Mariner Medical & Driving Services Ltd

Mariner Medical & Driving Services Ltd

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Mariner Medical and Driving Services Ltd is operated by Mariner Medical and Driving Services Ltd. The service provides mainly event cover, which is not a regulated activity and transport of patients from event sites which falls within our scope of registration.

We inspected this service using our comprehensive inspection methodology. We carried out the announced inspection on 17 November 2017.

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

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

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 during our announced inspection that the service provider needs to improve:

- The provider was not always completing pre-employment checks as detailed in its recruitment policy. The provider did not have evidence of references, identity checks, professional registration, where appropriate, for paramedics and volunteers.
- The provider did not have an effective system to ensure staff allocated to work had the necessary competence to undertake their role.
- Not all staff had undergone an appraisal or a formal review of their performance.
- Evidence of mandatory and external training completed by staff was not fully reflected in training records, so that training completion could not be fully assessed against best practice standards.
- There was no clear process for incident reporting and using this learning to improve practice.
- Standard care bundles were not in place for the transportation of patients.
- The provider did not have an effective system for cascading and sharing any lesson learnt from complaints.
- The provider had not developed a vision and strategy for the service. The provider did not formally engage all staff, to ensure that the views of all staff were noted and acted on. There was a lack of governance within the service. Some policies were absent or where present had not been reviewed and adapted for the service.
- Service user records were not always managed effectively and patient report forms were not always stored securely.
- The provider did not have a risk register and the provider was unable to demonstrate how risks were identified and escalated in order to protect patients. Audits such as infection control were not undertaken and therefore learning did not take place from review of procedures and practice.
- The provider did not have an effective system in place to ensure all vehicles were well maintained and safe for use.

However; we found the following areas of good practice:

- There was a positive culture within the service to learn and improve.
- The service had recently implemented improved systematic processes such as deep cleaning checks on vehicles.
- The provider had engaged with its partners and encourages them to provide positive or negative feedback.
- Staff and managers we spoke with understood the duty of candour regulations and the requirement to be open and honest.

Summary of findings

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

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		Mariner Medical and Driving Services Ltd is operated by Mariner Medical and Driving Services Ltd. The service provides mainly event cover, which is not a regulated activity and transport of patients from event sites which falls within our scope of registration. 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. We found practice the provider needed to improve in relation to recruitment, risk management and governance processes. However, we also found: • There was a positive culture within the service to learn and improve. • The service had recently implemented improved systematic processes such as deep cleaning checks on vehicles. • Staff and managers we spoke with understood the duty of candour regulations and the requirement to be open and honest.

Mariner Medical & Driving Services Ltd

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

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Background to Mariner Medical & Driving Services Ltd

Mariner Medical & Driving Services Ltd is operated by Mariner Medical & Driving Services Ltd. Mariner Medical and Driving Services Limited first registered with the Care Quality Commission (CQC) in 2014. It is an independent ambulance service in Grimsby, North East Lincolnshire. The service primarily serves the communities of North East Lincolnshire.

Mariner Medical and Driving Services Limited provides mainly event cover which is outside of the scope of CQC regulation. However, the service also provides transport of patients from event sites within its contracts with providers, which is within the scope of the CQC, and it is on this basis that the service was inspected.

The service employs two staff which includes the registered manager .together with team of bank staff. The service has four vehicles, three of which were in use at the time of the inspection.

The registered manager has been in post since January 2014.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,an additional CQC inspector, and a specialist advisor with expertise in the transport of patients.The inspection team was overseen by Lorraine Bolam, Interim Head of Hospital Inspection.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The service is registered to provide the following regulated activities:

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

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 the reporting period, November 2016 to November 2017 there was one episode of transport of a patient from an event site.

Twenty four bank staff worked with the service in addition to substantive roles in NHS ambulance services.

Track record on safety from November 2016 to November 2017. The provider reported:

- No never events
- No serious injuries
- One complaint

During the inspection, we visited the registered location in Grimsby. We spoke with two staff including the registered manager and operations manager. We were unable to speak with service users during the inspection; however, we reviewed feedback from service users. During our inspection, we reviewed one set of patient records which related to the transportation of a patient.

At the time of our inspection, there was one ambulance in use for the transportation of patients from event sites.

Summary of findings

We found the following issues during our announced inspection that the service provider needs to improve:

- The provider was not always completing pre-employment checks as detailed in its recruitment policy. The provider did not have evidence of references, identity checks, professional registration, where appropriate, for paramedics and volunteers.
- The provider did not have an effective system to ensure staff allocated to work had the necessary competence to undertake their role.
- Not all staff had undergone an appraisal or a formal review of their performance.
- Evidence of mandatory and external training completed by staff was not fully reflected in training records, so that training completion could not be fully assessed against best practice standards.
- There was no clear process for incident reporting and using this learning to improve practice.
- Standard care bundles were not in place for the transportation of patients.
- The provider did not have an effective system for cascading and sharing any lesson learnt from complaints.
- The provider had not developed a vision and strategy for the service. The provider did not formally engage all staff, to ensure that the views of all staff were noted and acted on. There was a lack of governance within the service. Some policies were absent or where present had not been reviewed and adapted for the service.

Emergency and urgent care services

- Service user records were not always managed effectively and patient report forms were not always stored securely.
- The provider did not have a risk register and the provider was unable to demonstrate how risks were identified and escalated in order to protect patients. Audits such as infection control were not undertaken and therefore learning did not take place from review of procedures and practice.
- The provider did not have an effective system in place to ensure all vehicles were well maintained and safe for use.

However, we found the following areas of good practice:

- There was a positive culture within the service to learn and improve.
- The service had recently implemented improved systematic processes such as deep cleaning checks on vehicles.
- The provider had engaged with its partners and encouraged them to provide positive or negative feedback.
- Staff and managers we spoke with understood the duty of candour regulations and the requirement to be open and honest.

Are emergency and urgent care services safe?

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

- The internal incident reporting process was not effective. There was no system to ensure all incidents were recorded, monitored and any learning or outcomes arising from incidents were shared with staff.
- There was no effective recruitment procedure, including checking of references and photo identification. In addition, there were no formal checks on continuing professional development of paramedic staff that had substantive employment.
- The provider had not carried out appropriate criminal records checks through the disclosure and barring service (DBS) for all members of staff.
- The provider did not have an effective system to undertake vehicle maintenance checks. On our inspection visit we checked all vehicle maintenance records and found one vehicle had an out of date MOT. Staff told us this vehicle was used regularly.
- The service did not have effective records management and data protection policies.
- We observed the safeguarding policies did not include contact information for the appropriate local authority safeguarding children team.

However, we found the following areas of good practice:

- The service had a policy on the duty of candour. Staff we spoke with understood the duty of candour regulations and the requirement to be open and honest.

Incidents

- The service had an accident and incident reporting policy. The procedure identified the type and seriousness of incidents that should be reported and how staff should report these. The registered manager and operations manager told us the procedure had been implemented in September 2017. The policy stated all incidents and accidents should be reported to the registered manager.
- The service did not have a system to undertake an appropriate investigation of incidents and use this investigation for learning.

- The operations manager told us the service was in the process of developing an incident reporting form.
- The service had not reported any serious incidents between November 2016 and November 2017 and on inspection the service stated that no incidents had occurred during this period. However, we were not assured incident reporting was embedded in the culture of the service.
- The service reported that there were no never events in the last 12 months. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The service had a policy on the duty of candour. 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. Staff we spoke with understood the duty of candour regulations and the requirement to be open and honest.

Mandatory training

- We checked staff training records. The service did not have systems to ensure all staff were up-to-date with other training requirements. We saw records which showed that eight of the 24 bank staff had up to date training in first aid. The registered manager told us all members of staff worked for other NHS providers and would be required to have up to date first aid training for that role. However, the service had not carried out its own checks to ensure all first aid training was up to date.
- The service did not have evidence to show that staff had training to undertake vehicles safety checks. This would ensure staff were competent to undertake the vehicle checks required.
- There was not a system in place to check on driving competence. The service did not have evidence to show staff had completed blue light training or an ambulance driver awareness course. The registered manager told us four members of staff had completed blue light training. When asked the registered manager was unable to provide records of this.
- The provider had given practical training to staff and volunteers, which involved practicing cardio pulmonary resuscitation (CPR) in a moving ambulance. This meant that staff would be able to practice a key skill in a different environment, as CPR is more complex in a moving environment.

Safeguarding

- The service had policies for safeguarding children and for protecting vulnerable adults from abuse which had been implemented in September 2017. The policy gave guidance to staff as to how to report urgent concerns.
- We observed the safeguarding policies did not include contact information for the appropriate local authority safeguarding children team. This meant that we were not assured that staff could make an urgent referral when required. The operations manager told us staff were given the safeguarding information at a training day in September 2017.
- There had been no reported safeguarding incidents in the last 12 months.
- Data provided by the service showed that all staff had completed safeguarding training in September 2017. The operations manager told us safeguarding vulnerable adults and child protection was a part of mandatory training. The mandatory training requirement had been implemented in September 2017.
- We observed the safeguarding certificates did not state training was at the appropriate level. Staff are required to have training for safeguarding children and vulnerable adults at level two and the safeguarding lead at level three. The registered manager could not provide assurance that training was at the appropriate level. This was a concern because this was not reflective of national guidelines for safeguarding, specifically the safeguarding adults: roles and competences for health care staff – Intercollegiate Document (2016).

Cleanliness, infection control and hygiene

- The service had an infection prevention and control policy. The policy stated staff should follow rigorous guidance on hand hygiene and personal protective equipment. The policy did not contain guidance on how to manage body fluid spillage or the safe disposal of waste.
- The registered manager told us the crew ensured their vehicle was fit for purpose, before, during and after they

had transported a patient. The staff assigned to the vehicle completed the day to day cleaning of the vehicle. Decontamination cleaning wipes were available on all vehicles.

- Vehicle checklists had recently been implemented. The effectiveness of this process could not be established due to the lack of data.
- Upon inspection, most of the equipment was visibly clean. However, there was damage to the driver seat of one of the vehicles, as it had considerable damage this was an infection prevention and control risk.
- The service had recently implemented an internal deep cleaning procedure for staff to follow. A deep clean involves cleaning a vehicle to reduce the presence of certain bacteria. A deep cleaning checklist was used to show when and what area of the vehicles were cleaned. Staff we spoke with told us a deep cleaning was undertaken every four weeks. When asked staff could only provide records of a deep clean in October 2017.
- New procedures had been implemented regarding the removal of clinical waste. A yellow clinical waste bin was available and was removed and replaced on an ad-hoc basis. As this was a new system, there were no historical records available to review.
- Sharps bins were available, securely stored and dated.
- We observed hazardous spillage equipment was available; however there was no evidence of training being provided for staff.
- Personal protective equipment was available on the ambulance; this included disposable gloves.
- We saw that coloured coded buckets were used for cleaning.
- There was no system in place to monitor cleanliness. The service did not have a system in place for infection control audits to be carried out to ensure that cleaning was effective, any contaminates were removed and appropriate action to reduce the risk of cross infection.
- We were informed that the service did not complete hand hygiene audits. This meant the service could not be assured that staff were compliant with infection control practices.
- Data provided by the service showed that all staff had completed infection prevention and control training in September 2017. The operations manager told us the service had developed a protocol to ensure all staff completed infection prevention and control training as a mandatory requirement.

Environment and equipment

- There was no effective system for vehicle maintenance checks. On our inspection visit we checked all vehicle maintenance records and found one vehicle had an out of date MOT. Staff told us this vehicle was used regularly.
- Safety tests were undertaken on vehicle equipment which had stickers to verify this.
- The registered manager told us servicing of the equipment had been undertaken by the same provider used by a local NHS provider. However, the registered manager did not have evidence of servicing and could not provide assurances regarding the procedure in the event of equipment failure, liability or responsibility should patient injury occur.
- We observed fire-extinguishers were tested, and a certificate provided. However, this was provided as one overall certification, and did not distinguish between fire-extinguishers within the premises and those located on the ambulances.
- The provider did not have an effective system for the reporting and management of faulty equipment. We observed some of the equipment including a handle of a carry chair and the worn strap on the stretcher was faulty. The registered manager provided assurances this equipment would not be used, and would be replaced.
- We observed perishable items were in date. The cupboards, drawers and response bags were well stocked. The registered manager told us these items were obtained through various organisations. However, there were no records, ordering processes or receipts to confirm the process.
- The registered manager told us an allocated member of staff checked and restocked the vehicles after use. This was supported by a 'white-board', where used items were recorded as a prompt for restocking. However, there was no policy or procedure to support this system, and there was no clear documentation regarding the stock levels required on each vehicle.
- The registered manager told us the vehicles did not have a garage. We observed vehicles were stored securely at the rear of the premises. The vehicle keys were kept in a locked shed at the rear of the premises.

Medicines

Emergency and urgent care services

- The registered manager confirmed medical gases were used for patients. This included compressed oxygen and nitrous oxide (an inhaled gas used a pain medication). Medical gases were stored in a locked room.
- There was no evidence that Entonox cylinders were stored at a temp above 10°C for 24 hours prior to use.
- The medical gases cylinders were adequately secured in a locked room and access was restricted to authorised personnel. However, the registered manager did not keep a list of the authorised personnel.
- Individual gas cylinder stores should have adequate signage to provide warnings and safety information on the hazardous products being stored. Signage should comply with The Health and Safety (Safety Signs and Signals). The service did not have visible safety signs in line with current guidance.
- The service did not have a policy or procedure which staff could follow on the safe use of medical gases.
- The registered manager told us that until recently medical gases had been sourced from another provider. The registered manager showed us records for an order placed in October 2017. The service did not have records to verify the ordering process prior to this date.

Records

- The service did not have formal records management and data protection policies.
- There was no record of staff receiving training on confidentiality and data protection.
- The registered manager told us they secured paper based records on the station. Patient report forms (PRF) were reviewed and fed back to staff and volunteers. However, when asked the registered manager could not provide evidence of this.

Assessing and responding to patient risk

- There was no formal process for bank staff to follow for deteriorating patients. The registered manager could not provide assurances that all staff knew what to do if a patient deteriorated during a journey.

Staffing

- The service employed 23 staff in total on a zero hour bank contract including drivers, first aiders and three paramedics. Records we reviewed did not contain all the required evidence to show appropriate recruitment checks were undertaken prior to employment.
- Proof of identification had not been obtained for 12 members of staff and references had not been obtained for any of the staff. This was not in line with requirements to have proof of identity including a recent photograph. The registered manager told us staff were known to them and references were not required. This was not in line with requirements for the service to obtain satisfactory evidence of conduct in previous employment.
- The service did not have an effective recruitment procedure. The operations manager told us the recruitment procedure would be updated to ensure relevant pre-employment checks such as identity and references would be obtained and held in the staff files. At the time of our inspection the service was in the process of updating all staff files.
- The registered manager told us patient transport service was provided on an 'on call' basis. Advanced bookings were made for patient transport service or patients were transferred from an event to the hospital.
- Patient transport was usually undertaken by two staff members. If an additional crew member was required the registered manager told us they would provide support.
- The service did not use agency staff but utilised the existing bank staff that worked available shifts and were flexible where required.

Response to major incidents

- The service was not part of local resilience plans for response to major incidents. This meant that there were no major incident plans in place.
- The service did not have a formal business continuity plan, which should include a process of calling ahead to the emergency department and what to do if the unit was on divert.
- The registered manager told us if adverse weather was expected, the event and need for transport would be cancelled by the organisers.
- The service carried out 'ad hoc' work so would assess resource requirements and capacity on an individual basis when requested. Demand fluctuated and the service only undertook work that was within their capacity.

Emergency and urgent care services

Are emergency and urgent care services effective?

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

- Standard care bundles were not in place for the transportation of patients.
- Appraisals of performance had not been completed for all staff.
- There was no formal process to obtain and record consent from patients or to treat and transfer a child when parents were not present.

However, we found the following areas of good practice:

- The service had implemented an induction policy and procedure.
- There were documented pathways in place for the transporting of patients to the most appropriate hospital.

Evidence-based care and treatment

- The service had limited policies and guidance in place to support evidence based practice. This included guidance from both the National Institute for Health and Care Excellence (NICE) and the Joint Royal College Ambulance Liaison Committee (JRCALC).
- There were no clinical standard operating procedures or care bundles in place when transferring patients if required. This meant that it was unclear if staff were following the most up to date guidance when providing care.
- There was evidence to show that the policies and procedures had been created two to three months prior to the inspection and uploaded onto the provider`s internet portal.
- The service did not have review mechanisms such as audits to check that staff were adhering to local policies and procedures.

Assessment and planning of care

- There were documented pathways in place for the transporting of patients to the most appropriate hospital. The registered manager told us this was the closest hospital to the location of the event.
- There were no formal pathways for the transport of patients from site. This meant there was no formal documentation that identified to staff when to transport patients and what monitoring they would require.

Response times and patient outcomes

- The service had transported one person in 12 months and did not hold any information about response times and outcomes.

Competent staff

- The service had an induction policy and procedure which had been introduced in September 2017. The operations manager told us staff undertook an induction programme that detailed the expectations and requirements of the role, the company and policies and procedures. We saw induction records for three recently recruited members of staff. Prior to September 2017 there was no evidence to show induction had taken place.
- The registered manager told us driver and vehicle licensing agency (DVLA) checks were completed prior to commencement of employment. At inspection there was evidence of these checks for three members of staff that were recently recruited.
- There were no arrangements for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor. Staff told us that if they had a concern about the standard of a crew member's driving they would inform the registered manager.
- The registered manager told us they regularly met with staff. However, there was no documented evidence of this taking place
- There was no evidence that staff had an appraisal.

Coordination with other providers and multidisciplinary working

- The majority of work was provided on an ad-hoc basis to local event and transport providers.
- Due to the small number of transfers undertaken by this service there was no information available at the time of inspection regarding working with other agencies.

Access to information

- The service had a limited number of policies, which were available at the ambulance station; however, these were not clinical policies.

- The service did not have a system to demonstrate that staff had access to policies or procedures.
- There was no formal process for sharing relevant information about events with bank staff. The registered manager told us a risk assessment was completed for each event booking. However, the registered manager could not provide evidence of this. Additionally, the registered manager told us they discussed each event at a pre-event briefing, which included exit routes as required. When asked the registered manager could not provide evidence of this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was no formal process to establish consent for care, treatment and transfer for if a child's parents were not present. The registered manager told us there was no standard procedure in place. This meant that staff members may not all be using the same process when treating a child without parental consent.
- The service did not have a formal policy or a standard operating procedure for mental capacity, consent, best interest decisions or deprivation of liberty. The registered manager could not provide evidence to show that staff gained consent or carried out an assessment of mental capacity prior to transporting a patient.
- Staff training records we checked showed that one staff member completed training in deprivation of liberty.

Are emergency and urgent care services caring?

We found the following areas of good practice:

- Staff took time to engage with service users.
- Staff maintained patients' privacy and dignity.

Due to the limited number of transfers and feedback from patients, there is limited evidence to complete this domain. We were unable to speak with patients during our inspection as the service did not provide any direct care or treatment during this period.

Compassionate care

- The registered manager told us they took the necessary time to engage with patients. They told us they communicated in a respectful and caring way, taking into account the wishes of the patient at all times. Staff we spoke with told us they maintained patients' privacy and dignity.
- The registered manager told us patients were also transported on a voluntary basis as a part of community service. This had been recognised when the service was nominated for the heart of the community awards in 2017.
- We asked the registered manager how they sought feedback from service users. A client evaluation feedback form was sent to the client to complete.

Emotional support

- Staff we spoke with told us they checked on patients, in terms discomfort, and emotional wellbeing during any patient transport journey.
- Staff we spoke with told us they understood the need to support family or other patients should a patient become unwell during a journey.

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

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

- The service did not have a procedure for patients who were from different cultures, had different faiths or spoke different languages. The service did not have access to translation services.
- There was no process for cascading and sharing any lesson learnt from incidents or complaints.

Service planning and delivery to meet the needs of local people

- The service provided mainly event cover which is outside of the scope of CQC regulation. However, the service provides transport of patients from event sites within its contracts with providers.
- The service provided an 'on call' service for patient transport and workloads were planned around this.
- The registered manager told us bookings were responded to quickly via telephone.

Meeting people's individual needs

Emergency and urgent care services

- The registered manager told us at the time of the booking for transport the call taker asked about the patient and their needs at the job booking stage. The needs assessment ambulance booking form was completed to reflect individual needs.
- An equality and diversity policy was in place so that those with additional needs including people with learning disability, or sensory impairment were considered.
- Although required only rarely, an on-line translation service was available to support communication with persons whose first language was not English.

Learning from complaints and concerns

- The service had a complaints policy which had been updated in September 2017. The policy outlined the process for dealing with complaints initially by local resolution and informally. Where this did not lead to a resolution, complainants were given a letter of acknowledgement within five days of receipt followed by a detailed response to the complaint.
- The complaints policy was not available on the vehicle. It was not clear how patients or their carers would make a complaint directly to the service if they wished to. This system meant that the complaints procedure was not readily available, and did not support service users not to identify themselves, if that was their choice.
- We looked at the procedure for acknowledging, recording, investigating and responding to complaints and found there was an effective system in place which ensured a timely response. We reviewed one complaint which the service received in the last 12 months and saw that it was resolved in line with the complaints policy.
- We found that the complaint had been investigated to see if there anything might have improved the patient's experience. The service had implemented a concussion recognition toolkit and a pocket guide for staff to refer to. The service had also reviewed its policies and procedures.
- There was no process for cascading and sharing any lesson learnt from complaints. For example, there was no evidence the changes to policies and procedures in response to the complaint had been communicated to all staff members. The operations manager told us the learning from complaints was discussed informally with staff as and when required.

Are emergency and urgent care services well-led?

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

- There was no formal recorded vision and strategy for the service.
- Governance arrangements to monitor the quality and safety of the service were not robust. Some important policies were absent or where present, had not been reviewed and adapted for the service.
- The service did not have a mechanism to identify and manage risk and measure the quality of the service delivered to patients. The service did not have a risk register.
- There was no system in place to disseminate learning from incidents and complaint outcomes.
- The service did not carry out audits to measure the quality and effectiveness of the service delivered such as cleanliness and infection control.
- The service did not routinely carry out appraisals and had not developed robust mandatory training.
- The service did not have an effective recruitment procedure.
- The service did not formally engage with staff, to ensure that the views of all staff were heard and acted upon.

However; we found the following areas of good practice

- There was a positive culture within the service to learn and improve.
- The service had started to engage with service users and encouraged them to provide positive or negative feedback.
- The service and its staff demonstrated a willingness to develop and improve the service provided.

Leadership of service

- The leadership team consisted of a registered manager who was also the registered manager and an operations manager.
- The registered manager or operations manager were present at events. This meant they had oversight of the organisation.
- Staff we spoke with told us that the registered manager was supportive and approachable.

- There was a whistleblowing policy to provide assurance to staff who wished to provide feedback about aspects of the service. The policy was updated in September 2016 and described examples of the type of concerns to be raised. The policy did not contain information for external organisations to contact to escalate concerns.

Vision and strategy

- The service did not have a formal vision and strategy. However, the registered manager was able to articulate their key priorities for the service.

Governance, risk management and quality measurement

- The provider did not have a robust governance framework to monitor the quality and safety of the service. There were gaps in assurance and a lack of awareness around the need to monitor risks or measure quality.
- Policies had not been adapted for the service, regularly reviewed and updated.
- The service did not have a mechanism in place to identify and manage risk and measure the quality of the service delivered to patients. The service did not have a risk assessment procedure to identify all risks and hazards as well as how to address them. Risks should be recorded, reviewed and held in a central location so staff are aware. We asked the operations manager to show us examples of risk assessments. We were told risk assessments had not been undertaken. The operations manager was unable to tell us what the current risks were relating to the service.
- The service did not have a formal process for identifying and prioritising risks and recording measures implemented to mitigate the identified risks within the organisation.
- The service did not have an effective system to ensure all vehicles were legally roadworthy.
- There was no system in place to disseminate learning from incidents, safeguarding and complaint outcomes.
- The service did not carry out any audits to measure the quality and effectiveness of the service delivered such as cleanliness and infection control. There were potential risks to staff and patient safety, through lack of observation and monitoring of performance.
- The service did not carry out appraisals and had not developed robust mandatory training.
- Appropriate criminal records checks through the disclosure and barring service (DBS) had not been carried out for each member of staff. The service had undertaken one DBS check for a recently recruited member of staff. The service had accepted 10 DBS checks carried out by another provider. The registered manager told us the other 12 bank staff members worked for an NHS provider and would be required to have a DBS check for that role. The service did not have an effective system in place to ensure DBS checks were carried out for all staff.

Culture of the service

- The registered manager was positive and showed a willingness to improve the service. Staff we spoke with were proud of the work that they carried out.
- Staff told us that the registered manager was supportive and approachable.
- Staff told us that team meetings were not held and they usually met individually with the registered manager if needed.

Staff engagement

- The registered manager told us staff were invited for training weekly. At these sessions, they were debriefed on the previous week's event and possible transport of patients. However, there were no formal minutes for these discussions.
- The service had put in place support for staff following a traumatic event; this included working with a therapist. Staff were also encouraged to support each other.

Public engagement

- The service's publicly accessible website contained information for the public in relation to what the service was able to offer.

Innovation, improvement and sustainability

- The service and its staff demonstrated a willingness to develop and improve the service provided.
- The provider had given practical training to staff and volunteers, which involved practicing cardio pulmonary resuscitation (CPR) in a moving ambulance. This meant that staff would be able to practice a key skill in a different environment, as CPR is very difficult to do in a moving environment.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must ensure a range of policies are implemented to support operations within the regulated activity. Policies need to be reviewed effectively and updated.
- The provider must ensure that there is a system in place to manage risk. This includes a system for identifying, mitigating and controlling risks appropriately.
- The provider must ensure they have undertaken all of the required employment checks, including enhanced disclosure and barring service checks, to comply with the fit and proper person's requirement.
- The provider must ensure there is a system in place to ensure all vehicles are legally roadworthy.
- The provider must ensure they have a records management system to maintain securely an accurate, complete and contemporaneous record for each patient.
- The provider must ensure that an up to date record of training, skills and competence is kept for all staff members, particularly if they are responsible for providing care and treatment to patients.
- The provider must make information about how to make a complaint or raise a concern about the service readily available for patients.
- The provider must ensure staff are supported in their roles by effective supervision and appraisal systems and ongoing training.
- The provider must consider ways in which incidents can be reported and investigated, ensuring all lessons learned are documented and shared with staff.
- The provider must consider completing hand hygiene audits to make sure staff are compliant with infection control guidelines and policies.
- The provider must consider implementing guidelines for the transportation of patients from an event site

Action the hospital SHOULD take to improve

- **Action the provider SHOULD take to improve**
- The provider should consider having a documented consent procedure which would include the Mental Capacity Act, best interest principles and deprivation of liberty.

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not being met** There was not a system in place to ensure all vehicles were checked and legal to be roadworthy. Regulation 15, 1(e)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met** There was no system of governance in place that effectively assessed the quality and safety of the service, identified, monitored and mitigated any risks relating to the service. Incident reporting was not embedded to highlight risk and when needed take appropriate actions in response to that risk. There was no risk register in place. There were no audits in place to monitor compliance in all aspects of service provision. This meant there was no effective way to measure the quality of the service being delivered against the required standard and to make improvements where required. Information about how to make complaints or raise concerns about the service was not readily available to service users.

This section is primarily information for the provider

Requirement notices

The provider did not have systems and processes to ensure that they were complying with mandatory training requirements for staff working for the service.

There was no system in place to demonstrate that policies were being regularly reviewed and updated to reflect current practice.

Regulation 17, 2(a)(b)(c)(f)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met** The service did not have effective systems and processes in place to record, training, appraisal, supervision and professional development of staff members and volunteers. Regulation 18, 2(a)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met** The service did not establish and operate effective systems to ensure that persons employed are of good character, have the appropriate qualifications, competence, skills and experience to undertake a voluntary role. This information was not readily available. The service did not establish and operate systems to independently assure themselves that staff registered with professional bodies had up to date registration without restrictions.

This section is primarily information for the provider

Requirement notices

Regulation 19, 1(a)(b)(c) 2(a)(b) 3(a)(b) 4(a)