Medic 1 Direct Ltd

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Not sufficient evidence to rate
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

Medic 1 Direct Ltd is a private ambulance service operated by . The service provides first aid services for the public and staff at events across England including transporting patients to emergency departments.

This service is registered with the CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC, which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medic 1 Direct Ltd provides services to patients taking part in or attending a sport or cultural event. These types of arrangements are exempt by law from CQC regulation. Therefore, at Medic 1 Direct Ltd, we did not inspect the services provided to patients taking part in or attending a sport or cultural event. However, providers are required to register with CQC if they transport patients off the event site to the local hospital. Medic 1 Direct Ltd had transported four patients to hospital from an event site within 12 months prior to inspection.

We inspected this service using our comprehensive inspection methodology. The Care Quality Commission does not have any regulatory powers in Wales; therefore, this was a partial inspection of the service. The provider's headquarters is in Wales but the regulated activity is carried out within England.

We inspected the provider's location in Canterbury, Kent, which is a non-operational administrative base. We carried out the announced part of the inspection on 16 January 2020. There were three members of staff present at the inspection, the registered manager, a paramedic and the fleet manager. .

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.

We rated it as **Good** overall.

- Staff followed infection prevention and control procedures to reduce the spread of infection to patients.
- Staff completed an induction programme and extensive training in a range of clinical skills and theory to enable them to undertake their roles.
- Staff received support through supervision and appraisal.
- Staff had been trained and understood their responsibilities to report safeguarding concerns.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and knew how to report them.
- There was a process to ensure staff understood the Mental Capacity Act (2005) and how to apply the principles in practice.
- The service carried out comprehensive risk assessments prior to each event and liaised with local services.
- Staff within the service had completed training to assist with meeting the needs of individuals including patients living with dementia and learning disabilities.
- The service encouraged feedback from patients.
- Staff felt supported by the managers of the service and said the managers were always available to discuss concerns.
- There were effective arrangements to manage risk. The risk register identified operational risks and described safeguards to manage those risks, it was regularly discussed and updated.
- There was an effective governance framework which provided a holistic understanding and assurance of safety, quality and patient experience.

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

Summary of findings

- The service did not always record and formalise governance meetings. We were told that the meetings occurred but that documentation of them was poor.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good 	Medic 1 Direct Ltd. is a private ambulance service operated by Medic 1 Direct Ltd. The service provides first aid for the public and staff at events across England including transporting patients to emergency departments. We rated the service as good for safe, effective, responsive and well led. We did not rate the caring domain due to limited evidence available for this service.

Summary of findings

Contents

Good

Medic 1 Direct Ltd

Services we looked at: Patient Transport Services

Summary of this inspection

Background to Medic 1 Direct Ltd

Medic 1 Direct Ltd is operated by Medic 1 Direct Ltd. Medic 1 Direct Ltd provides first aid for the public and staff at events across the country including transporting patients to emergency departments. The service has had a registered manager in post since the service started in 2012. The registered manager was also the Clinical Director of the organisation. It is an independent ambulance service with its headquarters in Wales. It has a non-operational base in Canterbury, Kent. There were no staff, vehicles, equipment or records permanently at this base. This was the second CQC inspection for Medic 1 Direct Ltd. The inspection took place on 16 January 2020. This is the first inspection to be rated.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and a specialist advisor with expertise in the ambulance service.

The inspection team was overseen by Catherine Campbell, Head of Hospital Inspections.

Information about Medic 1 Direct Ltd

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the non-operational base in Canterbury, Kent. We were unable to inspect the headquarters, as the Care Quality Commission (CQC) has no regulatory power in Wales.

The registered manager and staff travelled from Wales to Canterbury for the inspection.

We were unable to speak with patients during our inspection, as there were no local events taking place. We reviewed ten patient records for the service though these were not all related to emergency and urgent care. The provider has a fleet of six vehicles comprised of four ambulance trucks and two cars. The registered manager brought one ambulance, one kit bag and one medicines bag to the inspection from Wales. We reviewed records for ten members of staff including contractors.

The provider used the same processes, policies and systems for both regulated and the non-regulated activities. Therefore, we have reviewed the dual processes, policies and systems, and used this information to inform our judgement, as we did not observe any regulated activity during the inspection.

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

Activity (August 2018 to December 2019)

- The service conveyed four patients from the event site to the local hospital.
- There were six staff employed within the service consisting of the clinical director (registered manager), an administrator, the fleet manager, the head of operations, the head of procurement and the head of accounts..
- These staff were clinically trained and undertook event work as either emergency medical technicians or emergency care assistants.
- The clinical director was a registered paramedic.
- The service had 90 contractors (temporary staff) that it could use.
- The accountable officer for controlled drugs (CDs) was the registered manager.

Summary of this inspection

Track record on safety

- No never events
- No clinical or non-clinical incidents
- No serious injuries
- No complaints

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	Not rated	Good	Good	Good
Overall	Good	Good	Not rated	Good	Good	Good

Good

Patient transport services

Safe	Good
Effective	Good
Caring	Not sufficient evidence to rate
Responsive	Good
Well-led	Good

Are patient transport services safe?

Good

We rated it as **good.**

Mandatory training

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

- All staff had undertaken a comprehensive induction programme and mandatory training to equip them with the skills required to perform their role. All staff who worked at events conveyed patients to hospital, therefore we looked at mandatory training for all staff.
- The service had a staff training policy which outlined the purpose of training and the responsibilities of Medic 1 Direct Ltd in delivering training.
- Staff undertook mandatory training every year, with the exception of automated external defibrillator (AED) training, which took place every six months as per the service's policy. An AED is a portable medical device used to treat patients in cardiac arrest.
- The registered manager told us all staff, including contractors, undertook mandatory training modules including mental health, patient handling, basic life support, training, patient records training and de-escalation skills. There was also mandatory driving and medicines administration training for the relevant staff.
- At the time of inspection, the service reported 100% compliance with mandatory training. Mandatory training included seven modules: mental health awareness, manual handling, de-escalation, driver training, patient handover, basic life support and infection control.
- The records for 10 members of staff showed they had completed all mandatory training relevant for their role.
- Although the staff training policy stated staff should complete yearly driving assessments, the training records showed staff exceeded this requirement and undertook six monthly assessments on both cars and ambulances. The service monitored the driving performance of staff closely and was able to identify poor performance more easily.
- The registered manager told us the head of operations carried-out spot checks on the driving performance of staff.
- If staff did not attend mandatory training or this had expired, their duties were restricted to reflect the missed training. For example, if an emergency medical technician let their training lapse, they would practice as a first aider and their manager would oversee their clinical duties during an event. This provided assurance staff did not work out of their current scope of practice.
- Staff accessed an online learning system to complete theory modules and competency tests using personal logins. This meant staff could access training remotely which is important when the majority of staff were not located on-site.

Safeguarding

Good

Patient transport services

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- The service had a safeguarding policy for children and young people (CYP) due for review in June 2021 and a safeguarding policy for adults due for review in April 2021. These policies were used for both the regulated and the non-regulated activities. Both policies referred to current national legislation, which meant staff, worked in line with best practice.
- The service had reported no safeguarding concerns to the CQC in the 12 months prior to inspection.
- Staff at inspection told us they would report safeguarding concerns to the event manager for the service who then escalated this to the duty officer or the safeguarding lead for advice. The registered manager stated if the safeguarding concerns were urgent, the event manager would call the police or social services.
- Staff at inspection told us they would complete a paper safeguarding alert form, which they would store in the patient record form. Staff would discuss safeguarding concerns with the safeguarding lead that would refer to the local authority, although staff could refer directly. This was in line with the service's safeguarding policies.
- The registered manager told us staff did not have contact with patients until they have completed their induction, which included level two adult and children and young people safeguarding training. This ensured only staff who knew how to identify and report abuse worked with patients.
- NHS paramedics received their level three safeguarding CYP training through the ambulance trust they worked for. We saw the record for one paramedic, which showed level three CYP safeguarding training. This was in line with national guidance.
- The service reported 100% compliance to all safeguarding training.

Cleanliness, infection control and hygiene

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

- The service had an infection control and prevention policy. The provider used this policy for both the regulated and the non-regulated activities. The policy outlined how to perfrom effective handwashing and how to manage clinical waste, protective clothing, spillages and sharps.
- All staff wore uniforms. If a group of staff were away from home for an extended period of time then the service hired accommodation with laundering facilities. A vehicle often travelled to events with spare uniform also. The staff at inspection wore their uniforms, which appeared clean.
- There were service level agreements in place for the collection and destruction of clinical waste and sharps bins. We saw that staff had assembled the sharp bin on the ambulance correctly and had dated it also
- As we did not see patient contact, we were not able to observe compliance with the infection control policy during the inspection.
- We saw that staff had hand gels and personal protective equipment available in the vehicle and kit bags for use prior to and following any patient contact.
- All of the 10 training records we reviewed showed staff completed infection control training. The registered manager told us it included sepsis training and assessing handwashing techniques. The registered manager and a registered nurse from the local NHS trust delivered this training.
- Staff had a standardised approach to follow for cleaning the inside of vehicles. The service provided instructions that outlined when, what and who should clean areas of the ambulance such as the floor, cupboards and stretchers.
- Staff told us all vehicles received a deep clean at least weekly or more often if indicated. The fleet manager undertook training in clinical disinfection and deep cleaned the vehicles in-house.
- Since the last inspection, the registered manager had started to conduct clinical audits for infection control. The service now had assurance that staff complied with the infection control policies and standard operating procedures. We reviewed two audits that had been undertaken within the previous 12 months.

Good

Patient transport services

Environment and equipment

The design, maintenance and use of equipment and vehicles kept people safe. Staff were trained to use them. Staff managed clinical waste well. We were unable to comment on the design and maintenance of the ambulance station in Wales.

- The service had a vehicle equipment and inventory check procedure. This outlined the responsibilities of staff to undertake inspections of the vehicle and equipment prior to its use. The checklist seen at inspection was completed although we noted that the check on paramedic medicines was not clearly recorded. The monthly equipment maintenance checklist ensured the ambulance contained enough supplies of equipment that was clean and in working order.
- All equipment on the vehicle we inspected was clean, stored correctly and cupboards were clearly labelled with contents information.
- We saw the equipment on the ambulance we inspected had received servicing and maintenance within the last 12 months. This included the suction unit, carry chair and stretchers. A third party calibrated the resuscitation medical devices annually. This ensured emergency equipment was fit for purpose and safe to use.
- The registered manager told us if staff had not received equipment training or their training had lapsed, the team leader removed this bit of equipment from that member of staff's kit bag. This prevented staff from working out of their scope of practice.
- Staff told us if they discovered faulty equipment during an event, they would inform the team leader who would escalate this to base. Staff would remove the faulty piece of equipment from the vehicle.
- Head office would courier replacement equipment to the vehicle at the event site. There was also a back up vehicle that travelled to major events containing spare equipment and stock. At the events the service covered, staff could often obtain replacement kit from the local NHS ambulance resilience officer but this had not happened in practice. A resilience officer works as part of a team to assess, anticipate, prevent, prepare, respond and recover from threats to public safety such as extreme weather and outbreaks of disease.
- We were told there was a kit bag checklist, which the stores person used to stock the kit bags according to staff grade prior to each event. The registered manager explained once a kit bag was ready, the stores person attached a dated label to the outside of the kit bag. This helped staff identify kit bags that were and were not ready for use.If a member of staff wanted to use their own kit bag, the service ensured this underwent the same checks. However, the registered manager planned to stop staff using personal kit bags to align and standardise practice.
- The service brought a kit bag to the inspection as an example. The kit bag we reviewed contained the right equipment for both adults and children. However, the kit bag checklist was not available at inspection for use to ascertain that the bag was filled to specification.
- Road vehicles were roadworthy at the time of the inspection. The service had six vehicles including ambulances and two cars. We checked the government website and found all the vehicles had up to date road tax and MOT.
- Each vehicle had its own folder, which contained details of its previous ownership, road tax, MOT and registration. At the inspection, we reviewed the folder for the vehicle we inspected and found no omissions in documentation.
- There was a general risk assessment form for each ambulance. It highlighted potential hazards such as moving and handling and the current control measures. This enabled staff awareness of risks and what to do to mitigate the risk to the patient and/or themselves.
- The registered manager told us the service had a contract in place with a company for yearly servicing of vehicles. There was no formal replacement plan for vehicles but recommendations were made by the mechanic if a vehicle was not repairable and needed to be taken off the road.
- The service had a service level agreement with a garage that provided 24-hour, seven days a week breakdown cover. Staff told us if they had a vehicle breakdown at an event, they would call the garage, who would arrange a replacement vehicle. This ensured business continuity when things went wrong.

Assessing and responding to patient risk

Good

Patient transport services

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

- We reviewed 10 patient record forms for patients taken from event work. The provider had only undertaken four conveyed patients to hospital in the previous 12 months. Patients who were conveyed had frequent observations recorded.
- Staff had access to electronic and paper Joint Royal Colleges Ambulance Liaison Committee guidelines (JRCALC) so followed best practice guidelines during their work.
- All staff were equipped with the necessary skills to manage an aggressive or violent patient as they had completed de-escalation training. Staff also completed a nationally recognised two-day course in control and restraint, which related to a non-regulated activity provided within Wales.
- The provider had a policy named clinical escalation which detailed measures to take should a patient deteriorate during a journey.

Staffing

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

- The service employed six permanent members of staff and had 90 contractors (temporary staff) who undertook event or patient transport work. Some staff also worked for the local NHS ambulance trust.
- The service reported no sickness or turnover of permanent staff in the 12 months prior to inspection.
- The skill mix and staffing levels for an event were established following the planning meeting with the event organiser. The registered manager explained that the service assigned contractors to events based on their grade and availability to work. The service allocated staff on a rotational basis if there were more staff than available shifts. This ensured all staff had exposure to different events.
- Some events ran into the early hours of the morning. In these circumstances, the service split the shifts amongst staff to maintain safety. The registered manager stated staff worked typically between ten and 12 hours though this was entirely dependent on need as the service rostered flexibly. If the patient had mental health issues then three staff were allocated to a job.
- The service planned their journey to an event and organised set rest breaks along the way. This ensured staff did not drive for extended periods, which can cause tiredness. Accomodation was provided during event work and should journeys to events involved a lengthy drive.
- The senior management team covered an out of hours rota to provide 24 hours, seven days a week support to staff. The service informed staff of who was on duty at the start of each day. The telephone number for out of hours remained the same regardless of the event, which meant staff were familiar with the number.
- The service took into account skill mix when pairing staff together for an event. This enabled the service to provide safe care and treatment at all times.

Records

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

- The service had a management of health records policy. It outlined the responsibility of staff in relation to record keeping, storage, handling and security of patient record forms (PRFs) in relation to the Data Protection Act (1998).
- The service stored PRFs in a locked filing cabinet within a locked room. We were unable to observe this as the service kept PRFs at the headquarters in Wales. It kept PRFs for a minimum of 10 years. This was in line with national guidance.
- The registered manager explained the management of PRFs at an event site. Staff carried PRFs in a locked carry case during event work. Staff handed these to the team leader at the end of each day and they placed these into a locked cabinet. This ensured confidential patient information was stored securely.

- The senior administrator manually inputted PRFs into an electronic database. During the process, if there was any missing information they escalated this to the registered manager who discussed this with the relevant member of staff. The patient records were audited to look for errors, ommissions and themes and trends that constituted poor documentation.
- We saw the PRFs were comprehensive and consisted of 13 sections including medical history, observations, a body map and administration of medicines. All records that we looked at were legible and complete.
- The service planned to introduce an electronic patient record form. This was in development phase at the time of inspection. The digital software to be used would not allow a record to be completed without filling in every aspect of the form. The registered manager commissioned this as a way of improving documentation.

Medicines

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

- The provider had clear processes in place for the receipt, storage and administration of medicines. A 2018 policy for controlled drugs management had been written and shared with staff following our previous inspection. The reported process was that the event manager and a paramedic would receive the controlled drugs at the event site. They would complete an entry into the record book upon receipt. Staff told us they recorded administered controlled drugs within this logbook, detailing the date, time, batch number, patient record number and two members of staff signed this. They witnessed and recorded the disposal of any unused but opened controlled drugs.
- The service had a medicines management policy. It outlined standard operating procedures, protocols and responsibilities of staff about medicines including the management of medicine errors. It also clearly identified which medicines different grades of staff could administer using the Joint Royal Colleges Ambulance Liaison Committee guidelines.
- There was a service level agreement with a pharmacy to supply and dispose of medicines.
- The service received Medicines and Healthcare products Regulatory Agency (MHRA) alerts through the contracted doctor or pharmacist who contacted the registered manager. The registered manager told us she would share any such alerts through email to the relevant teams. An example given to us was of change of use for a medicine to control bleeding in women and how this was disseminated to staff via email and a training session.
- We saw the service had a Home Office for a controlled drugs licence dated April 2019. Companies and individuals in England, Wales or Scotland need to apply for Home Office licenses if they wish to produce, supply, possess, import or export controlled drugs. The registered manager was the accountable officer for controlled drugs.
- The service stored medicines within a locked cabinet inside a locked room at the headquarters in Wales. This was in line with the National Institute for Health and Care Excellence guideline NG46. The room had surveillance cameras so all activity within this room was captured. This was in line with best practice guidelines.
- There was an audit of the safe keeping in medicines by a registered pharmacy technician undertaken in May 2019 followed up by subsequent unannounced spot checks. Considerations for improvements were noted by the pharmacy technician and these recommendations were all implemented.
- The registered manager explained she collected the medicines from the pharmacy in person. Then at the base, the registered manager and another competent member of staff recorded the receipt of the medicines within a logbook and locked these in a cabinet.
- Each medicine bag had a code for identification. When staff used a medicine from the bag, the staff member would inform the event manager who ensured its replenishment.
- Staff at inspection told us, before an event, they signed out the medicines from the medicines cabinet and recorded this. The same process happened when medicines returned after an event. The registered manager cross-referenced any discrepancies in stock

levels with the patient record forms, which evidenced all administrations of medicine during an event. This meant the registered manager could easily identify any errors and the staff members responsible for the errors.

- The service brought one medicine bag to the inspection as an example. We inspected the contents of the medicine bag though we had no checklist to measure against. We found all medicines were within date and kept within their original boxes. We were told that there were checklists for medicines but we did not see one to affirm this.
- The registered manager reported staff disposed of partially used and open controlled drugs into sharps bins. This was in line with the National Institute for Health and Care Excellence guideline NG46.

Incidents

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

- The incident reporting processes gave assurance that all staff understood how and when to report an incident.
- The service had an incident reporting procedure. This was a clear guide to staff on types of incidents that may occur and had a pathway to follow for each type. Staff were able to follow this process to complete the correct forms and escalate according to the reporting line for each incident.
- The staff at inspection told us in the event of an incident staff would complete the incident reporting form and notify their manager. The incident reporting form would be kept with the patient record.
- We saw that incidents (for non emergency care work) had been documented on the correct forms and reported. For example, a crew reported that a vehicle failed to start after its lights were left on. The service had opportunities for learning and potentially preventing the same incident from occurring by monitoring such incidents. We were also told of a road traffic collision incident that had occurred outside of an event that the team kindly assisted at. The team did not ordinarily treat at these type of incidents but acted quickly in an emergency. From this, they learned that not all staff were proficient with bag valve masks (used to help people breathe) so initiated training in use of this equipment.
- The staff at inspection told us the service was developing an electronic incident reporting system, which could enable management to identify themes more easily. The service aimed to use this information to plan events and ensure mitigation of identified risks. However, this was a piece of work that had been ongoing for some time and noted at the last inspection.
- The service reported no 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.
- At the last inspection, there was no policy for duty of candour but this had been rectified and added to the serious incident policy. This was implemented immediately after inspection and staff were then given training on this subject. The training was to be repeated annually. 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 registered manager told us staff were always open and honest with patients.

Are patient transport services effective?
(for example, treatment is effective)

Good

We rated it as **good.**

Evidence-based care and treatment

Good

Patient transport services

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

- We saw from patient records that staff delivered evidence based care in line with the National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee guidelines.
- Staff followed NICE quality standards for Stroke in Adults. Patient records showed ambulance staff used a validated tool to screen a patient that had a sudden onset of neurological symptoms in line with best practice.
- Staff followed NICE quality standards for head Injury: assessment and early management. Patient records showed ambulance staff changed their initial advice, to discharge a patient, after the patient developed blurred vision following a head injury. They conveyed the patient to hospital in line with best practice.
- The service consulted external professionals such as medical consultants, patient safety officers and advanced nurse practitioners to develop and review policies. The service reviewed all policies every three years or sooner if there were changes to national guidance.

Pain relief

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

- We did not see pain relief given but when pain relief was administered staff indicated this on the patient records. Guidance was provided in the JRCALC guidelines to support staff with their assessment of patients, and the type of pain they may be experiencing.

Response times

The service monitored, and met agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

- The service provided first aid services for the public and staff at events. During an event, staff positioned themselves within the spectator areas and within the medical centre. This enabled the staff to respond quickly to any incident.
- A running sheet was kept by each crew to record the work they did during a shift. This showed response times This was completed and handed in at the end of each shift.
- The service had started to perform audits to monitor their response times. This meant the service was able to evaluate its compliance to the target and identify issues.
- Kit bags and vehicles were fitted with Global Positioning System tracking devices. This enabled team leaders to get the closest team along with the most suitable skill mix to the patient quickly.
- The service used the patient feedback form and feedback from event organisers to monitor the quality of care they provided.

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

- The service had conveyed only four patients to hospital in the previous 12 months. It was reported that once the patient was handed over to the hospital the service received limited feedback. With limited feedback provided, the service had no information or data to demonstrate that the treatment the service had administered to patients had been effective.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

- The registered manager reported all staff received an induction to equip them with the basic skills to undertake their role. It included mental health awareness, risk assessment, handover, communication skills, infection control and basic life support.

- Staff told us before having any patient contact they attended the induction and completed some of the mandatory training modules (dependent on existing skills and training). This ensured staff had the right skills and knowledge to commence their employment.
- The 'staff induction time plan' showed that within six months of the induction, staff had to complete first person on site, patient handling and driving assessment training. The head of operations was a driving assessor so readily available to train and update staff. The registered manager reported only when staff had completed this training would they be able to undertake that specific role. This ensured staff did not work outside of their scope of practice.
- Training records showed all staff had completed mandatory patient handling and driver assessment training.
- Documentation we reviewed showed the service offered emergency care assistant (ECA) training to all patient transport staff. We saw all ECAs had undertaken this training. Medic 1 Direct Ltd was an approved training centre, so staff could achieve a diploma in emergency care assistance.
- The service provided additional training based on staff learning needs, staff requests or in response to service need. Training records showed staff undertook additional training, such as a cardiac study day, training by the local 'flying medics' in North Wales and team leader training.
- The service circulated emails to staff informing them of the availability of training. Staff signed a register at the start of training and all attendees received a certificate. Certificates were kept in staff files, which were at the headquarters in Wales. We reviewed ten sets of training records along with staff files.
- At the last inspection, the service had no formal process in place for carrying out staff appraisals. This had changed and there were now yearly appraisals for staff. The service had a system for identifying and managing variable or poor staff performance and a record of staff development.
- The service was developing an IT system, which would enable the electronic recording of staff training to improve managerial oversight and access to information.
- Staff were able to complete external training courses with prior agreement from the registered manager. One member of staff told us he was being supported to completed further training with a hope of becoming a paramedic one day. This support was financial, time and general help to complete studies.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

- During event work, the team worked with many other services to make everything run smoothly and safely. They worked with event planners, other local ambulance services, NHS trusts, local councils and resilience officers. The registered manager attended planning meetings with event organisers as often the events they worked at would be big sporting events.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

- The service had a capacity and consent policy. The provider used this policy for both the regulated and the non-regulated activities. The policy reflected best practice in relation to adults, children and young people. It provided clear and comprehensive guidance to staff on assessing a patient's mental capacity, gaining consent, deprivation of liberty and record keeping.
- The records for 10 members of staff showed all staff had attended the mental health awareness, mental capacity act and Mental Health Act mandatory training.

Good

Patient transport services

- Staff understood their responsibility to gain patient consent. We saw staff documented when a patient did not consent to treatment such as administration of medicine.
- The provider had a policy and forms for use should a patient be deemed not to be for resusicitaion. The do not attempt resuscitation policy was written in 2018 and had a review date of 2021.

Are patient transport services caring?

Not sufficient evidence to rate

We did not rate care as we did not observe practice and all feedback related to work that did not include urgent and emergency care.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- We did not see any examples of patient care during the inspection. However, we reviewed feedback provided by patients and relatives, which was very positive about the service. We saw comment on the service's social media page also.
- We saw cards and feedback forms from patients thought these did not pertain to the four patients treated that came within the remit of this inspection.
- One patient from overseas wrote to the service once home to thank them for attending to a wound he needed treating. Prompt care during the event meant he did not need to make trips to hospital for daily dressings.
- A staff member told us how they prided himself on looking after patients even if it meant going above and beyond his usual duties. They told us that they had received feedback from a patient who he had helped to enter a property with stairs whilst the patient was on crutches. They then made him a cup of tea when they could have left the gentleman and his luggage at the door.

Emotional support

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

- We did not observe any direct care during the inspection.
- Staff recounted how a colleague spent time with a child with learning difficulties who was scared of ambulances. After an hour of play, reassurance and familiarisation, they were able to get the young boy to travel in an ambulance.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

- Feedback provided by an NHS service stated that 'staff in attendance are always professional but warm and empathic to the needs of our client group. The focus of Medic 1 is and always has been the needs and welfare of the patient'.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

We rated it as **good.**

Service delivery to meet the needs of local people

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

- The provider planned and delivered the service to meet the needs of local people. Administrators completed a standard booking form when receiving a referral for an event. It comprised of a number of questions such as the number of spectators, whether the event has

happened before and fire risks such as barbeques or open fires. The service used this information to risk assess the event and identify service needs such as staffing, number of vehicles and staff skill mix.

- Care was also delivered in conjunction with the various organisations that worked at events to ensure health and safety provision, healthcare facilities and disaster management strategies were all planned.

Meeting people's individual needs

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

- The service had vehicles which could accommodate wheelchair users but they did not transport children or bariatric patients. Other ambulance providers were used for these types of patients.
- The service had enrolled on the dementia friend's scheme, which aims to increase people's knowledge about dementia and how they can help to create dementia friendly communities. Staff completed online modules on dementia and obtained a certificate at the end of the course. Staff were equipped with the knowledge to enable them to identify the needs of a person living with dementia.
- Staff received training in the area of learning disability within the mandatory mental health training.
- Translation services for patients whose first language was not English were available. This was via a phone app or using an emergency services multi-lingual phrase book. A member of the team was also trained in British Sign Language.
- Vehicles enabled the patient to have a relative or friend accompany them to the local hospital.

Access and flow

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

- The service worked at events for which they had been awarded a contract to provide medical or first aid services. People could access the service at any time while at an event. Patients would be assessed by the crew and the event doctor and a decision made if the patient needed conveying to hospital.
- All first aiders had portable radios and automated external defibrillators with them during an event so they were equipped to receive live information and respond to any medical emergency quickly.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

- The service had a complaint resolution policy. The provider used this policy for both the regulated and the non-regulated activities. The policy was clear and outlined timeframes for dealing with complaints, such as acknowledgement of a complaint within seven working days and a response within 15 working days.
- The service had not received any complaints in the 12 months prior to inspection.
- Feedback forms were available within the vehicles and written in both English and Welsh.

Are patient transport services well-led?

Good

We rated it as **good.**

Leadership

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

- Staff feedback was very positive about the management of the organisation. They felt the senior management team valued their opinions and were readily available to listen to staff.

- The senior management team consisted of the clinical director, the senior administrator, head of operations, head of procurement and head of accounts.
- The senior management team reported to the clinical director. The fleet manager and the event staff reported directly to the head of operations.
- The service employed a qualified trainer who was also an advanced ambulance technician. He undertook a five-day residential course every year to maintain his trainer status. This ensured staff received training that reflected best practice.
- At the end of each event day, the team leader held a hot debrief. The team discussed the health and wellbeing of staff, calls and patient treatment and reflected on how the event had gone. This showed teams worked to resolve issues to improve the delivery of good quality care as the event continued.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

- The service had a mission statement, which was 'to give excellent care' and the service used the tagline ''Exceeding your expectations is our aim''. The service aimed to deliver excellence as a norm, support the team, to encourage open and transparent communication and be respected in the community for the quality and value of the service.
- The registered manager told us the future strategy of the business was to grow whilst continuing to be patient focused. There was no desire to lose the close, family feel that the managers had honed from when the business started. Since the previous inspection, more patient transport work had been undertaken for an NHS trust and the number of available staff had increased.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- The registered manager reported there was a no blame culture within the service. If there were any concerns about the competency of a member of staff, they would carry out a reflective session, identifying areas for improvement and schedule the correct training.
- The service had a whistleblowing policy which outlined the process for staff to follow if they wanted to raise serious concerns.
- The registered manager said that staff regularly visited the station informally to catch up with other members of staff. This showed staff actively engaged with the service.
- The service had an equality and diversity policy. The provider used this policy for both the regulated and the non-regulated activities. It outlined the responsibilities of the organisation and staff to ensure no direct or indirect discrimination occurred within the business.

Governance

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

- The registered manager told us the service reviewed the applicant's training records, details of references and the Health Care Professional Council (HCPC) register if applicable, during their interviews. This demonstrated the service had an effective recruitment process.
- The service had a disclosure and barring policy. The provider applied this policy to staff that provided both regulated and non-regulated activities. It outlined responsibilities, storage, usage, retention and disposal of disclosure and barring service (DBS) documentation.
- There was a service level agreement with a third party who managed the DBS checks. Once processed, the third party sent an email to the service who requested the employee to bring the physical document into the head office for review. The DBS reference numbers were

recorded in the staff records we reviewed. The service undertook a yearly check of DBS certificates and the Health and Care Professions Council registers. This ensured staff were suitable and qualified to carry out their duties.

- The registered manager told us prior to the start of an event all registered healthcare professionals had their registration checked. This provided the service with assurance that staff were legally fit to practice.
- All vehicles were tracked which allowed the service to monitor the standard of driving for all staff. If staff drove a vehicle above the speed limit, the duty officer received an email alert. The registered manager reported that this allowed the service to notice themes for repeat offenders.
- The head of operations undertook a yearly check of driving licences for all drivers. We saw evidence to show yearly driving licence checks took place, which included the driving licence number and the date of the check.
- All staff wore name badges, which had a barcode. The event manager was able to scan this barcode at the beginning of an event to check the staff member worked for the service. This ensured unauthorised staff did not assess or treat patients.
- If staff had treated a person during an event, the event manager and team leader would review the patient record form and discuss this with the member of staff involved to allow staff to reflect and provide feedback.
- The registered manager and the senior administrator took responsibility to submit notifications to the Care Quality Commission. There were no notifications submitted in the 12 months prior to inspection, as there had been no incidents meeting this threshold.
- The senior management team attended monthly governance meetings. We did not see the governance meeting minutes at this inspection though we saw them at the previous inspection. The registered manager admitted that they were poorly documented.

Management of risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- The service had identified risks to the organisation such as use of oxygen and medical gases , risk of road traffic accidents and ambulance station site hazards. The risk register identified the current level of risk, the risk score associated with it and actions for each of the domains. The risk register was rated according to the traffic light system of red, amber and green.
- The service had a business continuity plan that detailed how to be prepared for any events that might happen that could impact on extended service outage.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

- The service used social media to inform staff and the public of health related matters
- The service website had information for providers looking to source ambulance work, for staff and members of the public.

Public and staff engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- The service kept patient feedback forms within the vehicles. The forms allowed patients to provide feedback following receipt of care at events. These forms were available in the vehicle we inspected and asked patients or their relative to rate Medic 1 Direct Ltd on key aspects of care such as listening and response time.
- The registered manager told us the service received thank you cards and postcards from patients who had

received treatment. The service displayed cards on the noticeboard within the staff room and the managers provided feedback to named individuals. The staff at inspection were able to share examples of feedback received with us.

- The service contacted contractors by telephone, video calling, emails, face to face at training and social activities. This ensured the service kept staff from remote locations engaged. There were many social activities organised for the whole team including paintballing, Christmas dinners and when working at large events, staff ate meals together.
- The service received feedback and comments from event organisers who they had worked with which were shared with staff.
- All employed staff attended monthly team meetings which were minuted. The meeting minutes for August, September and October 2019 showed there were standard agenda items and discussions around matters such as uniform, workload, training and the staff Christmas 'get together'. The service could disseminate updates and changes to practice to large numbers of staff at once via email or at these meetings.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

- When vehicles were away at events for long durations, they found that some batteries would drain and lose charge. To remedy this, the maintenance team installed solar panels on the roofs of the ambulances.
- We were told about the advance technology used to track kit bags and vehicles. It enabled the event control room to deploy the nearest team to the patient. This meant staff with the correct equipment and skill could deliver emergency treatment to the patient without delay.