

Enhanced Care Services Ltd

Monks Brook

Quality Report

Unit 21 Monks Brook Industrial Park
School Close
Chandlers Ford
Eastleigh
SO53 4RA
Tel: 02380 201561
Website: www.enhancedcareservices.co.uk

Date of inspection visit: 19 March 2018
Date of publication: 24/07/2018

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

Ratings

Overall rating for this ambulance location

Emergency and urgent care services	
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Summary of findings

Letter from the Chief Inspector of Hospitals

Monks Brook was operated by Enhanced Care Services Limited (ECS), from a local headquarters which also housed vehicles and equipment. The service was run by two managing directors (one of whom was the registered manager) and a management team. The directors and all members of the management team were medically trained and some were experts in their field. Enhanced Care Service provided medical and paramedical services (to adults and children) at events of all types and sizes, which included urgent and emergency care and conveying of patients to acute hospital settings. Events were mostly sporting events but also included festivals and country shows. The service was designed to provide a higher level of care than is traditionally available at such events; this included enhanced and critical care. Services were provided directly to events and also as a 'bolt on' service. This meant they supplied medical professionals to other event medical companies, who were the main medical providers for the event. The CQC does not have powers to regulate medical and paramedical care and treatment provided at events. The report details our findings about the care and treatment provided to patients when conveyed from event sites to acute hospital settings.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 19 March 2018.

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

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

Services we do not rate

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

We found the following areas of good practice:

- The service provided a remote clinical advice line (RCAL) which gave staff immediate access to a member of the senior clinical faculty. All staff without exception mentioned the advice line as the first way they would report incidents to management and receive 'on the spot' support and guidance.
- After every 'significant' patient there was an operational debrief. A significant patient was a patient who had received significant medical care. This ensured that information was discussed and shared to facilitate learning from the experience. This meant that future risks could be mitigated enhancing the safety and effectiveness of the service.
- There was a genuinely open culture in which all safety concerns raised by staff were highly valued as integral to learning and improvement.
- An extensive training program had been developed so that management could be assured that staff had the right training and skills to provide the high quality service they expected.
- The service had an infection control policy and managed infection risk well.
- The service held a large stock of equipment. All equipment bags were set out in the same format and with the same equipment, which supported staff to access equipment promptly.
- Detailed analysis was undertaken before each event to identify risks and requirements in terms of medical support and cover. Steps were taken to mitigate identified risk in advance of events.

Summary of findings

- The provider had a set of policies that they reviewed on one, two or three yearly cycles depending on the type of policy.
- Robust recruitment procedures were in place.
- Staff spoke positively about the care of the service delivered by their colleagues and spoke of patients in a kind and respectful way.
- The registered manager planned staff numbers and skill mix in response to the type and size of the event and the requirements of the client. The service was able to control its own demand.
- The leadership was exemplary, creating an positive and supportive culture that ensured staff felt valued and respected.
- Staff felt fully engaged in developing the service.

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

- Staff appraisals were not fully completed
- Whilst staff had received high levels of appropriate mandatory training, there was no formal system in place for the provider to assure themselves that staff had received specific training regarding meeting patients' individual needs in respect of dementia or learning disability.
- There was limited patient feedback; however, the provider was looking at ways of improving this.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. You can read about these at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (area of responsibility) on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Emergency and urgent care services

Rating

Why have we given this rating?

Monks Brook was operated by Enhanced Care Services Limited (ECS), from a local headquarters which also housed vehicles and equipment. The service was run by two managing directors (one of whom was the registered manager) and a management team. The directors and all members of the management team were medically trained and some were experts in their field. Enhanced Care Services provided medical and paramedical services to events of all types and sizes, which included urgent and emergency care and conveying of patients to acute hospital settings. The service was designed to provide a higher level of care than is traditionally available through event providers, this included enhanced and critical care.

We found ECS to be an excellent well led service with high standards of governance. There were robust systems and processes in place to ensure the highest standards of care to patients.

Monks Brook

Detailed findings

Services we looked at

Emergency and urgent care;

Detailed findings

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Detailed findings from this inspection

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Background to Monks Brook

Monks Brook was operated by Enhanced Care Services Limited (ECS). The service was founded in 2015 by the Managing Directors Dr David Connor and Dr Edward Langford. Both are qualified medical doctors. It was registered with CQC in November 2016 for transport services, adding the regulated activity of treatment for disease, disorder or injury in May 2017.

It was an independent ambulance service in Chandlers Ford, Hampshire, providing prehospital event medical care. There were two types of activity; 20% of activity was where medical cover was provided directly to events, the remaining 80% was a 'bolt-on' service. This was where the provider supported other ambulance providers at

events bringing a higher level of medical care than the provider was normally able to do. The service operated nationally within the United Kingdom, with staff located throughout the country.

The service did not own any ambulances which transported patients to hospitals and therefore vehicles were not covered under the regulated activity inspected on the day. Whilst providing the 'bolt-on' service, if a patient required transferring to hospital, ECS staff provided care during the journey to hospital and also provided handover to NHS staff on arrival. This was the regulated activity we inspected.

The service has had a registered manager in post since November 2016.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a specialist advisor who was a paramedic

with experience and knowledge of emergency ambulance services and a second inspector. The inspection was overseen by an Inspection Manager and Mary Cridge, Head of Hospital Inspection.

Facts and data about Monks Brook

The service was 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 provider's headquarters in Chandlers Ford. We spoke with the registered manager, four directors (one of whom was also the registered manager), the administration manager and three staff including; registered paramedics and nurses.

Detailed findings

Following the inspection we spoke with the training manager, a paramedic, a doctor and a first responder. We also had communication with an event organiser that Enhanced Care Services had worked with.

The service had two vehicles, one for transporting staff to events and one for transporting patients within the event site. The service did not own ambulances which conveyed patients to hospital and therefore the vehicles were outside the scope of our inspection. We inspected the headquarters building, reviewed infection control practices, medical gas storage and medicine storage. We reviewed 27 patient records, cleaning records and policies and procedures relating to the running 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. This was the service's first inspection since registration with CQC in 2016.

Activity (January 2017 to December 2017)

- In the period January 2017 to December 2017

The company did not employ any staff directly. All were subcontracted and had other roles working in the NHS. This is a pre-requisite for staff to be on their database. There were two managing directors, a clinical director, a medical director, a pharmacist, an operations manager (recently recruited to), a fleet and equipment manager, an administration manager and a training manager. At

the time of the inspection there were 62 temporary staff on the database and the company were actively recruiting. The database of staff included critical care doctors, enhanced care doctors, first responders, nurses, nurse practitioners, paramedics, critical care paramedics, urgent care paramedics and a technician. The lead for controlled drugs (CDs) was the registered manager. Staff were available in between their NHS shifts. They were not required to complete a certain number of shifts with ECS as the system allowed them to sign up for shifts where they had availability.

Track record on safety

There were no reported never events in the 12 months preceding the inspection. Never events are serious patient safety incidents that should not happen if providers follow national guidance on how to prevent them. Each never event has the potential to cause serious harm or death but neither had happened.

There was one reported clinical incident and no serious injuries in the 12 months preceding the inspection.

There were no complaints received by the service in the 12 months preceding the inspection.

The provider contracted with other CQC registered independent ambulance providers to ensure delivery of contractual arrangements at events, for example via the 'bolt on' service.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Enhanced Care Service provided medical and paramedical services to events of all types and sizes, which included urgent and emergency care and conveyancing of patients to acute hospital settings. The service was designed to provide a higher level of care than is traditionally available through event providers, this included enhanced and critical care.

The service was run from the headquarters where vehicles and equipment were stored. The service supported events UK wide and staff were located across the country.

Summary of findings

We found the following areas of good practice:

- The service provided a remote clinical advice line (RCAL) which gave staff immediate access to a member of the management team. All staff, we spoke with, without exception mentioned the advice line as the first way they would report incidents to management and receive 'on the spot' support and guidance.
- After every 'significant' patient there was an operational debrief. This ensured that
- There was a genuinely open culture in which all safety concerns raised by staff were highly valued as integral to learning and improvement. This culture was appreciated by all staff we spoke with.
- An extensive training program had been developed in house so that management could be assured that staff had the right training and skills to provide the high quality service they expected.
- The service had an infection control policy and managed infection risk well.
- The service held a large stock of equipment. All equipment bags were set out in the same format and with the same equipment, which supported staff to access equipment promptly.
- Detailed analysis was undertaken before each event to identify risks and requirements in terms of medical support and cover. Steps were taken to mitigate identified risk in advance of events.

Emergency and urgent care services

- The provider had a set of policies that they reviewed on one, two or three yearly cycles depending on the type of policy.
- Robust recruitment procedures were in place.
- Staff spoke positively about the care of the service delivered by their colleagues and spoke of patients in a kind and respectful way.
- The registered manager planned staff numbers and skill mix in response to the type and size of the event and the requirements of the client. The service was able to control its own demand.
- The leadership was exemplary, creating a positive and supportive culture which ensured staff felt valued and respected.
- Staff felt fully engaged in developing the service.

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

- Staff appraisals were not fully completed
- The service relied on training staff received in the NHS in respect of meeting individual needs such as people living with a learning disability. The provider had no formal way of assuring themselves that each member of staff had received appropriate training and experience in meeting individual needs.
- There was limited patient feedback, however the provider was looking at ways of improving this.

Are emergency and urgent care services safe?

Incidents

- The service had processes to manage safety incidents well
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There had been no reported Never Events at Enhanced Care Services now referred to within this report as ECS. Staff we spoke with had an understanding about what Never Events were and that they needed to report any Never Events internally and nationally.
- The service had an incident reporting policy which was reviewed every two years. The policy was last reviewed in September 2016. The policy detailed a robust system which supported open and transparent reporting, incident investigation and shared learning.
- Staff were able to describe formal reporting systems for incidents, which were in line with the provider's policy. This was used to report the two incidents which had occurred. They also described how learning was shared through email, the provider's portal or via an instant messenger service. An example of this was an issue with information systems which required changes to processes and policies.
- Management told us that information was always shared in more than one way. Learning was also discussed at training days. For high importance messages, management were able to put out an 'assignment' through the portal. Staff were unable to book future shifts until the assignment had been completed. This was important because staff were located all over the UK and therefore it was unlikely that all staff would be together at the same time.
- The service provided a remote clinical advice line (RCAL) which gave staff immediate access to a member of the

Emergency and urgent care services

management team. All staff without exception mentioned RCAL as the first way they would report incidents to management and receive 'on the spot' support and guidance.

- After every 'significant' patient there was an operational debrief. A significant patient was one who had received significant care such as being anaesthetised. The significant patients all related to the regulated activity. This ensured that information was discussed and shared to facilitate learning from the experience. This meant that future risks could be mitigated enhancing the safety and effectiveness of the service.
- There was a genuinely open culture in which all safety concerns raised by staff were highly valued as integral to learning and improvement. For example at one event several people attended with heat illness. The directors decided it was appropriate to write a standard operating procedure (SOP) and referred to the knowledge of a member of staff with an interest in sports medicine to ensure this was appropriate.
- The Duty of Candour is a regulatory duty that relates to openness and transparency, it 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 patient. The directors of ECS, in conversation, demonstrated a good understanding of the Duty of Candour legislation. They reported there had been no incidents where the Duty of Candour legislation needed to be followed. Staff demonstrated their awareness and understanding of the duty of candour.

Mandatory training

- The service, required staff to have completed NHS training and at least two years in their NHS role before applying for a position. An extensive program had been developed so that management could be assured that staff had the right training and skills to provide the high quality service they expected. Mandatory training included safeguarding, medicines management, moving and handling and duty of candour.
- The training system ensured that only staff who had completed 100% of the training requirements could book working shifts. Once staff had completed training they still required sign off by management before they

were able to work. This followed several shadow events to ensure they had the right ethos. This meant that management could closely monitor training and the skills of staff to deliver care.

- All staff commented on the high quality of training which was provided and the professionalism with which it was delivered.

Safeguarding

- Staff understood how to protect patients from abuse. Staff gave examples of how they would recognise abuse and what steps they would take to ensure patients were safe.
- The registered manager was the safeguarding lead for the service and had extensive knowledge and training through his NHS role where he had completed level 3 safeguarding.
- There was a safeguarding policy in place, which ensured staff were aware of their responsibilities and reporting processes. Staff were provided with a safeguarding incident reporting form. Staff told us they would always discuss a safeguarding referral, when at an event, with RCAL giving them access to remote support and advice, especially in respect of difficult decision making.
- All staff had to complete the ECS's own electronic safeguarding training, which the provider said was level 2 training for both adults and children safeguarding. Staff provided evidence of level 2 and above safeguarding training on application to the role.
- Management told us they had plans to improve the current online safeguarding training package. A training day had been planned for safeguarding which would train all staff attending to level 3. For those staff who were unable to attend, we were told that training material would be made available to all staff.
- Although RCAL was the first port of call, it would be useful for staff if local safeguarding contacts were provided in the briefing pack. The provider told us they would educate staff to source local contact from websites.

Cleanliness, infection control and hygiene

- The service managed infection risk well.

Emergency and urgent care services

- The provider had an infection control and prevention policy dated February 2018, with the next review date in February 2021.
- There were a number of other policies and statements of practice in place supporting infection control and prevention. These included clinical waste and sharps management, hand hygiene and personal protective equipment. The provider had systems in place to ensure these were adhered to.
- The infection control lead had produced an Infection Prevention and Control (IPC) statement for 2017 summarising all measures which had been taken by the provider to mitigate the spread of infection.
- The service provided personal protective equipment such as disposable gloves, up to the elbow gloves, aprons, facemasks and safety eyewear. Conversations with staff confirmed the service provided them with PPE that they used.
- There was clear guidance about the disposal of clinical waste. This meant all clinical waste was sealed in secure bags, returned to headquarters where it was placed in a designated secure bin. The provider had a contract with an appropriate contractor to remove clinical waste on a regular basis.
- The service provided clear guidance about cleaning regimes for vehicles, which included six weekly deep cleaning, weekly cleaning and the staff cleaning vehicles after each patient transfer. Both vehicles inspected were visibly clean and records confirmed the vehicles had been regularly cleaned.
- The policy included detail about the cleaning of equipment, before, during and after use.
- Review of equipment stored at the headquarters showed equipment was visually clean. Cleaning equipment was colour coded as per the NHS National colour coding scheme to prevent cross contamination.
- There was a good supply of cleaning wipes to ensure equipment was cleaned in between use whilst at an event.
- Soiled equipment returned to store was clearly marked as such to prevent inadvertent use.
- Staff were required to provide immunisation records from their doctor.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- The ECS headquarters had sufficient storage space for equipment. There were suitable administration facilities, including IT facilities and secure storage for records.
- The service held a large stock of equipment. All equipment bags were set out in the same format and with the same equipment, which supported staff to access equipment promptly.
- The service had a process to monitor the expiry dates of all equipment. All equipment we looked at was in date and in good condition.
- In the circumstances when the provider supplied staff to other ambulance services, ECS staff were always provided with an ECS equipment bag. This provided assurance that appropriate, in date, working equipment was always available to a consistent and previously agreed standard. Conversation with staff confirmed they always had sufficient and appropriate equipment. When the ECS crew travelled on another provider's vehicle they used all their own equipment.
- Staff told us they were provided with event checklists which included rechecking equipment back to a checklist once on site. We saw evidence of this. This was a double check that they had all the equipment needed and knew where to locate it if needed in a hurry. Back up stocks were taken out so that staff were able to restock on site.
- There was a fleet and equipment manager in post who ensured that equipment and vehicles were fully maintained, well stocked and clean.

Medicines

- The service had a process for the ordering, receipt, storage of medicines and medical gases. The registered manager ordered medicines from a pharmaceutical wholesaler. Records maintained by the service provided a clear audit trail for medicines received into the headquarters, distributed into the paramedic bags, administered to patients and returned to headquarters for disposal.

Emergency and urgent care services

- There were arrangements for appropriate disposal and destruction of controlled drugs (CDs). CDs were audited monthly. We saw evidence that this had been completed fully.
- The registered manager had a home office licence that allowed them to order and receive controlled drugs. An annual drugs statement was produced in line with the conditions of the licence which covered breakages, losses or discrepancies. This ensured that all CDs were appropriately accounted for.
- Medical gases, such as oxygen, were stored securely at the headquarters and on the vehicles. Empty and full cylinders were stored appropriately in separate areas in the headquarters. There was appropriate monitoring of expiry dates.
- The Home Office Drugs Licence meant the provider had the ability to issue Patient Group Directives (PGDs). There were a number of PGDs in place, for example, for the use of co-amoxiclav, a commonly used antibiotic. This allowed qualified medical staff to respond quickly and appropriately administering medications needed, for example to treat certain infections.
- The Home Office Drugs Licence also meant they could purchase their own medicines rather than relying on healthcare professionals to do this under their own registration. This meant all medicines were standardised strengths and concentrations. Certain enhanced care medicines came in pre-filled syringes such as ketamine. There were safety systems in place, such as dedicated red syringes for rocuronium for paralysis for use by the critical care clinicians. This helped to reduce errors in low bandwidth, high stress situations. There was a clear emphasis on reducing errors and mitigating risk.
- Staff stored patient paper records in secure cabinets at the provider's headquarters. The provider followed national guidance about the length of time records were held for and disposed of records in a secure manner.
- We viewed a sample of 27 patient records. Information was clear, detailed the care treatment and advice provided. The records were dated, timed and signed by the member of staff making the record.
- The service did not have access to NHS patient records, however the managing director told us that where necessary, a patient's GP would be contacted.

Assessing and responding to patient risk

- Detailed analysis was undertaken before each event to identify risks and requirements in terms of medical support and cover. Steps were taken to mitigate identified risk in advance of events. For example if the event was a festival and potential drug use was expected a detailed plan was prepared and all staff were appropriately briefed. There was also analysis of the local area to ensure details of local hospitals (including specialities), trauma centres, fire services police and social services were part of the planning. This meant that patients could be transported to the most appropriate care provider in a timely manner.
- We saw that staff used a patient report form to risk assess individual patients, monitoring vital signs to support early identification of deteriorating patients. Staff used their professional skills and clinical experience to identify and follow appropriate treatment pathways.
- There was a procedure for monitoring a deteriorating patient, which staff followed. Vital signs were monitored and plans were made to transfer a patient to hospital if they became too unwell. Vital signs were recorded on patient report forms which were recorded regularly.
- Staff followed a safe discharge policy to ensure that only patients who had been treated appropriately and were well enough to be discharged were released from care. Where a patient did not follow advice and discharged themselves, appropriate escalation was followed, such as contacting the police.

Records

- The service had an information storage and sharing policy for the management of patients' records that staff complied with. Staff we spoke with indicated they followed this process, which included storage of patient records in secure boxes on the vehicle and the process for returning records securely to the headquarters.

Emergency and urgent care services

- Staff used their experience from working in the NHS to deal with behaviours which may challenge, and sought support from the police if patients demonstrated violent behaviour.
- Risk assessments were in place for use of medical equipment, manual handling of patients and clinical procedures such as emergency airway management.
- Clinicians recorded vital signs on a Patient Report Form (PRF). Many patients who presented for treatment were well, however when an unwell patient presented for treatment or there was a serious event incident clinicians used National Early Warning System (NEWS) 2. This followed guidance provided by the Royal College of Physicians, to assess patients. If a patient deteriorated appropriate steps to escalate care and treatment and arrange transport to an NHS hospital were taken.
- A strategic business plan had been prepared. This took into account the number of events, during the year, which had been turned down due to lack of capacity. Based on this a plan was prepared detailing the number of additional staff required including skill mix. ECS planned to double the workforce to meet expected demand. The plan included two month, one year and five year goals.
- ECS had a good understanding of their clients and which areas they wanted to target for expansion. They were also able to manage demand by accepting or declining requests for services. This meant they always had staff capacity for accepted assignments.
- The strategic business plan included an assessment of foreseeable risks and plans to mitigate these.

Staffing

- Staff were all contracted, not employed. They all worked in NHS roles around the country. Once they had completed the induction and training and had been signed off they were able to sign up for available shifts. All were free to choose their own working hours.
- Once an event had been booked, the registered manager determined the staffing levels and skill mix required through discussion with the client. This was dependent on the type and size of event and the level of cover the client required. Shifts were then loaded onto the scheduling system. Staff were only able to view shifts available at their grade. Staff then applied for shifts and these were confirmed by the registered manager to ensure suitability. Events were only confirmed with the client once the shifts had been filled. This ensured there was no risk of being short staffed.
- Staff told us the system worked well and they had never experienced a situation where roles had not been appropriately filled.
- Staff were required to produce evidence of their professional registration, qualification, training and competencies upon application and were not able to book any shifts until approved on the system by the registered manager as competent to do so.

Anticipated resource and capacity risks

Response to major incidents

- A risk assessment was in place for business continuity due to the loss of the headquarters.
- In the event of a major incident it was the responsibility of NHS emergency services to take the lead. ECS staff would support with their specialist skills under the direction of emergency services.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- We saw evidence that the service provided care and treatment based on national guidance, such as the National Institute for Health and Care Excellence (NICE) guidelines. This included management of conditions such as myocardial infarction and stroke. Patients were assessed using ABCDE (guidance from the Resuscitation Council).
- The provider had a set of policies that they reviewed on one, two or three yearly cycles depending on the type of policy. We reviewed a sample of the policies. Policies referred to national guidance. For example, the medicines management policy referred to The Human Medicines Regulations 2012.

Assessment and planning of care

Emergency and urgent care services

- ECS did not own a patient transport ambulance at the time of the inspection. When patients required transport to hospital, following treatment at an event, ECS staff accompanied them in an ambulance of a partner organisation for whom they were providing a 'bolt on' service.
- The provider adhered to national guidance for the management of patients with suspected heart attacks or strokes. Prior to all events the provider identified the locations of the nearest hospitals (including specialities) to the event they were supporting. This information was provided on a pre-event briefing sheet provided to all staff attending the event.
- The provider had a standard operating procedure in relation to sepsis. Clinicians used National Early Warning System (NEWS) 2, following guidance provided by the Royal College of Physicians, to assess patients. If a patient deteriorated appropriate steps to escalate care and treatment and arrange transport to an NHS hospital were taken.
- There were processes in place to assess the mental capacity of people presenting with a mental health condition. Specific guidance was in place regarding the discharge of patients who were under the influence of alcohol or drugs.
- A policy framework was in place for the senior team regarding safeguarding vulnerable people affected by mental health conditions.
- Targeted training had been provided to staff regarding the management of mental health conditions such as acute delirium.
- There was a specific discharge process in relation to the discharge of children. First responders were required to contact the RCAL prior to the discharge of any child.
- There were specific guidelines regarding administering medicines to children which ensured safeguards were in place to protect children.
- We reviewed the provider's recruitment policy February 2018. There were strict criteria for application and a person specification for each role. There were robust procedures in place including attendance at a selection day. Staff told us the recruitment process was rigorously followed and we reviewed two recruitment files as evidence of this.
- As part of the process the provider required prospective staff to produce evidence that they had recently completed a disclosure and barring service (DBS) check. The provider accepted enhanced DBS checks carried out by the member of staff's main place of employment. It was a requirement that DBS checks were less than three years old and a monthly check was carried out to pick up any which were about to go out of date. A new system was planned which would automatically produce an alert for DBS checks going out of date.
- Staff completed an induction process before they commenced working for ECS. This included, mission, vision and values, core training such as safeguarding, duty of candour and infection control. The induction process mirrors a portfolio which staff need to evidence. Staff are also required to sign a self-declaration for probity and integrity. Staff carried out shadow shifts before they were signed off as competent to work.
- Staff who held a professional registration such as nurses, doctors and paramedics were required to provide evidence of their experience and training at the interview stage.
- Qualified staff underwent competency assessments, for example in the use of pentrox (an analgesic). Pentrox was given under a local clinical instruction. The provider had a home office drugs licence.
- Regular team training days were provided covering manual handling, fire awareness and safeguarding. Within the team training days there were case based discussions. Staff openly discussed what went well, what could be improved and identified any learning gaps. Learning material was made available to staff unable to attend. Staff were located across the country and not all were able to attend the headquarters for every training session. The registered manager told us he was looking at remote learning opportunities. A recent minor injuries workshop had recently been held.

Response times and patient outcomes

- ECS were immediately on site at events and did not convey patients to hospital in their own vehicles. Therefore they did not participate in any national audits.

Competent staff

Emergency and urgent care services

- Prior to all events, staff working on events received a briefing paper inducting them to the event, facilities and working relationships with other providers. A briefing was also held at the start of the event including a 'skill of the day.' For example, if the event was a marathon, the skill of the day might be ensuring everyone knew how to identify runners who were dangerously ill as opposed to those who were exhausted because they had just run a marathon.
- The provider had started the appraisal process but was finding it time consuming due to the remote location of staff and staff other roles working in the NHS. At the time of the inspection two appraisals had been completed.
- Staff who belonged to professional registers were required to complete the relevant training and experience to maintain their registration. Staff were required to provide evidence of their renewed registration with professional registers.
- Providers of 'bolt-on' services, clients that ECS provided staff to, to attend events told us that they were always confident that staff provided by ECS had the necessary skills and experience. There were two main 'bolt on' services clients and we spoke with one and received a report from the other.

Coordination with other providers

- ECS worked with other independent ambulance providers as a 'bolt on' service, providing staff to support the service they provided at events. This meant that ECS were able to provide enhanced and critical care staff at events for which other providers may be the lead provider.
- ECS did not subcontract with NHS ambulance trusts, so did not have a requirement to escalate concerns with NHS ambulance trusts.

Multi-disciplinary working

- Following treatment, where a patient required transfer to hospital via ambulance, staff who had been providing treatment, accompanied the patient to hospital to ensure continuity of care for the journey and appropriate hand over to NHS hospital staff. ECS remained in charge of the patient's care until hand over at the hospital.

- ECS did not refer to other services, other than advising patients to contact their own GPs.
- Whilst attending events ECS worked in conjunction with other services attending the event, such as police, fire and rescue or coast guard.

Access to information

- Due to the nature of the work carried out by ECS staff did not have access to specialist notes about specific needs of patients and associated risks. On occasion the registered manager told us they contacted the patient's GP.
- ECS did not have ambulances which transported patients to hospital and therefore there was no requirement to have accurate and up to date satellite navigation systems.
- Staff could access the service's policies and procedures via the staff portal.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood their roles and responsibilities under the Mental Capacity Act 2005.
- All staff we spoke with demonstrated a good understanding about their responsibilities towards the Mental Capacity Act. This included assessing patient capacity to make specific decisions and carrying out best interest decisions when patients did not have capacity to make specific decisions about their treatment.
- The provider had mental capacity forms staff used to support and document assessments of patient capacity to consent to specific care and treatment.
- All staff had completed Mental Capacity Act training. This was mandatory and staff were not permitted to sign up for shifts until mandatory training had been completed.
- The provider did not convey section 136 patients. This is when patients with a suspected mental health problem are conveyed to a place of safety for assessment, rather being detained in police custody.
- Staff said they would take into account any Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders or advanced directives that patients had, if they

Emergency and urgent care services

were made aware of them. However, the provider did not have access to GP records and there was no formal process of identifying patients whether patients had a DNACPR in place.

Are emergency and urgent care services caring?

Compassionate care

- We were not able to observe interactions between staff and patients. This was because there was no suitable opportunity to observe staff providing care and treatment.
- Staff spoke positively about the care of the service delivered by their colleagues and spoke of patients in a kind and respectful way.
- Care and treatment was provided to patients in a separate area away from the public, providing privacy and dignity for patients.
- The registered manager told us about compliments received from clients and patients. We spoke with a client who told us they were very reassured by the staff provided. Overall there was a low quantity of feedback from patients. Although feedback forms were given to all patients, there was a low return. The provider was looking at ways of improving feedback.

Understanding and involvement of patients and those close to them

- Staff we spoke with told us they explained different treatment options to patients they attended. They told us that advice was usually about the next 24 hours as after that, they would expect a patient to be able to see their GP.
- One member of staff told us about a patient who, despite having an injured knee, chose to stay and enjoy the event. They had provided strapping and pain relief, following appropriate assessment, which had supported the patient's own decision.

Emotional support

- Due to the very limited feedback provided by patients, there was no information about emotional support given.

- Staff told us they supported patients' emotional needs by sitting with them, when they were upset. They said they adapted the emotional support to meet the needs of the patient. They also rang family members to let them know about the needs of the patient, at the patient's request.

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

Service planning and delivery to meet the needs of local people

- The registered manager planned staff numbers and skill mix in response to the type and size of the event and the requirements of the client. For example the 'bolt on' service to other ambulance providers was often used to provide enhanced and critical care staff to high risk events.
- The service did not have access to local patient records or alerts for patients who may present a risk to staff. To mitigate this risk, research was carried out prior to the event so that staff could be aware of any potential risks, such as whether there was likely to be gangs present at the event.

Meeting people's individual needs

- Staff took account of patients' individual needs.
- Staff told us they could access a language telephone line to assist communication with people whose first language was not English, if this was required.
- Staff were able to refer to the clinician advice line (RCAL) if they required any advice about how to meet individual patient needs. Staff told us they reacted to individual situations for example they had used a notepad and pen to communicate with a deaf patient.
- Staff required extensive NHS experience to work for ECS and this experience was relied upon in situations where patients had individual in relation to living with dementia or a learning disability. There was no way of formally assessing how much knowledge or experience individual staff members had about how to meet individual needs in respect of dementia or learning disability.

Emergency and urgent care services

- Information leaflets were also handed out to patients to ensure they had information on which to base their decisions.

Access and flow

- ECS did not transport patients to NHS Trusts, on their own vehicles, for treatment and therefore did not monitor or report on emergency turnaround times at emergency departments.

Learning from complaints and concerns

- The service had a complaints policy that set out the actions and time scales for investigating and responding to complaints.
- The service received no complaints between registration in October 2016 and the date of the inspection. All patients were given a feedback form following treatment.
- During the inspection we noted a learning and reflective culture which gave reassurances that complaints would be dealt with in accordance with the policy and learning from complaints would be shared, through mechanisms already in place.

Are emergency and urgent care services well-led?

Leadership of service

- ECS had leaders and managers with the right skills and abilities to run the service.
- The service was run by a senior management team supported by a management team. The senior management team consisted of two managing directors, a medical director and a clinical director. The management team consisted of an operations manager, a fleet and equipment manager, an administration manager, a training manager and an event manager. In addition leads had been assigned such as medicines, paramedic, medical, nursing and responder leads.
- There was a clinical operations delivery group which was made up of the management and senior management teams. The registered manager was also a managing director. There was a clearly defined structure

which was recognised by staff. Although the management team had other NHS roles they always ensured senior management were available to support events and the RCAL.

- All of the leads had extensive NHS experience and backgrounds. These included leadership roles in the NHS and multi-speciality qualifications. All had worked for a variety of organisations and most had achievements of note, such as setting up education schemes. All were registered with their professional body and were known and respected in their area of expertise.
- Staff we spoke with told us the leadership was 'absolutely fantastic.' Another told us that the leadership was very credible and that the leaders were well respected both inside and outside the organisation. Staff wanted to come and work for them because of their reputation.

Vision and strategy for this core service

- The registered manager stated the mission statement for ECS 'To promote, support and deliver superior event medical cover and critical care, with focus on robust governance, customer relations and skilled clinicians delivering the best possible care, irrespective of location, illness or injury.'
- The registered manager told us, ECS was launched to change the way event medicine was provided in the UK. The aim was to have no or very little impact on the NHS.
- Staff we spoke with told us they believed the service provided very high standards of care and that staff wanted to work for ECS because of the high clinical standards and the training programmes.

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

- ECS had a system for identifying risks and planning to eliminate or reduce them. We reviewed the provider's risk assessments. These detailed how the risks had been mitigated, for example, steps taken to reduce the risk transportation of controlled drugs for operational use.
- Directors meetings were held every three months. Directors discussed clinical governance, training, recruitment and documents that guide practice. We reviewed minutes of these meetings.

Emergency and urgent care services

- A clinical operations delivery group met bi-monthly. The purpose of the group was to ensure that the service was meeting its strategic objectives and that clinical and training services were delivered with quality, accountability, responsibility, safety and excellence. Representatives included members of the senior management team and the management team. The standing agenda always included patient safety and incident reporting. For example a difference of clinical opinion was reported as in incident and this was discussed to explore learning.
- The managing director told us the service was 'exponentially focussed on governance' with the aim of being the best event provider.
- There was a monthly audit of patient report forms to ensure continued quality; in addition all cardiac arrests were routinely reviewed. Any identified issues were discussed with individual staff members initially and anonymised and shared via the service's communication systems where necessary.
- ECS sought external confirmation of quality and systems. Another ambulance provider carried out an audit of the service in December 2017. ECS still awaited the full report, however a letter sent on 14th May stated they had found no concerns.

Culture within the service

- We observed an open and honest culture throughout the organisation from directors to staff on the ground.
- Staff described the leaders as approachable and 'good and what they do.' Staff told us that the leadership were always willing to listen and respond to feedback and consistently requested feedback.
- Another staff member told us that the leaders' professionalism stood out. They said they were constantly striving to improve the industry.
- Staff said leaders were personable and approachable. Clinical challenge was open to anyone at whatever level. There was a culture where a first responder felt comfortable to challenge the medical director and vice versa.

- Staff described a supportive organisation that values and invests in its staff. One staff member said 'They are a company I believe in.' Staff said they felt respected, valued and listened to.

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

- The service engaged with local organisations to plan and manage the service and had processes to engage with patients.
- There were patient satisfaction surveys that staff gave to all patients but there was very little response from these, which would support development of the service.
- ECS received thank you and compliment letters; we reviewed a sample, which demonstrated a high level of satisfaction.
- Staff reported regular communication through email, the portal and other media and that management were open to suggestions about improvements to the service.
- Despite the wide geography of staff location, staff told us they felt involved and were constantly asked for their view. The registered manager told us that when policies and procedures came up for review, staff were asked for their opinion at training days to ensure they felt part of the running of the organisation.
- There was a programme of meetings and teleconferences for all staff to ensure staff engagement was a key part of the success of the organisation.

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

- Discussion with the registered manager and the directors showed they were continually looking at ways to ensure ongoing improvement and the sustainability of the company.
- The registered manager told us the service were always looking at new ways of innovation. They were looking at new policies and procedures and were continually looking at ways to develop and innovate staff, by reviewing training and education and seeking feedback from staff about the training. Staff with special skill areas were asked to run training sessions for the team.
- Future plans involved purchasing or hiring ambulances and looking at air ambulance.

Outstanding practice and areas for improvement

Outstanding practice

- The service provided a remote clinical advice line (RCAL) which gave staff immediate access to a member of the management team. A system of back-ups was set up to ensure that calls were always answered. All staff without exception mentioned the advice line as key support to discuss any issue whether it be clinical, safeguarding, incidents or operational support and procedures. The system was innovative and vital to staff whilst working away from base. Staff told us the service was extremely helpful and very professional. The service was not just available to ECS staff but all staff from other providers in attendance at an event.
- Outstanding leadership meant there was a genuinely open culture in which all concerns raised by staff and people who used the service were highly valued as integral to learning and improvement. All staff were open and transparent. There was a robust recruitment and induction process with strong governance processes which meant that ECS was a highly respected organisation.
- ECS held a Home Office Drugs Licence which meant they could purchase their own medicines rather than relying on healthcare professionals to do this under their own registration. This meant all medicines were standardised strengths and concentrations. Certain enhanced care medicines came in pre-filled syringes, such as ketamine. There were safety systems in place, such as dedicated red syringes for rocuronium for paralysis for use by the critical care clinicians. This was in line with local air ambulance services and ahead of some NHS trusts. This helped to reduce errors in low bandwidth, high stress situations. There was a clear emphasis on reducing errors and mitigating risk.

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should continue to develop and implement the appraisal process.
- The provider should consider how they assure themselves that all staff have appropriate training in meeting the individual needs of patients in relation to people living with a learning disability or dementia.