Emergency Doctors Medical Services Limited

Emergency Doctors Medical Service

Quality Report

Unit 1H
The Gattinetts
East Bergholt
CO7 6QT
Tel:01206299441
Website: www.emergency-doctors.org

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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 know to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location

Emergency and urgent care services	

Summary of findings

Letter from the Chief Inspector of Hospitals

Emergency Doctors Medical Service is operated by Emergency Doctors Medical Services Limited. The service supplies paramedics, doctors, emergency technicians, and emergency paediatric first aiders (EPFAs) to provide first aid and medical cover and, if necessary, patient transport services (PTS) at organised events such as music festivals and sporting events amongst others. We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 30 August 2017.

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

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

The main service provided by this service was first aid and medical cover for events; however, this is not within our scope of regulation. We inspected this service under our emergency and urgent care framework. The service rarely conveys patients out of an event site. However, as the service has transferred patients from an event site via ambulance to local urgent and emergency centres between August 2016 and August 2017, the service falls into the scope of our regulation.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There was an up-to-date incident reporting policy and staff knew how to report incidents. There was evidence of actions and learning following events, which were shared with staff consistently.
- Vehicles were clean and up to date with servicing and MOTs. Equipment within the vehicles matched the equipment checklist. There was a range of equipment for all sizes and ages including neonatal equipment and life support equipment for children and adults.
- Medicines, including controlled drugs, were stored securely and in line with service policy. All medicines we checked were in date.
- The service employed a medicines and pharmaceutical adviser who could provide guidance on medicines, for example following any significant changes to legislation, guidance or best practice.
- Records were completed appropriately and stored securely.
- All staff were up-to-date with training for safeguarding children and vulnerable adults and staff knew how to report safeguarding concerns.
- There was an internal mandatory training programme and all staff were up-to-date with mandatory training.
- Driver training was provided in-house, even for those staff who had their driver training records transferred from their NHS employer. It involved a four-day emergency driving course accredited by the Institute of Health Care Development (IHCD).
- Staff always had access to a doctor for further advice regarding management of a patient's condition.
- Clinical staff were all trained in advanced life support (ALS) or immediate life support (ILS) and assessed on this yearly by a senior clinician.

Summary of findings

- Policies and procedures were comprehensive, up-to-date and in line with national guidance. Staff knew how to access policies.
- There was a comprehensive local audit schedule, which took place at each event to monitor performance.
- All staff had an appraisal within the past 12 months and received local induction to the service upon commencing work.
- Staff completed a familiarisation drive upon starting with the service to ensure driving competence. The service had their own driving standards assessment for members of staff who were trained in-house.
- There was additional specialist training to develop staff competencies, for example in suture and wound closure, and fascia iliaca blocks.
- The service had a medical cycle response unit to help staff reach patients in areas that may be inaccessible by a rapid response vehicle (RRV) or ambulance.
- Staff spoke highly of the positive, team-based culture at the service and the support from managers and were proud to work at the service.
- The service had a clear aim, namely to reduce hospital admissions and NHS costs by providing effective patient care on site.
- Clinical governance was embedded into the service, and there was a designated clinical governance group, led by two doctors and the lead nurse.
- There were monthly 'Capturing Learning in Professional Practice Settings' (CLiPPS) meetings to discuss incidents, learning and updates to national guidance or policy. These meetings were open to all staff and staff were encouraged to take an active role in these meetings looking at issues of clinical governance.

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

- Staff were not all familiar with the term duty of candour.
- Within the spill kit on one vehicle there was biocide spray and absorbent granules which had both expired in June 2017. We raised this to a member of staff who immediately replaced these. All other consumables were within date.
- The fridge, used for storing Rocuronium, had not been checked daily as specified by the policy.

Heidi Smoult

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		The main service provided by this service was first aid and medical cover for events; however, this is not within our scope of regulation. We have reported on the emergency and urgent care aspect of the service as the service, on rare occasions, transported patients from events sites to hospital in the event of an emergency. We found: • There was an up-to-date incident reporting policy and staff knew how to report incidents. There was evidence of actions and learning following events, which were shared with staff consistently. • Vehicles were clean and up- to date with servicing and MOTs. Equipment within the vehicles matched the equipment checklist. There was a range of equipment for all sizes and ages including neonatal equipment and life support equipment for children and adults. • Medicines, including controlled drugs, were stored securely and in line with service policy. All medicines we checked were in date. • The service employed a medicines and pharmaceutical adviser who could provide guidance on medicines, for example following any significant changes to legislation, guidance or best practice. • Records were completed appropriately and stored securely. • All staff were up to-date with training for safeguarding children and vulnerable adults and staff knew how to report safeguarding concerns. • There was an internal mandatory training programme and all staff were up to date with mandatory training. • Driver training was provided in-house, even for those staff who had their driver training records transferred from their NHS employer. It involved a four-day emergency driving course accredited by the Institute of Health Care Development (IHCD).

Summary of findings

- Staff always had access to a doctor for further advice regarding management of a patient's condition.
- Clinical staff were all trained in advanced life support (ALS) or immediate life support (ILS) and assessed on this yearly by a senior clinician.
- Policies and procedures were comprehensive, up-to-date and in line with national guidance. Staff knew how to access policies.
- There was a comprehensive local audit schedule, which took place at each event to monitor performance.
- All staff had an appraisal within the past 12 months and received local induction to the service upon commencing work.
- Staff completed a familiarisation drive upon starting with the service to ensure driving competence. The service had their own driving standards assessment for members of staff who were trained in-house.
- There was additional specialist training to develop staff competencies, for example in suture and wound closure, and fascia iliaca blocks.
- The service had a medical cycle response unit to help staff reach patients in areas that may be inaccessible by a RRV or ambulance.
- Staff spoke highly of the positive, team-based culture at the service and the support from managers and were proud to work at the service.
- The service had a clear aim, namely to reduce hospital admissions and NHS costs by providing effective patient care on site.
- Clinical governance was embedded into the service, and there was a designated clinical governance group, led by two doctors and the lead nurse.
- There were monthly 'Capturing Learning in Professional Practice Settings' (CLiPPS) meetings to discuss incidents, learning and updates to national

Summary of findings

guidance or policy. These meetings were open to all staff and staff were encouraged to take an active role in these meetings looking at issues of clinical governance.

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

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Emergency Doctors Medical Service

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to Emergency Doctors Medical Service

Emergency Doctors Medical Service is operated by Emergency Doctors Medical Services Limited. The service opened in 2012. It is an independent ambulance service in East Bergholt, Suffolk. As the service primarily provides first aid and medical cover for events, staff travel to these events nationwide.

The service has three ambulances, a rapid response vehicle, a command and control unit, and four medical response cycles.

The service has had a registered manager in post since June 2012.

Our inspection team

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

How we carried out this inspection

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the service's base in East Bergholt, Suffolk. This is the service's only base as the majority of its work is carried out at event sites. We spoke with the registered manager, operations manager, HR lead, director of patient quality and safety, and two members of operational staff. We also reviewed data and documents provided by the service before, during and after the inspection. During our inspection, we reviewed two sets of patient records. We were unable to speak with any patients or observe patient care due to the events focus of the service.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once previously, in January 2014, where it was found to be meeting all standards of quality and safety against which it was inspected.

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

Detailed findings

Activity

- In 2016, the service treated 2,336 patients across over 650 events.
- Between August 2016 and August 2017, the service had transferred three patients out of an event site to an acute hospital.

The service employs eight doctors, 16 registered paramedics, 16 emergency medical technicians, nine registered nurses, and 34 event and public first aiders, all under zero hours contracts. The service is led by the registered manager, who is also the medical director. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (August 2016 – August 2017)

- No Never Events
- No clinical incidents
- No serious injuries
- No complaints

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The main service provided by this service was first aid and medical cover for events; however, this is not within our scope of regulation. We have reported on the emergency and urgent care aspect of the service as the service, on rare occasions, transported patients from events sites to hospital in the event of an emergency.

Summary of findings

As this was the only core service provided by Emergency Doctors Medical Service that we have scope to inspect, the summary of findings are as above, under the main 'summary of findings' heading.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- There was an incident reporting policy which was accessible online via the staff portal. This had last been reviewed in January 2016 and was up-to-date. The policy was centred around CQC-reportable incidents only (such as serious injuries and applications to deprive a person of their liberty), and did not include reporting all types of incidents such as patients becoming abusive towards staff, or missing equipment, for example.
- When we raised this, we were told that these incidents tended to be documented in the event debrief forms available for staff to complete after each event. We reviewed the debrief forms for August 2017 and saw evidence of this; for example, one form documentedthat at an event there was equipment including gauze and pocket masks missing from the response bags.
- This type of incident was reported as part of the service's dashboard, which was displayed in the main office at the station to show the ten areas closely monitored by the service on a month-by-month basis, including medicines errors, falls, equipment failures, and infections acquired in relation to the care delivered. Under this dashboard, there had been three additional incidents between January and August 2017. Two of these were staff not wearing their ID and one was categorised as a complaint (clinical or non-clinical). The operations manager was responsible for completing and monitoring this.
- Incidents were then monitored as part of the ongoing annual audit process in order to identify patterns or areas of concern. This was shared with staff via the online portal and at monthly 'Capturing Learning in Professional Practice Settings' (CLiPPS) meetings.
- Staff we spoke with could explain how they would report an incident via the online reporting system but said for the above types of incident they would use the debrief forms.
- There had been a further two formally reported incidents (outside the remit of the dashboard discussed above) between September 2016 and August 2017. Both of these took place at the same event in August 2017. One was categorised as a significant event where staff had transported a cardiac arrest patient from an event site and the patient had later died in hospital. The second was categorised as an untoward incident and was a clinical error in relation to the correct use of a resin cast. We reviewed the investigations for these and saw there had been appropriate actions and learning, including a staff debrief following the event. The clinical director had also arranged a visit to the families of these patients to discuss the incidents. They were also on the agenda for discussion at the next 'Capturing Learning in Professional Practice Settings' (CLiPPS) meeting.
- There had been no never events between September 2016 and August 2017. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The two members of staff we spoke with were not familiar with the term duty of candour, although it was included in mandatory training and there were quick reference cards on the duty of candour on site for staff to access. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. However, staff did show an awareness of the need to be open and honest with patients and relatives or carers.

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

- The service used a clinical quality dashboard daily to monitor 10 key elements of safety and quality, including unreported safeguarding incidents, falls, and incidences of staff not wearing their ID, for example. This was collated into a monthly document and shared at monthly 'Capturing Learning in Professional Practice Settings' (CLiPPS) meetings. Examples of this have been reported on under the 'incidents' subheading, above.
- The service also had a log of quality assurance indicators (QAIs), in place since 2016. The purpose of this was to monitor and review their standards of quality

and safety, based on national UK legislation, guidelines, best practice and evidence based clinical care. For example, there were QAIs relating to the system of monitoring expiry dates; incident reporting; and minimum staffing levels among other indicators. The director of patient safety and quality oversaw this.

Cleanliness, infection control and hygiene

- All areas we inspected were visibly clean.
- There were appropriate hand cleaning facilities at the base and on vehicles.
- There were appropriate policies on infection prevention and control; management of clinical waste; and hand decontamination, which were accessible to staff via the online portal. The policies provided comprehensive guidance for staff on their roles and responsibilities, as well as background information on how infections could be transmitted and those most at risk.
- Vehicles were cleaned after each shift by two members of staff. They were also cleaned monthly as standard, and deep cleaned every three months. A deep clean would also be done immediately upon returning to the station if the vehicle had been contaminated whilst in use.
- We saw cleaning records for February to August 2017 and saw this had been carried out and signed off with no gaps in the records, in accordance with service policy.
- Vehicle cleanliness audits were carried out once a month by the registered manager and another medical staff member. This involved selecting two vehicles at random and assessing and recording factors including, but not limited to, whether step voids were clean and free of dirt; cab and windscreen cleanliness; and any dust or dirt on surfaces and joins. We reviewed the audits from July 2016 to July 2017 and saw there was only one occasion, in March 2017, where a vehicle had been non-compliant. There were actions to address this documented in the audit.
- The service used disposable linen for the purposes of preventing contamination.
- There were protective overall suits available on site in the event of severe contamination.
- In the event that uniforms were contaminated, the service supplied staff with replacements. Protocol for disposing of contaminated uniform involved cutting off the polo top to minimise further contamination and immediate disposal in clinical waste. Staff we spoke with were aware of this.
- The service had a contract with a local vehicle deep cleaning facility, which had specialist cleaning services such as fogging. We saw the contract, although they had not yet had to use this. There was also a clinical waste contract with an external disposal facility.
- As we did not observe any patient care being carried out due to the vast majority of the work being events cover, we were unable to assess staff compliance with policy and best practice in hand hygiene and infection control. However, staff we asked showed good awareness of the infection control policies and could give examples of what they would do in the event of severe contamination or treating or transporting an infectious patient.

Environment and equipment

- The site consisted of an office block, outdoor area where vehicles were kept, dedicated classroom, and an 'equipment and logistics unit' (ELU) where equipment was stored, and bags were made up in advance of an event. Within the ELU there was a locked medicines room.
- We inspected all these areas and saw they were well organised, spacious and free from dust or trip hazards.
- The service had three ambulances equipped to critical care transfer standard; a rapid response vehicle (RRV), and a designated command and control unit from which operations could be managed on event sites.
- We checked the service records in relation to the ambulances. They had been serviced and had up-to-date MOT certificates in line with specified requirements. The operations manager had responsibility for ensuring the routine servicing of the vehicles.
- We selected two ambulances at random to inspect. They were visibly clean and well laid out. Equipment and number of each item within the vehicles matched the equipment checklist. There was a range of

equipment for all sizes and ages including neonatal equipment, and paediatric life support equipment was stored in a separate clearly labelled bag. All equipment we checked was within servicing date.

- However, within the spill kit there was biocide spray and absorbent granules which had both expired in June 2017. We raised this to a member of staff who immediately replaced these. All other consumables were within date.
- Clinical waste and sharps bins, both within vehicles and in the ELU, were clearly labelled and emptied appropriately.
- Staff maintained the ambulance station, office, and storage areas to ensure they were visibly clean and safe from any trip or fall hazards. Within the ambulance station, clear signage was in place warning staff of the dangers in relation to COSHH (Control of Substances Hazardous to Health Regulations 2002) and other key health and safety issues.
- Vehicles were stocked with the appropriate equipment in advance of each event depending on what would be required, and there was a dedicated equipment replenishment area within the ELU. Any equipment not used would be returned to the ELU, reviewed and stock checks done.
- Staff stored ambulance keys in a locked key safe inside the ambulance station when not in use.
- The service had four medical motorcycles for use by those staff who had completed the medical cycle response unit (MCRU) training. These were equipped with the same emergency equipment as an ambulance or RRV, including a defibrillator, oxygen, burns dressings, sterile wound dressings, intravenous cannulas, major trauma dressings, traction splints and adult/paediatric airway management equipment.
- We checked the fire extinguishers within the ambulance station and on the two vehicles we looked at. They were fit for use and within servicing dates. The servicing records were stored in office files held by the manager.

Medicines

- The service was legally registered with the Home Office for the ordering, possession of and control of controlled drugs (CDs). This was in place since December 2016.
- There was a policy for medicines management, which we saw was within review date and based on guidance from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). This included the names of the responsible officers for medicines, namely the registered manager and the medicines adviser. It provided guidance to staff, for example on the scope of use for medicines, and arrangements for ordering, collecting and storing medicines including controlled drugs.
- There was an up-to-date policy on medical gases (last reviewed in January 2017).
- Staff had attended a mandatory training session on using Penthrox to ensure they were competent, as the service had recently moved to using Penthrox as an analgesic. The service still maintain a possibility of storing and using Entonox in case of supply failure of Penthrox, and Entonox was therefore still included within the medical gases policy.
- There was a service level agreement with the local NHS acute hospital for the supply of all medicines including prescription-only medicines (POMs) and controlled drugs (CDs). Orders for medicines were signed by the medical director (who was the responsible officer) and collected by a nominated person.
- The service had patient group directions (PGDs) in place for certain medicines, and this was specified within the medicines management policy. PGDs are written documents allowing certain health professionals to use medicines without specific recourse to a doctor.
- Ordering of CDs was the responsibility of individual doctors or paramedics. Controlled drugs were stored in a locked cupboard within the medicines room which was also locked when not in use. All CDs within the cupboard were in date and the CD book matched the stock levels. CDs were checked weekly. We reviewed the records of checks from June to August 2017 and saw this had been completed and signed off consistently.
- New stock was checked upon receipt into the service by two members of staff, one being a registered health professional, and entered onto the stock control register in accordance with the policy on medicines management.

- Medicines were stored securely in a locked pharmacy storage room within the ELU. All medicines we checked were in date. There were signs within the cupboard stating when the next drug was due to expire.
- There was a fridge in the medicines storage room, which was used only for storing rocuronium (a muscle relaxant). We were told the fridge temperatures were checked every day. The checking log showed there were 12 days in June 2017 and 12 days in July 2017 where checks had not been documented. The checking log for August 2017 was complete and signed off with no gaps. However, the fridge had an alarm to indicate if it was outside the safe temperature range. The medicines management policy specified that 'any variance from required temperature must be notified to the director for clinical and medical services immediately'.
- The service employed a medicines and pharmaceutical adviser who carried out a comprehensive annual audit of medicines management within the service but was also on hand to provide guidance on medicines, for example following any significant changes to legislation, guidance or best practice.

Records

- There was a policy for data protection and medical records management, which was up-to-date and last reviewed in February 2017. This contained guidance and information for staff including, but not limited to, the correct process for storing and disposing of patient record forms (PRFs) and the name of the data controller for the service
- Each ambulance had a supply of patient report forms (PRF). There were three types: a standard clinical record PRF used for general treatment on event sites; an ambulance team PRF used for patients with more complex conditions, such as a patient with a fractured femur who was stable but required transfer to hospital; and a critical care PRF with relevant sections on the nature of the critical care involved.
- Staff kept the records in a closed organiser inside a secure storage compartment in the ambulance. On returning to the station, staff placed the completed PRF inside a locked post-box, for the registered manager (RM) to retrieve and review. Records were then stored in a locked storage unit in the ELU for one year (in case staff needed to go back to them, for example in the event of an investigation), after which time they were transferred to a fireproof archive cabinet.
- We reviewed two PRFs for patients who had been transferred to hospital from an event site within the last year. They were legible, completed and signed off by appropriate staff.
- As part of the PRF audit, the records were marked where the treatment of that patient had resulted in avoidance of hospital admission. However, the version available on the service intranet page at the time of inspection was not completed within the last 18 months, although there had been a more recent audit carried out.

Safeguarding

- There was a safeguarding lead nurse for the service, who was trained to level four in safeguarding children and safeguarding vulnerable adults. Staff were aware who the lead was and how to report concerns.
- There was internal training for safeguarding children and vulnerable adults, which was mandatory even if staff had their safeguarding training records transferred from an NHS employer. Bronze and Silver Commanders and doctors in charge were trained to level three in safeguarding children; all other staff were trained to level two in safeguarding children. All staff were up-to-date with safeguarding training.
- Staff also received 'Prevent' training based on government training which aims to safeguard vulnerable people at risk of radicalisation.
- There was a section on the online staff portal to report a concern for either a child or young adult, or a vulnerable adult.

Mandatory training

- All clinical staff were also employed by NHS services and the service requested these training records prior to commencing work. The service also required staff to complete their internal mandatory training programme, which could be accessed on the staff portal.
- The internal mandatory training programme included four specific mandatory courses upon joining (safeguarding children; safeguarding adults at risk, Infection prevention; and moving and handling). There

were then a further 14 modules to be completed over the course of the year, which were assessed for each member of staff at annual appraisal. This was monitored by the director of quality and safety.

- We reviewed training compliance data and saw all staff were up-to-date with mandatory training, except some new starters who had been with the service for three or four months so had yet to complete the full training schedule within one year in accordance with policy.
- Staff we spoke with confirmed they were up-to-date with mandatory training and felt that the training equipped them to carry out their roles safely.
- We spoke with the training coordinator for the service, who was responsible for providing the in-house training for the medical cycle response unit. This training followed the police cycling course. Medical cycle responders were required by service policy to have completed the Events and Public First Aid (EPFA) training course and to have attended events for at least one year as a minimum standard.
- Driver training was provided in-house by a qualified instructor, even for those staff who had their driver training records transferred from their NHS employer. It involved a four-day emergency driving course and driving assessment. Drivers carried category C1 and D1 licences and this was documented in staff files.

Assessing and responding to patient risk

- Staff always had access to a doctor that they could contact to seek further advice regarding management of a patient's condition. Staff we spoke to confirmed there was always a senior clinician available for escalation.
- The service used NEWS to monitor for potential risks when treating patients. If staff were concerned about a patient's condition they were able to transport them directly to hospital.
- Clinical staff were all trained in advanced life support (ALS) or immediate life support (ILS) and assessed on this yearly by a senior clinician. There were also practical training days for assessing and treating paediatric patients.
- There was a sepsis triage tool on the PRFs and it was policy that all patients triggering on the sepsis warning tool must be seen by a doctor. All staff were trained in recognising sepsis as part of the service's mandatory training programme.
- When planning event cover, the registered manager would consider the likely risks and injuries as well as the risk level to the public, and deploy appropriately trained staff to the event based on the risk rating. The potential risks were discussed with the events provider as part of the planning prior to events.
- The two members of staff we spoke with showed awareness of how to deal with a deteriorating patient and escalate any concerns. They could described the actions they would take such as providing first aid, administering oxygen where appropriate, escalating to the doctor on site or on call, and transporting the patient to hospital if required.
- Five paramedics at the service were trained to treat patients requiring critical care.
- Mandatory training included managing conflict to ensure staff could manage patients displaying violent or aggressive behaviour.

Staffing

- Staff worked on zero-hours contracts due to the nature of the service deploying staff to events as and when they were booked. The medical director, operations manager, and director of quality and patient experience were the only permanent staff members.
- Staff could sign up to cover an event via the calendar on the online portal system. The operations manager would then deploy staff to an event dependent on resource requirements and skill mix.
- The service employed eight doctors, 16 registered paramedics, 16 emergency medical technicians, nine registered nurses, and 34 event and public first aiders.
- Staff never worked alone and this was specified in the lone working policy. Staff we spoke with confirmed this.

Response to major incidents

Emergency and urgent care services

- The service had, within the last three months, added a mandatory module on responding to major or terrorist incidents to its mandatory training programme for all staff. This had been developed to mirror government Citizen Aid training.
- The service kept a stock of 200 self-treatment packs to hand out to patients in the event of a mass casualty.
- We reviewed the service's business continuity policy which was within review date and contained appropriate information on contact details. There was a back-up server off site in case of loss of electronic information or if there was a fault with the control and command unit.

Are emergency and urgent care services effective?
(for example, treatment is effective)

Evidence-based care and treatment

- The service had comprehensive policies and procedures in place, including but not limited to policies on assessing and monitoring the quality of services; meeting nutritional needs and corporate and professional conduct.
- Policies were based on legislation, best practice and national guidance such as guidelines published by the National Institute of Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.
- Policies were reviewed as standard every two years, or more frequently if there was a specific change to legislation or national guidance.
- Staff were made aware of changes to policy via the online portal and at monthly CLiPP meetings. For example, we saw that there had been an update shared with staff on the British Thoracic Society guidelines, in the June 2017 meeting.
- There was a comprehensive local audit schedule which took place at each event, including privacy and dignity, patient care and professional conduct, and infection prevention and control.

Assessment and planning of care

- When making bookings for events and conducting risk assessments, the registered manager considered the likely patient group, the risks associated with the event and the skills, knowledge, and experience required by staff deployed to the event.
- Training included section 136 of the Mental Health Act, to help staff plan responsive care for patients experiencing mental health difficulties.

Response times and patient outcomes

- The service did not measure response times as its provision was on event sites.
- However, the service published an annual activity report to show how many patients they had treated and hospital admissions they had avoided. The last report estimated that treatment of injuries on scene resulted in 489 avoidances of A&E admissions over 2016.

Competent staff

- All staff had an appraisal within the past 12 months. New starters who had been at the service less than 12 months had dates booked in for appraisals. All staff we spoke with confirmed they were up-to-date with appraisals.
- Appraisals involved a self-assessment; a check with two other members of operational staff how they found working with that individual; and an overall assessment and sign off by either the medical director, operational manager, or director of patient safety and quality. This was the procedure for all staff roles including doctors. We saw evidence of this in the three staff HR files we selected at random.
- All staff received local induction to the service upon commencing work. This included orientation with the station, vehicles, policies and procedures and checking of ambulance driving licenses. Staff we spoke with confirmed they had received an induction to the service. We also saw documentation of these in the three staff files we reviewed.
- Staff completed a familiarisation drive upon starting with the service to ensure driving competence. The service had their own driving standards assessment for members of staff who were trained in-house (those already trained with the NHS could transfer their driving training records over to the service). Staff had a basic

assessment test for blue light driving every six months to maintain their competence. If staff received over six points on their driver's licence they would no longer be allowed to drive. This was specified within employment contracts and local policy.

- The service requested disclosure and barring service (DBS) checks from staff before starting work. DBS checks were then carried out every five years in accordance with national guidance and local service policy. These were kept in staff HR files.
- Staff were required to complete and sign an annual declaration of their fitness to practice, which we saw in the HR staff files we reviewed.
- Paramedics were trained in suture and wound closure. The training involved supervision over 10 wound closure to ensure competency before staff were signed off to close wounds themselves.
- Training in fascia iliaca blocks (a type of local anaesthetic nerve block) was provided to specialist paramedics, doctors and nurses. This involved face-to-face in-house training and then a period of supervised practice at a local NHS acute trust. This meant staff were competent to provide this treatment on event sites without having to transport the patient to an acute hospital.
- All staff were allocated a mentor upon starting their roles for support and development. The mentorship programme involved three formal meetings a year. One newly qualified paramedic we spoke with confirmed they had a mentor and found this beneficial for development and support.

Coordination with other providers and multi-disciplinary working

- Although transfers from event sites were rare, there was a protocol for transferring to hospitals or other providers. Service leads gave examples of where this had happened. In the event of a transfer, they pre-alerted the hospital that they were transferring a patient.
- The service did not have any subcontracts with NHS Ambulance Trusts and if a patient was required to be taken to hospital this would be done by the service's own staff.
- There was an up-to-date policy on delegating patient care to other health professionals based on guidance from the General Medical Council (GMC). This set out the roles and responsibilities of Emergency Doctors Medical Services (EDMS) staff when working with external providers and outlined situations where an EDMS doctor must accompany the patient to hospital.
- We were told that in the rare event of patient journeys off site, handovers and communication with hospitals ran smoothly. As staff were also employed with NHS services, they showed familiarity with coordinating with other providers, for instance upon arrival at A&E.
- Staff were also able to give examples of where they had contacted welfare teams, GPs or social care to support a patient.

Access to information

- Prior to each event the contact details of the relevant local acute trusts (as the service travelled nationwide to provide patient care) would be put in the vehicle so crews could easily access this and pre-alert the hospital if a transfer was required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an up-to-date and appropriate policy on capacity to consent, which included guidance for staff on assessing capacity and referred to relevant legislation and guidance. Any patients potentially lacking capacity were discussed with either the doctor on site or the on call doctor, and we were told the service would consider referring the patient to hospital for further capacity assessments if required.
- Consent was documented clearly in both the PRFs we looked at for patients who had been conveyed to hospital from an events site.

Are emergency and urgent care services caring?

Compassionate care

- As we do not have the scope to inspect services who provide cover at events, we were unable to see any interactions between staff and patients or speak to patients who had used the service.

- However, staff displayed a patient-centred approach and gave examples of patient care, for example where they had used screens or blankets to help protect patients' privacy and dignity.

Understanding and involvement of patients and those close to them

- There was an up-to-date local policy on 'respecting and involving those who use our service' which provided guidance to staff on keeping patients and relatives informed about care and treatment and empowering and supporting patients to be involved in their own care.
- The service had received 143 feedback forms from patients and relatives from June to August 2017. We reviewed a random sample of these and saw consistently positive feedback from patients. Comments included 'Very grateful for very efficient and safe care'; 'lovely, very kind, helpful and not judgemental'; and 'the staff put me at ease immediately'.

Emotional support

- Staff gave examples of how they supported patients and their friends or family who became distressed at events, sitting with them and keeping them calm whilst they had treatment or waited for family members.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The registered manager had regular contact with their event clients to best meet the needs of attendees and to seek opportunities to provide services at other events. Prior to each event, the service had a discussion with the client to plan and assess how they would be set up and provide care at the event site.
- The service did not provide services to the NHS or work under any subcontracts.
- The service had a medical cycle response unit comprising of four medical cycles, to help staff reach patients in areas that may be inaccessible by a RRV or ambulance.

Meeting people's individual needs

- There were mandatory e-learning modules on treating patients with learning disabilities or dementia, and service leads gave examples of how they would best respond to the needs of such patients, for example by taking them to a quieter area or involving family or carers in discussion about their care where appropriate.
- The service had a specialist stretcher for transporting bariatric patients and some of their staff had received specialist bariatric training.
- The service was at the time of our inspection, working on putting together 'distraction kits' to help meet the needs of children while they were being treated.
- Staff could access an online translation service for patients whose first language was not English via portable electronic devices that staff took to events.

Access and flow

- The size of the event determined the resources and skills required to meet the needs of individual events.
- Staff only transferred patients in an emergency capacity to hospital if required, which was rare. Therefore there was no monitoring of response times, or communication with NHS ambulance trusts.
- However, the service would pre-alert receiving providers in the event that an emergency transfer was required, to help ensure a smooth transition between care providers.

Learning from complaints and concerns

- There was an up-to-date complaints policy which set out the timeframe for responding to complaints. Written confirmation of receipt of the complaint was to be sent within 48 hours of receipt; and a written reply with resolution to be sent within 21 days of meeting the complainant.
- The service had received no formal complaints in the last 12 months.
- There was a complaints form for patients and relatives available on the service's website. We also saw feedback forms on the vehicles we inspected. Service leads told us that patients could also raise a complaint verbally directly with a member of staff while on site.

Emergency and urgent care services

Are emergency and urgent care services well-led?

Leadership / culture of service related to this core service

- The service was led by a doctor, who was the medical director. There was an operational manager and director of patient safety and quality, who together comprised the leadership team.
- For all work taken on by the service there was a senior staff member allocated to overseeing the welfare of their own staff.
- Staff spoke highly of the positive, team-based culture at the service and the support from managers. Managers and operational staff felt proud to work at the service.
- There were three trained trauma risk management (TRiM) practitioners at the service to provide support for staff involved in a situation that could result in distress or concern. Staff could self-refer on the online portal or recommend that another member of staff use the service.

Vision and strategy for this this core service

- The overall aim of the service was to reduce hospital admissions and the burden on acute trusts by treating patients on site wherever possible. Staff we spoke with showed awareness of this aim.
- There was a documented vision and strategy for the service and a set of 'operating principles' including delivering safe, effective, evidence based, risk assessed patient care; and operating based on reviewing cases, learning, and incorporating an effective learning and education pathway for all staff.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The service was split into three 'divisions' (Operations and Corporate, Clinical and Quality and Learning and Development). There was a designated clinical governance group, led by two doctors (including the registered manager) and the lead nurse who were specialists in emergency medicine, anaesthesia, critical and prehospital care. The group met quarterly to formally discuss clinical governance issues and updates, and oversaw all clinical activity. The lead nurse had been part of the group since September 2016 following a discussion that it would be beneficial to have nurse representation at clinical governance level.
- We reviewed minutes of these meetings from September and December 2016 and saw they were comprehensive and involved participation from all the group discussion of clinical governance issues and updates. Standing agenda items included clinical incidents, updates from the MHRA and any examples of deviation from policy and practice.
- There were monthly 'Capturing Learning in Professional Practice Settings' (CLiPPS) meetings to discuss clinical governance issues such as incidents, learning and updates to national guidance or policy. The service lead told us these meetings had been in place for about one year, because they wanted to involve staff at all levels in discussions around clinical governance. The two members of staff we spoke with told us they attended the meetings when they were able to and found them useful. The meetings were streamed on the staff online secure portal, which staff could access if they were unable to attend face-to-face.
- Staff were encouraged to take an active role in these meetings looking at issues of clinical governance. Each month staff presented recent cases they had worked on, providing explanations to the team on the situation, actions taking, the outcome and any learning from the case. The meeting minutes we reviewed from May to July 2017 demonstrated staff taking an active part in these meetings.
- The executive team met every six to eight weeks to discuss the business focus of the service.
- There was an up-to-date risk register for the service. Risks were red/amber/green (RAG) rated appropriately, depending on severity. The medical director was able to explain the reasons for these risks and any actions the service was taking to reduce these.
- The service used 'continuity of governance' (COG) documents to give an overall picture at the end of each shift. We reviewed three from July 2017 and saw they were complete and comprehensive, including

equipment and facility checks, any incidents or untoward events and actions taken, all medicines administered over the course of the shift, and a list of relevant staff names and contact numbers.

Public and staff engagement (local and service level if this is the main core service)

- The website included a section on patient advice after being assessed by staff at an event, including advice following a wound closure, or following head injury.
- Policies and procedures were available on the website for clients (i.e. events organisers) and the public to read.
- There were opportunities for staff to engage in the service; for example staff were encouraged to help conduct audits alongside a manager in an aspect of the service that particularly interested them. One member of staff who was skilled in web design and IT had created the online staff portal within the previous year, with support from managers, and this had been well received by the team.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The service was looking to develop its long-term or regular contracts to ensure sustainability, as they currently had a higher workload in the summer and much lower in winter, when there were fewer events and festivals.
- There were also areas of service improvement around developing the skills and competencies of staff, such as the fascia iliaca block training.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve
The provider should:

- Ensure consistent recorded checking of stock to ensure it is all within date.
- Ensure fridge temperature checks take place every day in accordance with local policy.
- Carry out regular audits of patient report forms (PRFs) and document any actions for improvement.