

Medical Center

Quality Report

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

Ratings

Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Outstanding 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

Medical Center is operated by Polaris Medical Services Limited. The service provides emergency and urgent care as well as ad hoc events services. At the time of inspection, the Medical Center had just started providing patient transport services and mental health transport services. As these services had only been running nine days, we did not inspect them.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 22 and 23 October 2019.

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

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

The main service provided by this service was emergency and urgent care.

The service has been inspected once before in early 2018, however the service was not rated as at the time CQC regulated independent ambulance services but did not have a legal duty to rate them. Our legal duty has since changed, and we are now able to rate these services.

Issues found during the 2018 inspection included;

- General governance was not robust and did not demonstrate a monitoring of the quality of the service.
- The provider did not have a record of all incidents or safeguarding referrals reported through trust processes and relied on the contracting trust to feed the information back either by telephone or during monthly contract meetings. This meant the provider did not have oversight of all incidents and safeguarding situations operational staff had been involved in and relied on the NHS trust to identify any immediate learning.
- Staff were not always involved in complaints from the NHS trust and did not always receive feedback.
- The service did not have an appraisal process, which the managers acknowledged prior to the 2018 inspection. The lack of appraisal process could have resulted in staff having unmet training needs.
- The service did not have an effective system in place to identify, limit and control clinical and non-clinical risks. The manager was able to identify a limited number of risks; however, there was limited evidence to demonstrate that all risks had been identified.

Our findings at this inspection showed this service had improved. We rated it as **Outstanding** overall.

The 2019 inspection found;

- The issues found at the 2018 inspection had been largely resolved.
- The in-house tools developed to support crews while treating patients were innovative and supported positive patient outcomes.
- The training opportunities available to staff were creative and encouraged a positive culture. The Medical Center was achieving recognised accreditation schemes that supported the local health economy and safeguarded the future development of the Medical Center.
- The service was expanding into areas that supported the local health economy, such as providing patient transport services to patients under section 136 of the Mental Health Act.

Summary of findings

- Patient feedback was overwhelmingly positive, we were provided with numerous examples of staff going above and beyond what was expected from them.
- The 'Make Ready' process supported smooth flow and quick turnaround of ambulances to ensure the service was as responsive as possible.
- The culture was open and positive; everyone was working towards the same goal. Staff felt able to raise issues with the managers knowing they would be dealt with.
- Managers understood the importance of regularly reviewing governance and risk. Staff now took minutes of meetings and outcomes to evidence this.
- Appraisal completion rates were at 99%.
- There were still a few issues regarding the sharing of information with NHS ambulance trusts. Trusts shared complaint and incident data, however safeguarding referrals still varied depending on who staff spoke with at the trust. This was out of their remit; however, managers should continue to develop relationships with the trusts.

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

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Overall summary

Emergency and urgent care was the main activity. We rated this service as outstanding for effective and caring because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided outstanding care and treatment. The in-house tools developed to support crews whilst treating patients were innovative and supported positive patient outcomes. The training opportunities available to staff were creative and encouraged a positive culture. The Medical Center was achieving recognised accreditation schemes that supported the local health economy. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, and we received numerous examples of staff going above and beyond. The ethos of putting the patient first was embedded within the culture. Staff respected patient's privacy and dignity, took account of their individual needs, and helped them understand their conditions. Staff understood the importance of supporting friends and family as well as the patient.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued.

Summary of findings

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Outstanding



Medical Center

Services we looked at Emergency and Urgent Care

Summary of this inspection

Background to Medical Center

Medical Center is operated by Polaris Medical Services Limited. The service opened in 2015. It is an independent ambulance service based in Iver, Buckinghamshire. The service serves communities across the East and South of Britain.

At the time of this inspection, the headquarters was based at Pinewood Studios. This was where the back offices were located which housed the managers' offices, human resources and staff files. An ambulance was also located at the headquarters in case a filming incident required paramedic assistance.

The base in Reading was a stand-by point for staff to be able to rest and restock ambulances. A training centre was also based at this location. The base in Slough was the main 'Make Ready' centre, this was where ambulances were cleaned, restocked and serviced.

The urgent and emergency care vehicles were operated mainly from the Slough base. The service provided emergency and urgent care to several NHS ambulance trusts as well as ad hoc events and support services to sports events, festivals and films, which CQC was unable to inspect as we do not have legal grounds to do so.

The service has had a registered manager in post since 2015.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector, and two specialist advisors with expertise as paramedics. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about Medical Center

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 headquarters and medical centre at Pinewood Studios as well as the 'Make Ready' station in Slough and the ambulance station and training centre in Reading.

The Slough and Reading locations provided an urgent and emergency service 24 hours a day, seven days a week. The medical centre was open 7.30am to 6.30pm.

The provider had 46 urgent and emergency services ambulances, the majority of which were kept at the Slough location.

We spoke with 17 staff including; clinical team leaders, 'Make Ready' staff, technicians, registered paramedics and managers. We spoke with five patients, four family members and reviewed four sets of patient records.

The accountable officer for controlled drugs was the registered manager.

Track record on safety for the last 12 months;

- No Never events
- 16 complaints






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Outstanding	Outstanding	Good	Good	Outstanding
Overall	Good	Outstanding	Outstanding	Good	Good	Outstanding

Emergency and urgent care

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

Are emergency and urgent care services safe?

Good 

We rated safe as **good**.

Mandatory training

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

All staff undertook mandatory training in their own time. Staff received email reminders if their training was due for renewal. If they did not complete their training, they would lose their pin, a number required to log into book NHS shifts. This would prevent them to undertaking any shifts for the NHS ambulance trust, until they had completed their training.

Managers had oversight of the mandatory training completed and reminded staff to complete it if it was out of date.

At the time of inspection, 90% of all staff were up to date with mandatory training. Training modules included; infection prevention and control, fire safety, moving and handling, conflict resolution and violence and aggression handling.

Staff we spoke with understood the importance of keeping up to date with training and took the time to complete it in order to keep their pin.

Safeguarding

Staff had training on how to recognise and report abuse and they knew how to apply it.

At the time of inspection, 100% of staff had completed safeguarding training for both adults and children. All crews received safeguarding level three children’s training face-to-face once a year, as well as annual online training. Training was in line with requirements as set out in the intercollegiate documents for adults and children safeguarding.

The clinical lead was the level five trained safeguarding contact for children and adults for the service. All staff we spoke with could name the safeguarding lead and said they would feel comfortable asking them for help with a safeguarding concern.

All staff we spoke with were positive about their training and understood how to recognise safeguarding concerns. Staff were able to show us how to complete a safeguarding referral form and describe when they would complete a referral form.

At the ‘Make Ready’ base in Slough, we saw an information board dedicated to safeguarding matters. This included the details of different safeguarding reporting policies of all the NHS trusts. Each week the board was refreshed and promoted learning for different aspects of safeguarding, such as cared for children. This acted as a reminder to staff and increased awareness of various safeguarding issues.

We saw that female genital mutilation and Gillick competencies training was included within safeguarding training. Staff knew their role and responsibilities regarding both these issues and knew who to ask for help.



Emergency and urgent care

Safeguarding training also included understanding of issues found on film sets and when to raise a concern.

We reviewed four staff files and noted they were all up to date and contained all requirements as listed in the 'Schedule 3' document, including driver's license, disclosure and barring service checks, health questionnaires and appropriate references.

At the previous inspection in 2018, we noted the provider did not have a record of all safeguarding referrals reported through trust processes and relied on the contracting trust to feed the information back either by telephone or during monthly contract meetings. At this inspection, staff were working to improve communication with their NHS ambulance trusts particularly the sharing of information, however this was still an issue due to perceived data protection breaches on behalf of the NHS ambulance trust. The NHS ambulance trusts advised the Medical Center when a safeguarding concern had been escalated, for example to local authority or police. The contracts Medical Center had with the NHS ambulance trusts stated that safeguarding referrals were reported through the ambulance trusts systems and they had responsibility for the review and onward referral. Staff informed us the NHS ambulance trusts saw the patients as "theirs" and did not feel the need to share the information with the Medical Center.

The provider expected staff to inform them at the end of the shift if there had been a safeguarding concern which they logged on their own system. We reviewed the log and noted it only included information from events. They relied on the information from the NHS trust to inform them of referrals made by their teams. Therefore, there was no internal process for the recording of all safeguarding referrals made by medical centre staff through the trusts reported process. There was no evidence the managers were cross referencing with information provided by the NHS trust to gain assurance of action taken against referrals made.

Cleanliness, infection control and hygiene

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

Staff cleaned ambulances and the stations with disposable mop heads, which ensured effective infection control practices. Staff also used colour coded cleaning equipment for the cleaning of different ambulance and station areas. This helped to reduce the risk of cross contamination, for example, using the same mop to clean a bathroom and kitchen. The service provided full training to the 'Make Ready' staff regarding the use of the mops.

The service had fully completed cleaning rotas for the whole of October 2019, as well as a fully completed log for water testing for legionnaires' disease. Therefore, there were assurances these areas were being monitored.

The 'Make Ready' team cleaned ambulances internally on each shift. Ambulances also had an internal and external deep clean every six weeks. Deep cleans were completed at the Slough station. The service used a swab machine to test the effectiveness of the clean, we saw results from swab tests showed low levels of bacteria and dirt. This gave us assurance that ambulances were cleaned to a high standard. Ambulances were also given a full internal monthly clean..

We observed ambulances were fully stocked with the appropriate personal protective equipment including hand sanitising gel, gloves, aprons in a variety of sizes and disinfectant spray to clean the stretcher between each patient use.

We inspected seven ambulances; all were clean except for one at the Reading base where black dirt was found behind a monitor. This was reported to the station manager and the ambulance immediately received another full clean.

The Reading station had an infection control advice board which provided information regarding how to reduce the spread of infection with effective cleaning. This acted as a reminder to staff to promote effective infection prevention control.

Hand hygiene audits showed 100% compliance; they rated whether the staff member used key hand hygiene moments, were bare below the elbows, cuts and grazes were securely covered and use of the required technique. Therefore, there was assurance staff were using effective hand washing techniques.

Environment and equipment



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

The fleet manager was responsible for the maintenance of vehicles. At the time of inspection, a paper-based master spreadsheet listed all vehicles and showed when MOT and vehicle tax was due, and the service record for each vehicle was linked to this spreadsheet. Managers were looking at developing an electronic system that alerted staff to repeat issues, for example mechanics found a type of bolt kept breaking. Therefore, a new type of bolt was found and replaced on all vehicles. The service hoped the new system would be “proactive, not reactive”.

The service had carried out safety checks on all portable equipment within the last 12 months.

All consumables were in date and compartments in the ambulance were clearly labelled. Any consumables due to expire before the vehicles next deep clean were destroyed.

The ‘Make Ready’ team were the only team to stock vehicles. The clinical team leaders and the ‘Make Ready’ team were the only staff to have access to consumables and medicines. This ensured there was no duplication of equipment and consumables on each vehicle. The team was responsible for ensuring all stock was rotated appropriately and identified which consumables were reaching their expiry dates.

The stations at Slough and Reading had CCTV for security purposes.

All ambulance keys were securely locked away in individual lockers which also contained the ambulances phone, fuel card and observation kit. There were different coloured lockers for each NHS ambulance trust they worked for. This enabled staff to quickly identify the kit they required depending on which contract they were working on that shift. For security reasons, only the ‘Make Ready’ team had access to the keys for each locker. The make ready team were present at shift hand over to ensure the crews had the right vehicle keys and the right equipment for the shift according to the ‘shift log’.

Any equipment that was no longer working and ready to be thrown away was stored in a clearly marked box ‘for destruction’. This ensured staff did not take this equipment with them on journeys.

All staff we spoke with had no concerns regarding the equipment. One member of staff stated it was all new or nearly new.

Fire extinguishers were placed in prominent positions around the stations and ambulances. All were up to date with their service and were full.

Ambulance stretchers were in good condition and capable of carrying patients with a weight limit of 400kg. We observed child restraint straps stored under stretchers on all vehicles.

Sharps bins were signed, dated and not filled above the fill line, in accordance with Health and Safety Executive guidelines.

Ambulances were stocked according to a loading list. Cupboards within the ambulance were either sealed with tape or had a colour coded lock. When the ‘Make Ready’ team stocked a cupboard the lock turned green, when the cupboard had been opened the lock turned red. It was therefore easy to see which cupboards had been accessed and needed further restock on return to base. Only the ‘Make Ready’ team had the key to change the lock green again, therefore the colour could not be changed in error. This kept turn-around times to a minimum.

We saw a new style of ambulance that had grooves in the flooring to allow the stretcher to be secured in the centre of the ambulance. This allowed crew to gain 360-degree access around a patient in case they required emergency care whilst the vehicle was in motion.

Technicians identified the pulse oximetry machines could be improved. Managers listened and sourced different machines. Crews suggested they completed run sheets in real time so when items were used, crews listed them at the time of use. This helped the ‘Make Ready’ team see immediately what required replacing and meant the crews didn’t need to remember at the end of the shift what equipment they had used.

Assessing and responding to patient risk



Emergency and urgent care

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

We saw staff had been trained to use the National Early Warning Score (NEWS2) and that patient report forms included a section to complete a National Early Warning Score assessment. Staff scored respiration rate, oxygen saturation, systolic blood pressure, pulse rate, level of consciousness or new confusion and temperature to assess patients who may potentially deteriorate.

Staff of all grades received adult basic life support training annually. All staff except non-clinical completed children's basic life support. Technicians and paramedics completed trauma life support and management of arrest training. Paramedics were required to complete additional training in advanced life support for adults and children. At the time of inspection, training records showed all staff were up to date with their training.

The phones on ambulances were all pre-programmed with pre-alert numbers to reach the local NHS hospitals, the NHS hospital trust's clinical help desk and urgent care desk. This meant in emergency situations, crew could quickly contact the right people to advise they were on route.

Each NHS ambulance trust had their own call handling centre that was responsible for emergency call handling. The call handling team contacted the crew with the details of the job. Staff advised us they were able to contact the call centre if they had any queries and the teams were always helpful and supportive.

Ambulance crews followed the emergency protocols of the NHS trust they were working for. All staff we spoke with knew the policies and procedures for each NHS trust and understood their responsibility to follow them.

All ambulances were fitted with an automatic external defibrillator to provide immediate support for cardiac arrest patients. The provider had serviced all automatic external defibrillators within the last 12 months. Training in the use of the device was part of annual mandatory training requirements.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The 'Make Ready' team had permanent contracts. Technicians and paramedics were self-employed and worked four shifts on, four shifts off cycle, which was a mixture of day and night 12-hour shifts. Staff reported these shifts worked well for them and stated they had flexibility regarding when they wished to work. Staff advised us that those who worked a four on, four off pattern had priority for shift allocation.

Crews provided their availability to the logistics manager a month in advance. The logistics manager was responsible for ensuring all shifts were adequately covered with the right mix of staff skill. The logistics manager monitored the total number of hours worked. They also ensured staff received adequate breaks between shifts. At the inspection, we saw the last week's rota and noted all shifts were covered.

Crews could also opt to work for the event side of the service if they wanted a change from frontline work.

The provider was introducing a new system they hoped to have in place by Christmas 2019 that encompassed the "Whole decision process". The new system would receive the job, allocate the crew according to competence completion, send the crew the job details and notify the film studio if the incident was film related.

Records

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

We reviewed six patient report forms and saw they met all requirements of Joint Royal Colleges Ambulances Liaison Committee practice, for example they were clearly signed and dated and times of treatment were recorded accurately.



Emergency and urgent care

Crew had access to a secure, locked box on the vehicle to store paperwork. When crews returned to base, they stored patient report forms in a secure locked post box, both of which prevented unauthorised access to records and protected patient confidentiality.

When completing journeys on behalf of an NHS trust, staff used report forms specific to the trust and returned them to the trust within 48 hours.

The NHS ambulance trust retained the completed report forms after crews had signed a 'delivery record form'. This showed responsibility for the forms had been handed over, however Medical Center still retained their own records detailing each job.

Patient records were audited monthly and discussed at the clinical governance meeting. We saw record audits for three months and noted all records, 20 per month, were fully completed, signed and dated.

Medicines

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

The main stock of medicines were stored securely in locked medicines cabinets and fridges within a temperature monitored room. There were designated medicine bags for paramedics and technicians and each one contained only medicines the member of staff could administer. These were stored within individual labelled lockers for each ambulance, which were also temperature monitored. The 'Make Ready' staff alerted the clinical team leader if the temperatures rose above 27 degrees in the storage areas or seven degrees for the fridges. Monitoring the storage temperature ensured the effectiveness of the medicines. Staff knew to contact the medicines manufacturer for advice if temperatures went out of range and would destroy medicines in the event of prolonged time outside of the correct temperature.

The team were looking to introduce a traffic light system that would alert them as soon as the temperature went outside the recommended range.

The clinical lead had developed a Patient Group Directive product guide. This was a detailed document that listed every medicine used by the Medical Center staff, including over the counter medicines such as paracetamol, the body that regulated that medicine, which NHS hospital trust allowed the use of that

medicine and which grade of staff could administer it. The clinical lead reviewed this document annually. On receipt of this document, staff signed a slip to state they understood it and would abide by its content, managers discussed the use of the Patient Group Directive at appraisal. This helped ensure all staff acted in accordance with medical administration regulation. A Patient Group Directive allows some registered health professionals to supply and/or administer specified medicines, without them having to see a prescriber, such as a doctor. On the six patient report forms we reviewed, we saw appropriately qualified paramedics had administered the medicine.

There was a clear process for checking in medicines from delivery to storage, checking in and out of kit bags and destruction. We reviewed these records, and all were complete with no gaps.

Each bag contained an up to date stock sheet which was marked red if the medicine was close to expiry. The 'Make Ready' staff labelled the next vial that was due to expire so the crew knew to use that one first. We reviewed four stock sheets which were all completed and up to date.

We saw all controlled drugs and their Home Office licence were held at the Slough base.

All medicine kit bags were tagged and labelled with the date. This ensured it was clear to crew the bags were ready to be used. Once a bag had been opened and used, it was stored in a separate locker until restocked and placed back in circulation.

The paramedic bag and technician bags were different colours for ease of identification.

Managers stipulated that paramedics were not allowed to use their own kit bags as the Medical Center would not have oversight of the quality of the equipment or medicines that they may contain.

Oxygen was stored safely in separate and well-ventilated cages, one for empty cylinders and one for full. All oxygen on the ambulances was within expiry date and stored correctly in accordance with British Compressed Gases Association 'Code of Practice 44: The Storage of Gas Cylinders'.

We reviewed records showing medicine's kit bags being returned. At Reading, within a period of six weeks, there were 13 instances where there was no signature to say



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the kits had been returned. The 'Make Ready' team reviewed kits daily and stated there had been no occasion over those six weeks where a kit bag had been missing, however this was not reflected in the paperwork. The clinical team leader reported they reviewed the sign in/out sheets weekly and discussed noncompliance with the policy with individual crew members.

At Reading we noted one opened bottle of liquid medicine where staff had recorded the date of opening on the bottle. However, on the stock sheet within the bag, the expiry date still showed March 2020 which was not the advised three months post-opening of the bottle. The clinical team leader advised us once any liquid medicines are opened the bottles should be discarded. We saw the bottle was immediately removed and placed in the locked cupboard ready for destruction at the Slough site.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

We saw the provider's incident log that was divided by the different NHS trusts and the Medical Centers own incidents. Therefore, it was clear who was accountable for investigating each individual incident.

We saw incidents were discussed as a standing agenda at monthly clinical governance meetings. Outcomes and learning was shared with staff at monthly email updates and during team meetings.

Staff understood duty of candour and gave recent examples of where it had been applied. Duty of candour is where providers must be open and honest with service users and other 'relevant persons' when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Staff showed us grab bags that had colour-coded bags of saline and glucose fluid. This had been introduced after

an incident at a trust as the bags looked similar and the wrong fluids had been administered. The provider had acted on the learning from the incident and instigated change as a result.

Another example of learning from an incident was, the NHS ambulance trust had received a faulty batch of medicines and shared this information with the Medical Centre staff. Although they had not received medicine from this batch they undertook a review their in-stock medicines to ensure safe practice.

At the previous inspection in 2018, we noted that the Medical Center did not have a record of all incidents reported through trust processes and relied on the contracting trust to feed the information back either by telephone or during monthly contract meetings. At this inspection, we found this had now improved. Staff we spoke with said relationships with NHS hospital trusts had improved and the trusts contacted them more frequently.

One example of feedback was an inadequate pre-alert for an unwell patient. When the crew arrived, the patient was very unwell. The NHS ambulance trust took responsibility and investigated the incident and fed back the outcomes. The staff member was updated.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Outstanding



We rated effective as **outstanding**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff resources, for example policies and procedures referenced the resuscitation council 2015 guidelines as well as the National Institute for Care Excellence.

As part of the contract with NHS hospital trusts, the service was required to work to National Institute for Care Excellence and Joint Royal Colleges Ambulance Liaison Committee guidelines. We saw all company policies were written in line with these guidelines.



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Hardcopies of policies were available within the stations for staff to easily access. We saw they were all up to date. It was the clinical team leader's responsibility to ensure the hard copies were the latest versions and this was included in their daily check lists.

All policies were available to staff in electronic formats and staff had access to them using the ambulance phone or their own personal mobile phone. Therefore, staff could access information whilst on the road.

We viewed seven policies. Managers had reviewed all of them within the last 12 months. They were informative, detailed and referenced up to date legislation.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We saw crew use pain scoring tools to assess a patient's level of pain. Crew also had access to a facial tool for children and adults with communication difficulties. The tool showed a variety of different facial expressions and the patient could point to the one that most closely resembled their level of pain.

On all ambulances checked, staff had access to a variety of pain relief; from paracetamol and gas and air to morphine. All pain relief was in date, stored appropriately and correctly recorded.

All crew we spoke with understood which staff grade was able to administer which pain relief medication.

Response times

The NHS trusts used a system that sent alerts to clinical team leaders, if key performance indicators were breached. If staff were regularly in breach it was the clinical team leader's responsibility to talk with the individual staff to determine whether additional support or training was required.

The NHS trust's key performance indicators were displayed to remind staff what they were expected to achieve against mobilisation times, time to leave the hospital and the time on scene. This kept the information at the forefront of staff's minds.

The provider did not have control of the dispatch of ambulances, this was under taken by the NHS trust control centre who then held the data relevant to response times. This was not shared in detail with the provider, however they would be informed if they were not performing as expected. The Medical Center monitored the aspects of the process they were responsible for, such as clear-up times, on scene times (convey and non-convey), mobilisation times and total job cycle. For the six months prior to inspection, the provider was meeting national standard times for the five areas above.

The Medical Center exceeded 'See and Treat' key performance indicators for four out of the last six months. The two months that the key performance indicators were not met were missed by less than 2%. 'See and Treat' provides focused clinical assessment at the patient's location, followed by appropriate immediate treatment, discharge or referral.

Patient outcomes

There were holistic approaches to assessing, planning and delivering care and treatment to people who used services. Innovative approaches to care and how it was delivered were actively encouraged.

Managers used new techniques and technologies to support the delivery of high-quality care.

We saw clinical auditing was an integral part of the providers' monitoring of patient outcomes. We saw 10 audits for cardiac arrest outcomes – return of spontaneous circulation and survival to discharge and sepsis. All were meeting national targets.

The Medical Center had developed a variety of in-house evidence-based tools to support staff in providing a quality service.

We saw the 'Make Ready' team had created separate incident packs for major haemorrhage (bleeding in excess of 150ml, per minute), maternity, paediatric and trauma. This meant if a crew found themselves on a job that required specific items, the crew were able to quickly access the pack, knowing it contained all relevant equipment. All three packs were available on ambulances and at the medical centre at Pinewood Studios.



Emergency and urgent care

The managers team had also created numerous in-house leaflets, guidelines and references to support crews while they were on a job.

There was a smart triage system, a set of action cards for crew attending trauma patients. The tool guided staff in assessing the patient, the patient was tagged with a wrist band, with a bar code and urgency rating.

The provider had developed a paediatric measuring tape to support the assessment of children based on their height as this was a more accurate way to determine treatment rather than age. The tape provided base line data for breathing, walking and respiration and had been developed using National Institute for Health and Care Excellence paediatric baseline assessment tools.

Vehicle packs contained resuscitation procedures including, airway, respiration, circulation and traumatic arrest management, new-born resuscitation pathways, sepsis pathways, national early warnings and cardiac pathways. All were attached to the patient report forms as part of the clinical record.

The trauma life support booklet included information crews could quickly access such as techniques for tourniquets (a device for stopping the flow of blood through a vein or artery, typically by compressing a limb with a cord or tight bandage) and splints. There were two versions, one for paramedics and another for non-clinical staff to support various levels of knowledge.

The airway managers manual had been developed after managers recognised nationally that there were a high number of incidents involving intubation. The manual was equipment specific and followed best practice guidelines. Intubation is the insertion of a tube into a patient's body.

A field guide provided information for crews to protect themselves from and treat infections for example shingles and measles.

A wound care document provided a dressing formulary that listed how dressings should be used and the frequency of change.

The trauma checklist guidance document included pathways for; haemorrhage control, managers of airways, respiration and circulation, disability including limb function and exposure, examination and extrication. The tool also included a body map.

We saw the provider used a disposable; single use ventilator that was hands free. This ensured a safer post cardiac arrest period as there was no drop in ventilation whilst staff accessed other equipment or manoeuvred a patient.

All the above were given to staff during induction, were available in vehicles and on bases. We saw the tools had assessment questions, a practice tool and reflective practice tool that formed part of the appraisal process. All crew we spoke with gave overwhelmingly positive feedback regarding these tools.

Competent staff

The service made sure staff were competent for their roles. Patients had their needs assessed by staff with the right skills and knowledge. The continuing 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 used innovative and creative ways of training and developing their staff that made sure they put their learning into practice to deliver outstanding care that met patient's individual needs. There was a proactive support system in place for staff that developed their knowledge and skills and motivated them to provide a quality service.

Managers recognised the continuing development of staff skills, competence and knowledge as being integral to ensuring high quality care. Managers proactively supported staff to acquire new skills.

The Medical Center were the first independent ambulance to provide paramedic training alongside Outreach Rescue Medic Skills, an education programme to train to be a paramedic based at a university in Scotland. The Medical Center paid the lump sum amount for the training, then the trainees repaid this via a more manageable monthly direct debit. They had also arranged for the training to take place at Reading, to save trainees going to Scotland. Trainees also had additional support from one of the clinical team leaders whose sole job was to provide training. Trainees were also guaranteed a paramedic job at Medical Center once training was completed. At the time of inspection, there were 70 people completing the training.



Emergency and urgent care

Once qualified, staff had access to the newly qualified paramedic programme to support them in their role. Staff also received support in gaining the Community Health Education qualification to become a technician.

Staff reported the training opportunities were good. Staff were given opportunities to attend training courses such as the 12 lead “boot camp”, difficult airways course, the pre-hospital trauma life support course and the airways course. We noted the dates were advertised in the staff room and all were offered to staff at a reduced cost.

The Medical Center had also applied to teach the first response emergency care course which was competency based. The system is modular based, enabling a participant to progress through each level from three to six if desired. On successful completion of all levels and competencies, the participant can apply for registration as a paramedic with the Health Care Professions Council.

At the training centre in Reading we saw staff had access to detailed scenario training. The use of the area and the types of training we saw were a practical way to train and develop staff. It ensured staff could put their learning into practice to help deliver outstanding care that met patient’s individual needs. The type of training changed on a regular basis. At the time of inspection, we saw a training room was designed as a bedroom with litter and confined spaces to enable staff to understand the impact of a poor environment on the treatment of patients.

Staff reported managers were responsive if they identified crews were not ‘pulling their weight’. Managers addressed concerns with individual crew members immediately and we saw development plans were put in place.

Three members of staff had received Trauma Risk Managers training. The benefits of which included, early identification and intervention and enhanced oversight of trauma patients at risk of deterioration.

Staff reported they would often be crewed with a clinical team leader which ensured ongoing oversight of the quality of care crews were providing for patients. This was an informal review and any improvements to practice were discussed informally during the shift.

The ‘Make ready’ staff received a six-week induction and shadowed another member of staff or the team leader.

The induction process involved potential staff members having all their documentation – qualifications, barring

checks etc checked and undergoing a skills assessment – Adult and paediatric basic life support using the resus council algorithms and National Institute for Health Care Excellence guidelines. The candidate was also interviewed by Human Resources, clinical team leader’s and managers. Unsuccessful candidates were able to reapply for the role six months later.

The Medical Center had their own in-house driving instructors who assessed the driving skills of all staff yearly. All licences were checked as part of the application process and then re checked at six-month intervals.

All staff had a mentor that they could go to for help and support.

At the previous inspection in 2018, we identified the service did not have an appraisal process. At this inspection, the appraisal completion rate was 99%. Staff we spoke with reported they were beneficial and an opportunity to identify development needs and “Get my point across”.

Multi-disciplinary working

All those responsible for delivering care worked together as a team to benefit patients.

The operations director and head of departments attended monthly provider meetings with all NHS ambulance trusts and then fed back key performance targets to the teams.

At our previous inspection in 2018, we found there were communication issues with NHS hospital trusts not sharing information. There were three areas of concern; incidents, complaints and safeguarding. On this inspection, staff advised that regarding incidents and complaints the situation had improved, however there was still a lack of information sharing for safeguarding concerns.

At the Slough base, we saw recent operations bulletins for one of the NHS hospital trusts. This ensured ambulance staff were aware of any updates, issues or concerns at the hospitals they were attending.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards



Emergency and urgent care

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

Staff monitored consent practices and records to ensure patients were involved in making decisions about their care and treatment.

At the time of inspection, 85% of staff were up to date with their Mental Capacity Act and Deprivation of Liberty Safeguard training.

Consent, mental capacity act and deprivation of liberty safeguards training was a part of mandatory training. At the time of inspection, additional training was being offered to the patient transport services staff who would be transporting patients under section 136 of the mental health act.

We saw the provider's policy on consent. Staff we spoke with knew where to find the policy as well as its content. Staff knew their responsibility in obtaining consent and when to act in a patient's best interest if they lacked capacity or was unconscious.

Whilst accompanying crews, we saw all patients were asked for consent and this was recorded on the patient report form. We saw there was space on the patient report form to note when treatment was provided without consent but was in the best interest of the patient, for example if they were unconscious.

Are emergency and urgent care services caring?

Outstanding



We rated caring as **outstanding**

Compassionate care

Staff were highly motivated and inspired to offer care that was compassionate and kind and took account of patients' needs.

Staff treated patients with compassion and thoughtful kindness, respected their privacy and dignity, and took

account of their individual needs. Staff acted to provide personalised high-quality compassionate care. Patients thought staff went the extra mile and their support exceeded their expectation.

A staff member advocated for an extremely frail end of life patient to keep them out of hospital, in line with their wishes. The Medical Center received a letter of thanks from the head of the hospice caring for the individual, commending their patient centred approach.

Staff were efficient yet friendly, and on all jobs we observed staff introduced themselves. For example, we saw one crew attend an elderly patient living with dementia who had fallen. The crew used humour to calm them down and when the patient repeatedly asked the same questions, the crew answered as if it was the first time they had been asked.

Where staff had been reported to have provided outstanding patient care or clinical excellence, they were presented with a certificate. A review of examples included a quote from a family member "Their manner was warm and friendly, and they had an excellent approach to patient centred care and should be commended. They could not have done more whilst taking my mum to A&E". Another stated "(Crew) led a paediatric cardiac arrest involving a very young child and showed exemplary skill and calmness in managing the scene, establishing an advanced airway, whilst showing great caring for the child's family, thank you".

Emotional support

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

Staff recognized respecting patient's needs. We saw crew taking patient's personal, cultural, social and religious needs into account.

We saw staff attended to not only the patient, but also supported and reassured families, especially where children had been involved in the incident.

Managers had developed a customer care booklet to support staff when attending a patient. It promoted the patient being at the centre of everything staff did and how to support patients and their families in a crisis.



Emergency and urgent care

Where appropriate, we saw staff refer patients and their families to outside agencies such as Children and Adolescent Mental Health Services.

Understanding and involvement of patients and those close to them

Staff were fully committed to working in partnership with patients. Staff empowered patients to have a voice. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff used plain English to explain to patients, what was happening, the reason for it, whether the patient would feel anything, such as tightening or pain, and explained next steps.

Staff adapted their communication with patients to be age appropriate.

During a job involving a suicidal teenager, the crew empowered the patient to be involved in the planning of next steps and decisions around contacting Children and Adolescent Mental Health Services. The patient was an active partner in their own care.

We saw ambulance crews on several different jobs advise patients and their families of any signs or symptoms that meant they should call an ambulance again.

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

(for example, to feedback?)

Good



We rated responsive as **good**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The Medical Center strived to be known as innovative in providing person centred care based on best practice.

The service was flexible and responsive to people's individual needs and preferences. The service was actively involved in the local health economy and worked towards building further links.

Nine days prior to the inspection the service had taken on a contract from an NHS trust ambulance provider to provide patient transport for patients who were detained under section 136 of the mental health act. This was following another provider ceasing to operate. To ensure staff had the knowledge to undertake this new role, they were being provided with the relevant training to enable them to respond to the local need. The provider had taken an interest in the needs of the local people and was working in a responsive way to ensure the continuation of the service.

The training opportunities available to staff was having a positive impact on the health economy of local communities. This was because of the number of staff the provider was actively supporting to become paramedics.

We spoke with staff from one of the trusts the Medical Center worked with and they described them as their "Golden boys, we can definitely rely on them to do a good job."

Meeting people's individual needs

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

People's individual needs and preferences were central to the planning and delivery of tailored services.

We saw a provider policy detailing how to support patients from 25 different regional and religious backgrounds. Staff we spoke with were aware of the policy and knew to reference it if they were unsure how to support a patient or their family.

We saw staff had access to picture books to communicate with patients who were not able to communicate verbally or who did not speak English. This was also appropriate for use with young children.

To support staff in transferring bariatric patients, all ambulances were fitted with winches and four ambulances contained bariatric stretchers. The stretcher was able to hold weight up to 400kg.



Emergency and urgent care

All ambulances had tail lifts which enabled wheelchair users to access the ambulance whilst in their wheelchairs.

The service used a language line for patients whose first language was not English. The phone numbers were preprogrammed into the ambulance phone for quick, easy access.

Access and flow

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

As the service worked under contract to NHS trusts, it was the trust who managed the access and flow of the service. The crews logged on with NHS trust at the start of their shift and logged off at the end. The crews received direct communication and direction from the NHS trust.

The Medical Center used a 'Make Ready' system to ensure quick turnover of ambulances and to ensure vehicles were readily available for paramedics and technicians to use. The 'Make Ready' team was separate from the ambulance crew, it was their job to ensure adequate stock, clean vehicles and complete maintenance.

We saw the Medical Center had blue light service contracts with various automobile service providers to ensure if an issue occurred whilst a crew was on the road it could be dealt with quickly. This ensured ambulances were not spending large amounts of time awaiting repair.

The Medical Center had introduced an innovative 'down time' alarm system to keep ambulance crew time off road to a minimum. This was set to a minute before the NHS hospital trust approval time and ensured staff kept within the key performance indicators for their NHS hospital trust. Thus, improving ambulance response times.

Learning from complaints and concerns

The service treated concerns and complaints seriously and shared lessons learned with all staff.

At the previous inspection in 2018, we noted staff were not always involved in the complaints process and did not always receive feedback from the NHS trusts. At this inspection, this had improved, and we were provided with examples of learning that had occurred because the outcome of complaints investigated by the NHS trust had been shared.

One of the NHS ambulance trusts had a policy that crew could be sent on any job until the final few seconds of their shift. On several occasions crew had been sent on a job three counties away within the last 30 seconds of their shift. As a result of this the provider had received a complaint about the crew's attitude on one of those jobs. In response managers negotiated with the trust that this was not to happen in the future as it impacted staff welfare and breached workforce legislation. Patient care was also discussed at the crew members appraisal.

We saw there was a monthly private provider meeting with the NHS trusts for who the provider worked and this meeting included the discussion of complaints. We were told learning was shared through staff memos and one to one discussion. Staff confirmed the clinical team leader's feedback information and updates from any complaints that had been raised. The clinical team leaders also supported staff to write responses to complaints.

In the 12 months prior to inspection there were 16 complaints. Complaints were acknowledged on receipt and the complainant was kept informed of progress with an aim to conclude and respond within 15 days. If this could not be achieved the complainant would be informed and advised of the new time line.

Are emergency and urgent care services well-led?

Good



We rated well led as **good**

Leadership of service

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

The managing director had overall responsibility for the Medical Center. The director of operations reported to them and was responsible for overseeing the director of events and director of finance, the head of operations, the compliance officer and clinical leads.



Emergency and urgent care

All stations had a station manager to oversee the daily running of the bases.

The rate of change was such that when CQC requested details of the managerial structure three months prior to inspection, by the time of inspection the managers' structure had changed to accommodate the new stations the company had taken over.

Staff reported all leaders were visible and extremely approachable including the managing director. Staff we spoke with described a culture of mutual respect as the directors, heads of and leads had all been paramedics. Therefore, they understood the stresses of the job and were able to support staff.

Staff advised us they thought the managers' team were innovative when new equipment came on the market. They would evaluate the product and then invest. One staff member said, "I've worked at a lot of places and to get something implemented is a battle, here it's the opposite."

Vision and strategy for this service

Leaders and staff understood the providers values and strategy and knew how to apply them.

The provider's values had been developed by the directors and formed the basis of the induction process. All staff we spoke with knew the provider's values which were committed to excellence, working together and facing the future.

Staff we spoke with were aware of the strategy for the provider including expansion plans. Staff were involved in areas of expansion that interested them or where they had specialist skills, for example transportation of patients under section 136 of the mental health act.

Staff we spoke with were aware of the direction of travel for the service. They were able to describe the growth of the service and all felt the growth, although quick was done in a controlled and safe way.

All staff we spoke with were able to describe the services' primary goal, to provide safe patient care.

Culture within the service

Staff felt respected, supported and valued. The service provided opportunities for career development. The service had an open culture where staff could raise concerns without fear.

All staff we spoke with advised us they enjoyed working for the company. One staff member said they had worked for several private ambulance firms and Medical Center was "Definitely the best of the bunch".

The 'Make Ready' team reported they very much felt part of the team, they were made to feel important. All staff we spoke with felt listened to.

Everyone we spoke with understood the importance of good care and following clinical guidance and best practice. Staff realised if they did a good job then the NHS ambulance trusts were likely to make more shifts available and they would.

We saw posters promoting 'Legendary Colleagues'. This was a dedicated email address where co-workers could vote for colleagues they felt went "Above and beyond".

After care from incidents was reported to be very good. The week before the inspection a crew had attended an abused patient, managers met them at the hospital, supported them through making police statements, sent the crew off shift after the job and arranged occupational health support.

The NHS trust's emergency contact centres notified clinical team leaders when staff attended a difficult call, the clinical team leaders then made themselves available to crew to discuss any issues or concerns and debrief. Staff were able to access support from a mental health charity if they required further support with any post-traumatic stress related issues.

The clinical lead was the provider's mental health champion and supported staff who had experienced difficult calls.

Managers investigated concerns raised by staff. One member of staff advised us they had concerns regarding the appropriateness of a colleague to do the job. Managers immediately reviewed the situation and appropriate action was taken.

Governance



Emergency and urgent care

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

At the last inspection in 2018, we found general governance was not robust and did not demonstrate monitoring of the quality of the service. At this inspection, we found monitoring of the service had improved.

The 'Make Ready' team had a monthly meeting led by the logistics manager. Information shared included processes, changes and getting feedback from the teams.

The clinical team also met monthly for the clinical governance group, to discuss incidents and complaints, clinical changes, patient satisfaction and training.

The provider had monthly monitoring meetings with the NHS trusts for whom they worked. Minutes of these meetings showed operational statistics, clinical overview, complaints and risks were discussed. From the information reviewed and through discussion, it was clear the provider was actively trying to influence the amount and type of information they were provided with from the NHS trust.

Heads of department met monthly to review compliance, governance, operations and resourcing. However, the heads of department meeting minutes did not show the date and time of the meeting, who was in attendance or who had sent apologies. Therefore, it was difficult to audit progress against actions as there was no chronological order. Out of five actions one did not have an allocated lead. Therefore, there was limited assurance someone was reviewing this issue.

These meetings fed into and dictated the direction of the monthly directors' meetings. These focused on the future of Medical Center and reviewed pace of change as well as the direction and expansion of the company.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and

escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

At the previous inspection, we found the service did not have an effective system in place to identify, limit and control clinical and non-clinical risks. At this inspection, we found the understanding of risk had improved.

Staff we spoke with at all levels were aware of the current risks to the business. Mainly the rapid expansion of the company and the financial risks associated with this.

A few weeks prior to the inspection another local independent ambulance service had ceased to provide a service. Managers at Medical Center had been notified that their premises were available to rent, however had initially rejected the plan due to the stations not being up to standard. However, it was acknowledged the expansion of the business meant there was a risk they would out grow their current foot print. Therefore, they pursued the renting of the available premises. The identified risk relating to the standard of the premises were being addressed through refurbishment and was not to be used until the physical environment met national standards.

The provider had also recruited some of the staff previously employed by the old company. They had made the decision not to transfer staff, but all staff had to go through the full application and recruitment process. This decision was made due the potential risk of staff not being of the required calibre and not all staff were offered employment.

Identified risks were captured on the provider's risk register. The risk register was divided into categories including; compliance, financial, operational and strategic and included details of further actions, the person responsible for the action and the next review date. The register was formally reviewed each quarter.

Public and staff engagement

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



Emergency and urgent care

Patients and clients were encouraged to give feedback through use of feedback forms which we saw advertised within ambulances. Managers advised us they engaged in regular conversations with NHS partners to gain feedback.

We saw patient satisfaction was monitored during monthly governance reviews. We saw a compliment was shared via patient experience during the June 2019 meeting, thanking staff for their help and support during a cardiac arrest.

In the 12 months prior to this inspection there had been two station meetings. One at Slough and one at Reading. Staff were only paid for the time they spent on shift, and not for attending meetings in their own time and turn out for station meetings was low. Staff advised us that they lived a long way from station bases and therefore did not want to travel in on their day off to attend station meetings.

In response to this, managers had introduced monthly email updates and several teams, such as the 'Make Ready' team, had an online chat group where information was shared, and shift availability discussed. Managers also used the company Facebook page to communicate with staff.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

At the time of inspection, the provider was going through a period of rapid growth. Managers calculated a growth rate of over 700% within the last year.

The in-house support materials were an innovative and proactive method of supporting crews.

The managers spent time sourcing equipment that would be most beneficial to patients and staff, rather than the cheapest or standard equipment. For example, the single use ventilator.

Just before this inspection, the Medical Center had expanded to include patient transport services, including patients detained under the mental health act.

The service was aiming to grow their educational side of the business with an aim to train more staff to become paramedics. The Medical Center were the first independent ambulance providers in the country to provide this training. The managers understood this would not only support the business but also the local health economy, that had a shortage of paramedics.

Outstanding practice and areas for improvement

Outstanding practice

The in-house tools developed to support crews whilst on jobs were innovative and supported positive patient outcomes.

The training opportunities available to staff were creative, encouraged a positive culture. Medical Center was achieving recognised accreditation schemes that supported the local health economy and safeguarded the future development of Medical Center.

Staff provided compassionate care that empowered patients to be active partners in their care.

The 'Make Ready' process supported smooth flow and quick turnaround of ambulances to ensure the service was as effective as possible.

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure they have overview of all safeguarding incidents.

The provider should ensure kit bags are always signed back in.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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