that quality assurance checks were undertaken for deep cleaning of vehicles.**
- We found the provider's premises were maintained to a high standard of cleanliness. A cleaning policy was in place for the premises which referenced the premises cleaning schedule, described procedures for the cleaning of equipment and also included an infection control policy. The policy included arrangements for clinical waste disposal.
- Clean linen was laundered and stored appropriately in the premises. The service used anti-fungal, anti-viral and antibacterial cleaning equipment and fluid spillage kits on board the ambulance vehicles. Posters informing of hand hygiene washing technique best practice were displayed in the premises.
- One member of staff was assigned to the general maintenance, cleaning and restocking of ambulance vehicles and equipment. However, we were not assured that the cleanliness of vehicles was consistently maintained to a high standard. There were no records available of regular cleaning checks.
- The provider informed us arrangements were in place for the deep cleaning of vehicles every six weeks and we observed a deep cleaning checklist. However, we did not see evidence of recent deep cleaning of vehicles or that quality assurance checks were undertaken for deep cleaning of vehicles. We were unable to confirm that a full complement of sterile consumables and personal protective equipment were available as the stock was removed between events.
- The management of premises and equipment policy described arrangements for maintaining standards of hygiene and for the audit of cleanliness. However, we did not find evidence that audits were completed.
- The management of premises and equipment policy included arrangements for the disposal of clinical and non-clinical waste. We observed sharps boxes were available for the safe storage and destruction of sharps. Clinical waste bags were used for the safe storage and disposal of medicine waste. Black bags were utilised for the safe storage of general waste. Clinical waste was stored in a secured yellow container within the garage area. A waste management company was contracted for the safe removal and destruction of clinical waste.
- The management of premises and equipment policy stated that all staff responsible for undertaking the cleaning of equipment would be provided with appropriate training. However, we did not review evidence of infection control training being undertaken by staff in the previous 12 months.

Environment and equipment

- **The service had suitable premises and equipment although paediatric monitoring equipment including basic life support equipment, paediatric defibrillation and paediatric safety restraint for use during patient journeys was deficient or absent from vehicles.**
- The provider's ambulance station and headquarters building was appropriately designed for the purpose and maintained to a high standard. The management of premises and equipment policy described arrangements for maintaining the suitability of the premises. The policy was due for review in January 2019. Health and Safety posters were visible in various areas of the workplace.
- The premises included a dedicated equipment storage and make ready room. The room was warm and dry with a window for ventilation and was tidy and well organised. The equipment room's temperature was monitored. Items within the storage area were protected by limited access and CCTV cameras.

- The service maintained a fleet of three ambulance vehicles for the transport of patients from event sites and one vehicle used to transport patients within the event site venue. One member of vehicle maintenance staff (fleet engineer) was assigned to the general maintenance, minor repair and service schedule of the ambulance vehicles. The provider informed us the fleet was maintained on a 24 hour basis including breakdown support. Each vehicle had safety checks every four weeks and staff followed a procedure for fault reporting.
- Evidence of regular vehicle checks and vehicle fault procedures were obtained during the inspection. We reviewed maintenance check sheets for ambulance vehicles including historical records. In the garage area we observed a planned maintenance wall chart which showed for each vehicle the date of the last safety check, jobs to do and dates of planned services.
- Vehicles maintenance was supported through a dedicated service desk which maintained vehicle details including ministry for transport test certificates. Vehicle test expiry dates were notified one month before expiry. When the ambulance vehicle required repair or service that was beyond the capability of the fleet manager, the vehicle was sent to a specialist garage.
- We checked the condition of two ambulance vehicles and found these were in a road legal and fully working condition. The vehicles appeared generally very clean and tidy. Items that were available for inspection on the vehicles were mainly within their expiry dates. Re-use items were clean and free of body fluids. However, we identified an issue with storing the vehicle outside for extended periods with a build-up of damp mould which had not been rectified during a recent deep clean. Also the stretcher on one vehicle was not within its service date. This was discussed with the registered manager at the time of inspection.
- One member of staff general maintenance, cleaning and restocking of ambulance vehicles and equipment. We reviewed the checklists which were maintained for each equipment bag which was located in the equipment storage and make ready room. We reviewed the equipment provided within a selection of first aid and trauma equipment bags. Check lists for each bag were maintained on a white board. A database provided evidence of regular stock rotation and expiry checks. All stock which had an identifiable expiry date was within its expiry date window. The system used enabled the accurate and timely re-stocking of equipment, supporting items being available and in-date prior to patient contact taking place.
- Medical devices used by the service included manual and automated defibrillators and communications equipment. Each item requiring service and located within the store room was serviced in line with the manufacturer's guidance and the requirements of the medicines and healthcare products regulatory agency.
- We did not find there was equipment fitted on the ambulance vehicles for the transport of children or policies and procedures in place to support the safe transport of children. We discussed this shortfall with the provider during the inspection. Paediatric monitoring equipment including basic life support equipment, paediatric defibrillation and paediatric safety restraints for use during patient journeys was deficient or absent from vehicles. However, we found no record of children being transported off-site, which the provider confirmed.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.**
- The service had processes in place to recognise and respond to patients at risk of clinical deterioration. Targeted advice to support clinicians was available for common emergency presentations on the reverse of the patient report form.
- Staff had access to up to date guidelines including the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.
- We were informed that staff had access to clinical advice and support through the clinical director and escalation support was available from the medical director. Senior managers confirmed they were on-call should an issue or clinical query arise. However, we did not review evidence of a roster or on-call plan for clinical or managerial support on call. We did not find evidence that escalation support was needed in the 12 months prior to our inspection.
- The provider explained the steps the service took to address patients' needs but to avoid unnecessary journeys to hospital. The patient had their treatment and any ongoing course of treatment explained where

this was appropriate and prior to discharge from scene the responsible clinician advised the patient as to follow up with their general practitioner. This was confirmed by our review of the patient report forms for seven instances of patient care in 2018.

- For patients experiencing acute mental health needs, their assessment was included within the initial assessment by the clinician undertaking the primary assessment in conjunction with any other health professionals in attendance, including the police. The provider informed us that where patients transferred between services a formal handover was provided and recorded in the patient report form. However, we did not review evidence of handovers taking place at hospital destinations.
- The service did not transport patients detained by the police under Section 136 of the Mental Health Act.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe.**
- We were assured staffing was sufficient to meet the requirements placed on the service.
- The service employed 15 full-time and part-time staff. Other staff were employed on a flexible, ad-hoc basis according to the needs of the service.
- A workforce policy was in place which was reviewed in January 2019. The policy described how safe numbers of staffing were planned for each event attended. The provider used Health and Safety Executive national guidance in the planning and staffing of events.
- A recruitment and selection policy was in place which was reviewed in January 2019. The policy covered the recruitment and selection of suitably qualified and competent staff including contractors and temporary staff.
- The provider used a staff management system which supported workforce management and scheduling. Staff were selected using a database which outlined what training the member of staff had undertaken. The system was widely used in the sector to monitor training compliance and to provide compliance and renewal checks.
- We reviewed the on-line workforce system the service used to record and monitor staff details. Staff used by the service were required to upload evidence of their suitability and competence prior to being deployed by the service. This procedure ensured, for example, that both permanent and temporary staff were appropriately licenced to drive ambulance vehicles. The service only selected staff for work assignments when their status was 'approved'.
- The system alerted the service when expiry dates were due and when updates were received. The service reviewed the staff information system on a daily basis. The provider also used the system to support an annual audit of staff information which we found was in progress during our inspection visit.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff giving care.**
- Patient medical records were maintained and stored securely but were appropriately accessible to staff of the service.
- Managers we spoke with referred to the provider's records policy although we did not review this document.
- We reviewed a selection of seven patient report forms related to patient treatment and transport from the event site which occurred during 2018. The patient report form provided evidence of the assessment and treatment of patients and of their subsequent transport to hospital. However, each patient report form was only partially completed.
- Patient report forms were carbonated in triplicate, two for the service and one for the patient and the emergency department of the receiving hospital. This ensured that hospital staff had access to accurate records of pre-hospital patient observations, care and treatment. However, we did not establish a clear requirement for the triplicate copy of the patient report form.
- A number of different checklists to support the completion of the patient report form were in use. Managers we spoke with told us audits of patient records were undertaken. However, we did not review evidence of records audits or of action plans developed from these.

Medicines

Emergency and urgent care services

- **The medicines management policy did not fully describe the provider's intention to procure and administer patient group direction medicines in line with legislation and guidance.**
- The medicines management policy was reviewed in January 2019 and was subject to regular review with the stated aim that it remained accurate and within current best practice. The policy covered supply and ordering, storage, administration and disposal of medicines. The policy stated that medicines which are administered by HCPC Registered Paramedics should follow the directions provided within the national pre-hospital guidelines Joint Royal Colleges Ambulance Liaison Committee (2016) and be within the relevant legal exemptions.
- We found medicines were stored within a secured room, under CCTV surveillance with restricted access. The area was warm, dry and medicines were secured within a large locked safe. All medicines were logged and tracked in line with the medicines management policy. Temperature monitors were placed within the medicines area although there was no record of regular temperature recording. The service did not store any items which required refrigeration. All medicines inspected were within their expiry dates. Some medicines placed within the first aid bags were split and separated from their boxes and patient information leaflets.
- The provider stated they no longer ordered or stored controlled medicines. We found evidence of a controlled medicine being ordered by the service, with no accompanying documentation to log and track this medicine.
- The service used a reputable pharmaceutical supplier for the provision of medicines. Medicines were ordered as and when required with no formal stock requirement. We did not find evidence of a general medicines stock checklist.
- The registered manager was the clinical lead responsible for the stock management and record keeping for medicines within the service, and for conducting audits. The registered manager informed us audits of medicines were carried out two to three times per month. The system for the stock management, tracking and audit of medicines followed robust processes. However, the system was newly in place so that historical records were still to be generated.
- Gas cylinders were obtained from an authorised and reputable supplier. Gas cylinders we reviewed were full and within their expiry dates. Medical gases were stored on a shelf and within a locked steel container. Some gas cylinders were stored on a shelf above head height. There was no clear system of separation of full and empty gas cylinders. We did not find evidence of risk assessments in place for the storage of cylinders, or of the tracking of gas cylinders in accordance with national guidelines.
- A formal procedure was in place for the reporting of medicines incidents and adverse events, in accordance with the medicines management policy. There were no medicine related incidents raised at the time of inspection.
- The medicines management policy did not fully describe how the service managed patient group directions (PGD's). We found no evidence that a pharmacist or doctor authorised PGD's. The service stored and utilised medicines not contained within Schedules 17 and 19 of the human medicine's regulations 2012 without an effective PGD status.

Are emergency and urgent care services effective?

Good

We rated emergency and urgent care as **good** for effective.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- The service provided care that followed national guidance and procedures. The service used current guidelines to form the basis of treatment including the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) national guidelines. For example, the service utilised medicines specified within JRCALC to treat patients.
- Staff had access to up to date guidelines including the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. Policies were available to staff online.

- The clinical lead informed us they had some input to the writing and creation of clinical policies. Policies and procedures were in the process of being reviewed during our inspection to ensure they reflected current practice, guidelines and legislation.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were uncomfortable or in pain.**
- We found evidence the service documented pain scores for patients in patient report forms.
- Pain relief being administered was evidenced from patient records, which indicated that two levels of pain relief were used. We were unable to find evidence that patients with a recorded pain score of seven or above were administered relief for severe pain symptoms.
- Staff had access to pain scoring in the JRCALC guidelines.

Response times

- **The service planned its attendance to ensure that vehicles and staff were appropriately located to provide a response in a timely manner.**
- We reviewed a selection of seven patient report forms related to patient treatment and transport from the event site which occurred during 2018. The service did not provide separate evidence of its activity information or evidence of monitoring response times.
- As all areas of an event site were accessible in a timely manner, routine monitoring of response times was not undertaken. The service informed us it was able to respond to patient needs in a very short period of time facilitated by a 12-bedded medical centre. We did not review this facility as part of our inspection.

Patient outcomes

- **Managers monitored the effectiveness of care and used the findings to improve them.**
- There were no nationally specified key performance indicators currently used for the type of service provided by Ise Vale Medical Services Ltd.
- Due to the nature of services provided, patient outcome information was limited. The service did not provide evidence that it monitored or audited the clinical quality of patient outcomes.

Competent staff

- **The service made sure staff were competent for their roles.** Managers appraised staff's work performance, provided support and monitored the effectiveness of the service.
- Staff attended induction and role-specific training prior to working with the service. We reviewed evidence of the training materials used for staff induction.
- A workforce policy was in place which was reviewed in January 2019. The policy confirmed that each member of staff received an induction to the service at the start of their employment and a subsequent period of mentoring and supported practice.
- The provider used a staff management system which supported workforce management and scheduling. The system was widely used in the sector to monitor training compliance.
- The workforce policy described how the provider addressed the ongoing training and development needs of staff. The policy stated staff completed an annual appraisal which provided input to a development plan for the member of staff and the appraisal process was supported by regular clinical supervision.
- We spoke with two members of staff who confirmed they had received an appraisal within the last 12 months and had found it a useful process supportive of their development. Staff also knew the date of their next appraisal.
- Staff we spoke with confirmed they had opportunities to develop their skills and training was provided by the service.

Multi-disciplinary working

- **Staff of different kinds worked together as a team to benefit patients.** Staff supported each other to provide good care.
- The provider included the provision of fire and rescue services as a part of the range of services it offered to commissioners of public events. This meant an integral service was offered to event organisers which included fire and rescue services.
- The service communicated with other healthcare professionals particularly during events to ensure that patient needs were assessed and treated in a timely manner. Prior to events taking place, a multidisciplinary meeting was held with event stakeholders to discuss the planning and delivery of the public event.

- The provider attended a safety advisory group which included the NHS ambulance service, the police and the local authority.

Health promotion

- **The service identified patients requiring extra support during their initial assessment and ensured they accessed support services.**
- The service shared contact information with patients during events for health and wellbeing support services, for example for drug and alcohol awareness.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **The provider had a consent and capacity policy in place** which was reviewed in January 2019. The policy included procedures for obtaining consent to care and treatment which reflected current legislation and guidance. The policy included the assessment of capacity and making best interest decisions.
- From January 2019 the service had put in place a do not attempt resuscitation policy. The policy provided guidance for staff where a patient with a valid DNACPR decision required transport.
- The consent and capacity policy stated that each member of staff, including contract staff and others who obtained the consent of patients would receive training in the principles of the Mental Capacity Act (2005) and the associated Code of Practice.
- The policy stated that where paramedic staff or other healthcare professionals received consent and capacity training through another NHS or CQC registered provider this was accredited by the service with the approval of the clinical lead. It was the responsibility of the member of staff to provide evidence of completion of training.
- However, we found some members of staff we spoke with were unclear as to the consent and mental capacity training they had undergone. We found also that not all staff were fully clear as to the application of consent, the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The service did not transport patients detained under section 136 of the Mental Health Act.

Are emergency and urgent care services caring?

There was insufficient evidence to rate caring.

Compassionate care

- We did not observe patient care during this inspection.
- The service had in place a patient centred care policy which was reviewed in January 2019. The policy covered undertaking ongoing assessments and arrangements for ongoing care of the patient.
- The service also had in place a dignity and respect policy which dealt specifically with treating patients with dignity and respect and ensuring their privacy was maintained. The dignity and respect policy was reviewed in January 2019.
- We observed that ambulance vehicles were fitted with blinds in each window apart from the side door, supporting the privacy of patients.

Emotional support

- The patient centred care policy included information for staff as to enabling and supporting patients. The dignity and respect policy also included information about enabling and supporting patients.

Understanding and involvement of patients and those close to them

- The patient centred care policy included information about involving patients and other relevant people. The policy also covered providing information to the patient.

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

Good

We rated emergency and urgent care as **good** for responsiveness.

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of its patients.**
- The service was planned in advance to meet the needs of visitors and event participants who presented as

patients. We were informed this was primarily the responsibility of the operations manager. The service used health and safety executive national guidance to support the planning and staffing of events although we did not review evidence of this.
- The service contributed to the planning of each event it was contracted to support so that an appropriate and adequate number of clinical and support staff were available to meet people's needs.
- The provider used a staff management system which supported workforce management and scheduling. The system was widely used in the sector in planning and arranging the staff needed to support public events. We reviewed the functioning and use of the staff management system in allocating staff.
- During a public event the service communicated with other healthcare professionals to ensure that patient needs were assessed and treated in a timely manner. Staff in the role of coordinators worked jointly with other professionals, for example the NHS ambulance service and the police to ensure patient safety.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- The service planned for and addressed the individual needs of patients through a range of means.
- The dignity and respect policy was reviewed in January 2019 and included information about protected characteristics as defined by the Equality Act 2010. The policy provided guidelines for staff and contractors to support the delivery of care which considered the protected characteristics.
- Translation services were available to support patients whose first language was not English. We were informed a range of resources were available to staff to provide translation, including the use of pictures to enable translation in situations where other forms of communication were a barrier. However, we did not find evidence of multi-lingual or picture phrase books for patients with communication difficulties in two ambulance vehicles we inspected.

Access and flow

- **Patients could access the service when they needed it.**
- We reviewed seven patient report forms which related to patient treatment and transport from the location of an event to acute hospital services which occurred during 2018. The patient report form provided evidence of the assessment and treatment of patients and of their subsequent transport to hospital. We were not able to review the records of patient hand overs to NHS acute or ambulance services.
- The service confirmed that most of the patient contact undertaken did not include the transport of patients from the event site, which was reflected in the relatively low number (seven) of actual transfers conducted whilst carrying our regulated activities for the 12 months prior to our inspection.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- The service had systems and processes in place to handle and respond to complaints.
- A complaints policy was in place which the provider had last reviewed in January 2019 prior to our inspection. The policy covered how patients were to make complaints and how staff were to record and acknowledge the complaint. Complaints were graded according to their seriousness. The policy also covered responding to and investigating complaints. The policy included arrangement for notifying the Care Quality Commission of complaints.
- Staff we spoke with were aware of the member of the management team responsible for complaints. The service confirmed the procedure that staff followed in engaging with patients wishing to make a complaint. Following the receipt of a complaint the person that raised the complaint was contacted within 24 hours to provide an update. The complainant was subsequently contacted to explain the outcome of the investigation of their complaint.
- The complaints policy explained how complaints were recorded within a complaints database and monitored. The policy stated that a summary of complaints was prepared quarterly and complaints were monitored for trends and action taken to improve the service.
- An appendix to the policy included a complaints form and a complaints closure form. We were unable to review any completed complaint forms during the inspection. The service confirmed that no complaints were received in the 12 months prior to our inspection.

- The service told us it followed up complainants for feedback about the investigation of their complaint after it was completed. We saw that complaint feedback leaflets were available for patients and people connected with them. We did not see evidence of completed feedback forms.
- The service informed us that following an investigation, the complaint was discussed by the management team to identify learning and potential improvements.

Are emergency and urgent care services well-led?

Good

We rated emergency and urgent care as **good** for well-led.

Leadership of service

- **Managers of the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- The service had a clear leadership structure in place which was set out in a 'family tree' structure diagram available to staff at induction. Staff we spoke with were aware of who they reported to and of the provider's organisational structure.
- The management team consisted of the provider and owner of the service, the registered manager and clinical manager experienced in pre-hospital care, a general manager, an operations manager, a part-time medical director and a nurse practitioner.
- The leadership of the service operated effectively through direct and open communication with staff. Staff said managers were visible and approachable. Staff we spoke with told us managers were knowledgeable and gave clear directions in response to questions from staff.

Vision and strategy for this service

- **The service had a vision for what it wanted to achieve.**
- The aims and objectives set out in the provider's statement of purpose was, "Our vision was to provide a high standard and efficient service consisting of unscheduled and emergency care, event medical cover and first aid training across the United Kingdom which was accessible to everyone 24 hours a day seven days a week".
- The provider informed us that the vision and strategy for the service was being rewritten at the time of our inspection. One manager we spoke with told us the 'strap-line for the service was "protecting people, site and product." Another manager told us the strategy the service followed was 'to be the very best you can possibly be.' Staff we spoke with told us that besides a formally stated vision and strategy, the patient always came first and that staff were very caring in all aspects of their practice.

Culture within the service

- **Managers promoted a positive culture that supported and valued staff.**
- Staff said they worked in a culture that was positive, friendly and supportive. The service was described to us as open and welcoming. It was team driven and relied on team effort. Staff said they felt respected and valued as a member of the team and were happy to work for the service. We observed that staff interacted in a positive and supportive way.
- A whistle blowing policy was in place which commenced in January 2019 which encouraged staff to raise concerns.

Governance

- **Governance processes were developing as the provider was growing its business.**
- The service had in place a governance policy which was reviewed and updated in January 2019. The policy described governance arrangements for the service including internal governance systems, arrangements for working with partner organisations, maintaining service quality and safety, performance monitoring and service improvement and audit processes.
- The policy described the function of a governance committee which met bimonthly to assess, monitor and improve the quality and safety of the service. The governance committee was responsible for monitoring compliance with the provider's governance arrangements and taking appropriate action where

progress was not achieved. The provider confirmed the governance committee met regularly but no records of meetings were available for the three months prior to our inspection.
- The governance policy stated that following each meeting of the governance committee, minutes were to be prepared as a record of the meeting and to detail actions or areas identified for improvement.
- The staff induction document included information as to the governance and committee structure for assuring quality at location level. We did not review this information during our inspection.
- Managers told us the management team had met in January 2019 and typically met on a weekly basis. The agenda included clinical governance, staff and disciplinary matters, incidents and complaints. Managers told us that separate clinical governance meetings were held periodically, usually when the medical director was available, to discuss any concerns or issues regarding their role and duties within the service. Regular meetings involving the fleet manager were held to discuss fleet management. Minutes or other records of action points arising from these meetings were not available. There was no evidence of clinical meetings or concerns being raised and actioned.
- The provider informed us that no external reviews of its services had been conducted in the 12 months prior to our inspection. The provider informed us that copies of contracts held with third party organisations were not available. No contracts were held with NHS organisations.
- The provider told us its business continuity plan was being rewritten at the time of our inspection.

Management of risk, issues and performance

- **The service had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- The provider had awareness of managing and controlling risks which was undertaken as part of event planning. However, the management of risk was not coordinated or reviewed from a whole organisation perspective by the provider.
- The provider's governance policy described arrangements to undertake formal risk assessments. As part of planning for medical cover requests and operational deployments a risk assessment was undertaken. The risk assessment followed health and safety executive national guidance and was in addition to the event organisers risk assessment.
- The governance policy stated that where appropriate, a formal review of risk identified when planning events was undertaken to ensure that all levels of medical cover were appropriate based on the risk score and to minimise the level of risk to patients and staff.
- Managers we spoke with confirmed that event planning included assessment of risk and included risk scoring and that management of risk formed an important part of the provider's planning. However, we did not find evidence of risk assessments which were undertaken following national guidance.
- We did not find evidence of a risk register for the service. The provider informed us its risk register was under review at the time of inspection. We did not find evidence that the provider monitored or audited clinical quality and risk.
- We found no evidence that a lack of local risk register or auditing of risk had resulted in adverse outcomes for patients.

Information Management

- **The service collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards.**
- The provider's governance policy was last reviewed in January 2019 and included details of information management procedures used in the service. Information about safety and quality of services was published on a bi-monthly basis. A summary of performance and governance was published externally which included outcomes of audit and reviews, staff deployed for events covered and outcomes of complaints.
- We were informed that policy and clinical and medical updates for staff were sent out electronically, and confirmation was received that staff had read and understood the policy.
- Members of staff communicated through secure electronic media. A secure portal was under

development at the time of inspection which had a planned completion of February 2019. We were informed that staff had chosen this as the preferred method of communication.

Public and staff engagement

- **The service engaged with patients, staff, and commissioners to plan and manage appropriate services.**
- The service monitored patient satisfaction using posters inviting feedback and feedback leaflets on ambulance vehicles. Kit bags included feedback leaflets and staff were encouraged to hand these out to patients. Patients could choose to phone, email, on-line or postal alternatives to give feedback. Patient feedback forms were identified by the patient report form reference. However, we did not see evidence of completed feedback forms.
- The service told us event commissioners were also asked for feedback. We were informed the feedback was positive.
- Staff could communicate with the service on-line using a secure web site. The service informed us that the staff survey was being revised at the time of our inspection.

Innovation, improvement and sustainability

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- The provider included the provision of fire and rescue services as a part of the range of services it offered to commissioners of public events. This meant an integral service was offered to event organisers which included fire and rescue services.
- The service informed us of a training package it had implemented for staff and commissioners of services for best practice in responding to acid attacks. The package included training for commissioners as well as staff.
- Managers were not aware of any formal procedures or policies in place governing quality improvement.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must manage and control risks associated with cleanliness of vehicles and infection prevention and control, particularly by maintaining the cleanliness of vehicles consistently to a high standard and undertake quality assurance checks for deep cleaning of vehicles (Regulation 12 (2) (h)
- The provider must revise the medicines management policy to reflect arrangements to procure and administer patient group direction (PGD) medicines in line with within Schedules 17 and 19 of the human medicine's regulations 2012 and arrange for a pharmacist and doctor to authorise PGD's. (Regulation 12 (2) (g)
- The provider must implement in full the safeguarding procedures described in the safeguarding policy including the role and functions of the designated safeguarding lead and ensure safeguarding training is completed to the appropriate level for all staff. (Regulation 13 (2))
- The provider must ensure paediatric monitoring equipment including basic life support equipment, paediatric defibrillation and paediatric safety restraints for use during patient journeys is provided on vehicles used to transport children (Regulation 15 (1) (c)).

Action the hospital SHOULD take to improve

- The provider should ensure staff receive training in assessing and supporting patients experiencing acute mental health needs (Regulation 9).
- The provider should ensure paramedic staff or other healthcare professionals provide evidence of having completed consent and capacity training for approval by the clinical lead (Regulation 11).
- The provider should implement a risk register for the service so that the management of risk is coordinated and reviewed from a whole organisation perspective (Regulation 17).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The medicines management policy did not fully describe the provider's intention to procure and administer patient group direction medicines in line with legislation and guidance.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The cleanliness of vehicles was not consistently maintained to a high standard or quality assurance checks undertaken for deep cleaning of vehicles.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Staff did not have a full understanding of safeguarding procedures and were unclear as to the designation of the safeguarding lead. Lack of evidence of safeguarding training certificates was not in line with the Safeguarding Intercollegiate Document, 2019.**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Paediatric monitoring equipment including basic life support equipment, paediatric defibrillation and paediatric safety restraints for use during patient journeys was deficient or absent from vehicles used for the transport of children.