Medicare EMS Group UK Limited

Head Office

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

Head Office is operated by Medicare EMS Group UK Limited. The main service provided by Medicare EMS Group UK Limited was first aid and medical cover for events. Events are not within our scope of regulation and we do not inspect events. However, at some events, the service provided emergency transport. Emergency patient transfers fall into our scope of regulation and require inspection.

The service provides support to event organisers in need of event medical cover. Events include horseracing, concerts and other large stadium events. Medicare EMS Group UK Limited supply rapid response vehicles crewed by paramedics, emergency medical technicians and first aid personnel.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 05 December 2017, along with an unannounced visit on 15 December 2017.

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

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

From January to November 2017, Medicare EMS UK Limited completed 104 patient transfers by ambulance, from an event to an emergency department. We inspected this service under our urgent and emergency care framework.

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:

- Staff knew how to report incidents and learning from incidents was shared.
- There were safeguarding systems and processes to ensure that people were kept safe.
- Vehicles and equipment were visibly clean and serviced.
- Records were completed appropriately and stored securely.
- Medicines, including controlled drugs, were stored securely and in date.
- Policies and procedures were based on best practice, legislation and relevant national guidance and were easily accessible for staff.
- Staff had the skills, knowledge and training to deliver effective care and treatment.
- The service had introduced the trauma network standards within their horseracing portfolio to ensure jockeys received the best quality outcomes following a traumatic injury.
- Patient and client feedback was consistently positive.
- There were clear lines of management responsibility and accountability, The executive management team displayed a clear ethos of patient safety and delivering a high standard of medical care.

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

- The service did not date patient feedback forms, therefore it was unclear when the patient feedback had been obtained. We raised this on our inspection and the service was responsive, immediately editing the patient feedback forms to include the date.

Summary of findings

Heidi Smoult
Deputy Chief Inspector 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 main service provided by Medicare EMS UK Limited was first aid and medical cover for events; however, this is not within our scope of regulation. We have reported on the urgent and emergency care aspect of the service as the provider has transported patients, from event sites to local emergency departments, by ambulance. The service had processes in place to ensure patients were safe from harm and abuse. Care and treatment was based on best practice, legislation and relevant national guidelines. Patient feedback was positive. The service was planned and delivered to meet the needs of people using the service. The leadership, management and governance of the organisation assured the delivery of high-quality care.

Head Office

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

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Background to Head Office

Medicare EMS Group UK Limited opened in 2003. It is an independent ambulance service in Chelmsford, Essex. Medicare EMS Group UK Limited has one registered location, Head Office, which has been registered with the CQC since June 2017. Prior to this, the service was registered at a different address for four years. Head Office has had a registered manager in post since June 2017.

Medicare EMS Group UK Limited provides support to event organisers with event medical cover. Events include horseracing, concerts and other large stadium events. With the exception of the directors and executive management team, all staff work on a flexible basis, allocated to events based on availability and profession.

The service operates from Head Office, with two additional satellite bases located in Coventry and Hartlepool. The satellite bases hold supplies and have vehicle storage and cleaning facilities.

The service has 16 ambulances, seven 4x4 off-road vehicles and two cars.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a second CQC inspector. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Facts and data about Head Office

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the service base, Head office, in Chelmsford, Essex. We spoke with 10 members of staff including directors, duty managers, registered paramedics and emergency medical technicians. We reviewed six sets of patient records and three staff files.

There were no special reviews or ongoing investigations of the service by the CQC during the 12 months prior to inspection. Head Office had not been previously inspected, since registering with CQC.

The service does not operate under subcontracting arrangements with the NHS or private providers. Work is directly procured through clients running events, and is dependent on demand.

Activity (January 2017 to November 2017)

Detailed findings

- The service attended 1291 events, at which there were 104 emergency and urgent care patient journeys undertaken.

With the exception of the directors and the executive management team, all staff were employed on a flexible basis. The service employed 66 registered paramedics and 67 emergency medical technicians on zero hour contracts. Independent ambulance services are exempt from the requirement to appoint an accountable officer for controlled drugs.

Track record on safety (January 2017 to November 2017)

- No never events
- 11 clinical incidents resulting in no harm
- No serious injuries
- One complaint

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The main service provided by Medicare EMS Group UK Limited was first aid and medical cover for events. Events are not within our scope of regulation and we do not inspect events. We have reported on the urgent and emergency care aspect of the service as the provider has provided emergency transport to patients from events sites to a local emergency departments via ambulance. Emergency patient transfers fall into our scope of regulation and require inspection.

Summary of findings

There were effective processes in place to protect people from abuse and avoidable harm. Care and treatment was based on best practice, legislation and relevant national guidance. Staff delivered compassionate care. The services were planned and delivered to meet the needs of people. There was evidence of effective oversight and management, while the service continued to grow and develop.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- The service had effective processes to record and manage incidents. Staff followed an up-to-date incident reporting standard operating procedure, available to staff electronically. Staff reported incidents through an electronic reporting system. Staff accessed the reporting system via a tablet device, found on all vehicles.
- The executive management team had oversight of all reported incidents and appointed an appropriate duty manager to investigate the incident. Learning from incidents was shared with staff either at an event brief or by email. Staff told us about an incident where a vehicle was damaged while accessing an event site. Following this, new processes were put in place and staff were briefed about the changes.
- Staff we spoke with understood the incident reporting policy and knew how to report an incident. Staff were aware of the types of incidents that they needed to escalate and were encouraged to report incidents.
- From March 2017 to November 2017, the service reported 11 incidents. All of the incidents reported resulted in no harm to patients.
- In the same reporting period, the service reported no never events. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- 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. The service had a duty of candour standard operating procedure for staff to follow. Staff we spoke with could describe the principles of duty of candour and could give examples of incidents that would trigger duty of candour. The service had had no incidents that would trigger the duty of candour process.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service did not have a clinical dashboard (or equivalent) to measure the quality of the service. However, all patient report forms and patient experience forms were reviewed for themes and trends. Clinical quality was discussed bi-monthly at the clinical governance meeting.
- The service had a comprehensive data management system to collate clinical quality information. The service also had key point indicators (KPIs) for each client to monitor the service. The service had met the required KPIs set out by their clients.

Cleanliness, infection control and hygiene

- The service had processes in place to maintain standards of cleanliness and hygiene. The service had an up-to-date infection prevention and control standard operating procedure, available to staff electronically.
- All clinical areas we inspected, including ambulances and the vehicle cleaning area, were visibly clean and free from clutter.
- We inspected two ambulance vehicles and found these were visibly clean. The vehicles had hand sanitising gel dispensers and a range of personal protective equipment, such as disposable gloves and aprons. Personal protective equipment ensures staff safety and reduces the risk of cross infection.
- Staff cleaned the vehicles after each shift and recorded this on the vehicle log form. The service used a fogging system to deep clean vehicles. A fogging system deep cleans vehicles by applying chemical disinfectantsas a fog or mist. This reduces the numbers of airborne micro-organisms and applies disinfectant to surfaces that may be difficult to reach.
- All vehicles received a deep clean every 12 weeks, or more regular following contamination. We checked the vehicle deep cleaning records and found all vehicles had had a deep clean within the last 12 weeks.
- Each vehicle was ATP test swabbed before and after each deep clean, in order to ensure the deep clean had been effective. ATP testing is a process of quickly measuring actively growing microorganisms.
- The service had external arrangements for the management of clinical waste. The service separated and stored all waste appropriately ready for collection. Waste was collected as and when required.

- We saw that staff wore the correct clean uniform on shift. The service had a comprehensive uniform standard operating procedure in place for staff. The registered manager reported that soiled uniforms were disposed of in clinical waste and replaced.
- As we do not have the scope to inspect events, we were unable to assess staff compliance with hand hygiene and infection control. However, staff could give examples of what they would do in the event of severe contamination or when treating an infectious patient.

Environment and equipment

- The site had an office block and a large warehouse for vehicle storage. The service had a secure storeroom, for all medicines and equipment.
- The site was secured via keypad entry. Only the executive management team had key access into the locked storeroom. The site also had CCTV in operation.
- The service had effective processes in place to ensure equipment and vehicles were serviced and fit for use. All vehicles had an up-to-date service record, MOT, insurance certificate and vehicle licence tax.
- We inspected two ambulances at the Head Office base and both vehicles had secure storage compartments for equipment. We saw that medical gases were stored safely within the back of the vehicles.
- The service had an agreement with a local garage for the service and maintenance of vehicles. All vehicles that required repairs were taken out of service and flagged, until repairs had been completed.
- Staff completed a vehicle checklist at the start of their shift, ensuring all vehicles were clean, free from defects and had the correct stock and equipment on board.
- Horseracing clients had strict regulations about stock and equipment levels. Staff could be subject to spot inspections and heavy fines if found non-compliant. To ensure compliance, the registered manager had a clear oversight of stock levels using a digital management system. As of November 2017, the service had passed all spot inspections.
- The digital management system logged all grab bag contents, including expiry dates of single use equipment. The bags were then sealed with a security tag. All opened grab bags were checked, restocked, and a new security tag was added. We checked 20 items of disposable single use equipment and found all were within their expiry date.
- The service had advanced life support equipment. we saw six defibrillators which could monitor the vital signs of patients. We also saw four machines which delivered chest compressions, either continuously with an airway in place, or 30 compressions without an airway in place. Both machines could be used simultaneously. All of the equipment had up-to-date safety testing and calibration certificates.
- Staff told us that, in comparison to other services, the quality of the equipment and vehicles at Medicare EMS UK Limited was of an excellent standard.
- Each grab bag had a small sharps box for the disposal of sharp medical items, such as needles and syringes. Staff removed used sharps boxes at the end of their shift and disposed them within clinical waste.
- Staff followed an up-to-date standard operating procedure for the Control of Substances Hazardous to Health (COSHH). The service had completed comprehensive COSHH risk assessments.

Medicines

- The service had processes in place to manage and monitor the use of medicines and stock levels. The service had an up-to-date medicines management standard operating procedure for the management of all medicines and controlled drugs.
- The service undertook a weekly medicines audit to ensure all medicines remained within their expiry date. The registered manager monitored medicine stock levels through the digital management system. The service also had a system to track exactly when a medicine had been administered.
- Medicines were stored securely within a locked storeroom. All medicines we checked were in-date and stored appropriately. Bags were sealed with a security tag, ready for use. All medicines were tracked on the digital management system, which flagged to staff when a medicine was due to expire.
- Medicines listed by the Medicines and Healthcare Regulatory Agency (MHRA) for paramedic use and by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) were obtained and stored on site. Paramedics also had access to over the counter medicines such as paracetamol in the medicine grab bags.
- The service had a patient specific direction (PSD) for the use of tranexamic acid following a patient injury whilst

horseracing. A PSD is a written instruction, signed by a prescriber, for medicines to be administered, following an assessment. The medical director had oversight of the PSD application.

- Controlled drugs (CDs) were stored securely in a safe, within a locked storeroom. Duty managers and the executive management team were the only staff members that had key access to the storeroom and the locked safe. The duty managers kept a register for CDs, ensuring that all CDs were signed out prior to an event and the unused CDs signed back in. The clinical director audited the use of controlled drugs and tracked CDs through the patient records and the CD registers. The CDs were checked during the weekly medication and equipment audits. We found that the CD stock matched the register.
- The service kept an up-to-date electronic controlled drug disposal log. All CDs were disposed using denaturing kits. Denaturing kits were available at the base and in the ambulances.
- From leaving the site until their return, paramedics kept controlled drugs secured on their person. At the end of their shift the CDs were signed back onto the CD register.
- Medical gases, such as oxygen and medical nitrous oxide and oxygen mixture (pain relieving gas), were stored in a locked cage, secured to the wall. All of the cylinders inspected were full and within their expiry date.

Records

- Records were completed appropriately and stored securely. The service had an up-to-date clinical information governance standard operating procedure, which set out the process for the creation, storage, security and destruction of clinical information.
- Following patient contact, staff stored report forms securely in the service vehicle. At the end of a shift, patient records were stored in the office, in a locked filing cabinet, until they were scanned onto the system. During an emergency transfer, a copy of the patient report form was handed to the receiving hospital.
- We reviewed the patient report forms for six emergency transfers completed in 2017. They were legible, fully completed and signed off by the appropriate staff member. Staff recorded the clinical observations of a patient, and the medicines administered, ensuring a smooth patient handover at the receiving hospital.
- The registered manager reviewed all patient report forms to collate trends, identify good practice and ensure staff were completing the forms appropriately. The register manager sent feedback to staff regarding their completion of documentation.

Safeguarding

- The service had effective processes in place to keep children and young people safe and protected from abuse.
- The service had an up-to-date standard operating procedure for safeguarding. The procedure covered abuse of both adults and children. The document provided staff with contacts details for all local authorities, in the event that staff needed to raise a safeguarding concern.
- All staff had been trained up to safeguarding adults and children Level 3. The registered manager and two directors had completed safeguarding adults and children Level 5. Staff told us that they would raise any safeguarding concerns to the duty manager or duty director.
- The service had a safeguarding flow chart for staff to follow if they had a safeguarding concern. All staff had access to this flow chart electrically via a work tablet or smart phone.

Mandatory training

- All clinical staff worked for the service on a flexible basis. The service expected all staff to complete the Medicare EMS UK Limited mandatory training program, regardless of the training they had completed elsewhere. The service suspended contracts if staff were not up-to-date with mandatory training.
- The service used an external provider for mandatory training. The training program offered continual professional development credits for staff registered with the Health and Care Professions Council. The training was online, which staff could access from home computers.
- The registered manager monitored staff compliance electronically and sent reminders to staff when their mandatory training needed to be updated. At the time of our inspection, the completion rate for mandatory training was 99%.

- The service provided induction training to all new staff, which focused on training staff in the use of equipment, and site and vehicle familiarisation. Each element of the induction required a staff signature to evidence it had been completed.
- The service did not provide blue-light driver training. The registered manager told us that all drivers had to be in receipt of blue-light driver training from their main employer. Staff without additional driver training were not permitted to drive vehicles for Medicare EMS UK Limited.

Assessing and responding to patient risk

- Directors conducted a risk assessment for each venue, in collaboration with their client. If necessary, the directors would conduct a pre-event site visit, to determine logistics. We reviewed risk assessments for past events and found them to be thorough and complete.
- Each event had a duty manager on site. The duty manager ensured all staff were aware of the risks associated with the event, prior to the start of the shift. For all events, staff could contact the on-call duty director if they needed to escalate any concerns.
- The registered manager told us that at some events, crews were led by a clinician, employed by the event organiser. The clinician provided medical advice and would determine when a patient's deteriorating condition needed to be escalated.
- The service calculated staffing requirements and the skill mix based on needs of the client, the size of the venue and the level of service that was required.
- Patient report forms identified key patient observations for staff to complete, including heart rate, blood pressure and respiratory rate. If, based on patient observations, staff had significant concerns regarding patient well-being, they would either emergency transfer the patient or call 999 for an emergency ambulance, depending on which vehicle had been deployed. Staff we spoke with showed an awareness of how to deal with a deteriorating patient and escalate any concerns.

Staffing

- All staff, with the exception of the executive management team, were employed on zero hour contracts. The hours worked varied from month to month and were agreed with each individual employee. The service employed 66 registered paramedics, 67 emergency medical technicians and 13 first aiders.
- The medical director was an accident and emergency consultant, working at an NHS hospital. The clinical director and the operations director both had a paramedic background. The three directors provided clinical guidance and had oversight of the clinical aspects of the service.
- All work completed by Medicare EMS UK Limited was pre-planned and staff provided their availability for the year. The directors reviewed availability and positioned staff at events based on individual skills, training, and profession.
- Staff accepted or declined their shifts via the digital management system. As of November 2017, no shifts had gone unfilled.

Response to major incidents

- The service was not part of any local resilience or major incident plans; however, the service had a major incident plan was in place for their events.
- If a major incident occurred at an event, staff would prioritise the needs of the clients and provide support as agreed with the event organiser.
- The service had a thorough business continuity plan in the event of a fire or a loss of communications. All electronic records were backed up on a secure hard-drive to reduce the risk of service disruption.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- Staff delivered care and treatment in line with evidence-based practice.
- Policies and procedures followed recognisable and approved guidelines, including the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and the National Institute for Health and Care Excellence (NICE) guidelines. The standard operating procedures (SOPs) we reviewed, including the medicines management and incident reporting SOP, were all up to date and had clear dates for review. SOPs were reviewed yearly, or more frequently if there was a change to legislation or national guidance.

- The registered manager monitored Medicines and Healthcare Products Regulatory Agency (MHRA), JRCALC and NICE update alerts. Any updates were posted on the digital management system for staff to review.
- Staff were expected to read all of the SOPs on the digital management system and sign to agree that they had understood the procedure.

Assessment and planning of care

- When making bookings for events and conducting risk assessments, the registered manager considered the likely patient group, the risks associated with the event and the skills, knowledge, and experience required by staff.
- The transfer pathways for care were assessed prior to an event, which ensured that patients were transferred to the most appropriate hospital. This assessment considered both hospital speciality, such as major trauma, and distance from the event. Where possible, the service aimed to reduce the pressures on local emergency departments by treating the patient on-site.
- Staff assessed and managed patient pain and had access to appropriate pain medicine, including medical gases. From the patient records we reviewed, we saw evidence of pain management, including the administration of pain relieving medical gases.

Response times and patient outcomes

- The service did not compare response times as its provision was on event sites.
- Due to the nature of the service, staff only treated patients once and as a result, patient outcomes were difficult to obtain. Once a patient had been transferred to the appropriate emergency department, the service did not follow-up on the patient outcome. However, the registered manager reviewed all of the patient record forms to ensure that care was provided to national and service standards.
- The service audited their response times at event ad part of the KPIs required from their clients. The service did not participate in any national audits to provide a benchmark against similar services. Instead, the service used client feedback to measure performance.

Competent staff

- The service had systems in place to ensure staff had the right skills and were competent in their role.
- All staff had a local induction to the service upon commencing work. This included an orientation to the base and the vehicles. Staff files showed fully completed induction forms in the three we reviewed.
- The registered manager encouraged all new staff to complete mandatory training in the first few weeks of their start date.
- All paramedics and ambulance technicians were required to have completed a blue light driver-training course with their main employer. However, the registered manager told us that they had recruited a paramedic without the training and had funded the staff member to complete the course, prior to their employment. Staff were required to submit evidence of the completion of a blue light driving course.
- Staff submitted their up to date evidence of qualifications, competencies, and skills at the recruitment stage and then again yearly. The registered manager checked this to ensure staff were fit to practice. The registered manager also checked staff driving licences to ensure they were in-date and had the correct vehicle categories to legally drive the provider's vehicles.
- As the service employed casual staff, the directors did not conduct regular appraisals. The directors explained that as staff worked on an ad hoc basis, a comprehensive appraisal would be difficult to complete. However, the registered manager reviewed all of the patient record forms and gave formal feedback to each member of staff on a monthly basis. Any training or support required was provided by the service.
- Staff told us they had been given time to familiarise themselves with vehicles, equipment and processes and were well supported by their colleagues.
- The service provided additional training to staff. For example, following an incident, staff received refresher training on the correct application of a traction splint.

Coordination with other providers and multi-disciplinary working

- The service co-ordinated with event organisers and other agencies, when required. For example, a director would routinely meet with clients wishing to plan an event, in order to carry out a comprehensive risk assessment and agree the resources that would be required.
- In the event of an emergency transfer, the service would have pre-planned which hospital to transfer the patient,

based on the emergency. The service did not have any subcontracts with NHS ambulance trusts. If a patient required an emergency transfer, this would be done in a Medicare EMS UK Limited ambulance.

- For some events, patient care was delegated to other health professionals. For example, at stadium events, a clinician would lead the Medicare EMS UK Limited team. In an emergency, the clinical lead would identify which hospital the patient should be transferred to.
- Staff employed by Medicare EMS UK Limited were employed by various NHS and private providers, allowing for good practice to be shared across providers.

Access to information

- Staff had access to all SOPs electronically, via a company tablet or smart phone. When a policy was reviewed, staff were alerted to a changes via the digital management system. After each change, staff had to read and agree that they had understood the change in procedure.
- Before each event, staff were given information on the client, event, and potential risks. All local trauma centres were identified before an event, in case of an emergency transfer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff followed a comprehensive SOP for capacity and consent. The document set out the roles and responsibilities of each staff member when gaining consent to treatment and assessing capacity.
- Staff received training in consent and the Mental Capacity Act which, formed part of the mandatory training program.
- Of the six patient report forms we reviewed, consent had been obtained on five forms. One form had not been fully completed. Staff completed an assessment and best interests review for patients who lacked capacity. This structured assessment allowed staff to clearly demonstrate when a patient lacked capacity.
- Patient consent forms were held on vehicles and were to be used for any invasive procedures. In addition, staff had patient refusal forms for staff to complete, in the event a patient refused treatment.

Are emergency and urgent care services caring?

Compassionate care

- As we do not have the scope to inspect events, we were unable to observe any interactions between staff and patients, or speak to patients who had used the service.
- The service actively sought feedback from patients using the service, however due to the nature of the service, feedback was limited. Staff provided patients with a patient feedback questionnaire which asked patients to rate the service on various elements including whether staff showed dignity and respect.
- Staff described a patient-centred approach and gave examples of when they had delivered compassionate patient care. Staff spoke about the need to maintain the dignity of patients and one staff member told us about an example where blankets were used to protect the dignity of a patient.

Understanding and involvement of patients and those close to them

- Staff described the importance of involving patients and those close to them, in any emergency transfer decisions.

Emotional support

- Staff explained how they used their skills and experience to provide reassurance to patients needing treatment.

Supporting people to manage their own health

- Staff described situations where patients had refused to be transported to hospital, following an injury. If this occurred, staff would give health advice and recommendations for when the patient should seek medical treatment.

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

Service planning and delivery to meet the needs of local people

- The directors had regular contact with their event clients to meet the needs of attendees. Prior to each event, the service had a discussion with the client to plan and assess how they would provide care at the event site.
- Medicare EMS UK Limited provided no services to the NHS, and only worked directly with private clients.

Meeting people's individual needs

- Sports people, mainly jockeys, were the mostly the patients Medicare EMS UK Limited transferred in an emergency. When the service provided medical care to the public, the event organiser used their own emergency vehicle. Therefore, the service had tailored their service and ambulances to meet the individual needs of their patients, specifically jockeys. The service had dedicated equipment to care for horse-related injuries and staff had received specialised training. The service also worked to the trauma network standards. However, the service did transport members of the public from large arena events.
- The service did not have access to translation services. The registered manager told us that the event organiser would provide a translator if required.
- The service had no specialist bariatric equipment. If a bariatric patient required an emergency transfer, staff would call 999 for a bariatric ambulance to attend the scene.

Access and flow

- Different factors including the size of the event, type of event and patient group, determined whether emergency transport would be required.
- For pre-planned work, staff provided their availability for the year. The directors reviewed availability and positioned staff at events based on individual skills, training, and their profession.
- Staff only transferred patients to hospital in an emergency capacity. There was therefore no monitoring of response times, or communication with NHS ambulance trusts.

Learning from complaints and concerns

- The service had an up-to-date complaints SOP, which set out the process for managing complaints. Written confirmation of receipt of the complaint was to be sent within three days of receipt; and a written substantive reply, with resolution, to be sent within 25 days. For cases deemed to be of significant complexity, the service allowed up to 60 days for resolution.
- Complaints could be received verbally or in writing. Staff were aware of the complaints SOP and the process of referring a complaint to the duty manager.
- The service had received one complaint from January to November 2017. The complaint was fully investigated with a written response and an apology sent to the complainant within 25 working days. We saw that lessons were learned and this disseminated to staff.

Are emergency and urgent care services well-led?

Leadership / culture of service

- The service was led by a chief executive and with support from five directors; an operations director, a medical director, a managing director, a clinical director, and an education director. Daily running of the service was overseen by operational duty managers based at each site.
- The service had a clearly defined management structure and all of the staff understood their roles and responsibilities. Staff knew the process to escalate concerns and who they reported to.
- For an event held outside of office hours, one of the directors was allocated as the duty director. The duty director would be on call to enable staff support and client contact.
- Staff told us that they were proud to work for the service and expressed how the managers were friendly and easy to get along with. The culture of the service was positive and staff told us they felt well supported in their role.
- Staff told us that they felt confident to raise any issues or concerns with the directors and that they would take their concerns seriously.
- There was an up-to-date lone working SOP to ensure staff safety when working alone. However, the registered manager told us that no staff members worked alone due to the needs of their current clients and the large scale of the events covered.

Vision and strategy

- Medicare EMS UK Limited aimed to provide high quality medical services at events, using experienced ambulance staff. From speaking with the directors, we found there was a clear ethos of patient safety and delivering a high standard of care.
- The provider was committed to delivering a patient and client focused approach to everything they did. The service had introduced the trauma network standards to horseracing and aimed to promote these standards across the horseracing industry.
- The values of the service had been developed around the CQC five domains; to provide a safe, effective, caring, responsive and well-led service. The registered manager told us that the service had developed their audit program based on the CQC key lines of enquiry.
- The main objective for the service was to develop a wider client base in the. The service aimed to use their experience and expertise in the horseracing industry when tendering for new contracts.

Governance, risk management and quality measurement

- The service held clinical governance meetings on a bi-monthly basis(once every two months), attended by the company directors. We reviewed the minutes of the meetings held in April 2017 and July 2017. They showed areas of discussion around safeguarding compliance, the service risk register and audits with resulting actions. We saw that actions had been completed by the next meeting.
- The provider held monthly duty manager meetings led by the operations director. These meetings updated the duty managers about any matters arising regarding incidents, complaints staff training needs and changes to SOPs. The duty managers communicated information to staff at shift briefings.
- The service had a comprehensive risk register, which took account of their high impact risk assessments. The service also included some risks with a low risk rating which would have a greater impact at a corporate level due to loss of reputation, should such incidents occur.
- The service mitigated risks by developing clear and up-to-date standard operating procedures for staff to follow. Backup systems were also in place to reduce the impact if the service's electronic management system were to fail.
- Due to the nature of the business, the service did measure the quality of emergency transfers. The registered manager audited all patient patient records for quality and gave feedback to staff. The quality of medical cover at events was also measured via client feedback; all of which indicated that Medicare EMS UK Limited was providing a quality service.
- The disclosure and barring service (DBS) helps employers make safer recruitment choices by identifying individuals not fit to work with vulnerable people. Medicare EMS UK Limited required all staff to present an up-to-date DBS certificate, prior to commencing work. The directors told us that they were encouraging all staff to enrol onto the DBS online service, allowing certificates to be easily checked online. We checked three staff files and found DBS certificates to be in-date.

Public and staff engagement

- The service had regular client feedback following events. We saw feedback often took the form of emails to the directors. The feedback we reviewed was positive.
- The service actively sought patient feedback and staff distributed feedback forms following care at events. However, the service had not dated the returned forms to inform service improvement. We raised this on our inspection and the service was responsive, immediately editing the patient feedback forms to include the date.
- The completed feedback forms we reviewed consistently rated the service as excellent.
- The service had an annual staff survey to gain feedback from staff. The staff had responded positively for a majority of the areas covered in the survey. We saw that the directors had taken action on areas needing improvement, such as further defining the role and responsibilities of team leaders.
- The service had a regular staff newsletter circulated to staff by email, which informed staff about topics such as training opportunities and governance.

Innovation, improvement and sustainability

- The service had invested in technologies to ensure the service had safe working practices and provided patients with high quality care.
- The service had a bespoke digital management system, developed to manage resources and clinical governance. This system provided a high level of oversight of safety and quality of the service to the directors.

Emergency and urgent care services

- The service had advanced equipment in place to manage patients following serious trauma.
- The service had introduced trauma network standards to their horseracing clients in order to provide the best quality outcomes for jockeys involved in trauma. Staff had information about the nearest emergency department and the nearest trauma centre for each venue. Staff had guidance to ensure patients were taken to the most appropriate care environment for their injuries, following the use of the trauma triage tool.

Outstanding practice and areas for improvement

Outstanding practice

- The service had introduced trauma network standards within horse racing, to ensure jockeys received the best quality outcomes following a traumatic injury.

Areas for improvement

Action the hospital SHOULD take to improve

- The service did not date patient feedback forms, therefore it was unclear when the patient feedback had been obtained. We raised this on our inspection and the service was responsive, immediately editing the patient feedback forms to include the date.