Opelwood Limited

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Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Opelwood Limited, trading as North East Medical Services, is operated by Opelwood Limited. It is an independent ambulance service which provides emergency and urgent care in the form of transport from events to hospital. The organisation is also able to provide a patient transport service but is not currently undertaking such work at this location.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 22 March 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 we take regulatory action as necessary.

We found the following areas of good practice:

- The service had a system for recording and reporting incidents. Staff were aware of their roles and responsibilities in respect of reporting incidents, near misses, and concerns.
- Staff mandatory-training-compliance rates were high in all but one area, and the service provided regular updates and additional training, based on reflective assessment of needs.
- The service had policies and procedures to protect vulnerable adults and children. Staff knew how to report safeguarding concerns.
- There were systems to maintain the cleanliness of vehicles and equipment, and managers and staff were aware of good practice in infection prevention and control.
- Medicines were stored appropriately and there was a medicines policy, which outlined arrangements for their storage, administration, and disposal.
- Confidential patient records were completed clearly and stored securely.
- Staff were aware of their responsibilities to assess and respond to patient risk. They were trained in basic observations.
- Staffing levels and skill mixes for each event the service attended were planned to ensure that people were safe from avoidable harm and received safe care and treatment.
- The service's policies and processes were largely based on national guidance and recommendations.
- The service's induction process developed and supported staff through mandatory training and mentoring to ensure competency. Training and support were priorities within the service.
- Staff understood the need to seek patient consent and to assess capacity to agree to treatment.
- Staff also understood the need to ensure dignity in public places and for those in vulnerable circumstances and to treat patients and their families with compassion.
- The service had taken steps to enable it to work with patients with various complex needs, including learning disabilities and dementia, and with those whose first language was not English.
- Staff recognised the strategic aims of the company and were aware of management's aspiration to expand its services.
- The service's policies and procedures were all up-to-date and were easy for staff to access.

Summary of findings

- Staff roles were made clear within the service's recruitment policy and its medicines policy. All staff joining the service were subject to a Disclosure & Barring Service check and reference check.
- Staff were positive about the service's culture and felt able to raise concerns with managers. Staff said that managers were approachable and supportive and that they responded to and acted upon staff feedback.

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

- Up-to-date fire-safety-training compliance was very low.
- There was no evidence that any of the service's medical machinery had been calibrated.
- Managers were not able to provide us with evidence that the mechanic who serviced their medical equipment was competent to do so.
- Some stocks of oxygen and of nitrous oxide/oxygen mixture cylinders were stored next to empty cylinders, and the service did not keep spare cylinders of compressed oxygen in stock.
- The service did not have a written policy or protocol for dealing with disturbed or violent patients.
- The service's business continuity plan did not set out what to do in the case of office fire/destruction, loss of premises/files/stores/vehicles, involvement of one of its vehicles in a road traffic accident, or any systems back-up.
- There were no specific protocols for assessing and treating patients with suspected heart attack or stroke.
- There were no specific protocols for assessing and treating potentially vulnerable adults, such as those with learning disabilities or mental health issues, or children.
- Managers could not tell us how many staff had had their annual appraisal interviews.
- The written complaints procedure produced by the service erroneously stated that CQC could help with a complaint and did not explain the role of the Parliamentary and Heath Service Ombudsman, nor how and when to contact the ombudsman.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North 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		Opelwood Limited provides medical cover for sports games, festivals, and community events. Emergency & Urgent Care Services comprise a very small proportion of its work; there had been only eight instances of transport from events during the 12 months prior to our inspection. We do not currently have a legal duty to rate independent ambulance services, but we highlight good practice and issues that service providers need to improve.

Opelwood Limited

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Background to Opelwood Limited

Opelwood Limited opened in 2015. It is registered with CQC as an independent ambulance service (trading as 'North East Medical Services'), which primarily serves the communities of Humberside, Yorkshire, and the North East.

The ambulance service uses one ambulance, one ambulance car, and two bicycles to provide a first-aid and ambulance service for sporting, performance, and community events. There are some exemptions from regulation by CQC which relate to particular types of service. (These are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.) Event cover such as this falls under one of those areas of exemption. However, because its ambulance and ambulance car are occasionally used to transfer patients from an event to hospital, we class Opelwood Limited as a provider of urgent & emergency care, and so it is registered with CQC. The organisation is also registered to provide a patient transport service (PTS), but it is not currently undertaking this type of work; having carried out a few instances of PTS work early in its existence, it has since been unable to secure any further contracts. However, managers told us that they hope that, by expanding the business and fleet, they will be able to attract new PTS business soon.

Overall, the service is currently registered to provide the following regulated activities:

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

The service has had the same registered manager in post since the organisation opened in 2015. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations.

This was our first inspection of the service since its registration with CQC.

Our inspection team

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

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Opelwood Limited's main service is event cover: working to ensure the safety of performers, spectators, and event staff throughout sporting, performance, and community events by providing first-aid, medical, and ambulance cover. The company's services are hired on an event-by-event basis by the organisers of those events. The service works across Humberside, Yorkshire, and the North East, in areas including Hull, Flambourgh, Bridlington, Hornsey, Driffield, York, Scarborough, Durham, Newcastle, Leeds, and Sunderland. It acquires most of its work by word-of-mouth and repeat business, frequently working for football clubs, running clubs, and local authorities.

At the time of our inspection, the service employed approximately 70 staff, all on a casual basis, apart from the managing director and general manager, who were part-time employees, together totalling 1.5 whole time equivalent posts. It also used 12 additional, self-employed workers. In total, 14 registered paramedics, seven nurses, two A&E consultants, seven emergency medical technicians, 20 first aiders, and 30 other first responders were available on a casual basis to work at events for the service. Of these, 23 were trained to drive patients from events, with 18 trained to drive under 'blue-light conditions'. Paramedics used their own controlled drugs (CDs), so the service did not have its own accountable officer for CDs.

Event cover services do not fall into CQC's scope of regulation. CQC regulates only the Emergency & Urgent Care service provided by Opelwood Limited, which occurs when the service transports a patient from an event site to a hospital or other similar location for medical care. This activity comprises a very small part of Opelwood Limited's business: In the 12 months prior to our inspection – from March 2017 to February 2018 inclusive – the service carried out eight Emergency & Urgent Care patient journeys.

During the inspection, we visited Opelwood Limited's offices and base at the Louis Pearlman Centre. We examined both of the vehicles that the service uses for transporting patients from events to hospital. We spoke with six members of staff, including a registered paramedic, an ambulance crew member who was also a driver, and four members of the management team, all of whom also worked as crew members and/or drivers for the service. No one was using the service at the time, so we were not able to speak with any patients or their carers or relatives, but we reviewed eight sets of patient records.

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 one reported complaint.

The service occasionally worked with two other local, independent ambulance providers to cover events.

Emergency and urgent care services

Summary of findings

We found the following areas of good practice:

- The service had a system for recording and reporting incidents. Staff were aware of their roles and responsibilities in respect of reporting incidents, near misses, and concerns.
- Staff mandatory training compliance rates were high in all but one area, and the service provided regular updates and additional training based on reflective assessments of needs.
- The service had policies and procedures to protect vulnerable adults and children. Staff knew how to report safeguarding concerns.
- There were systems to maintain the cleanliness of vehicles and equipment, and managers and staff were aware of good practice in infection prevention and control.
- Medicines were stored appropriately and there was a medicines policy, which outlined arrangements for their storage, administration, and disposal.
- Confidential patient records were completed clearly and stored securely.
- Staff were aware of their responsibilities to assess and respond to patient risk. They were trained in basic observations.
- Staffing levels and skill mixes for each event the service attended were planned to ensure that people were safe from avoidable harm and received safe care and treatment.
- The service's policies and processes were largely based on national guidance and recommendations.
- The service's induction process developed and supported staff through mandatory training and mentoring to ensure competency. Training and support were priorities within the service.
- Staff understood the need to seek patient consent and to assess capacity to agree to treatment.
- Staff also understood the need to ensure dignity in public places and for those in vulnerable circumstances and to treat patients and their families with compassion.
- The service had taken steps to enable it to work with patients with various complex needs, including learning disabilities and dementia, and with those whose first language was not English.
- Staff recognised the strategic aims of the company and were aware of management's aspiration to expand its services.
- The service's policies and procedures were all up-to-date and were easy for staff to access.
- Staff roles were made clear within the service's recruitment policy and its medicines policy. All staff joining the service were subject to a Disclosure & Barring Service check, and reference check.
- Staff were positive about the service's culture and felt able to raise concerns with managers. They told us that managers were approachable and supportive and that they responded to and acted upon staff feedback.

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

- Up-to-date fire-safety-training compliance was very low.
- There was no evidence that any of the service's medical machinery had been calibrated.
- Managers were not able to provide us with evidence that the mechanic who serviced their medical equipment was competent to do so.
- Some stocks of oxygen and of nitrous oxide/oxygen mixture cylinders were stored next to empty cylinders, and the service did not keep spare cylinders of compressed oxygen in stock.
- The service did not have a written policy or protocol for dealing with disturbed or violent patients.
- The service's business continuity plan did not set out what to do in the case of office fire/destruction, loss of premises/files/stores/vehicles, involvement of one of its vehicles in a road traffic accident, or any systems back-up.
- There were no specific protocols for assessing and treating patients with suspected heart attack or stroke.
- There were no specific protocols for assessing and treating potentially vulnerable adults, such as those with learning disabilities or mental health issues, or children.

Emergency and urgent care services

- Managers could not tell us how many staff had had their annual appraisal interviews.
- The written complaints procedure produced by the service erroneously stated that CQC could help with a complaint and did not explain the role of the Parliamentary and Heath Service Ombudsman, nor how and when to contact the ombudsman.

Are emergency and urgent care services safe?

Incidents

- There were no reported never events for this service.
- Staff we spoke with understood how to report incidents. The service had a written accident & incident reporting policy that set out how the organisation would act in response to, and learn from, incident reports in order to improve the quality and safety of its service delivery. The policy set out the accountability, responsibility, and reporting arrangements for all staff in relation to incidents.
- One incident resulting in a minor injury had been reported during the period from March 2017 to February 2018. This had been addressed and recorded appropriately, and learning had been disseminated to all staff.
- The service had a written duty of candour policy that set out how staff must respond if something should go wrong. Staff we spoke with understood their roles and responsibilities under this duty, although they had not had occasion to use it.
- We noted that the duty of candour policy also contained references to whistleblowing. We raised this with the management team during our inspection, and the general manager told us that he had conflated duty of candour with NHS guidance about freedom to speak up amongst staff. He told us that, following our conversation, he understood the difference and would prepare a separate whistleblowing policy without delay.
- There had been no incidents requiring the application of duty of candour in the period from March 2017 to February 2018.

Mandatory training

- All staff were required to hold a certificate in First Aid at Work. Additional mandatory training that all staff were required to undertake during their first three months with the service comprised:
  - Safeguarding adults and children
  - Automated External Defibrillator
  - Manual handling
  - Equality & diversity
  - Information Governance
  - Mental Capacity Act and consent

- Privacy & dignity
- Fire safety training
- Infection prevention and control, including hand-washing
- Data protection
- Health and safety
- Resus
- Basic Life Support.

Some of these modules were classroom-based and others could be completed using an online workbook. Following completion of these modules, new members of staff would be deemed competent and be considered to have completed their induction training.

- At the time of our inspection many of Opelwood Limited's 'in-house' training needs were being met by its sister company.
- The service accepted evidence of previous NHS training in place of in-house training. For example, paramedics who were employed in substantive roles in NHS ambulance trusts and took part in ongoing training within those trusts provided Opelwood Limited with certificates to prove the training had been completed satisfactorily. Copies of these certificates were kept in individual members of staff's record folders.
- We noted that many of the sets of staff records that we examined did not contain a full range of copy certificates. However, managers told us that they would not offer work to any member of staff who had not either completed in-house training or provided certificates to prove that they had completed appropriate training elsewhere. We randomly checked staff names on recent events work to gain assurance that this was the case.
- The service also used the online facilities of the Health & Care Professions Council to ensure that paramedics were qualified and registered.
- To be eligible to drive for the service members of staff were required to be over 21 years old, to have been qualified for at least two years, and to have acquired no more than six licence penalty points.
- Eighteen of the 23 staff members who drove for the service were trained to drive under 'blue light conditions'. The service did not use any vehicles weighing more than 3500 kg so there was no requirement for those staff to have category C1 on their driving licences.
- The company kept a record of training compliance rates on a spreadsheet; this demonstrated that all staff were up-to-date with all mandatory training, with the exception of fire-safety training, at the time of our inspection. Up-to-date fire-safety-training compliance was very low because the company had been offered free training on this topic by a local further education college, but no date for this training had yet been agreed.

Safeguarding

- The service had a written safeguarding policy that set out definitions of abuse and how to recognise harm. It listed local authority contact details and useful resources, and it contained links to national guidance. Staff we spoke with demonstrated an awareness of potential safeguarding issues, and knew to whom within the organisation they should report any safeguarding concern that might arise.
- There were four named safeguarding officers for children within the management team. Three of these officers were trained to level 2 and one was trained to level 3 in safeguarding.
- There were two named safeguarding officers for vulnerable adults within the management team. One of these officers was trained to level 2 and the other was trained to level 3 in safeguarding.
- The registered manager was the safeguarding lead and was trained to level 3. She and some paramedics carried out training for other staff within the organisation, and all staff were up-to-date with safeguarding training.

Cleanliness, infection control and hygiene

- The service had an infection prevention and control lead officer and a written infection prevention and control policy, which all staff were required to sign to confirm that they had read and understood it. Managers advised us that all staff were aware that anything a patient has come into contact with must be disinfected before its next use. The policy also focused strongly on personal hygiene and cleanliness.
- Both of the vehicles that we examined were visibly clean, as were cupboards, equipment, and packaging in the storeroom. The vehicles' base and garage areas were also visibly clean, tidy, and free from clutter.

- We observed cleaning schedules and records displayed on the wall of the station, and we saw that the service used a local, colour-coded system for cleaning equipment.
- The service used multipurpose, antimicrobial wipes to clean surfaces and equipment within its vehicles. Managers advised us that they had chosen not to use bleach because of the associated risk of skin burns. Most of the cleaning products used by the service were designed for domestic use, although it did stock some small biohazard kits.
- Managers told us that any heavily contaminated vehicle would be subject to a full 'deep clean' and that all of their cleaning equipment was disposable and would be disposed of and replaced following any deep clean. We observed that there were very few replacement cleaning items in stock (e.g. mop heads), but managers assured us that there were sufficient for their needs. Managers and/or crew members carried out their own deep cleaning of vehicles rather than use a specialist contractor.
- The ambulance was stocked with appropriate personal protective equipment, including gloves and hand-cleansing gel.
- We saw that managers had carried out regular observations of staff compliance with hand-hygiene guidance. All staff observed had followed correct procedure, and records demonstrating this were kept in staff folders.
- We were unable to observe any member of staff in uniform during our inspection, so we cannot comment on uniform cleanliness.
- The service had separate waste-disposal systems for domestic waste, clinical waste, and sharps. We saw that staff used appropriate containers for each type of waste and that offensive waste was collected for disposal by a contractor.
- There was no sluice room available to the service; staff told us that they would use an ordinary drain should they need to dispose of body fluids.
- Managers advised us that clean linen for the ambulance was stored in a cupboard at Hull Royal Infirmary and that the service had an informal arrangement with that hospital to exchange linen regularly.

Environment and equipment

- Opelwood Limited's premises were within a building of offices and storage units situated on a business park. The premises included an office, a storage room, and a base for the service's vehicles. At the time of our inspection, the vehicles were parked in the communal car park for the building. Keys to the vehicles were stored securely.
- We inspected both of the vehicles used by the service. Ministry of Transport and insurance certificates for the vehicles were up-to-date and both vehicles had been serviced within the preceding year.
- Fire extinguishers on both vehicles had been serviced recently.
- The service's two Automated External Defibrillators (AEDs) were tested and calibrated annually. There were no calibration stickers on the AEDs, but managers told us that they checked it monthly. There was no evidence that any of the other medical machinery had been calibrated.
- Records suggested that the oxygen piping on the service's ambulance had not been serviced since 2013; best practice would be to carry out this check at least annually. Managers explained that this piping was checked annually by a motor mechanic, as part of the servicing of the vehicle and other items of on-board equipment, such as carry chairs and stretchers. However, they were not able to provide us with evidence that this mechanic was competent to service ambulance equipment.
- Each item of portable electrical equipment on board the ambulance bore a sticker to show that it had been safety tested within the preceding year.
- Managers carried out a full, monthly, maintenance check of equipment and stock on the vehicles, including ensuring that first-aid kits had not passed their expiry dates.
- All consumables that we examined were within date and stored appropriately.
- We examined the contents of some of the service's medical bags for paramedics and other crew members; the contents were appropriate for their needs.
- We saw in the service's records that, in the year preceding our inspection, crews that were taking vehicles to events had not always completed mechanical vehicle checklists beforehand. Managers were already aware of this and had begun to check the vehicles, equipment, and stocks before every event

themselves. They had also begun to create a mandatory checklist of equipment for use by crews so that responsibility for this could be given to crews and monitored by managers.
- The ambulance had a paediatric restraint system, which could be used to adapt the stretcher for the safe transport of young children.

Medicines

- The service had a written medicines policy, which stated each staff member's level of remit to administer drugs and which drugs each was permitted to access.
- The registered manager of the service was the accountable officer for drugs. She checked stock numbers and expiration dates once each month and ordered all medicines required.
- No controlled drugs (CDs) were kept by the service. Paramedics working for the service were accountable under their own registrations for obtaining, monitoring, and storing CDs. The service would request the name, expiry date, and batch number of each CD a paramedic carried.
- An emergency department consultant ordered medicines for the service. A senior paramedic also ordered some medicines that did not require a prescription by a doctor. Orders were sent to a local pharmacy from where the logistics manager would collect the medicines.
- Medicines held by the service were subject to Joint Royal Colleges Ambulance Liaison Committee guidelines. Two sets of paramedic drugs and one set of medical drugs were held, alongside technicians' bags. Each bag was sealed using a rip tag.
- All medicines were stored safely and securely. Tamper-evident tags were used on bags, and checks were in place to ensure that medicines were available when needed. The medicines were logged on a spreadsheet with their batch numbers, expiry dates, and, when bagged, tag numbers of the bags in which they were held.
- Drugs bags were signed out by crew members before events. On return to base the bags were checked and signed back in by a manager.
- Stocks of oxygen and of nitrous oxide/oxygen mixture cylinders were stored securely, and access to them was restricted. Some stock cylinders were stored loose on a shelf next to empty cylinders; best practice would be to keep empty medical gas cylinders stored separately.
- The service did not keep spare cylinders of compressed oxygen in stock, but would telephone the manufacturer for a replacement when the cylinder in use became empty.
- Out-of-date injectable diazepam stocks were returned to the pharmacy for destruction. All other out-of-date drugs were destroyed at the service's base, unless they were to be given to its sister company to be used for training purposes, in which case they were marked clearly and kept in another lockable cabinet. The sister company was then responsible for the disposal of those drugs.

Records

- The service had a written policy for the creation, storage, security, and destruction of medical records. Patient record forms (PRFs) were paper-based and were stored securely in the service's office. They were kept for 10 years before destruction by shredding. A PRF relating to a child would be kept until that child reached 25 years of age.
- Blank PRFs were individually numbered. Before each event, staff members were allocated a small number of blank PRFs. These were returned to managers, whether used or not, within 48 hours of the event, checked by the receiving manager, and stored in a box in a locked cupboard.
- A registered nurse audited each completed PRF, to ensure that clinical information was correct and any medication given was appropriate. She would report any concerns to managers, who would then assess and provide for any training needs arising.
- We reviewed PRFs for each of the eight patients whom the service had transferred in the period from April 2017 to March 2018. All were completed clearly and comprehensively.
- Only the registered manager, general manager, and human resources manager had access to staff record files, which were held in a locked cupboard in the service's office.
- Six months after a member of staff left the service a manager would destroy that person's file by shredding.

Assessing and responding to patient risk

- Staff we spoke with were aware of their responsibility to assess and respond to patient risk. They were aware of Joint Royal Colleges Ambulance Liaison Committee protocols for assessing patient risk and of how to use

them. Training was provided as part of induction during First Aid at Work sessions, and refresher sessions on assessing risk were also provided regularly, with paramedics providing training on basic observations and on deteriorating patients.
- Monitoring of patients for the early detection of deterioration was covered comprehensively by the service's written policy on managing the conveyancing of patients. The policy included appropriate escalation processes.
- On the PRFs we examined, we saw that ambulance crews recorded patient observations and any treatments provided during transfers and shared this information with staff on arrival at the destination.
- The service had a written do not attempt cardiopulmonary resuscitationpolicy.
- The service did not have a written policy or protocol for dealing with disturbed or violent patients.

Staffing

- Managers advertised events requiring staff to those eligible, by level of training and experience, via the service's secure messaging service. Staff who wanted to work at those events would then apply using that system, and managers then selected staff from those who had applied to work at the event, ensuring an appropriate mix of skills and experience for the shift. Staff we spoke with described this system as very easy to use, efficient, and practical.
- Managers described the service's long-standing alliance with two other independent ambulance services, with which it shared staff where necessary to fill gaps. Managers told us that they gained verbal assurances from their counterparts in those services that they were suitable organisations for their staff to work with, and that the staff of those services had appropriate Disclosure & Barring Service checks and qualifications.
- Managers would also work shifts when no other members of staff were available.
- The service had recently expanded quickly, and managers had temporarily frozen recruitment activity.

Response to major incidents

- The service's business continuity plan set out what to do in the case of computer malfunction, telephone malfunction, staff sickness, vehicle breakdown, or a staff member becoming ill whilst at work. However, there were no planned arrangements for office fire/ destruction, loss of premises/files/stores/vehicles, involvement of a vehicle in a road traffic accident (ambulance), or any systems back-up.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- The service's policies and processes were based on National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. The senior paramedic monitored updates to NICE and JRCALC guidelines and shared these with managers, who then updated the service's policies and shared them with staff via the online messaging service and on the service's online forum.
- Staff we spoke with were aware of the service's policies and how to access them, and knew whom to contact for advice.
- All managers were available to be contacted by telephone during events.

Assessment and planning of care

- For larger events, the service produced medical plans and shared these with the relevant NHS ambulance trust(s) and acute hospital(s) before the event, thus ensuring that any conveyance of patients would be to the appropriate hospital. From smaller events, patients were taken to the nearest emergency department.
- Staff had access to additional clinical advice whilst on site via telephone call to an on-call manager.
- There were no specific protocols for assessing and treating patients with suspected heart attack or stroke.
- There were no specific protocols for assessing and treating potentially vulnerable adults, such as those with learning disabilities or mental health issues, or children.

Response times and patient outcomes

- The service did not collect information about response times as all of its regulated work was generated by attendance at events, so its vehicles and staff were already present when their services were required.
- The service had transferred only eight patients in the year preceding our inspection, so very little information

about patient outcomes was available. However, the service did encourage patients to get in touch following treatment to provide feedback about their recovery, and managers told us that event organisers would often provide them with information about patient outcomes.
- Managers monitored the service's patient record forms and audited them quarterly. However, the type and infrequency of regulated activity carried out by the service determined that it was not possible for managers to gather meaningful data in order to participate in national audits.

Competent staff

- The service's written recruitment and selection policy outlined its recruitment objectives, the application and interview process, job descriptions, Disclosure & Barring Service checks, employment checks, and staff induction.
- The service's induction process comprised a three-month period during which all mandatory training was to be completed and staff were supervised when working at an event. Mentors also supported new staff during this period and sometimes for longer, until both parties were assured of the member of staff's competency.
- Managers also shadowed events to provide support to less experienced staff and frequently worked alongside staff as additional crew members.
- All paramedics and technicians working for the service were experienced practitioners and worked for NHS ambulance trusts in their substantive roles.
- The service offered fortnightly training sessions on topical issues and/or refresher sessions to all staff. Staff we spoke with told us that they found these informative and valuable.
- First Response Emergency Care (FREC) courses were available to all staff via the service's sister company. Managers encouraged staff to progress through the through the different levels of FREC qualification.
- Staff were aware of their responsibilities to assess and respond to patient risk. They were trained in basic observations and life support and therefore knew how monitor an ill or deteriorating patient.
- When putting together a team to work at a larger capacity event (where attendance expectations numbered hundreds or even thousands) managers selected only those staff who had completed major incident training.
- The service had an appraisal system and aimed to carry out an annual appraisal interview with each member of staff. However, only two of the six staff files that we reviewed bore evidence of any review at all, and managers could not tell us what the compliance rate was overall.

Coordination with other providers

- The service shared staff with two other independent ambulance services, where this was necessary to fill gaps. Managers told us that they gained verbal assurances from their counterparts in those services that they were suitable organisations for their staff to work with, and that the staff of those services had appropriate Disclosure & Barring Service checks and qualifications.

Access to information

- Managers carried out a risk assessment before every event so were able to provide staff with appropriate information when offering them work. Additionally, each member of staff selected to work at an event was given a pack containing information such as contact numbers for managers and local NHS services.
- Managers also used Voice over Internet Protocol (VoIP) systems, the service's messaging system, and mobile phones to provide staff with additional information about events.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a written policy on Consent & the Mental Capacity Act, which required staff to gain consent before treatment and to document this on the Patient Record Form (PRF). Each of the PRFs that we examined had been completed appropriately in respect of consent.
- Managers and staff told us that, in the case of an unconscious or confused patient, they would presume implied consent. Staff would act in the best interests of the patient. They would seek opinion from any family member present, but the urgency of patient need would be prioritised.
- Training in the Mental Capacity Act and deprivation of liberty safeguards was part of the service's induction programme.

- The service had a written do not attempt cardiopulmonary resuscitation policy.

Are emergency and urgent care services caring?

Compassionate care

- Although we were unable to speak with any patients or service users to gain their perspective during our inspection, staff we spoke with explained the steps they would take to ensure dignity in public places and for those in vulnerable circumstances. They described using blankets and/or repositioning themselves to cover patients where necessary whilst moving them into vehicles and then closing vehicle doors before moving or repositioning patients inside.
- We reviewed several messages of thanks and appreciation received by the service, and noted that staff were described as "very helpful, professional, and polite" and "reliable, capable, and competent."
- The service had a written policy for managing the conveyance of patients, which included detail about what to do in the event of a deteriorating patient. Staff we spoke with were aware of the policy and able to describe what they would do in these circumstances, including ensuring respect and care for any relatives and/or carers travelling with the patient.

Understanding and involvement of patients and those close to them

- Staff we spoke with described occasions when they had explained to patients and their relatives/carers whether transport to hospital was necessary and, if so, whether it would be better for those patients to be taken in the service's ambulance or to use private transport. They outlined clearly how they would explain the benefits and concerns associated with each option, offering choice where possible, and so involve the patient/relative/carer in this important decision about their care.

Emotional support

- Staff we spoke with described how they had recently offered emotional support to the family, including a young grandchild, of a patient who was taken seriously ill at an event and required transport to hospital.

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

Service planning and delivery to meet the needs of local people

- When agreeing the terms of a contract to cover an event, the general manager of the service would speak with the event's organisers to ensure the proposed cover would meet the needs of those running, governing, and attending the event. He would then prepare a risk assessment using National Ambulance Resilience Unit frameworks.
- Before larger events, the service also produced medical plans and sent them to the relevant NHS ambulance trust(s) and/or acute hospital(s) for authorisation.

Meeting people's individual needs

- The service had taken steps to enable it to work with patients with various complex needs, including learning disabilities and dementia, and with those whose first language was not English. Staff had access to pictorial books and language booklets to aid communication, to a 'language line' translation service, and to a language app for smartphones.
- Parents/guardians/carers were able to travel on the ambulance with patients who were being transported to hospital.
- The service's ambulance was not able to accommodate bariatric patients. In the event that a bariatric patient required conveyance, the crew would call the local NHS ambulance trust. However, the vehicle did have a wheelchair suitable for bariatric use, enabling the crew to move patients to a place of safety whilst awaiting the NHS ambulance.

Learning from complaints and concerns

- The service had a written complaints procedure that set out how the organisation would act in response to a complaint from a service user or client. However, the procedure erroneously stated that CQC could help with a complaint. Furthermore, the procedure did not explain the role of the Parliamentary and Heath Service Ombudsman, nor how and when to contact the ombudsman.
- Managers told us that staff advised patients verbally about the complaints process and encouraged them to

share their views. If a complaint could not be resolved this way, complainants would be advised to write to the registered manager of the service, who would begin the formal complaints procedure detailed in the service's policy.
- Patients and/or their representatives could also comment upon, compliment, or complain about the service on its website.
- One complaint had been received during the period from March 2017 to February 2018, and this had been investigated and documented in line with the company's written procedure. Learning identified from the complaint had been disseminated to all staff.

Are emergency and urgent care services well-led?

Vision and strategy

- The registered manager told us that staff at all levels of the organisation had created service's vision: 'Together we care, we respect, we deliver'.
- The company's strategy included plans to expand its number of ambulances, to increase the number of events it covered, and to gain work in passenger transport services (PTS). Staff we spoke with recognised these strategic aims and were aware of management's plans for the service. A second ambulance had recently been purchased and was being commissioned at the time of our inspection.
- Managers had aspiration for Opelwood Limited to become a 'feeder' organisation for the BSc (Hons) Paramedic Science course at the University of Hull, by providing placements for students. They had begun talks with another independent ambulance service about doing this jointly, using their own service as the basis of practical experience and its sister company's FREC level 3 and 4 courses as the training foundation for this planned pathway.

Governance, risk management and quality measurement

- Governance meetings were convened based upon need. Although notes were taken there were no formal agendas or minutes. Managers worked together in the office and at events regularly and so felt there was no need for regular, formal, management meetings. They cascaded information to staff via the service's secure messaging service, both online and using smartphones, or via staff meetings which were, again, on a 'when-needed' basis.
- The service's policies and procedures were all up-to-date and were accessible via its online scheduling and communicationsystem and in paper format. Paper copies were signed by staff to confirm that they had read and understood them.
- The service did not have a whistleblowing policy. Managers we spoke with were somewhat confused about the duty of candour (which refers to being open and honest with patients and their representatives when things go wrong), and had conflated this with NHS guidance about freedom to speak up amongst staff. They had therefore embedded references to whistleblowing within the service's policy on duty of candour. We raised this with the management team during our inspection, and the general manager told us that he understood and would prepare a separate whistleblowing policy without delay.
- The service did not keep a formal risk register of corporate or operational risks. Managers told us that their main concern for the service was bid-undercutting by other companies who were less experienced in the event-cover field.
- The service carried out risk assessments for the events it covered using National Ambulance Resilience Unit frameworks. For larger events, it produced a medical plan and shared this with the relevant NHS ambulance trust(s) and acute hospital(s) for authorisation before the event.
- The service had also carried out risk assessments in respect of its vehicles and for all substances it stocked that were subject to Control of Substances Hazardous to Health (COSHH) regulations.
- Staff roles were made clear within the service's recruitment policy and its medicines policy. All staff joining the service were subject to a Disclosure & Barring Service (DBS) check, unless evidence of an NHS DBS check within the last two months was provided. The service was registered with DBS online and could therefore check DBS numbers at any time.
- Managers carried out monthly audits of paperwork, medicines, and infection prevention and control measures. Compliance rates were high overall.

- The service did not work to key performance indicators (KPIs) in respect of its regulated activity, due to the very small number of patient transfers per year.

Leadership of service

- The owner and managing director of the business was also the nominated individual and registered manager for the provider and location. A general manager and an additional management team comprising an assistant general manager, a transport & logistics manager, a senior paramedic, a human resources manager, and a North East area coordinator supported her.
- Managers of the service described themselves as very supportive of the team and as having an 'open-door' policy. Staff we spoke with supported this view, and said that managers were approachable and would listen to their views. However, we did not have any opportunity to speak with more remote operational workers to hear their perspectives on the leadership of the service.

Culture within the service

- The members of staff we spoke with described the service's culture as positive, with one describing it as having "a family feel".
- The service was flexible to support staff who were experiencing difficulties. Managers gave us an example of a staff member who did not feel able to work at the busier events that they covered but wanted to work where possible and so was offered shifts at 'low-key' events, always alongside experienced staff.
- Staff we spoke with told us that they would be comfortable with raising any incidents or issues of concern with managers, or with asking for training or support.
- Managers told us that they would address any poor performance using training and mentoring.

Public and staff engagement

- Staff encouraged patients and their families/carers to provide feedback via the service's website. We saw several examples of feedback from patients and event organisers.
- Most management communication and engagement with staff was via the service's online scheduling and communicationsystem or face-to-face when working together at events. There were also occasional team social events, such as a Christmas meal.
- Managers of the service had added a mentorship programme to the online scheduling and communicationsystem in response to staff feedback.

Innovation, improvement and sustainability

- The registered manager told us about 'Daisy Days', which were education days provided by the service. Daisy Days were days offered to schools, playgroups, and other organisations for children, during which those children were invited to board the ambulance. The management team told us that even very young children had benefited from these days by learning about some first-aid techniques and by overcoming fear of ambulances and their equipment.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should improve its staff fire-safety-training compliance rate.
- The provider should improve deep-cleaning of its vehicles to meet best-practice guidelines.
- The provider should check that all medical machinery is calibrated correctly.
- The provider should gain assurance that the mechanic who services its items such as carry chairs, stretchers, and oxygen piping is competent to do so.
- The provider should adopt a policy for dealing with disturbed or violent patients and share it with staff.
- The provider should add arrangements for work after office fire/destruction, loss of premises/files/stores/ vehicles, involvement of one of its vehicles in a road traffic accident, or any systems back-up to its business continuity plan.
- The provider should adopt specific protocols for assessing and treating patients with suspected heart attack or stroke.
- The provider should adopt specific protocols for assessing and treating potentially vulnerable adults, such as those with learning disabilities or mental health issues, and children.
- The provider should carry out annual staff appraisal interviews.
- The provider should correct the reference to CQC, explain the role of the Parliamentary & Health Service Ombudsman (PHSO), and give the PHSO's contact details in its complaints policy.