Care Quality Commission

Elite Event Medical Services Ltd

Elite EMS Headquarters

Quality Report

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

Ratings

Overall rating for this ambulance location

Emergency and urgent care services	

Summary of findings

Letter from the Chief Inspector of Hospitals

Elite Event Medical Services Ltd is operated by Elite Event Medical Services Ltd. The service provides emergency and urgent care and a patient transport service. As this was a focused inspection, we only inspected the emergency and urgent care core service.

We inspected this service using our focused inspection methodology. We carried out an unannounced part of the inspection on 15 and 16 February 2018.

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.

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 an effective system in place for reporting incidents, which staff understood. Learning was shared.
- The service had systems in place to ensure the safety and cleanliness of vehicles and equipment and to protect people from the spread of infection.
- Premises and equipment were appropriate and generally well maintained.
- The service had a fire safety risk assessment for the premises and a policy that gave guidance for all staff in terms of managing fire safety on vehicles.
- Appropriate systems were in place to ensure the safe storage and management of medicines.
- The service had effective systems in place to safeguard adults and children and monitored staff's compliance with mandatory training.
- Patients' individual care records were well managed and stored appropriately.
- Appropriate procedures were in place to assess and respond to patient risk.
- Staffing levels and skill mix was planned and reviewed to ensure that people were safe from avoidable harm and received safe care and treatment at all times.
- Effective staff recruitment processes were in place. All necessary checks on new staff had been carried out.
- There was an effective system in place to demonstrate that policies had been developed, reviewed, and updated to reflect current practice.
- The service monitored patient outcomes. There were service level agreements in place at the time of the inspection.
- Effective multidisciplinary working was in place.
- Systems were in place for staff to seek patient's consent, and assess capacity to agree to treatment when required.
- Feedback messages from patients using the service were positive.
- Information about the needs of the local population was used to inform how services were planned and delivered and took into account the needs of different patients through the initial risk assessments carried out.
- Patients had access to timely care and treatment.
- Effective procedures were in place to manage complaints about the service.
- The service had managers at all levels with the right skills and abilities to run a service working to provide high-quality sustainable care.
- The service had a clear vision underpinned by strong patient-centred values.
- There was an effective governance framework to support the delivery of the strategy and high quality care.

Summary of findings

- The service had an open and learning culture, focused on patient care.

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

- Systems for environmental risk assessments were not always effective. However, immediate action was taken during the inspection to address this.
- The service was in the process of implementing effective systems for formal staff supervision and appraisal, and for ensuing staff were compliant with mandatory training.

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

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central Region), on behalf of the 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 was well led with experienced and capable leaders who drove improvements in the service with a focus on the best possible care in emergency situations for patients in need. The leaders promoted a positive staff culture and encouraged staff development to deliver the best possible care and treatment for all patients. Effective systems were in place to ensure patients received safe and high quality care and treatment at all times.

Elite EMS Headquarters

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

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Detailed findings from this inspection

Background to Elite EMS Headquarters

Elite Event Medical Services Ltd was registered with Care Quality Commission (CQC) in 2011. It is an independent ambulance service based in Tamworth, Staffordshire. The service provides an emergency and urgent care transport service, working under contracts with two NHS ambulance trusts, patient transport services and event medical cover and first aid training.

The service has a registered manager who has been in post since 2011. A registered manager is a person who has registered with the CQC to manage the service. The registered manager understood their responsibilities and demonstrated this by managing the service to provide high quality care. The service was in the process of moving location to new premises.

Our inspection team

The team that inspected the service comprised a CQC Inspection Manager, Phil Terry, two CQC inspectors, and a specialist advisor with expertise in ambulance services.

The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspections.

How we carried out this inspection

During the inspection, we visited the service at Unit 15, The Anders, Tamworth, unannounced on 15 and 16 February 2018. Due to an incorrect registration, this location was not registered as a separate location with us. The provider had submitted an application to for the service's new location, under which this report is now published.

Facts and data about Elite EMS Headquarters

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

The service provides an emergency and urgent care transport service, working under contracts with two NHS ambulance trusts, patient transport services and event medical cover and first aid training. It provides emergency and urgent care services to children as part of the contracted work with two NHS trusts.

The service has a range of 50 vehicles suitable for blue light emergencies, transporting patients anywhere in the UK, to and from hospital. The service employs around 249

Detailed findings

staff, including temporary staff. The roles of staff employed include, paramedics, associate ambulance practitioners, NMC nurses, GMC doctors, emergency care assistants, emergency care practitioners and clinical trainers. The majority of their work is emergency frontline and urgent care jobs, this is approximately 74%. The remaining 24% is patient transport services.

CQC registered the service to carry out the regulated activities:

- Transport services, triage and medical advice provided remotely.
- Treatment of Disease, Disorder and Injury.

The service had been inspected twice since registration, in January 2013 and in February 2014 and was fully compliant with the outcomes assessed on the last inspection.

We spoke with ten staff including paramedics, ambulance drivers and managers. We did not speak to any patients or relatives as none were present on the days of inspection. We inspected four vehicles and equipment and looked at the documents and records maintained by the service. We also visited the new premises the service was in the process of transferring to.

Activity (February 2017 to February 2018)

- In the reporting period February 2017 to 2018 there were 58,800 emergency and urgent care patient journeys undertaken.
- There were 21,120 patient transport journeys undertaken.

38 Health and Care Professions Council registered paramedics, 95 Institute of Health and Care development trained paramedic technicians, 62 emergency care assistants and 32 ambulance care assistants worked at the service, which also had a bank of temporary staff that it could use. The accountable officer for controlled drugs (CDs) was the service's registered manager.

Track record on safety

- There had been no reported never events. 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 had been no reported clinical incidents.
- There had been no reported serious injuries.
- There had been nine reported complaints in the past six months.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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

See information under this sub-heading in the main service section.

Summary of findings

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 that:

- There was an effective system in place for reporting incidents, which staff understood. Learning was shared.
- The service had systems in place to ensure the safety and cleanliness of vehicles and equipment and to protect people from the spread of infection.
- Premises and equipment were appropriate and generally well maintained.
- The service had a fire safety risk assessment for the premises and a policy that gave guidance for all staff in terms of managing fire safety on vehicles.
- Appropriate systems were in place to ensure the safe storage and management of medicines.
- The service had effective systems in place to safeguard adults and children.
- The service monitored staff's compliance with mandatory training.
- Patients' individual care records were well managed and stored appropriately.
- Appropriate procedures were in place to assess and respond to patient risk.
- Staffing levels and skill mix was planned and reviewed to ensure that people were safe from avoidable harm and received safe care and treatment at all times.
- Effective staff recruitment processes were in place. All necessary checks on new staff had been carried out.

Emergency and urgent care services

- There was an effective system in place to demonstrate that policies had been developed, reviewed, and updated to reflect current practice.
- The service was equipped to manage a variety of health-related complaints.
- The service monitored patient outcomes. There were service level agreements in place at the time of the inspection.
- Effective multidisciplinary working was in place.
- Systems were in place for staff to seek patient's consent, and assess capacity to agree to treatment when required.
- Feedback comments from patients using the service were positive.
- Information about the needs of the local population was used to inform how services were planned and delivered.
- The service planned to take into account the needs of different patients through the initial risk assessments carried out.
- Patients had access to timely care and treatment.
- Effective procedures were in place to manage complaints about the service.
- The service had managers at all levels with the right skills and abilities to run a service working to provide high-quality sustainable care.
- The service had a clear vision underpinned by strong patient-centred values.
- There was an effective governance framework to support the delivery of the strategy and high quality care.
- The service had an open and learning culture, focused on patient care.

However:

- Systems for environmental risk assessments were not always effective. However, immediate action was taken during the inspection to address this.
- The service was in the process of implementing effective systems for formal staff supervision and appraisal, and for ensuing staff were compliant with mandatory training.

Are emergency and urgent care services safe?

Incidents

- There was an effective system in place for reporting incidents, which staff understood. Learning was shared.
- There had been no reported never events. 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 an initial paper reporting form, which was to be completed at the time of the incident then investigated by one of the team leaders. Records were then transferred to the service's electronic operation system so that incidents could be tracked by managers. No serious incidents had been reported in the past year.
- Incident reporting templates were available staff told us, which enabled all incidents to be reported at the time of occurrence by frontline staff.
- We were told that the process in place for investigating incidents, which would include investigations being completed within one week of the incident and information shared with the reporter and the wider team. The service had started a database for the recording or monitoring of incidents, the investigations, outcomes or learning. Staff showed us the electronic system that clearly detailed all incidents reported with a system for review and investigation, when required. Learning was shared via staff meetings, messages on the staff clinical noticeboard and by regular staff messages sent by email to all staff.
- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Emergency and urgent care services

- The service had a policy in place, which described their responsibilities under the duty of candour legislation. Staff had an awareness of the requirements of duty of candour. We did not see any incidents reported that had required application of duty of candour.
- The service was in the process of establishing a clinical dashboard to monitor safety. Staff showed us the electronic system that was being used. Once fully operational, this would record all performance and safety information. This would then be used to drive improvements in the service.

Mandatory training

- The service had processes in place to monitor staff compliance with mandatory training. Mandatory training was an annual cycle for all staff, who were expected to complete this. There was a structured induction programme in place for all new staff. All staff were expected to complete mandatory training modules annually.
- The newly established training and development team were in the process of developing an updated mandatory training programme, which was going to be on the service's electronic system to accurately monitor staff compliance with training. We saw that this process was being completed on the electronic system.
- Data we received from the service showed that there was 100% compliance with mandatory training. We checked four staff files and found clear evidence of current compliance with mandatory training.
- Staff received training in safe systems, practices and processes. Topics included on mandatory training were:
  - Driving assessment.
  - Basic life support and use of automated external defibrillators.
  - Intermediate life support.
  - Safeguarding children level three and safeguarding adults level two.
  - Prevent.
  - Capacity and consent.
  - Dementia awareness.
  - Deprivation of Liberty safeguards.
  - Infection, prevention and control.
- Moving and handling training was done in house on staff induction.

Safeguarding

- There were effective systems and processes in place reflecting relevant safeguarding legislation to safeguard adults and children from abuse.
- There were clear guidelines for staff who needed to refer a child or adult, depending on which NHS ambulance trust they were providing the job for. There was a safeguarding policy in place for adults and children at risk in place. This had been reviewed in 2017 and it contained relevant guidance for staff to recognise and report any potential safeguarding concerns and reflected national guidance. It also contained a comprehensive list of local authority safeguarding contact numbers for use in an emergency.
- All staff received safeguarding children training at level three, and safeguarding adults at level two and staff training records seen evidenced this. No new member of staff was permitted to work directly in contact with patients until this training had been provided.
- Staff we spoke with said they had completed safeguarding children training to level three and safeguarding adult's level two. Staff were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients. Relevant information and relevant contact numbers for safeguarding were seen on staff noticeboards.
- Arrangements for checking all staff's fitness to work with vulnerable adults and children were effective and essential checks had always been carried out. The service carried out a Disclosure and Barring Service (DBS) check on all newly appointed staff. We saw all staff working had a current DBS check recorded in accordance with the service's policy.
- Female Genital Mutilation (FGM) was included in safeguarding training, which all clinical staff attended. Staff were aware that they have a mandatory reporting duty to report any cases of FGM in females under the age of 18 years of age, including those females who have given birth to a female infant.
- Child Sex Exploitation (CSE) was included in safeguarding training. CSE is a form of child abuse and reportable to children's social services in line with safeguarding procedures. Staff were aware of the potential indicators of abuse, the forms to use and how to complete an interagency referral. The policy for safeguarding children included FGM and CSE.

Emergency and urgent care services

- The service also providing training to staff for 'Prevent', which is part of the government policy to safeguard children and vulnerable people from being radicalised to supporting terrorism.
- The clinical lead was the service's safeguarding lead and had level four safeguarding children training in line with national guidance.

Cleanliness, infection control and hygiene

- There were effective systems and processes in place to protect people from the spread of infection. The service was able to demonstrate how they assessed the risk of infection and took action to prevent, detect and control the spread of infection.
- The service had a policy for infection prevention and control. We saw this detailed the responsibilities of individual staff in relation to wearing appropriate protective equipment, reporting of illness, training, education, and handwashing. This had been reviewed in a timely manner. There were also standard operating procedures for the cleaning of vehicles whilst away from the main base. This included guidance for staff to follow, including, vehicle cleaning, the disposal of waste and managing sharps injuries.
- There was an area for cleaning the vehicles with the necessary equipment to clean all vehicles. Disposable mop heads were available and different colours used for different areas. There were separate and clearly marked areas for cleaning equipment and all surfaces were all able to be wiped clean easily.
- All equipment and vehicles used were checked prior to the start of the shift and on return to base. Any equipment used was cleaned and prepared for next use. The service used a formal checklist to complete these daily checks and there was a comprehensive system in place regarding recording these checks.
- We inspected four vehicles and found all were visibly clean and fit for purpose. All equipment inside was visibly clean and storage was well organised. We checked sharps boxes on four vehicles. These were almost all secure and dated on opening. However, one vehicle had an unsecured sharps box, which was not dated but had been used. This was rectified when we spoke with the staff.

- Ambulance interior surfaces and equipment were visibly clean and records of daily checks had been completed. We saw records of deep cleaning of each vehicle on a monthly basis. Staff had a specialised 'fogging' machine for decontaminating vehicles when required.
- Suitable arrangements were in place regarding deep cleaning of vehicles, which took place monthly or more frequently when required. Records confirmed this.
- Hand sanitising gel was available on vehicles alongside clinical wipes. Appropriate hand washing facilities and hand gels were in place to be used by staff whilst at the base unit. Hand hygiene audits were carried out monthly, and records showed 100% compliance in the past three months.
- Personal protective equipment supplies were available for staff use on each vehicle.
- Staff wore uniform shirts and trousers. They were responsible for their own laundering and the policy gave appropriate guidance for the necessary temperatures for clothes to be cleaned at.
- There were arrangements for managing general and clinical waste. In the vehicles there was a selection of waste bags, including for clinical waste and spillage kits. A specialist contract was in place for collecting clinical waste and sharps boxes. The clinical waste bin was locked and stored appropriately.
- Covers for the stretchers were obtained from local NHS ambulance services and returned there. Cupboards, shelves, equipment and packaging in the storeroom were visibly clean.
- We were told when they were away from the main site staff were able to use the NHS ambulance stations for cleaning vehicles. The service carried out work for NHS trusts across the country and at times, vehicles and staff would be temporarily based at off site locations. We also saw the provider had a detailed policy in place regarding off site cleaning for all staff. Staff told us ad hoc checks were carried out by managers on those vehicles used when carrying out services at remote location. Details of these checks were recorded on the service's electronic system.
- The manager told us the service was due to move to new premises at the beginning of March 2018 and that training and event cover equipment had been temporarily stored in the main unit area of the current location. Due to this temporary situation, we found an amount of stored equipment in the main unit on site,

some of which was not visibly clean. This equipment was not in current use, and the manager took immediate action to remove this from the main unit area once we raised it.

- We saw that all staff received infection prevention and control as part of their mandatory training.

Environment and equipment

- Premises and equipment were appropriate and generally well maintained.
- The service had effective systems in place to ensure the safety and maintenance of equipment. The maintenance and use of equipment meant that there was always safe, ready to use, equipment for the vehicles. This was monitored by the fleet manager by an electronic system. There was a detailed electronic record of all equipment on each vehicle maintained. This showed the location of all equipment and when it had been serviced.
- Staff were trained on all the equipment used by the service. Details were recorded on the service's electronic system. We also saw posters on display with clinical updates on the staff noticeboard.
- The premises were safe and secure and were manned by staff 24 hours a day. There were security cameras on the site.
- The service had a fleet of 50 vehicles, including 15 hire vehicles. Staff said 27 vehicles were out in use at the time of our inspection. The exterior of vehicles seen were intact. There was no damage to wing mirrors, or lights, and doors were working properly. The equipment inside the vehicles appeared well maintained. Vehicles were equipped with electronic navigation systems.
- Essential emergency equipment was available on the vehicles and a standard vehicle checklist was completed by staff at the start of each shift.
- Electrical equipment was checked for safety annually and equipment had maintenance checks. The service had a comprehensive record of equipment servicing and electrical safety testing. All equipment was secured within the vehicles.
- Clinical supplies were stored in a clean and dry environment and the service had an effective system for storage and stock control. We checked a sample of clinical supplies and they were within use by dates. There was no evidence of over or understocking.
- The maintenance, servicing and MOT testing of the vehicles was recorded in a file for each vehicle and on

an electronic system which alerted the fleet manager when MOTs, road tax, insurance and servicing was due. Records seen showed that all vehicles were fit for use and had had the required checks and maintenance carried out.

- On inspection of the main unit area of premises, we found the main unit to be cluttered with stored training and event equipment ready for the move to the service's new premises, which had been delayed. Whilst this part of the main unit area had been cordoned off, this main area was where ambulance cleaning and restocking took place. We found stacked cardboard boxes and fabric furniture alongside electrical equipment and some unsecured medical gases. We raised this immediately with the manager as it posed a potential fire risk to the building and the staff. The manager explained that the delay to the move to the new premises had affected the service's plans and that these items had been temporarily stored for just over a week. The manager took immediate action to address this whilst we were on site. When we returned the next day, all this equipment and stock had been removed and the main unit area was completely free of clutter and was fit for purpose. The main unit was completely clear of all clutter, cardboard boxes and training equipment. The area was clean and organised, which posed no fire or evacuation risk. The area could be used safely and there was no risk to staff.
- We saw that a fire safety risk assessment was in place and did reference the temporary storage issues. When we returned on the second day, this risk assessment had been reviewed and updated to give clear guidance for all staff using the premises. We saw that all fire safety equipment had been well maintained and was fit for use. Weekly fire alarm checks had been carried out. The service had a designated fire safety officer. We saw that environmental risk assessments of the premises and vehicles were carried out and reviewed when circumstances changed in accordance with the service's policy. Fire safety procedures and evacuation protocols were detailed in the staff handbooks given to all staff and also formed part of annual mandatory training.
- The service had its own secure car park and the base location was in a business unit with security barriers and fences. The base location used by the service had storage facilities to support the delivery of the service.
- We spoke with staff in the operations room and they told us that the service used remote locations on

temporary bases for staff that were on work in other parts of the country. Processes were in place for the restocking and cleaning of vehicles when away from the main base. The manager showed us the standard operating procedures (SOPs) for maintaining consistency in the cleaning and restocking of vehicles that could not return to the main base daily. These included processes such as what staff are to do if the vehicle breaks down, or if they needed clinical advice.

Medicines

- The service had effective systems in place to ensure the safe storage and management of medicines.
- The service had a medicine's policy in place, which reflected current practices in medicine, such as, ordering, storage and disposal. The policy gave guidance on the safe handling, storage and disposal of medicines and medical gases.
- Medical gases in use were stored securely in the vehicles and they were locked in a secure container within the main unit at the base. We did find a small number of cylinders loose and freestanding in the cordoned off area in the main unit, but these were empty. The manager removed them immediately once we drew their attention to this.
- Medicines were stored securely within a locked room, which was only accessible by clinical staff. The storage area was well organised and have appropriate facilities for the storage of controlled drugs (CDs). Some prescription medicines are controlled under the Misuse of Drugs Act (1971). These medicines are called controlled medicines or controlled drugs. Stricter legal controls apply to controlled medicines to prevent them being misused, being obtained illegally and causing harm. A CD register was used to record the details of the CDs received, administered as well as CDs that had been disposed. CDs were stored in a locked cupboard within a locked room. Each pack of CDs taken out on emergency vehicles was recorded in a separate CD register. Appropriate records were kept of their administration with the specific case number recorded. Stock checks of all medicines were completed monthly. Only clinical staff had access to the locked medicines cupboard. A CCTV camera was in place in the medicines' store room. There was also a separate lockable cabinet for medicines for disposals and a record of all disposals

was maintained. Staff confirmed no medicines, including CDs, had been reported as missing. The service had a licence from the Home Office for the storage and use of CDs.

- The accountable officer for controlled drugs was the registered manager for the service.
- Appropriate Patient Group Directions (PGDs) were in place for the paramedics working in the service and staff followed this guidance. A PGD is defined by the Human Medicines Regulations (2012) as a 'written direction that relates to the sale, supply and administration of a description or class of medicinal product'. A PGD enables named, authorised, registered health professionals listed in Schedule 16 of The Human Medicines Regulations, which includes paramedics and nurses, to administer a parenteral medicine for which there is not another exemption to a pre-defined group of patients. For paramedics, this will be for any injectable medicines not listed in Schedule 17 or Schedule 19 of the HMR. PGDs are ideally suited to the emergency care environment as patients are not identified before presentation for treatment and there is not usually an opportunity for the individualised care a prescriber can offer.
- The service had a medical director, who oversaw the prescription of medicines used in the service.
- We saw suitable arrangements in place to action medicines safety alerts and recalls.
- Medicines update training was not included in the mandatory training topics. It was covered on induction but no refresher training provided. Senior staff said medicines' management would be assessed and discussed through clinical supervision with one of the four mentors.
- Medicines were stored in specific bags. Staff checked out the medicines at the start of the shift and checked them back in at the end of the shift. There was a technician's kit and a paramedic's kit. Staff said they worked to the medicine's policy of the NHS ambulance service they were supporting. Records seen confirmed these checks were carried out.
- Patient records were completed when a medicine was administered on site.

Records

- Patients' individual care records were well managed and stored appropriately. Records seen were accurate, complete, legible and up to date in all cases.

Emergency and urgent care services

- Patient record forms (PRFs) were managed and written appropriately. We found PRFs seen to be accurate, complete, legible, and up to date and stored securely.
- Guidance for staff was in place for the storage of records when ambulances did not return to site daily guidance. We saw that secure facilities were available on vehicles to store records.
- A PFR was completed for each patient at the scene and was brought back to base. Records were stored securely on site, information transferred onto the electronic system and the forms were sent to the relevant NHS ambulance service that allocated the mission.
- In relation to patient transport services, a 'run record' was produced which detailed the main information required about the patient and the transport details. They were stored securely on site.

Assessing and responding to patient risk

- Appropriate procedures were in place to assess and respond to patient risk, including appropriate response to vehicle breakdown.
- The service had a transfer of patients' policy, a resuscitation policy and the management of deteriorating patients' policy which clearly outlined the roles and responsibilities of staff. This included communication between the service and the planned destination, information to be given to patients and documentation. The policy highlighted links to the consent policy, reminding staff to ensure consent in place, prior to transfer.
- The service would gather as much information about the patients, including children, from the requesting NHS ambulance service, then risk assess each patient individually This would include if they needed the specialist bariatric ambulance, or increased moving and handling equipment for transferring from the patients home to the vehicle. Similar protocols operated for patient transfer request, bookings for which were taken by the control room staff.
- A full set of observations and initial assessment, past medical history, blood glucose levels, a Glasgow coma scale assessment and stroke assessment were completed for each patient. Patient observations were recorded.
- We saw that a pain assessment was recorded for each patient.
- The clinical lead was available 24 hours a day, seven days a week, for advice for staff if required.

- The service provided first aid at events and if patient's condition deteriorated, the service would transfer them to the nearest emergency department.
- The service also provided patient transport services, and received bookings from NHS ambulance trusts. Staff told us that one crew member sat with patients being transported in the rear of the vehicle. This meant they could directly observe the patients throughout the journey and respond if they witnessed a decline in the patients' condition.

Staffing

- Staffing levels and skill mix were planned and reviewed appropriately to ensure patients received safe care and treatment at all times. Staffing levels, including paramedic staffing, met the needs of patients during the inspection. Provision of paramedic staffing met the requirements of the contracting NHS trusts. Rotas were planned according to the number of requests from the NHS ambulance trusts. The service had a control room which monitored the whereabouts of all vehicles and was in constant communication with the staff on the vehicles regarding patient journeys and new requests for work.

- The service employed a mix of staff including:
  - GMC Registered Doctors.
  - NMC Registered Nurses.
  - Emergency Care Practitioners (Nurse and Paramedic Background).
  - Registered Paramedics.
  - Associate Ambulance Practitioners.
  - Ambulance Technicians.
  - Emergency Care Assistants.
  - Urgent Care Assistants.
  - Ambulance Care Assistants.
  - Advanced First Aiders.
  - First Aiders.
  - Clinical Trainers.
  - Driver Trainers (for emergency blue light and non-emergency driving).
  - Control room staff.
  - Ambulance fleet assistants.
  - Department Managers.
  - Learning and Development Department.

- From the 249 staff, 62 had permanent contracts, 117 were bank or on a zero hours contract and 70 were self-employed.

Emergency and urgent care services

- When the service was booked to cover an event, a risk assessment was completed which determined how many and what grade of staff were required. This was based on the size of the event and the risks associated with the activity. When staffing levels were determined, staff were then allocated.

Anticipated resource and capacity risks

- Control room staff monitored the whereabouts of all vehicles in use at all times using an electronic tracking system.
- The effective fleet management system in place meant that additional vehicles were able to be deployed quickly to manage increased demand as and when needed.

Response to major incidents

- Suitable arrangements for dealing with risks that might affect the service's ability to provide it's services (such as staffing problems, power cuts, fire and flood) were in place and understood by staff. Staff were aware of what to do in the event of a fire, chemical spill or health and safety incident.
- A mobile 'control room' vehicle was available with suitable equipment to maintain a control room function for the services in an emergency.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- There was an effective system in place to demonstrate that policies had been developed, reviewed, and updated to reflect current practice. The service's policies were based on evidence-based guidance, standards, best practice, and legislation, including Joint Royal Colleges Ambulance Liaison Committee and the Resuscitation Council guidance.
- We reviewed 20 policies in place for the service, including those for recruitment, staff induction and training, risk assessment, incidents, medicines management, fleet management, resuscitation, infection control and criteria for transport. The policies had a date when first produced and a version number and a date of next review.

- Senior staff were aware of current evidence based guidance, standards and best practice were used to develop how services, care and treatment delivered.Staff had access to the policies via secure access to the service's intranet.

Assessment and planning of care

- The service was equipped to manage a variety of health-related conditions. For emergency response cases, staff completed an initial assessment of patients at the scene including an initial assessment and vital signs. They recorded the initial treatment provided and the management plan.
- For patient transport bookings, senior staff told us information about patients' needs was collected at the point of booking, and communicated to staff face to face. Information included the patients' age, weight, medical conditions, disabilities and any infections. There was evidence that risks were assessed as part of point of initial bookings to ensure that care could be provided safely and necessary equipment was available.
- Patients' nutrition and hydration needs were considered and there were some arrangements such as bottled water in the vehicles which could be given to the patient if required.
- A policy was in place for the treatment and transport of children, which gave sufficient guidance for staff in care and treatment of children and young adults.

Response times and patient outcomes

- The service had two formal service level agreements in place at the time of the inspection. The service monitored patient outcomes in accordance with these agreements with the two NHS ambulance trusts. The manager reported that the service's response times were 97% compliant with the parameters set by the NHS ambulance trusts. Staff recorded time of call out, time on scene and the time they left on the individual patient records.
- We saw that information captured during some events detailed actions taken by the staff to address clinical findings and any actions taken by staff members. This included advice for follow up with GPs or other services. The service did not analyse this data to determine the number of patients using the service, the treatment given or the patient outcome.
- The service monitored the number of patient transfers completed.

Emergency and urgent care services

- The service did not participate in national audits or accreditation processes.
- The service collated feedback from patients and event organisers, but this was used to improve services.

Competent staff

- Effective staff recruitment processes were in place. All necessary checks on new staff had been carried out.
- The service had effective systems in place to manage effective staff recruitment processes. From four current staff files reviewed, we saw that staff had an employment contract issued. All staff files showed evidence of at least two satisfactory references being requested and reviewed. All staff applications showed a clearly defined work history.
- A recruitment and selection interview had been carried out to consider staff's competency for the role they had applied for, which was in accordance with the recruitment policy.
- The recruitment manager told us the service always undertook Disclosure and Barring Check (DBS) checks on all staff prior to their employment. This was evidenced in staff files seen.
- We saw that all staff had received an induction and that the induction and staff recruitment policy had been reviewed. The manager had also arranged for a supervision and appraisal system to be implemented. We saw a detailed policy regarding this was in place, identifying staff's learning and development needs, linked to their continuous professional development and registration with their professional body (if applicable). They were required to undertaken training and provide certificates for the service.
- A member of staff said they had a day's induction with the service and a day with an NHS ambulances trust. Staff handbooks were given at induction and used to inform staff of relevant policies and procedures to be followed.
- The newly appointed training manager lead was in the process of implementing a formal system for observations of practice and supervision. Four paramedics who were mentors who were able to provide support for other staff as well.
- Paramedics were registered by the Health and Care Professions Council (HCPC). The HCPC is a statutory regulator of 16 health and care professions in the United Kingdom. It sets and maintains standards of proficiency and conduct for the professions it regulates. Its key

functions include approving education and training programmes which health and care professionals must complete before they can register with the HCPC; and maintaining and publishing a register of health and care providers who meet pre-determined professional requirements and standards of practice. We saw the service regularly checked the registration of all paramedics in the service.

Coordination with other providers and multi-disciplinary working

- Effective multidisciplinary working was in place. The service had two formal contracts in place. Senior staff reported effective relationships with the acute NHS trusts and a range of event organisers.
- The service informed other services of treatment given and also for those patient transfers to the local NHS emergency department from events. Patients transferred to emergency departments were handed over to the department. The assessment and treatment provided were explained and a copy of the patient record sheet given to the accepting service.
- Information gathered during patient assessments was recorded on the patient treatment form. These were signed and dated by the staff attending the patient. The patient was provided with a copy of the form on discharge when required. A copy of the form was given to staff within the emergency department if patients were transferred to an NHS acute trust
- All patients were given advice on any follow up care, however no referrals were made.

Access to information

- Control room staff took relevant patient details including contract details for GPs where know. Staff had access to the service's electronic system which detailed relevant clinical guidelines. All vehicles had satellite navigation systems.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff had received training in the Mental Capacity Act 2005 as part of induction and mandatory training days. A Mental Capacity Act (2005) policy was in place that provided clear guidance for staff on assessing patient's ability to make informed decisions.

Emergency and urgent care services

- Patients receiving care or treatment were asked to sign the treatment record to confirm they understood the advice or treatment given. Verbal consent was recorded on the form.
- We were told that vulnerable adults and children usually attended with parents or guardians. Consent for treatment by the individual staff member was obtained prior to the completion of any treatment.
- The service had consent policy which detailed the expectations of staff to consider consent with all patients and to detail that consent was to be sought before any treatment. The policy also gave guidance on the consent process for children, and highlighted the guidelines in the safeguarding policy relating to treating patients less than 18 years.
- The service had a do not attempt cardiopulmonary resuscitation policy (DNACPR). This policy gave clear guidance for staff on managing bookings and also for ambulance crew to check original DNACPR documentation when receiving a patient.
- We saw from samples of patient treatment records that consent had been recorded to the course of treatment outlined by staff.

Are emergency and urgent care services caring?

Compassionate care

- We were not able to observe crew interacting with patients, as this was an unannounced inspection.
- We saw a sample of 10 comments and feedback messages received by the service which were complimentary about the care and respect shown by staff to patients.
- The manager was in the process of implementing a formal system to capture patient feedback and collate results and themes to help make improvements in the service.

Understanding and involvement of patients and those close to them

- We saw from samples of patient treatment records that patients and relatives had been informed of their treatment, where practicable to do so.

Emotional support

- Staff demonstrated an awareness of the needs of patients and their relatives and carers and how they would support them at times of distress, especially during emergency situations. Information was available to staff so they could signpost patients to relevant external support organisations.

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

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. The service used information available from other organisations to help shape the design and delivery of its service. The service had service level agreements with two NHS ambulance trusts. The service was tendering for another provider agreement in the south of the country.
- The service provided a range of vehicles including a treatment centre, an emergency response vehicle, and specific bariatric and high dependency vehicles. It also had recently obtained specific vehicles for the transport of patients with mental health illnesses or needing anonymity. Those vehicles had Home Office approved Category A cells, and processes were in place for patients to be risk assessed first before use. The contract for this service had not commenced at the time of this inspection.
- For events, the size of the event being held determined the number of staff in attendance. Event organisers and their stakeholders were involved with the planning of the service. The team were hired to perform specific roles. The roles and responsibility of the service was determined in advance through discussion with the event organisers and were detailed in the event contract, which stipulated roles and expectations.

Meeting people's individual needs

- The service planned to take into account the needs of different patients through the initial risk assessments carried out. The emergency response and patient booking process meant patients' individual needs were able to be identified.
- Service managers confirmed that they used accompanying family, friend or carers to support

patients requiring additional support in assessments and treatment. This included, children, visually impaired patients, and patients whose first language was not English.

- Vehicles were designed to meet the needs of bariatric patients.
- There was access to translation services, and aids for visual or hearing impaired. Staff could access to the NHS ambulance trust's translation service if required.
- The service had in place a policy giving staff guidance for supporting patients with a vulnerability and this included patients living with a dementia or with a learning disability. Staff confirmed they had received dementia awareness training.

Access and flow

- Patients had access to timely care and treatment. This was achieved by the control room function that co-ordinated emergency response to patients in need. The service could attend a location at the time of incident to assess patients in a timely manner.
- The service took bookings for patients transport journeys from the local NHS hospital or direct from the private individuals. The booking system was managed by control room with a 24 hour on call telephone service. An electronic system recorded of all patient bookings and event cover with details of booking calls made.
- Managers said staff were dedicated to reach the highest standards of care, and to aim to exceed the government target of 95% of patients arriving within 30 minutes of their appointments. Over the last year, 97% of patients had arrived before or on time for appointments.

Learning from complaints and concerns

- There was guidance available on vehicles for patients to make a complaint or express their concerns. Leaflets were available explaining how patients and those accompanying them could contact the service management team to make a complaint or express their concerns.

- The service had a complaints' policy in place, which had been reviewed in 2017. This gave clear guidance to staff on how to record a complaint and how it would be investigated. Timescales for response were 25 days for most complaints and 45 days for complex complaints. Staff were aware of the complaints' procedure.

- There had been nine reported complaints in the past six months. We saw they had been investigated appropriately.
- We were given examples of complaints and compliments. These were responded to appropriately and learning was shared with the team, via team meetings and emails.

Are emergency and urgent care services well-led?

Leadership of the service

- The service had managers at all levels with the right skills and abilities to run a service working to provide high-quality sustainable care.
- The service was led by the manager with significant experience of working in the independent ambulance industry.
- The registered manager was the owner of the service. Given the expansion of the service over the past three years, the leadership team had expanded to provide oversight and operational capacity to manage the service.
- It had recently employed a new general manager, compliance manager, a training manager and a new clinical lead. They were all in the process of embedding themselves and new procedures into the service. The leadership team were in the process of developing enhanced organisational and accountability structures throughout the service.
- The fleet manager had systems in place for managing the vehicles and equipment.
- Senior staff were experienced and knowledgeable about their areas of responsibility. They were clear about the standards they expected from staff.
- Staff spoken with were clear on their role and how to report to and said leaders were very visible in the service.

Vision and strategy

- The service had a clear vision underpinned by strong patient-centred values.
- The registered manager had a clear vision for the service to develop the service to be one of the largest and highest quality independent ambulance providers in the country.

Emergency and urgent care services

- We viewed the new premises and we could see the service's vision moving forward with the expansion.
- The service's mission statement was to 'To provide a financially stable solution that offers a high quality patient driven service through a highly trained, motivated and committed workforce'.
- Clear values based on compassion and a timely emergency response to patients in need were evident.
- Staff were fully aware of the vision and strategy of the service and were enthusiastic about the way the service was expanding.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of the strategy and high quality care.
- There was a range of policies and standard operating procedures which underpinned the governance structure. This was supported by a monitoring system which showed who had read and who had yet to read the standard operating procedure or policy update. The service introduced new procedures to reflect good practice and national guidance and when necessary.
- Policies were reviewed regularly and covered key issues such as raising and responding to concerns, adverse incident investigation, complaints, driving policy, consent, medicines management, management of controlled drugs, medicines management and infection prevention and control. This ensured patient safety as much as possible, and promoted a consistency of approach in day to day working.
- The service actively reviewed the risk register at the clinical lead and operational management group meetings. There was a clinical risk register and a corporate risk register. This included risks such as vehicle breakdown and failure to maintain paramedic cover. They took action to mitigate risks, for example, in managing limited car parking on the site visited.
- Managers reviewed risks monthly and reported them to the senior management team. They supplied an action plan to mitigate each risk and this included actions such as planning for the transition to the new premises.
- The service had clear working arrangements with partners. They based service delivery on a service level agreement developed with local NHS ambulance providers. The service level agreement was reviewed regularly. The local NHS ambulance service senior staff met with the leaders in the service and monitored activity reports from the service.
- Clinical staff were clear about their roles and what they were accountable for.
- Quality and performance monitoring arrangements were in development. Service activity levels with staffing level information was reported at board level.
- The service was accredited by the Information Commissioners Office (ICO).
- The service had informed us of the change in their location three years ago, and believed they had been registered to operate at two locations. However, as the original notification to us had been rejected, the location we inspected was in effect an unregistered location. We had taken other action to address this before the inspection and the registered manager was fully aware of the importance of complying fully with all requirements of registration under the Health and Social Care Act 2008. A new post, CQC compliance manager, had just been recruited to.

Culture within the service

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- The service had an open and learning culture, focused on patient care. Clinicians worked with a mutual respect, candour and honesty.
- Staff shared learning through monthly team meetings and their intranet.
- The organisational culture promoted staff wellbeing. Colleagues or managers debriefed the crew after their missions and we saw evidence of peer support.
- There was a clear whistleblowing policy to support staff in raising concerns.
- Staff were generally able to take sufficient breaks during a shift, but a minority of staff said they were required to attend at 10am to check their vehicles and equipment prior to an 11am start to the shift. Their shift was 12 hours but they had to return the vehicle to site at the end of a shift and may not finish until 12.30am. Managers were monitoring this on an ongoing basis.

Public and staff engagement

Emergency and urgent care services

- Staff said that they felt listened to and the managers were approachable.
- We saw that patient feedback was very positive, complimenting staff on their helpfulness, punctuality and all recommending the service for future use.
- The manager showed us the new electronic systems to be introduced to formally capture patient and staff feedback via surveys and spoke of the service's plans to use this further develop the service.

Innovation, improvement and sustainability

- At the time of the inspection, the service was focused on the transition to the new premises, which covered an area of over 30,000 feet and contained a variety of rooms and work spaces to provide an innovative setting for the service's expansion plans.
- The service was planning to deliver all their own in-house training, with a purpose built 360-degree training simulation room, which would be able to be used by other organisations and student paramedics. This training facility was being designed to be a 'state-of art' virtual environment in which staff could carry out drills and training in a 'real life' environment.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- To review systems for environmental risk assessments.
- To continue to implement effective systems for formal staff supervision and appraisal.

- To monitor the effectiveness of the system for ensuing staff are compliant with mandatory training.