Emergency Medical Services (UK) Limited

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

Ratings

Overall rating for this ambulance location

Emergency and urgent care services

Summary of findings

Letter from the Chief Inspector of Hospitals

Emergency Medical Services (UK) Limited is operated by Emergency Medical Services (UK) Limited. The service provides emergency and urgent care and a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 28th to 30th March 2017.

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

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

The main service provided by this ambulance service was urgent and emergency care. This was sub-contracted from two local NHS ambulance trusts. A patient transport service was in place; however, there were no contracts to provide this service. At the time of the inspection this service was provided on an ad-hoc basis to the local hospitals. The same staff were used for both services therefore, both services are reflected in the main service section of urgent and emergency care.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There was a genuinely open culture in which all safety concerns raised by staff, people who use services and from the NHS Trusts from which the service sub-contracts, are highly valued as integral to learning and improvement.
- Robust investigations were carried out. Feedback and lessons learnt because of incidents were shared amongst staff.
- There were reliable systems in place to prevent and protect people from health-care associated infections. Infection prevention and control procedures were embedded.
- Equipment and vehicles were well maintained.
- Medicines were stored and handled appropriately and regular audits took place. Patient group directions were in place and all were signed and in date.
- Safeguarding vulnerable adults, children and young people was given sufficient priority.
- Record keeping was in line with best practice. Records were stored confidentially and an audit of all the patient report forms allowed the management team to benchmark and ensure that staff were following the correct care and treatment for patients. The management team would feedback any underperformance to the crews and take appropriate action.
- Staff were aware how to detect and respond to deteriorating patients and followed national guidelines. A national early warning score was used to detect early deterioration. Crews could access advice and support from a clinical hub at the NHS Trust from whom the service sub-contacts.
- Staffing was managed by a resource manager. All shifts were able to be covered. Shift patterns were in line with the working time directives.

Summary of findings

- The service had a proven track record in the management of first on scene at a major incident and exercising their business continuity plan.
- A range of pathways were used that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. These pathways were from the NHS Trust from whom the service sub-contracts.
- An audit of patient report forms captured if the pathways were followed correctly and we saw evidence of learning when this was not the case.
- Key performance indicators were audited and results were excellent.
- Patients had their needs assessed and their care provided in line with evidence based practice
- Response times were in line with the NHS Trusts from which the service sub-contracted. If the service did not meet the response times then the NHS provider would contact the management team who would investigate.
- Training and education was high priority and a strong focus for the service. The service worked in close collaboration with their sister training and education organisation. They provided training programmes for the emergency care assistant and ambulance technician roles and supported their staff through these programmes.
- The continued development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported to acquire new skills.
- The service was committed to working collaboratively and had taken part in joint training sessions with the fire and rescue services and the mountain rescue teams.
- The NHS ambulance services and hospital staff we spoke with reported good working relationships with the service.
- Various means of communication was used to enable staff to access information, these included newsletters, and email.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. People were supported to make decisions and their mental capacity assessed and recorded on the patient report form.
- Feedback from people who used the services was consistently positive about the way staff treated people.
- There was a strong person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Staff were respectful and showed a caring attitude to relatives and carers travelling with the patients.
- Staff explained to the patients what each observation, treatment was for, and why they were performing the checks.
- The service was planned and delivered in a way that met the needs of the NHS Trusts from which the service sub-contracted.
- The service worked with the NHS ambulance services to support them to meet patient demand for the service
- Patients' individual needs were managed and staff had received training to care for patients with dementia and learning disabilities.
- Translation services were available.
- Complaints were managed and investigated thoroughly and feedback and training was given to staff.

Summary of findings

- The leadership strived for continuous improvement. There was a clear proactive approach to seeking out and embedding new and more sustained models of care and governance processes.
- Leadership was strong, open, honest and supportive.
- The leadership was knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them. Performance information was used to hold staff to account.
- There was a clear vision and strategy, driven by quality and safety.
- Staff understood the vision, values and strategic goals.
- All staff prioritised safe, high quality, compassionate care and there was a culture of collective responsibility between all staff.
- The information used in reporting, performance management, and delivering quality care was accurate, valid, timely and relevant.
- There was effective and comprehensive processes in place to identify, understand, monitor and address current and future risks. Audit processes functioned well and had a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.
- Information and analysis was used proactively to identify opportunities to drive improvements in care. Service developments and efficiency changes were developed and assessed to understand their impact on the quality of care. The impact on quality and financial sustainability was monitored effectively.
- Financial pressures were managed so that they did not compromise the quality of care. However, we also found the following areas that the service provider needed to improve:
- Sharps bins were not signed and dated
- The audit of medicines did take place and the variance was discussed at the management risk meeting however, any variance needed further investigation

Following this inspection, we told the provider that it should make some 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		The service provided an urgent and emergency care and a patient transport service. It sub-contracted to NHS acute hospitals and ambulance trusts. The service provided high quality care. The leadership was strong, knowledgeable about quality issues and priorities, understood what the challenges were and strived for continuous improvements. Training and education were excellent and the service had the governance processes and information in place to manage current and future performance. The impact on quality and financial sustainability was monitored effectively.

Emergency Medical Services (UK) Limited

Detailed findings

Services we looked at
Emergency and urgent care; Patient transport services (PTS);

Detailed findings

Contents

Background to Emergency Medical Services (UK) Limited

Emergency Medical Services (UK) Limited is operated by Emergency Medical Services (UK) Limited. The service opened in November 2009. It is an independent ambulance service based in Darlington, County Durham.

At the time of the inspection, a new registered manager had been appointed and was registered with the CQC on 1st November 2016.

The service is registered to provide the following regulated activities:

- Diagnosis and screening
- Surgical procedures
- Transport services, triage and medical advice
- Treatment of disease, disorder and injury

This service had not received a previous CQC inspection, there were no compliance actions/requirement notices or enforcement associated with this service.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 28th to 30th March 2017.

Our inspection team

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

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Emergency Medical Services (UK) Limited provided emergency and urgent care and a patient transport service. The service sub-contracted to NHS ambulance services and NHS Acute Hospital Trusts. At the time of the inspection, the service had contracts with two NHS Ambulance services and provided ad-hoc patient transport services to the local hospitals.

From January 2016 to December 2016, the service operated 8945 shifts.

During the inspection, we visited the headquarters and the ambulance station from which the service was based. We accompanied two crews, one covered the Cumbria area and the other covered the Darlington area. We spoke with 13 staff including; a registered paramedic, ambulance technicians, emergency care assistants, trainee technicians and management. We spoke with nine patients and one relative. During our inspection, we reviewed 15 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the first CQC inspection the service had received since registration with CQC, and we found that the service was meeting all the standards of quality and safety it was inspected against.

Employed by the service were ten registered paramedics, four ambulance care assistants, nine emergency care assistants, eight ambulance technicians, two mechanics, one fleet assistant, one cleaner, one auditor, one manager who dealt with resources, one event co-ordinator, one human resources manager and an IT operative. All the clinical staff were on zero hour contracts. The accountable officer for controlled drugs (CDs) was the registered manager.

The service operated six emergency ambulances, one urgent care ambulance, three patient transport ambulances, and one rapid response vehicle.

Emergency and urgent care services

Summary of findings

Are emergency and urgent care services safe?

The main service provided by this ambulance service was urgent and emergency care. This was sub-contracted from two local NHS ambulance trusts. A patient transport service was in place, however, there were no contracts to provide this service. At the time of the inspection this service was provided on an ad-hoc basis from the local hospitals. The same staff were used for both services therefore, both services are reflected in the main service section of urgent and emergency care.

Incidents

- Between October 2016 and January 2017 there were three incidents reported relating to patient care and eight not related to direct patient care.
- We saw evidence of how incidents were shared with staff through several different forums. These were through the monthly newsletters, the managing director (MD) weekly information letter, staff meetings and email to staff. Pop up messages would appear on an information technology (IT) system used for crews to access their shifts, which ensured they were presented with messages prior to being able to access their shifts.
- Staff shared an example of learning from an incident. This incident was when a crew failed to spot the parameters for sepsis. We saw evidence of the investigation, feedback given to the crew, sepsis posters were displayed at the station and in the vehicle documents packs. Information was sent out in the various newsletters.
- We were told of an incident that involved a brake failure of an ambulance, which happened on two different ambulances. No harm was caused however, the potential of harm was recognised and the directors grounded the fleet. This meant they had to contact the NHS trust for which the service sub-contracted and withdraw the service until they were assured the vehicles were road worthy. This demonstrated integrity and that patient and staff safety was paramount.
- There were no never events recorded since the service had commenced . Never events are serious patient safety incidents that should not happen if healthcare

providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- There was a new incident reporting policy in place from January 2017 and we saw evidence of the accident and incident reporting form.
- We saw evidence from the monthly management/ risk meeting minutes that an operations monthly overview included discussions relating to station issues and health and safety issues.
- Within the quarterly clinical governance meeting, clinical risks and risk register were discussed.
- The management team had an understanding of the duty of candour and staff were trained within the statutory and mandatory training. However, staff were not able to provide examples of when this was implemented as any patient related incidents were investigated by the NHS ambulance service which the service sub-contracted and they would employ the duty of candour regulatory duty. 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) ofcertain 'notifiable safety incidents' and provide reasonable support to that person.
- There had not been any incidents that required joint investigation with the NHS Trusts.

Clinical Quality Dashboard

- The service had developed an audit tool that specifically looked at performance and patient care.
- An auditor was employed full time to undertake audits, which included auditing the patient report forms (PRF)'s.
- Audit results were broken down into completion of the PRF, patient history, primary survey, pain scores, observations, and where appropriate the recording of an electrocardiograph, peak flow, blood sugar, and assessment for stroke. This allowed the management team to benchmark and ensure the staff were following the correct care and treatment for patients.
- The management team would feedback any underperformance to the crews and take action, for example provide further training if required. This information provided assurance to the team and was shared with the NHS Trust from which the service sub-contacted if requested.

Cleanliness, infection control and hygiene

- We inspected six ambulances; we found them all to be visibly clean and tidy.
- We observed personal protective equipment on board the ambulances, which included hand sanitizer gel.
- We observed crews cleaning the ambulance inside and out at the end of the shift, and cleaning between patients use.
- We spoke with a cleaner who described the routine of deep cleaning which was every 10 weeks and we saw evidence that deep cleans had taken place.
- Staff were able to describe the correct procedures for cleaning following the transport of a patient with an infection.
- We observed staff complying with good hand hygiene, no wristwatches were worn, and staff uniforms were clean.
- We were told monthly hand hygiene audits took place. We viewed results to show March 2016, April 2016, August 2016 and February 2017. This included observing staff hand hygiene and using the correct method for tying clinical waste bags and correct colour bucket for washing ambulances. Staff were given feedback as appropriate during the observation.
- We saw segregation of clinical and non-clinical waste took place and processes were in place for the removal of clinical waste.
- The sluice contained colour coded buckets, disposable mops and cleaning materials which, were clearly labelled and stored in locked metal cabinets. Posters clearly displayed the colour coding system.
- There was a policy for the management of sharps, hand hygiene, personal protective equipment, and uniform that had been approved. Awaiting approval was an infection control and waste management policy.
- Sharps bins were not over full and were disposed of appropriately; however, they were not signed and dated.

- Clean linen was available on the vehicles and in the stock room. Used linen was disposed of and replenished by arrangement at the hospitals.

Environment and equipment

- The ambulance station had a large garage area were the ambulances and response car were kept. There was a large room for crews, which had office desks and access to computers.
- The station had a finger print clocking in and out system and the station had closed circuit television.
- The store room was clean and tidy with stores clearly labelled in plastic tubs kept off the floor. There was evidence of good stock rotation and all consumables were in date.
- Staff told us they had no issues with lack of equipment or stores.
- We observed the vehicles were stocked with equipment for the treatment of adults and children. Safety harnesses were available for the transport of children.
- Safety appliance testing of electrical equipment was carried out annually. Stickers were used to confirm servicing had been done and these were up to date.
- During the vehicle deep cleans the cleaner also rotated and replenished stock.
- We saw the use of a vehicle daily inspection form, which was used at the start of each shift. Crews had to clean the ambulance, check the clinical equipment, check oil and brake fluid levels, check vehicle electrical equipment such as lights, horn, the vehicle interior seat belts and stretchers, comment on the vehicle exterior and check other equipment such as radio, mobile phone, fuel card and the vehicle pack which contains information such as pathways and guidelines.
- The service used a data capture device for independent ambulance services that held data regarding the MOT details, vehicle faults, insurance, tax and daily checks. The device sent alerts to the managing director when MOT, servicing, tax and insurance was three months from expiring.
- During the inspection, we spoke with the mechanic who provided the ongoing maintenance of the vehicles. A six weekly safety inspection check was performed on each vehicle. Servicing was done annually or every 10,000 miles.

  The service had an environmental management system policy and an environmental policy that were awaiting approval.

Medicines

- The service had a medicine management policy which was in date.
- Medical gases were stored in a cage in a locked garage with used and empty cylinders clearly separated. The cage had hazard warning signs. Gases were obtained directly from the external supplier.
- Oxygen and analgesic gases were securely stored on the ambulances. These were full and in date.
- On the station, there was a room which contained a locked metal drug cabinet for the storage of medicines. The room had a key safe outside with coded access. The code was changed regularly and staff were informed of the change of code, by a letter in their letter tray on station.
- Paramedic and technician bags containing medicines were kept in the locked room.
- There was a signing out book for medicines removed from the cupboard, and each paramedic and technician bag had a book to audit the use of medications.
- We checked the medicines bags and the balances were correct. However, when we checked the medicines in the cupboard against the balances in the book there was a variance for two medicines, where the amount in the cupboard was less than in the book. This was highlighted during the inspection and we found the error had occurred at the booking-in stage and all the medications had been accounted for.
- A monthly medicine audit took place. This included looking at stock balances, expiry dates, batch numbers so that when medicine alerts were received they could easily be cross-referenced. There was also an audit trial of medicines used matched against the medicines given documented on the patient report

- We viewed audits, which showed variances at times. The management team told us that the variances were discussed at the management and risk meeting and a decision was made if they needed to investigate further.
- Controlled drugs were ordered by the paramedic and stored at home in line with The Human Medicines Regulations 2012. A paramedic told us that he kept controlled drugs in a locked cabinet at home and we observed the safe storage in the safe on the ambulance.
- We viewed patient group directions (PGDs) which allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. A signed copy by each staff member was stored in their personal file.
- Paramedics did not need to sign the PGD's as the Schedule 17, and 19 of the Human Medicines Regulations covered them. However, one drug used was not covered. This was highlighted during the inspection and the management team completed a PGD for this shortly after the inspection.

Records

- There was an information systems security policy, a data protection policy, a freedom of information policy and an information governance policy. These were all in date and had a review date.
- Completed patient report forms were placed in a locked metal box on station and collected daily. A copy of the patient report form was left at the hospital following the handover of the patient.
- We observed that all patient identifiable information was stored securely to protect confidentiality.
- Separate records were used for the non-transportation of patients. For example if a patient refused transport. These were provided by the NHS Trust and were placed in the secure box for audit at the end of each shift.
- The service audited the completion of the patient report forms. This included the medical history, complaint, examination, pain scores, clinical observations, any missing information, mental capacity assessment, and permission to leave patient at home if the patient refused transport. Reports were produced and feedback from the audit was given to the crews, discussed in the audit meetings and feedback could be given to the NHS Trust if requested.
- Once audited records were sent securely to the NHS Trusts for which the service sub-contracted.
- We saw evidence of information shared in the newsletters for example what the audit showed regarding pain scoring and to remind staff that this should be carried out on all patients and repeated following every intervention.
- During the inspection, we looked at 15 patient report forms. All were dated, timed, legible and fully completed.

Safeguarding

- Statutory and mandatory training included safeguarding adults and children. Paramedics were trained at level three for children and adults and other staff were trained at level two.
- A safeguarding lead was level three trained for both adults and children. We recommended level 4 children safeguarding training as a safeguarding lead. The lead showed us evidence that they had booked onto a course shortly after the inspection.
- Staff we spoke with were aware how to refer a safeguarding concern. The process varied depending on the NHS Trust the service worked with.
- We heard of several examples from staff of safeguarding referrals.
- Staff were aware how to recognise female genital mutilation and child exploitation.
- Domestic violence awareness was covered in the safeguarding training and staff told us of an example of an incident were they reported an incident to the police.

Mandatory training

- All staff were up to date with their mandatory training. This included face to face training on a variety of topics such as dementia awareness, dignity at work, fire safety, health record keeping, infection, prevention and control,

information governance, medicine management, Mental Capacity Act, manual handling, learning disability awareness and safeguarding adults and children.

- A workbook was used for follow up training.
- Staff undertook a four week driver training course which included blue light driving. All training was provided by qualified driving instructors.
- The service supported and paid for their staff to undertake the C1 driver training to allow them to drive all the ambulance vehicles. Those who chose not to do the driver training were allocated to vehicles, which did not require a C1 on their licence.
- There was a driving standards policy in place.

Assessing and responding to patient risk

- All staff were trained to assess for the early detection and treatment of a deteriorating patient.
- Pathways were used in conjunction with the NHS Trust from which the service sub-contracts.
- Crews could access the clinical hub of the relevant ambulance service. This provided clinical advice from a senior professional.
- A National Early Warning Score (NEWS) was used, which supported the process for early recognition of those patients who were becoming unwell. The audit of the patient report forms demonstrated that NEWS was recorded on all patients.
- Staff we spoke with were aware of procedures to follow if a patient deteriorated. An example was shared when a patient was being transferred with a diagnosis of an aneurism. The patient began to deteriorate and the technician crews immediately took them to the nearest emergency department using blue light driving.
- Patient transport service staff would ring 999 for an emergency ambulance if a patient deteriorated.
- Staff received training in dementia awareness and dealing with disturbed or violent patients. Staff shared an incident that had happened when a member of staff was assaulted by a patient with dementia. Communication had not been passed to the crew regarding the patient's history of dementia. This was reported and actions put in place to ensure that full medical history of patients was shared with crews.
- The service had a radio communication system that had a SOS button. This alerted all the other staff members holding a radio, so they could summon help or intervene if necessary. The system also had a camera with a video recording facility. This was to support patient and staff safety and used if a situation became volatile.

Staffing

- There was a stable workforce up to November 2016; however, after a loss of one of the NHS contracts the service moved all clinical staff onto zero contracts, due to the loss in revenue. This inevitably resulted in some staff leaving to secure more regular work.
- The crews we spoke with had regular work. At the time of the inspection, there were 10 paramedics, eight ambulance technicians, eight trainee ambulance technicians, nine emergency care assistants and four ambulance care assistants.
- A resource manager dealt with the rostering of staff. This was done using an online system that staff could access from home. The shifts were allocated for the week ahead and shift times varied depending on the workload. Staff were able to request preferences and electronic messages could be sent to staff for availability of shifts.
- The service was able to fill the shifts needed to provide the work for which they were contracted to provide.
- Breaks were in line with the NHS Trust and there was a 30 minute unpaid leave for shifts over eight hours and 15 minutes paid leave.
- There was a minimum of 11 hours between shifts in line with the working time directive. If crews finished their shift late and this impacted on the 11 hours between shifts, they would start later the next day.
- There was a flexible working policy, a rest breaks policy and short term absence policy which were all in date.
- The sickness and absence rate was 0.08% in 2016. Staff reported sickness via a support line.

Emergency and urgent care services

- We were assured competencies and human resources checks, for example driving licence checks and disclosure and barring service (DBS), were up to date. An IT database would highlight and alert when staff were due training and various checks. If these did not happen then the staff member would be removed and shifts could not be allocated.
- The service used an external provider to deliver occupational health support and a counselling service.
- We checked staff files and all had up to date DBS checks, two references, health clearance, registration and certificate checks, and driving licence checks for penalty points and convictions. The IT system used would alert when these checks were due ensuring annual checks took place.

Response to major incidents

- The service did not have a role in major incidents unless they were first on scene. Staff received first on scene training and triage packs were on board each ambulance, these include tools the crews need to carry out triage. Staff spoke of an example where they were first on scene at a multi-car collision on a motorway. They had reflected on the incident and had followed the correct procedures and worked well with the multi-agency response.
- The service had a business continuity and adverse weather policy. An example was shared when the business continuity plan was put in action. A bomb scare in an area next to the ambulance station occurred and police requested the ambulance station to be evacuated. They were able to run the service from the headquarters base and the IT system was cloud based therefore could be used in other places.

Are emergency and urgent care services effective?
(for example, treatment is effective)

Evidence-based care and treatment

- A range of pathways were used that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. These pathways were from the NHS Trust from which the service sub-contracted.
- Guidelines and pathways were easily accessible for the staff.These were in vehicle folders and bulletins from the NHS Trusts were displayed in the ambulance station and also emailed to staff.
- A hand held radio communication system gave access to apps and to JRCALC guidelines.
- The patient report form audit captured if the pathways were followed correctly and we saw evidence of learning when this was not the case. For example when pain scoring was not always repeated following intervention, reminders were sent in the weekly information letter and the staff concerned were contacted individually.

Assessment and planning of care

- Patients had their needs assessed and their care provided in line with evidence based practice. If patients did not require transport to hospital then crews would 'see and treat' and leave the patient at home if appropriate. Additional support or advice would be given if necessary for example, a referral to the GP.
- Crews were aware of local protocols for the transportation of patients who required specific hospitals. For example, if a patient had a suspected heart attack or stroke, they would take the patient to the appropriate centre for the treatment of that condition. For example, this may require bypassing the local hospital to go to a tertiary centre.
- Protocols for the treatment of children were followed as directed by the NHS Trusts.

Response times and patient outcomes

- Response times are in line with the NHS Trusts from which the service sub-contacted. If the service did not meet the response times then the NHS provider would contact the management team who would investigate.
- A performance indicator used was a 20-minute turnaround at the hospitals. If there was an hour delay, the service was fined, by the NHS Trust from which the service sub-contracted.

- The service could electronically track all vehicles and could monitor the speed, route, time spent on scene, and the time spent at the hospitals.
- The service provided a 999 service for one NHS Trust and were dispatched to Red 1 calls, which are immediate life threatening calls, if they were the nearest crews.
- Between January 2016 to December 2017 key performance indicators were measured these included the number of cardiac arrests attended where the patient had a return of spontaneous circulation (ROSC). Out of nine cardiac arrests, eight resulted in a ROSC. The care bundle for assessment of stroke using the face, arms, speech, time (F.A.S.T) test and recording of blood sugar showed 100% of patients had this performed. The recording of two pain scores, one prior to intervention and one post intervention was audited; 93% had two recordings. As a result, the management team reminded staff via the newsletters, staff meetings and email to record two pain scores. The asthma care bundle was audited looking at 41 cases, 37 of which had peak flow recorded and four patients were unable to record one. All patients had oxygen saturation recorded. Electrocardiographs were recorded for 99% of eligible patients.
- The service did not take part in any national audit or wider benchmarking.

Competent staff

- Training and education was a high priority for the service. The service worked in close collaboration with its sister training and education organisation. It provided training programmes for the emergency care assistant and ambulance technician roles and supported staff through these programmes.
- Continuous professional development (CPD) was ongoing and we saw displayed in the ambulance station a list of study days staff could sign up to attend.
- Training was given when needed as a result of incidents, complaints and audit of patient care and outcomes.
- Staff were given an induction period. The length of time was dependent on experience. The induction included an awareness of the policy and procedures. The crews were then given a period where they were crewed with established members of staff.
- All staff maintained a CPD portfolio folder. This was broken down in sections, which included certificates and course objectives, reflective discussion and reflective practice notes, and mentoring diary.
- A staff handbook was provided for all staff. This contained general employee information such as appearance and attitudes, human resources policies, and information on health, safety and environment.
- A process had commenced for staff annual appraisal, which included the introduction of the CPD portfolio and the appraisal documentation. The management team explained that since they commenced management of the company in October 2016, it was too early to do appraisals and wanted to ensure training and education were in place and crews had an opportunity to commence their portfolio to ensure a meaningful appraisal. The service had plans in place to ensure all appraisals would be completed within the next 12 months.

  The staff we spoke with thought highly of the education and support that was provided to them.

Coordination with other providers

- There were agreed care pathways with the NHS Trusts from which the service sub-contracted. This ensured patients were treated in a way to achieve the best possible outcome. We heard examples of pathways followed such as the stroke and sepsis pathways.
- Patients were taken to the appropriate hospital, based on their needs. For example, patients with major trauma were taken to a tertiary centre for major trauma.
- The service had taken part in joint training sessions with the fire and rescue services and the mountain rescue teams.
- The NHS ambulance services and hospital staff we spoke with reported good working relationships with the service.

Multi-disciplinary working

- We observed effective and thorough handovers to the hospital teams.

  Staff liaised with the wider multidisciplinary team as necessary. For example, they told us that if a patient did not require transport to hospital following assessment

and treatment at home, they would liaise with the patients GP if necessary. We heard of examples of working in partnership with the police and fire and rescue services at road traffic collisions.

Access to information

- Newsletters were produced and staff could assess these on station and via email. These included a weekly information letter, a medical director update, and operational updates.
- Bulletins containing operational information from the NHS Trusts from which the service sub-contracted were displayed on station, to ensure staff were up to date on changes.
- A staff handbook contained human resources information and summaries of policies and procedures.
- The service used a UK wide radio and communication system, that had apps which supported clinical decision making and a foreign language translation tool. This allowed a single device that offered all communication needs, on any SIM network, so it was not limited and could move to another network if the signal was poor, allowing radio and telephone contact at all times.
- There were accurate and up to date satellite navigation systems on all vehicles.

  A staff forum had been developed for private closed communications across the workforce, which was accessible from any mobile device. This improved communication across the team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training on consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards as part of their mandatory training.
- The staff we spoke with were aware of MCA and could give examples of how decisions about consent were made for example, if a patient was unconscious.
- The patient report form had a section, which was completed to check consent had been gained and a mental capacity had been assessed. Audit demonstrated that these were always completed.
- Staff spoke of conveying patients who were subject to a section 136, and ensured a risk assessment prior to this.

  A section 136 is part of the mental health act that comes into use when you are in public. Professionals can use this section if they think you have a mental illness and you need care or control.
- Some patients transferred had "do not attempt resuscitation" orders in place. Staff were aware to check that these were in date, the original copy and still relevant prior to transferring patients.

Are emergency and urgent care services caring?

Compassionate care

- Two patient surveys took place for patients who had accessed the patient transport service. One between January 2016 and June 2016 and the second one between July 2016 and December 2016. All patients rated the overall experience as very good. Comments included staff were friendly and helpful, nothing was too much for them and they were very pleasant and cheerful.
- We observed staff ensured patients dignity in public places.
- Staff were respectful and showed a caring attitude to relatives and carers travelling with the patients.
- Staff were observed checking the patient remained pain free throughout the journey to hospital.

Understanding and involvement of patients and those close to them

- Staff explained to the patients what each observation, treatment was for, and why they were performing the checks.
- Explanations were clear and in a way, the patients could understand.

Emotional support

- We did not observe patients in distressing events however a crew told us of an example when they provided emotional support to relative at scene of cardiac arrest and death of patient's wife.

Supporting people to manage their own health

- We did not observe this however, we were told if patients needed additional advice, for example how to manage diabetes then they would give advice and sign post the patient to local support services.

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

Service planning and delivery to meet the needs of local people

- The NHS ambulance trusts from which the service sub-contracted would stipulate the amount of shifts that would need to be covered as part of the contract.
- The service had been able to fill the shifts requested by the sub-contracting organisations.
- A resource manager was employed to manage the allocations of shifts using an electronic database.

Meeting people's individual needs

- Staff received training in caring for patients with dementia, learning disability and patients with complex needs.
- We did not observe crews caring for a patient with dementia or a learning disability however, they told us that they would encourage the carers to accompany the patient to help reassure them.
- Access to translation services was by using an internet site on an app on their mobile phones/radios.
- Bariatric equipment was not available on the ambulances. If patients needed specific bariatric equipment then this would be requested from the NHS ambulance services.

Access and flow

- The service worked with the NHS ambulance services to support them to meet patient demand for their service.
- The services response times and turnaround times were monitored by the NHS ambulance trust from which the service sub-contracted; the service did not hold these figures.

Learning from complaints and concerns

- Between October 2016 and January 2017 there were eight complaints relating to patient care. Seven of these were from the NHS ambulance trusts from which the service sub-contracted and one was from other agencies. Three of these complaints were substantiated.
- There had been no complaints directly from patients or their carers.
- Each complaint was thoroughly investigated. One of the complaints was that a paramedic did not convey a patient to hospital, but failed to inform the clinical hub, as a result information was sent to all staff reminding them to contact the clinical hub.
- The service had received a complaint from an NHS ambulance service that the crews had failed to recognise the parameters for the recognition and treatment of sepsis. As a result feedback was given directly to the crew, sepsis posters were displayed on station and within the vehicle document packs, and we saw evidence of information relating to sepsis in the newsletters.

  Learning from complaints were shared with staff through monthly newsletters, the managing director (MD) weekly information letter, within staff meetings, via email to staff and pop up messages could appear on an information technology (IT) system used for crews to access their shifts which ensured they were presented with messages prior to been able to access their shifts.
- We saw patient information posters in each vehicle and leaflets. These asked patients 'How are we doing?' and provided details of how to complain.

Are emergency and urgent care services well-led?

Leadership / culture of service related to this core service

- The leadership team consisted of a managing director, who was a paramedic, a medical director, a clinical director who was a paramedic and tutor, head of finance, HR/compliance manager and a resource manager.
- The staff we spoke with knew who the leaders were and said that the directors were approachable and visible.

- Staff described the culture as open and honest. Staff felt supported by the management team and told us it was a nice place to work.
- The managing director (MD) told us that he would offer a debrief to staff if they had a particularly difficult job. Staff corroborated this. The MD would telephone crews if they had a successful resuscitation to congratulate them.
- Through the audits of the patient report forms, the management team could see what incidents the crews attended and offer support and training if needed.
- A counselling service was available via an external provider.
- Thank you letters received were given to the crews and a copy placed in their personal file. The managing director would meet the staff member and thank them personally.
- The service made staff nominations and star of the week awards, staff were given a voucher.

Vision and strategy for this core service

- There was an organisational development strategy 2016-2017. The aspiration was to develop organisational capacity and capability to ensure the service could respond quickly to both internal and external challenges. This was to be achieved by improving interpersonal and departmental processes, improve communication, enhance the ability to respond to change and organisational challenges, more effective and efficient decision-making processes, the development of transformational leadership and improving skills and abilities in dealing with conflict within the company.
- There had been significant progress towards this strategy at the time of the inspection. Systems, processes, policies and procedures had been developed. Effective communication methods were embedded, meetings were in place, which supported decision making, strong leadership was evident and we saw no evidence of conflict within the company.
- The service had values, which were resonant across all groups of staff. These include openness, honesty, integrity, excellence and accountability and responsibility.

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

- There was a monthly management/risk meeting. Attendees included the managing director, registered manager with the CQC, compliance manager, auditor, accounts manager, resource manager, and the events coordinator.
- The agenda included an operations overview, health and safety issues, fleet overview, resource and sickness overview, complaints and incidents, CQC update, performance, accounts, future business development and the risk register.
- The risk register was updated regularly, and had mitigated, and live risks. There were two live risks. The first risk specified the lack of an equipment register. The service did have one but wanted to have a register attached to the IT database that they used. The second risk was lack of occupational health support. This had been recently put in place with an outside company who dealt with screening and occupational support for the workforce. As this was a new process, the service wanted this to remain as a live risk until they could be assured it was working effectively.
- All patient report forms were audited which captured key performance indicators and which demonstrated excellent results. From January 2016 to December 2016, these included the return of spontaneous circulation in eight out of nine patients following a cardiac arrest. The FAST test and blood sugar monitoring was performed in 100% of patients, all patients with asthma, (who were able to perform a peak flow) had their peak flow monitored and their oxygen saturations recorded. Electrocardiographs were recorded on 99% of eligible patients and 93% of patients had two pain score recordings. .
- The management team told us from May 2017 they were to monitor further key performance indicators, which was to include auditing the sepsis care bundle ensuring patients received oxygen, fluids management and a pre-alert was made to the hospital. Patients with a single limb fracture have their pain score monitored, circulation assessment and immobilisation. Auditing the patients who have heart attack (ST segment elevation myocardial infarction) utilise the primary percutaneous

catheterisation intervention tertiary centre and the care bundle for patients having had a stroke will be monitored to ensure they are attending a specialist stroke unit and crews are bypassing the local emergency department if appropriate.

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

- Patient questionnaires were sent to patients who have used the patient transport service and positive feedback had always been received.
- The MD told us it was difficult to survey patients who had used the emergency service as this was sub-contracted from a NHS ambulance service, which did their own surveys.
- The MD told us a future aspiration was to involve patients in the development of services.
- Staff engagement had increased over the last six months, with the introduction of the newsletters and a monthly staff meeting. Staff could add to the agenda of this meeting. Volunteers for staff representation to the business meeting had been requested.

Innovation, improvement and sustainability

- The service developed an audit tool to audit key performance indicators and patient report form audits, looking at clinical outcomes and patient care. This allowed the service to ensure patient outcomes were met and intervene early if improvement was required.
- The adoption of an IT system supported the service in the management of human resources and fleet management. This gave alerts if data was due to expire, for example if a MOT was due or a staff member's disclosure and barring service (DBS) check was due.
- The service created and implemented training programmes and professional standards for the roles of a technician, trainee technician, and emergency care assistant. The purpose was to ensure all staff operated safely and consistently within their scope of practice. The courses were accredited by outside agencies, and included modules that prepared staff for further education and career progression.
- The service used a UK wide radio and communication system, that had apps which supported clinical decision making and a foreign language translation tool. This allowed a single device that offered all communication needs, on any SIM network, so it was not limited and could move to another network if the signal was poor, allowing radio and telephone contact at all times. This had an instant messaging facility, GPS tracking, and an SOS function. It also had a built in camera for video recording. The SOS facility and video recording function was to increase patient and staff safety.
- A staff forum had been developed for private closed communications across the workforce, which was accessible from any mobile device. This improved communication across the team.

Outstanding practice and areas for improvement

Outstanding practice

- There was a genuinely open culture in which all safety concerns raised by staff, people who use services and from the NHS Trusts from which the service sub-contracted, were highly valued as integral to learning and improvement.
- An audit of patient report forms identified if pathways were followed correctly and we saw evidence of learning when this was not the case.
- Key performance indicators were audited and results were excellent.
- The organisation had the governance processes and information to manage current and future performance. The information used in reporting, performance management and delivering quality care was accurate, valid, timely and relevant.
- There was effective and comprehensive processes in place to identify, understand, monitor and address current and future risks. Audit processes functioned well and had a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.
- The leadership strived for continuous improvement. There was a clear proactive approach to seeking out and embedding new and more sustained models of care and governance processes.
- Leadership was strong, open, honest and supportive.
- The leadership was knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them. Performance information was used to improve the service
- Complaints were managed and investigated thoroughly and feedback and training was given to staff.
- There was a clear vision and strategy, driven by quality and safety.
- Training and education was a high priority and had a strong focus for the service. The service worked in close collaboration with their sister training and education organisation. They provided training programmes for the emergency care assistant and ambulance technician role and supported their staff through these programmes.
- The continued development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported to acquire new skills.
- Feedback from people who used the services was consistently positive about the way staff treated people. There was a strong person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- All staff prioritised safe, high quality, compassionate care and there was a culture of collective responsibility between all staff.
- Information and analysis was used proactively to identify opportunities to drive improvements in care. Service developments and efficiency changes were developed and assessed to understand their impact on the quality of care. The impact on quality and financial sustainability was monitored effectively.
- Financial pressures were managed so that they did not compromise the quality of care.

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should ensure sharp bins are signed and dated
- The provider should further investigate more thoroughly any variances found in the audit of medicines.