Multi Health Medical Services UK Limited

Multi Health Medical Services UK

Quality Report

Unit 1, Asquith Avenue Business Park
Asquith Avenue,
Gildersome,
Morley,
Leeds,
West Yorkshire,
LS27 7RZ
Tel: 01924366851
Website: www.multihealthmedical.co.uk

Date of inspection visit: 21 March 2018
Date of publication: 06/07/2018

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Multi Health Medical Services UK is operated by Multi Health Medical Services UK Limited. It is an independent ambulance provider based in Morley, West Yorkshire. The provider`s main service was providing medical cover at public and private events. We did not inspect this part of their service at this inspection.

The provider was registered to provide the following regulated activities:

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

The provider had provided emergency and urgent care for one patient in the last 12 months which was a transfer from an event to hospital. The provider had not carried out any patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 21 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 issues that the service provider needs to improve:

- There was no information and guidance about how to complain made available and accessible to everyone who used the service either on the provider website or carried on the PTS vehicle.
- Staff did not know what a never event was.
- The recording and management of never events and near misses were not included in the provider`s policy documents.
- Staff did not know what the basic principles of duty of candour legislation were and how to apply them.
- The provider did not have a duty of candour policy.
- The provider did not have a system to record and audit the issuing of non-prescription drugs by staff
- The process reported in the operations manual in relation to the issuing and auditing of non-prescription drugs was not aligned with processes operating within the service.
- The provider did not carry out regular hand hygiene or personal protective equipment audits to ensure levels of compliance.
- The provider`s ambulance did not carry a stretcher with a six point harness.
- The provider did record any health and safety audit activity.
- The provider did not have a risk register or a system to manage foreseeable risk.
- The provider did not have a business continuity plan.

Summary of findings

- The provider did not have a system to measure and record levels of staff adherence to policies and procedures.
- The four monthly meetings between the managing director and director of operations and the six monthly meetings with the management team and the Emergency Care Practitioner (ECP) did not have an agenda and the minutes and actions were not recorded.
- The provider did not have a system to ensure the operations manual and policies within it were updated with relevant information in a timely manner.

However, we found the following areas of good practice:

- The director of operations and the temporary team leader had a Business and Technology Education Council (BTEC) Level three advanced driver qualification.
- The temporary team leader who was acting as safeguarding lead had undertaken safeguarding level three training for children and adults.
- Staff we spoke with could describe different signs of potential abuse that could lead to a safeguarding referral.
- The provider`s ambulance, was visibly clean and all equipment carried on the vehicle was in date and where required had been tested in accordance with portable appliance testing (PAT).
- The station environment was spacious, clean, tidy and well organised.
- There was evidence that equipment had been regularly tested and test dates were recorded in an equipment log book.
- Staff completed checks of the vehicle and equipment carried on it before deployment. There was evidence that the checks had been recorded.
- The director of operations was aware of the principles of assessing mental capacity and making best interest decisions.
- The leaders had been visible because they worked on all operational activity.

Following this inspection, we told the provider that it must take eight actions to comply with the regulations and that it should make four other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected urgent and emergency care. Details are at the end of the report.

Ellen Armistead

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	Rating	Why have we given this rating?
Emergency and urgent care services		Multi Health Medical Services UK provides urgent and emergency services for patients transferring from private and public events to hospitals as part of some of their events contracts. They had transferred one patient to hospital in the last 12 months. We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve. There were a number of areas for improvement identified during the inspection including nine actions the provider must take and fiver actions the provider should take. There were three requirement notices issued which required the provider to send CQC a report outlining what action they were going to take to meet the requirements. Full details are at the end of this report.

Multi Health Medical Services UK

Detailed findings

Services we looked at
Emergency and urgent care.

Detailed findings

Contents

Background to Multi Health Medical Services UK

Multi Health Medical Services UK is operated by Multi Health Medical Services UK Limited. The company was founded in 2007 and offered services throughout the UK providing medical support at public and private events. The service registered with the CQC in May 2012. It is an independent ambulance service based in Morley, West Yorkshire.

The service had a registered manager, who was also the director of operations, in post since 2016.

The company provided a range of services including: urgent and emergency paramedic and first aid medical coverage at both private and public events including the ability to transfer a patient off site to hospital if required; blood and organ transport; first aid training and repatriation of patients. On site only event medical provision is currently not regulated by CQC

The focus of this announced inspection was in relation to the urgent and emergency care of patients.

The provider was registered to provide the following regulated activities:

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

This provider was subject to an announced focussed inspection on 21 March 2018.

The provider employed two full time staff; the registered manager who was also the director of operations and a managing director who was the safeguarding lead. At the time of this inspection the managing director was on leave of absence. To cover the absence the company had employed a temporary team leader to work one day a week to support the director of operations with the daily running of the company. The leadership team could access advice from an Emergency Care Practitioner (ECP) on a voluntary non-contractual basis approximately twice a year and as needed.

The provider tendered for business for events throughout the country or provided additional resources for events in support of other independent ambulance providers when requested.

When the provider was contracted to provide medical cover at an event, and the resources required exceeded two, they would seek additional resources from another independent ambulance provider who had a pool of staff to use. The additional staff at the event would be working for the provider from where they were sourced, not Multi Health Medical Services UK, even though they had the contract for the event.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and two

specialist advisors. One of the specialist advisors was a paramedic and the other had expertise in ambulance governance. The inspection team was overseen by Lorraine Bolam, Interim Head of Hospital Inspection.

Facts and data about Multi Health Medical Services UK

Multi Health Medical Services UK first registered with the CQC in May 2012. The provider is an independent ambulance service in Morley, West Yorkshire and operated at events throughout the UK. The company provided a range of services including: urgent and emergency paramedic and first aid medical coverage at both private and public events; aid training and repatriation of patients.

The service had a registered manager who was also the director of operations.

During the inspection, we visited Unit 1, Asquith Avenue Business Park, Asquith Avenue, Gildersome, Morley, Leeds, West Yorkshire, LS27 7RZ which was the provider`s operating base.

The building was a privately leased building in an industrial estate. The exterior of the building was fitted with security lights and a CCTV system. The whole building was alarmed. There was a car park to the front of the building with ample space for the provider`s ambulance and private vehicles.

The ground floor had an alarmed entrance door and a converted garage which was used as a training room and for storage of consumable items which were kept in plastic storage crates. The ground floor also had a unisex toilet with disabled access for staff or visitors. There was also a cupboard for the storage of cleaning products and equipment which was not locked.

On the first floor there was a large training room which was also used as a meeting room. Equipment was also stored there. Adjoined to that was a separate shared office which was used by the providers staff. The office contained a number of locking filing cabinets used for storing documents. The first floor had welfare facilities for staff to use.

We spoke with two staff, the operations director and the temporary team leader. During our inspection, we reviewed one patient record.

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 had been previously inspected in November 2013.

Activity (April 2017 to March 2018)

- In the reporting period April 2017 to March 2018 there was one emergency and urgent care patient journey undertaken.
- There were no routine patient transport journeys undertaken.

Track record on safety

- No Never events reported.
- No clinical incidents of no harm or resulting in low harm, moderate harm, severe harm, or death reported.
- No serious injuries reported.
- No complaints reported.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Multi Health Medical Services UK Limited is an independent ambulance service operating from Morley, West Yorkshire. The provider provides medical support at public and private events. Events are currently not regulated by us. The provider did undertake urgent and emergency care for patients transferring from an event to a local hospital which is regulated by CQC. The provider had one ambulance equipped for treating and transporting patients and could hire other vehicles for events if required.

Summary of findings

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 issues that the service provider needs to improve:

- There was no information and guidance about how to complain made available and accessible to everyone who used the service either on the provider website or carried on the PTS vehicle.
- Staff did not know what a never event was.
- The recording and management of never events and near misses were not included in the provider`s policy documents.
- Staff did not know what the basic principles of duty of candour legislation were and how to apply them.
- The provider did not have a duty of candour policy.
- The provider did not have a system to record and audit the issuing of non-prescription drugs by staff
- The process reported in the operations manual in relation to the issuing and auditing of non-prescription drugs was not aligned with processes operating within the service.
- The provider did not carry out regular hand hygiene or personal protective equipment audits to ensure levels of compliance.

Emergency and urgent care services

- The provider`s ambulance did not carryastretcher with a six point harness.
- The provider did record any health and safety audit activity.
- The provider did not have a risk register or a system to manage foreseeable risk.
- The provider did not have a business continuity plan.
- The provider did not have a system to measure and record levels of staff adherence to policies and procedures.
- The four monthly meetings between the managing director and director of operations and the six monthly meetings with the management team and the Emergency Care Practitioner (ECP) did not have an agenda and the minutes and actions were not recorded.
- The provider did not have a system to ensure the operations manual and policies within it were updated with relevant information in a timely manner.

However, we found the following areas of good practice:

- The director of operations and the temporary team leader had a Business and Technology Education Council (BTEC) Level three advanced driver qualification.
- The temporary team leader who was acting as safeguarding lead had undertaken safeguarding level three training for children and adults.
- Staff we spoke with could describe different signs of potential abuse that could lead to a safeguarding referral.
- The provider`s ambulance, was visibly clean and all equipment carried on the vehicle was in date and where required had been tested in accordance with portable appliance testing (PAT).
- The station environment was spacious, clean, tidy and well organised.
- There was evidence that equipment had been regularly tested and test dates were recorded in an equipment log book.
- Staff completed checks of the vehicle and equipment carried on it before deployment. There was evidence that the checks had been recorded.
- The director of operations was aware of the principles of assessing mental capacity and making best interest decisions.
- The leaders had been visible because they worked on all operational activity.

Emergency and urgent care services

Are emergency and urgent care services safe?

We found the following areas of good practice:

- The one completed patient record form for a patient transferred from an event to hospital was reviewed. All the appropriate information had been completed in full.
- The director of operations and the temporary team leader had a Business and Technology Education Council (BTEC) Level three advanced driver qualification.
- Staff we spoke with could describe different signs of potential abuse that could lead to a safeguarding referral and there was a process to support referrals.
- The provider`s ambulance was visibly clean. All equipment carried on the ambulance was inspected and found to be in date and where required tested in accordance with portable appliance testing (PAT).
- The station environment was spacious, clean, tidy and well organised. There was evidence the equipment had been regularly tested and test dates were recorded in an equipment log book and were up to date at the time of the inspection.
- Staff told us they completed vehicle and equipment checks before deployment. We saw evidence of this in the vehicle and equipment checklists.

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

- Staff we spoke with did not know what a never event was.
- The provider`s incident policies did not include never events or near misses.
- Staff we spoke with were not aware of the basic principles of duty of candour legislation or how to apply it.
- The provider did not have a duty of candour policy.
- There was no evidence that a hand hygiene or personal protective equipment audit had been carried out.
- There was no six- point stretcher harness in the providers ambulance.

Incidents

- The service had not recorded any never events during the past 12 months. Never events are incidents of serious patient harm 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.
- Staff we spoke with did not know what a never event was.
- The provider did have an incident policy which stated that accidents, incidences, and non-conformances should be documented and that investigations should then be undertaken. The policy did not include never events or near misses.
- The registered manager, who was also the director of operations, told us no incidents had occurred or been reported in the past year.
- The temporary manager told us if an incident or concern occurred staff would submit an incident form to the director of operations that would review the report and decide what action to take.
- Although the provider had not reported any incidents or never events in the last 12 months, during our inspection there was evidence of a formal system for reporting and responding to incidents if they occurred.
- The provider did not have the ability to collectively review incidents or never events in order to identify any trends or learning because of the low level of incident report linked to the low levels of regulated activity.
- Staff we spoke with were not aware of the basic principles of duty of candour legislation.
- The provider did not have a duty of candour policy.
- 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.

Mandatory training

- We reviewed the personal files of the managerial staff. The files showed training had been undertaken in the

past year on a range of topics. Courses completed included, basic life support, complaints, consent, conflict resolution, dementia, equality and diversity, fire safety, infection prevention, Mental Capacity Act, Mental Health Act, privacy and dignity, and safeguarding adults and children level three.

- The provider was totally reliant upon the provider that supplied Multi Health Medical Services UK with staff for events , and who could provide urgent and emergency care, had received and were up to date with their mandatory training. We did not see evidence the provider had a system to confirm this.
- There was evidence in training records from April 2017 that two people who had expressed an interest in working for Multi Health Medical Services UK had received initial training. There was no evidence of any subsequent follow up or annual refresher training for those staff.
- There was evidence the director of operations and the temporary team leader had a Business and Technology Education Council (BTEC) Level three advanced driver qualification.
- None of the drivers required any additional driving qualifications because the ambulance was less than 3500kg and therefore the staff did not require C1 on their driving licence.

Safeguarding

- The managing director was the designated safeguarding lead. There was evidence that the managing director had undertaken safeguarding training for children and adults level three.
- The temporary team leader was acting as safeguarding lead at the time of the inspection due to the absence of the managing director. We saw evidence the temporary team leader had undertaken safeguarding level three training for children and adults. Staff we spoke with could describe different signs of potential abuse that could lead to a safeguarding referral.
- The director of operations and the temporary team leader told us before the ambulance was deployed information about local safeguarding services and police contact phone numbers were provided to staff as well as contact details for safeguarding leads within Multi Health Medical Services UK. This information was included as part of an event plan.
- The director of operations told us if there were safeguarding concerns staff would contact the Multi Health Medical Services UK safeguarding lead for advice. Advice would be provided by the safeguarding lead over the telephone or if possible the safeguarding lead would meet the member of staff and provide advice.
- The provider`s operations manual stated if there was an immediate risk of harm then a verbal safeguarding referral should be made straight away to the local authority safeguarding team. However, the safeguarding referral form stated all safeguarding concerns should be escalated to the organisation safeguarding lead within 24 hours. Specifying this timescale on safeguarding forms could mean there was a risk safeguarding referrals would not be undertaken in a timely way based on staff assessment of the specific situation.
- We acknowledged that because the service carried out low levels of regulated activity the risk to vulnerable people in relation to the reporting of safeguarding incidents within 24 hours was low. However, due to the potential for the service to win contracts and increase the levels of regulated activity in the future this was a concern.
- The provider`s safeguarding children policy stated key words used by the child should be recorded, but only if the child agrees. However, national guidance states there may be occasions where it is necessary to record the child's statement without consent in order to safeguard wellbeing.
- There was no evidence of any contact information in relation to the provider`s safeguarding lead or the local authority safeguarding key contacts being readily available for staff on the provider`s ambulance. The director of operations told us the information was available for staff on a credit card sized card. However, the director of operations could not locate one for us to inspect in the ambulance or in the providers premises.
- Staff reported safeguarding training was online with no face to face component.

- Staff we spoke with told us they had not made any safeguarding referrals.

Cleanliness, infection control and hygiene

- The provider had an infection control policy which covered the responsibilities of management, general infection and control considerations, adherence to infection and control practices and vehicle care. However, there was no evidence as to how the provider would monitor and audit staff activities or adherence in relation to these.
- The provider had one urgent and emergency care vehicle, which was inspected. The vehicle was visibly clean. All equipment carried on the ambulance was found to be in date and where required tested in accordance with portable appliance testing (PAT).
- The vehicle had, cleaning wipes, personal protective equipment including gloves, aprons and face masks. Hand cleansing gel was personal issue and carried by staff who worked on the ambulance.
- During the inspection we did see that a record was kept of when the vehicle had been cleaned. However, there was no evidence of any audit activity to ensure compliance with this policy.
- There was no evidence an audit of hand hygiene or personal protective equipment had been carried out.
- Staff told us they would wear their own uniforms or uniforms issued by the company while at work for Multi Health Medical Services UK. They told us after each use the uniforms were washed at high temperature with antibacterial solution and tumble dried.
- During the inspection the staff we spoke with dressed in their own clothes so we could not evidence if the uniforms worn when working for Multi Health Medical Services UK were clean or not.
- There was no evidence the provider observed staff hand washing.

Environment and equipment

- The station environment was spacious, clean, tidy and well organised.
- The urgent and emergency care ambulance carried essential emergency equipment. The electro cardiogram machine and defibrillator had been removed from the vehicle due to the recent cold weather to prevent the batteries being discharged. The electro cardiogram machine and defibrillator were stored on the first floor of the providers operating base and kept fully charged ready for use.
- The equipment including that which required portable appliance testing (PAT) was serviced and tested by an external specialist company.
- The director of operations told us all equipment was serviced on a yearly basis in accordance with the policy in the equipment manual. The policy stated if there were problems with equipment then staff would record a written statement and inform the director of operations so problems could be rectified.
- There was evidence the equipment had been regularly tested and test dates were recorded in an equipment log book and were in date at the time of the inspection.
- Staff told us they completed vehicle and equipment checks before deployment. We saw evidence of this in the vehicle and equipment checklists.
- The urgent and emergency care ambulance had a current Ministry of Transport annual test certificate (MOT) and there was evidence the vehicle had been serviced. The vehicle weight was below 3500kgs so there was no requirement for the drivers to have a C1 classification on their driving licence.
- During the inspection of the ambulance we found there was there was only a four point stretcher harness. The stretcher should have a six point harness.
- The provider`s operations manual stated health and safety audits should be undertaken to ensure the health and safety of staff in the workplace and that staff used personal protective equipment. The director of operations told us he undertook 'spot checks' of the levels of compliance but he did not document these or have a record to outline which areas the `spot checks` had covered.

Medicines

- The provider`s operations manual stated before deploying the ambulance medicine packs were signed out to 'qualified and competent staff' and then 'signed back in on return'. However, there was no evidence that

the issuing of non-prescription drugs by the provider to staff was recorded or audited. The process reported in the operations manual was therefore not aligned with processes operating within the service.

- We acknowledged that because the service carried out low levels of regulated activity the risk to patients in relation to errors in the issuing of non-prescription drugs was low. However, due to the potential for the service to win contracts and increase the levels of regulated activity in the future there was a concern the service did not systems in place to deal any increase.
- The provider had a supply of non- prescription drugs which were ordered from a local supermarket pharmacy and kept locked in a safe. Once the stock was low the drugs were reordered and collected.
- Paramedics that worked at the same event as Multi Health Medical Services UK staff and who could be involved in providing urgent and emergency care and transporting a patient off-site carried their own controlled drugs in accordance with exemption 17 of the Medicines Act 2012.
- Medical gases were supplied to the provider by the British Oxygen Company (BOC). There were no medical gases stored on the provider`s premises. There were three Entonox bags which were inspected; the bags did not contain any cylinders, only delivery pipes, all of which had in date service stickers.
- In order to replenish any medical gases the provider travelled to the local British Oxygen Company (BOC) depot returning empty cylinders and collecting full ones.
- Medical gases were stored correctly on the ambulance and the only medicine stored on the vehicle was a bag of saline.

Records

- Patient report forms submitted by staff were paper based. When these were finalised they were taken from the ambulance, delivered to the main office and handed to the director of operations to review. The paper forms were stored securely in a locking cabinet after review.
- The director of operations told us patient records would be retained for ten years before destruction.
- The patient record form was an A4 double sided document which was not carbonated. There was no evidence as to how the patient information on the form could be passed to hospital staff when a patient was admitted.
- One completed patient record form for the only patient transferred from an event to hospital was reviewed. This was in the period between April 2017 and March 2018. All the appropriate information had been completed in full including the patient's personal details, assessment, observations, treatment provided, diagnosis and outcome which on that occasion was transfer to hospital.
- Staff we spoke with were aware of DNACPR and special notes. However, due to the type of work carried out by Multi Health Medical Services UK it was highly unlikely that staff would encounter a patient with a DNACPR.
- Staff would be made aware of special notes including pre-existing conditions or safety risks by speaking to the patient, relative, carer of friend. This information would be recorded on the patient record form.
- Due to the low level of regulated activity we could not evidence assurance that the patient records would be passed to the relevant care/health/staff at a receiving provider.

Assessing and responding to patient risk

- Staff we spoke with told us the actions they would take in the event of a patient deteriorating. Both told us they would treat the patient in accordance with their condition and either transport the patient to the hospital in the provider`s ambulance or transfer the patient by local NHS ambulance.
- Staff we spoke with were aware of Joint Royal Colleges Ambulance Liaison Committee (JRCALC) protocols for assessing patient risk and how to use them.
- Staff we spoke with told us the decision to transfer a patient from an event site was based on a number of factors including clinical severity of the patient`s condition. In addition if the event contract did not stipulate that Multi Health Medical Services UK should have the ability to transfer patients off site then the response time from the local NHS ambulance trust would also be considered before deciding whether to transfer the patient themselves as an emergency.

- Staff told us any clinical advice and escalation processes would be discussed with the director of operations.
- There was no evidence of any policies or procedures being in place to manage violent or aggressive patients. Staff we spoke with told us if a patient was or became violent or aggressive then the on-site event security staff would be contacted to intervene. Staff could not explain what action they would take if a patient who was being transferred from an event to hospital became violent or aggressive.

Staffing

- We reviewed the staff files for the managerial staff including the temporary team leader. The files for the managing director and director of operations contained all relevant documentation, evidence of course attendance and qualifications.
- The provider did not have a shift pattern to align to in order to meet demand. If the provider had a contract to supply medical support for an event including the ability to transfer patients off-site the staffing and skills required would be set by the event organiser or by the Safety Advisory Group (SAG).
- When the provider was contracted to provide medical cover at an event and the resources required exceeded two they would seek additional resources from another independent ambulance provider who had a pool of staff to use.
- The additional staff at the event would be working for the provider where they were sourced from not Multi Health Medical Services UK, even though they had the contract for the event.
- Multi Health Medical Services UK was totally reliant upon the provider supplying them with staff for events to ensure the competencies of the staff were up to date.

Anticipated resource and capacity risks

- There was no evidence the provider planned for future demand because the provider did not have any regular permanent event contracts requiring the provision of urgent and emergency care.
- Due to the nature of the providers work they did not have guaranteed contracts with event organisers and therefore anticipated resources and capacity risks could not be planned for.
- There was no evidence the provider managed foreseeable risk. There was no evidence the provider had a risk register. Staff we spoke with told us risks were managed through the event plan which was written by the event organiser.

Response to major incidents

- There was no evidence the provider had a business continuity plan. The director of operations told us if the provider`s current business premises became unusable they would operate on a mobile basis. There was no evidence this had been tested to confirm it was a viable solution.
- The provider did not form part in any NHS trust major incident plan staff therefore had not had any training or experience in responding to major incidents.
- The provider had local arrangements with other independent ambulance providers to loan an ambulance in the event of their vehicle being unavailable due to mechanical problems.
- There was evidence of a fire evacuation plan displayed on the walls in prominent places in the building. However, there was no evidence the plan had been tested or simulated fire drills had been carried out.

Are emergency and urgent care services effective?

We found the following issues that the service provider needs to improve:

- There was no evidence the provider had the ability to measure and record levels of staff adherence to local policies and procedures.
- The provider did not do any staff appraisals.
- We did not see any evidence of how the provider could check staff had read, understood and were complying with the policies.

However, we found the following areas of good practice:

- The director of operations was aware of the principles of assessing mental capacity and making best interests decisions.

Evidence-based care and treatment

- The provider`s policies were based on National Institute of Care and Excellence (NICE) Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines.
- The provider had the following policies ; drugs management policy, health and safety policy, services consent and capacity policy, data protection policy, infection control policy, vehicle cleaning schedule policy, safeguarding children policy, safeguarding vulnerable adults policy, complaints policy, recruitment policy, equal opportunities policy, mandatory training policy, training health and safety policy, monitoring policy and reviewing policy.
- The provider was reliant upon the primary employer of staff working for Multi Health Medical Services UK to ensure they followed National Institute of Care and Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines and used the guidance to plan patient care and treatment.
- There was no evidence the provider recorded or had the ability to measure and record levels of staff adherence to local policies and procedures.
- We acknowledged that because the service carried out low levels of regulated activity the risk in relation to non-adherence to the services policies and procedures by staff was low. However, due to the potential for the service to win contracts and increase the levels of regulated activity in the future the lack of a system to measure and record levels of compliance was a concern.

Assessment and planning of care

- The provider planned for the appropriate levels of care in discussion with the event organisers and through the safety advisory group .This included the number of staff and skills required. It also covered the pathways for care, including conveyance to the appropriate hospital by NHS ambulance if the event contract did not stipulate that Multi Health Medical Services UK had to provide that service.
- The provider did not have company protocols for patients with mental health issues and those with suspected heart attack or stroke or for the treatment of children. The director of operations told us those protocols formed part of the event plan written by the event organiser.

Response times and patient outcomes

- The provider did not monitor response times because they provided event medical cover only and were already on site when patients presented.
- The provider`s response times in relation to their regulated activity was not monitored due to the low levels of regulated activity carried out.
- Due to the low level of regulated activity carried out by the provider and the unpredictable nature of their contractual arrangements it was not possible for the provider to gather meaningful data and therefore they did not participate in or take part in national audits.

Competent staff

- The provider had a recruitment policy that covered the application procedure for sub-contractors who would be selected for duties in accordance with their experience and qualifications and what information was required to be held in staff personal records. This included a training log of all mandatory training that had to be completed prior to commencing duty, for example, Safeguarding children, Protection of Vulnerable Adults, Infection control etc.
- However, the director of operations told us Multi Health Medical Services UK did not sub-contract staff to work for them. If additional staff over and above the two full time employees were required they would seek additional resources from another independent ambulance provider who had a pool of staff to use. The additional staff at the event would be working for the provider where they were sourced not Multi Health Medical Services UK even though they had the contract for the event. This contradicts the company policy.
- The provider did not do any staff appraisals. We were told us that the two owners were the only employees.
- The director of operations told us staff expressing an interest in working on a casual basis for Multi Health Medical Services UK received one to two day induction course. The induction included an introduction to the

company, safeguarding training from the operations director or managing director, manual handling training from the operations director, and a basic life support assessment from director of operations.

- The director of operations told us as part of the induction process staff would be asked to read the operational manual and policies within it. However, we did not see evidence of how the provider could check staff had read, understood and were complying with the policies.
- We acknowledged that because the service carried out low levels of regulated activity the risk in relation to not having a system to check if newly recruited staff had read, understood and were complying with the policies low. However, due to the potential for the service to win contracts and increase the levels of regulated activity the lack of a system to check and record this was a concern.
- There was no formal internal driver training or assessment carried out by the provider.

Coordination with other providers

- We saw evidence of a multi-agency approach to the planning of urgent patient transport services from an event from an event plan. Staff liaised with the event organisers and were included in local NHS ambulance service plans.
- Senior managers attended 'Safety Advisory Group' meetings along with representatives of the fire brigade, police, local NHS ambulance services and the local authority. The group discussed the anticipated risks associated with urgent patient transport provision from the event. The group also performed risk assessments, which enabled them to agree the resources required in conjunction with the client.
- Staff told us and we saw from reviewing one patient report form that it was made available when handing over patients taken via ambulance to a receiving NHS facility. The staff that we spoke with indicated that they would pre-alert the receiving facility.

Multi-disciplinary working

- As no patient contact was observed during the inspection we were not able to observe any patient handovers from for Multi Health Medical Services UK with hospital staff.
- Due to the low level of provider regulated activity we were only able to review one patient record form there was no evidence of any multi-disciplinary work on the form between Multi Health Medical Services UK and the hospital staff.
- The one patient record form that was reviewed during the inspection did not evidence how the patient information had been passed to the receiving provider.
- Due to the nature of the type of work carried out by the provider there were no referrals to other services or systems and processes in place to facilitate this.

Access to information

- Staff told us there was a satellite navigation device stored in the office for use on the ambulance. We saw that the device was in working order. If the device was not working managerial staff used their own satellite navigation devices on the ambulance. It was reported that updates to the maps on the satellite navigation device in the office were undertaken every three to six months. Staff also told us they access to paper maps.
- As the provider did not plan patient treatment or transport in advance only carrying out treatment in either an emergency situation or in accordance with their contractual arrangements, staff did not have access to any care plans, advance decisions or do not attempt cardio pulmonary resuscitation (DNACPR) orders unless volunteered by the patient, relative or carer.
- Staff told us event plans would contain a map of the event site and the locations of the nearest NHS accident and emergency hospitals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider`s operations manual had a policy providing information about seeking consent for children and adults. The director of operations

described appropriate methods for seeking consent in adults and children. The director of operations was aware of the principles of assessing mental capacity and making best interests decisions.

Are emergency and urgent care services caring?

Compassionate care

- Due to the infrequent nature of the providers regulated activities we were unable to observe any direct patient care during our inspection.
- Although we did not observe direct patient care staff we spoke with told us they would ensure dignity in public places and for those in vulnerable circumstances by using blankets to cover patients. Any activity inside the ambulance such as moving a patient was done with the doors closed.
- Staff we spoke with described how they would take steps to try and minimise distress for patients and families. This included speaking to patients in a reassuring, polite, and friendly way, and explaining what was happening.

Understanding and involvement of patients and those close to them

- We did not observe any patient care during our inspection.
- There were no patient feedback forms to review due to the infrequent nature of the provider`s regulated activity to ascertain if Multi Health Medical Services UK staff had understood and involved patients and those close to them.
- There was no patient feedback on the provider`s website which could be reviewed to ascertain if Multi Health Medical Services UK staff had understood and involved patients and those close to them.
- We acknowledged that because the service carried out low levels of regulated activity the risk in relation not obtaining patient feedback to increase understanding of patients and those close to them was low. However, due to the potential for the service to win contracts and increase the levels of regulated activity in the future the lack of a system to gather feedback was a concern.

Emotional support

- Due to the infrequent nature of the providers regulated activities we were unable to observe or evidence any direct emotional support for patients, relatives or carers.
- There was no patient feedback on the provider`s website which could be reviewed to ascertain if Multi Health Medical Services UK staff had provided emotional support to patients, relatives or carers.

Supporting people to manage their own health

- Due to the infrequent nature of the provider`s regulated activities and the type of work undertaken we were unable to observe or evidence any direct support for people to manage their own health.

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

Service planning and delivery to meet the needs of local people

- Before carrying out any event medical cover we saw evidence the provider had contacted the event organiser to ensure service proposals met the needs of those running, governing and attending the event.
- The service did not provide services to the NHS, nor did they carry out any CQC regulated activities under subcontracts.

Meeting people's individual needs

- The provider`s policy in relation to consent and capacity covered what staff should do when dealing with patients with learning difficulties, dementia and older people with complex needs.
- The provider`s operations manual reported staff could access a multilingual phrase book to facilitate communications with people who did not speak English as a first language. The phrase book was stored in the glove box of the provider`s ambulance.
- The registered manager told us he could use his telephone as a translation device.
- The operations manager told us one of the owners were trained to use sign language.

Learning from complaints and concerns

- The provider had not received any complaints in the last 12 months therefore no benchmarking could be carried out.
- The provider`s complaints policy included the aim of the policy, managing complaints, specific responsibilities, records, audit and monitoring and complaint review.
- Staff we spoke with told us a patient who wished to make a complaint would have to approach the event organiser because the provider had removed any company telephone number from the side of their vehicle because the contact number had recently changed.
- There was no evidence that the provider gave the event organiser Multi Health Medical Services UK complaint forms with advice as to the routing of completed forms to facilitate a patient, relative or carer making a complaint.
- There was no evidence of any leaflets or notices within the provider's ambulance to explain how a patient, relative or carer could make a complaint.
- There was no evidence on the company webpage as to how a patient, relative or carer could make a complaint.

Are emergency and urgent care services well-led?

We found the following issues that the service provider needs to improve:

- There was no evidence as to how the provider would ensure staff we aware of and understood the company`s vision and strategy.
- The provider`s vision and strategy was not included on the company website.
- There was no agenda, minutes or actions recorded during the meetings between the director of operations and the managing director or for the meetings with the ECP.
- There was no risk register either for corporate or operational risks.
- The provider did not have any key performance indicators to work to.
- Some information in the manual was out of date.
- Managers told us there was not a mechanism in place to record assurance all staff had a copy of the provider`s operations manual which contained company policy and procedures and that they had familiarised themselves with the contents before working for the organisation.
- There was no evidence of an adequate system to ensure the operations manual and policies are updated and reviewed regularly with relevant information.

However, we found the following areas of good practice:

- The leaders had been visible because they had been active on all operational activity.

Leadership of service

- The company was owned and run by two people; a director of operations responsible for the day to day running of the business, a managing director who was the safeguarding lead.
- The company had employed a temporary team leader working one day per week to support the director of operations while the managing director was taking a leave of absence.
- The leadership team could access advice from an Emergency Care Practitioner (ECP) on a voluntary, non-contractual, basis approximately two times a year and as needed. This person was described as a medical director in the provider`s operating manual.
- We were unable to speak to the managing director due to them taking leave of absence or the Emergency Care Practitioner (ECP), who is the medical director, because they lived outside the United Kingdom.
- There was evidence the leaders had been visible because they had been active on all operational activity.

Vision and strategy for this this core service

- The provider`s operations manual contained the company`s mission statement which stated that Multi Health Medical Services UK was a company dedicated to providing cost effective medical provisions without cutting back on the level of cover we believe in; providing the highest standard of pre-hospital care, promoting health and safety at all time, providing

outstanding levels of service to all of our clients, using the most qualified staff to provide immediate care and providing training to staff, thus enabling them to perform their duties.

- Due to the infrequent levels of regulated activity and the irregular contractual arrangements there was no evidence as to how the company could achieve the aims of the mission statement.
- The provider`s operations manual stated the service vision was to provide 'a dedicated team of individuals within the private sector and establish a successful foothold in the event medicine sector.' The vision was underpinned by values including equality, excellence, commitment, honesty, team work, and respect.
- Although staff who had expressed an interest in working for Multi Health Medical Services UK were asked to read the provider`s mission statement, service vision, values and policies there was no evidence as to how the provider would ensure staff had understood them or were adhering to them.
- The provider`s vision and strategy was not included on the company website. There was mention of "Caring in the community" stating this has been the company motto since 2007 but there were no further details.

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

- Staff we spoke with told us the director of operations and the managing director met every four months to discuss issues affecting the company. The director of operations told us there was no agenda for the meeting and the minutes and actions were not recorded.
- Staff we spoke with told us the director of operations and the managing director met with an Emergency Care Practitioner (ECP) every six months to give advice on any medical or legislative changes. This was done via a telephone call as the ECP lived abroad. There was no agenda for the meeting and the minutes and actions were not recorded.
- The file for the temporary team leader showed some recruitment documentation was recorded. This included an application form, emergency contact form, DBS check, driver health check, driving license, CV, and passport. There was no contract of employment available in the file. Details of two referees were included in the file. However, one of the named referees was the director of operations for Multi Health Medical Services UK.
- There was recruitment information and training qualifications in the personal files of the managing director and the director of operations.
- The personal file of the managing director had evidence of qualifications in safeguarding vulnerable adults Level 3, safeguarding children and young people level 3, advanced health and social care and intermediate health and social care certificate. There was a copy of a DBS check dated 7th December 2016.
- The personal file of the director of operations had evidence of qualifications in Business and Technology Education Council (BTEC) level 3 ambulance aid and notification of performance, Business and Technology Education Council (BTEC) Level 3 ambulance emergency driving and notification of performance, certificate of competence practical phlebotomy, certificate of attendance and completion of theory and dry lab phlebotomy. There was a copy of an advanced DBS check dated 18th January 2017.
- There was no evidence the provider had a risk register either for corporate or operational risks.
- Due to the nature of the provider`s work and low level of regulated activity we were told the provider did not have any key performance indicators to work to.
- The provider had an operations manual and information in it stated the contents had been reviewed in April 2017 and was due for review in April 2018. There were no version control numbers on the manual. This manual contained policies for the service.
- We saw some information in the manual was out of date. For example, references were made to Criminal Records Checks, rather than Disclosure and Barring Service checks, and to the Health Professions Council (HPC), rather than the Health and Care Professions council (HCPC).
- There was no evidence of a disclosure and barring Service (DBS) policy, duty of candour policy, quality policy and process or whistleblowing policy.

- The procedures outlined in the operations manual did not always reflect the procedures described by managerial staff. For example, the policy stated medicines would be signed out before jobs and signed back in to the office afterwards. However, the operations director said no medicines were stored on site. Information in the manual relating to safeguarding children was not always consistent with appropriate guidelines in relation to reporting timeliness and recording any disclosures from children.
- The provider`s operations manual stated all staff working with the service should be able to access a copy of the operations manual. Managers told us there was not a mechanism in place to record assurance all staff had a copy of this manual and they had familiarised themselves with the contents before working for the organisation.
- There was no evidence of an adequate system to ensure the operations manual and policies within it had been updated appropriately with relevant information.

Culture within the service

- Due to the nature of the providers work and the fact they have two full time employees it was not possible to evidence what the culture was like in the organisation.
- Organisational change was managed by the managing director and the director of operations both of whom owned the company. As the company did not directly employ any other staff no evidence could be obtained as to how organisational change would affect staff.

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

- Due to the nature of the providers work and low level of regulated activity the only staff engagement undertaken were debriefing an event.
- Due to the nature of the provider`s workforce no formal or informal team or staffing meetings had been held. Apart from the owners, who were director of operations, and the managing director, all other staff who worked alongside Multi Health Medical Services UK staff did so in addition to their full time employment and many worked shifts, therefore organising team or shift meetings were difficult.
- Staff told us engagement did take place before an event being held to ensure staff knew their roles and what the contingency plans were. We did not see any evidence the engagement was recorded and if there had been any staff feedback or any issues raised which required action.
- The management team did work on all the services events and therefore had face to face contact with staff.

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

- Due to the low level of regulated activity carried out by the provider and the unpredictable nature of their contractual arrangements we did not see any evidence during the inspection of innovation, improvement or sustainability.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that staff know what a never events is and how to report it.
- The recording and management of never events and near misses must be included in the provider`s policy documents and acted upon as required.
- The provider must ensure all staff know what the basic principles of Duty of candour legislation are, how to apply them, and have a Duty of candour policy.
- The provider must ensure there is a system and process in place to ensure policies, procedures and guidance are continually reviewed to make sure they are up to date and remain fit for purpose.
- The provider must have a system to measure and record levels of staff adherence to policies and procedures.
- The provider must ensure people are able to easily access the complaints system and make a complaint to any member of staff, either verbally or in writing.
- The provider must have an effective system to record and audit the issuing of non-prescription drugs by staff. This must also be reflected in the operations manual.
- The provider must have a system to identify, audit and manage risk.

Action the hospital SHOULD take to improve

- The provider should look at having effective communication systems to ensure that people who use the service, those who need to know within the service and, where appropriate, those external to the service know the results of reviews about the quality and safety of the service and any actions required following the review.
- The provider should ensure all patient and stakeholder feedback is listened to, recorded and responded to as appropriate. It should be analysed and used to drive improvements to the quality and safety of services and the experience of engaging with the provider.
- The provider should ensure equipment is accessible at all times to meet the needs of people using the service. This means it is available when needed, or can be obtained in a reasonable time so as not to pose a risk to the person using the service, specifically a six-point stretcher.
- The provider should have a business continuity plan.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Regulation 16 Receiving and acting on complaints** (2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. **How the regulation was not being met:** • People were unable to easily access the complaints system and make a complaint to any member of staff, either verbally or in writing.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 Good governance** 2(a) systems and processes such as regular audits of the service provided and assessment, monitoring and improving the quality and safety of the service. 2(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; 2(f) ensures that audit and governance systems remain effective.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

- Staff did not know what a never event is and how to report it.
- The provider did not record and manage never events and near misses or include them in policy documents to allow them to be acted upon as required.
- The provider did not ensure there was a system and process in place to ensure policies, procedures and guidance are continually reviewed to ensure they are up to date and remained fit for purpose.
- The provider did not have a system to measure and record levels of staff adherence to policies and procedures.
- The provider did not have a system to identify, audit and manage risk.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

Regulation 20: Duty of candour

20(1) Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

How the regulation was not being met:

- The provider did not ensure all staff knew what the basic principles of Duty of candour legislation are, how to apply them, and they did not have a Duty of candour policy.