British Telecommunications Public Limited Company

Adastral Park (Martlesham)

Quality Report

Adastral Park
Martlesham
Ipswich
Suffolk
IP5 3RE
Tel:01473651037
Website:www.ataadastral.co.uk

Date of inspection visit: 17 October 2017
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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.

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

Adastral Park (Martlesham) is a private ambulance service which provides first aid support to those working in and visiting Adastral Park Business Park. All staff working for Adastral Park (Martlesham) work at Adastral Business Park and provide their service on a voluntary basis.Adastral Park (Martlesham) is operated by Adastral Park (Martlesham). It provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 17 October 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 areas of good practice:

- The team carried out an annual major incident simulation training to ensure that the staff were prepared if an incident occurred on the site.
- There was a dedicated team of skilled volunteers who were proud to be part of the rapid response team and demonstrated excellent team work.
- There was a comprehensive training schedule in place to ensure that staff had the appropriate skills to respond to medical incidents at the site.
- The rapid response team worked together with the local ambulance trust as community first responders. This ensured training for team members and allowed them to maintain their skills. Team members were able to support the ambulance service in the local community.
- The service was recognised and valued by the working population of the business park.
- Comprehensive and appropriate risk assessments and policies were in place.
- A red flag protocol was in place to ensure that a medical emergency outside of the skill level of the rapid response team was escalated to the 999 service immediately.

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

- There was a lack of formal governance. Incidents were not recorded and learning from incidents was not shared with staff effectively outside of team training sessions.
- There was a lack of oversight of equipment servicing.
- There was a lack of oversight of stock control and monitoring of consumable items expiration dates.

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 one requirement notice Details are at the end of the report.

Summary of findings

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Patient transport services, triage and medical advice provided remotely were the main activity provided by the service. We do not have a legal duty to rate independent providers of ambulance services.

Adastral Park (Martlesham)

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Adastral Park (Martlesham)

Adastral Park (Martlesham) is operated by Adastral Park (Martlesham). The service opened in 1970. It is an independent ambulance service in Ipswich, Suffolk. The service primarily serves the working population of Adastral Park Business Park.

The service has had a registered manager in post since 2011. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC on 14 August 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspectorand one other CQC inspector.The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

How we carried out this inspection

During the inspection we visited the ambulance station, the control room and inspected one vehicle. We spoke with four members of staff including the station officer and the training officer. We spoke with two patients and one relative. We also received nine 'tell us about your care' comment cards, which patients had completed before our inspection.

Facts and data about Adastral Park (Martlesham)

Adastral Park is a business site located near Ipswich, Suffolk. It covers 350 acres with over 80 buildings housing around 5000 permanent and contracted staff and hosts approximately 50,000 visitors per year.

Adastral Park (Martlesham) is a private ambulance service which provides first aid support to those working in and visiting Adastral Park Business Park. All staff working for Adastral Park (Martlesham) were employed at Adastral Park Business Park and provided their skills to the ambulance service on a voluntary basis. All staff were trained in first person on the scene (FPOS) first aid and were qualified community first responders. The service had one vehicle. The service did not transport children.

The service is registered to provide the following regulated activities:

Detailed findings

Transport services, triage and medical advice provided remotely.

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 inspected once in January 2013 which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (January 2017 to September 2017)

- In the reporting period January 2017 to September 2017 there were10 patient's attended. Five patients were transported in the ambulance.

Track record on safety:

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

There were 11 members of the rapid response team. Four members were first person on scene (FPOS) enhanced trained, three were FPOS intermediate trained and four people were FPOS basic level.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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We found the following areas of good practice:

- The team carried out an annual major incident simulation training to ensure that the staff were prepared if an incident occurred on the site.
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- The rapid response team worked together with the local ambulance trust as community first responders. This ensured training for team members and allowed them to maintain their skills. Team members were able to support the ambulance service in the local community.
- The service was recognised and valued by the working population of the business park.
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Patient transport services (PTS)

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- There was a lack of formal governance. Incidents were not recorded and learning from incidents was not shared with staff effectively outside of team training sessions.
- There was a lack of oversight of equipment servicing.
- There was a lack of oversight of stock control and monitoring of consumable items expiration dates.

Are patient transport services safe?

Incidents

- No never events were reported in the 12 months prior to our inspection.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.
- There was no formal incident reporting policy in place. Incidents were not formally identified, reported or investigated. No incidents had been formally recorded between September 2016 and September 2017. During our inspection the station manager told us that incidents were identified and discussed at fortnightly training sessions. Four members of staff confirmed this.
- A member of staff told us about an incident that had occurred when a team member attending a patient could not locate an item in their grab bag. They described how this incident was discussed and learning from the incident was identified. However this was not formally recorded.
- Learning from incidents was shared with staff at fortnightly training sessions. This was not formally recorded and the learning was not shared with team members that were not in attendance at the team training. We raised this with the station officer and they told us that they would implement a learning log. A copy of this was provided following the inspection. The log contained details of the incident or learning situation, reflection and lessons learnt mitigation and method of sharing learning.
- All members of staff that we spoke with were able to demonstrate an understanding the duty of candour. 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.

Cleanliness, infection control and hygiene

- The service had one vehicle. The vehicle was visibly clean and tidy.

Patient transport services (PTS)

- There was a vehicle and equipment cleaning policy in place which outlined the cleaning requirements for the vehicle and equipment including frequency, items to be cleaned and chemicals to be used.
- We reviewed the cleaning records and saw that the vehicle had been cleaned fortnightly as per the policy between March 2017 and September 2017.
- Cleaning wipes were available in the vehicle and staff confirmed that the vehicle was wiped clean after a patient had been treated in the vehicle.
- Deep cleaning of the vehicle was undertaken quarterly. We saw details of the deep cleaning process outlined in the vehicle and equipment cleaning policy. We saw records that this had been completed quarterly for the previous 12 months. We saw that the next deep clean date was due to be completed on 30 December 2017.
- The vehicle had a hand soap dispenser for hand washing. There was a full hand gel dispenser in the vehicle.
- Personal protective equipment such as gloves and aprons were available.
- Staff were responsible for cleaning their own uniforms. Two members of staff confirmed that they washed their own uniforms. However as members of the rapid response team were volunteers and had full time jobs on the site they were only required to wear their uniform when carrying out training exercises and when representing the team on duty such as at events on and off the business park.
- Appropriate spill kits for the cleaning of body fluids including blood were available in both vehicles.
- The service used single use sheets and blankets that were disposed of after use to reduce the risk of spread of infection.
- Staff were able to access infection prevention and control advice from the local ambulance trust.

Environment and equipment

- The vehicle was kept in a purpose built station. Access to the building was via a door locked by a keypad. Vehicle keys were kept in the ignition of the vehicle to enable immediate access. However we did not see evidence that staff had completed a risk assessment to ensure that unauthorised personnel could not gain access to the vehicle.
- The maintenance, servicing and MOT for the vehicle was managed by the business park fleet services. There was a garage on the business park where the vehicle was maintained. Information relating to the vehicle service, MOT and tax due dates were recorded on a white board. All details were in date, tax was due 1 June 2018, MOT 25 May 2018 and service 24 May 2018.
- Oversight of vehicle maintenance was the responsibility of a member of the team. This person was accountable for the scheduling of routine maintenance and preventative works. They told us that the fleet garage was very responsive and if there was a fault with the vehicle it was resolved the same day.
- There was a vehicle check sheet which staff completed fortnightly. Checks included tyre tread, battery checks and stock check. We reviewed records and saw that the checks were completed between March 2017 and September 2017.
- Not all equipment on the ambulance was up to date with servicing. The scoop, stretcher and compact chair all had service due stickers dated March 2017. We asked if records were available to show that the equipment had been serviced more recently. The station officer confirmed that the equipment service had not yet taken place. After our inspection they provided a booking confirmation showing that the servicing of this equipment would be carried out on the 6 November 2017.
- Other equipment including piped oxygen and gas cylinder gauges had service dates due February 2018. Two fire extinguishers on the vehicle had service due dates January 2018 and January 2019.
- There were out of date consumables on the vehicle. For example we found eight airways, a head strap and tourniquet out of date or open.We brought this to the attention of the training officer. The items were disposed of immediately in the clinical waste.
- We checked an equipment bag and found six out of date guedel airways. All other equipment was in date. The items were disposed of in the clinical waste.

Patient transport services (PTS)

- There was a member of staff known as the quartermaster who was responsible for fortnightly stock checks of stock for replenishing vehicles and grab bags. Stocks were stored securely in the ambulance station. We checked 17 consumable items. All were within expiration date.
- The service had a contract with an external company to dispose of clinical waste. There was a clinical waste bin which was located in the ambulance station. This bin was not locked; however it was stored behind a locked door in the ambulance station.
- Clinical and non-clinical waste was segregated using colour coded bags. There was a waste bin available for domestic waste.
- There was a weekly test of the pager and text notification system.
- The vehicle was wheelchair accessible and straps were available to secure the chair safely.

Medicines

- The ambulance carried medical gases (oxygen and nitrous oxide). Cylinders were secured safely within the vehicle. Both were within expiration date (oxygen 11 December 2017 and nitrous oxide 21 January 2018). No other medication was carried.
- A spare oxygen cylinder and a spare nitrous oxide cylinder were stored securely on the wall in the ambulance garage. The nitrous oxide cylinder had an expiration date of 9 July 2017. We bought this to the attention of the station officer and they put a notice on the cylinder noting the expiration date and that it was not for use. They advised that it would be replaced.
- The station officer told us that staff administered oxygen and nitrous oxide when clinically indicated. Evidence was provided that demonstrated medical authorisation for this was in place. Information provided after the inspection confirmed that first person on the scene basic training (FPOS-B) included the administration of oxygen and first person on the scene intermediate (FPOS-I) included the administration of nitrous oxide.
- Staff confirmed that they did not keep any medicines and did not administer medication. They told us that they carried over the counter medicines but these would be offered to the patient and self-administered. We saw packets of paracetamol, aspirin and glucose gel. All were within expiration date.

Records

- Staff used a patient report form (PRF) to record treatment given to patients. Completed PRFs were stored securely in a locked box in the ambulance station. Information from this form was recorded electronically and the document archived in secure storage.

Safeguarding

- All staff had been appropriately trained to safeguard children and vulnerable adults. National guidance (Intercollegiate Document, 2014) recommends staff should be trained to one of five levels of competency, dependent upon role and interaction with patients. Records showed 100% of staff had been trained to level three adults and children in accordance with the community first responder training requirement. Safeguarding formed part of the annual mandatory training.
- Safeguarding training was delivered by the local ambulance trust as part of the community first responder training. Safeguarding referrals were made via the ambulance trust through the safeguarding single point of contact. There was a protocol in place as to how to escalate safeguarding concerns.
- Safeguarding responsibilities were outlined in the service operational policy.
- Two members of staff we spoke with were able to give an example of potential safeguarding situations and knew how to escalate any concerns.
- The service reported that no safeguarding concerns had been raised in the 12 months prior to our inspection

Mandatory training

- All members of the rapid response team (RRT) were required to hold a first aid at work qualification and to have qualified as a community first responder.
- Staff were required to attend 65% of fortnightly update training sessions. Training sessions included infection prevention and control, burns and bleeding and

unresponsive casualty. The station manager recorded attendance and this ensured staff received the required amount of update training. At the time of our inspection 100% of staff had met this requirement.

- All members of the RRT were registered community first responders (CFRs). This enabled them to access training facilitated by the local ambulance trust. This training was mandatory as part of the CFR training and revalidation. The training included first person on the scene basic training (FPOS-B), occupational health and safety, and continued professional development.
- An external provider delivered driver training. RRT members were allocated a driver class dependent on their level of training.Class one team members had completed an emergency ambulance driving course and were able to transport patients under blue light, class two could transport patients in a non-emergency situation and class three had not received any additional driver training and were not authorised to transport patients. At the time of our inspection seven members of staff were driver class one and four were driver class three.
- At time of inspection 100% of class one drivers were up to date with their blue light driver training.

Assessing and responding to patient risk

- The service had an operational red flag policy which detailed patient conditions that should immediately be escalated to the local ambulance service via the 999 system. This was a comprehensive list which included obstructed airway not cleared by simple measures, ventilator support indicated, cardiac arrest, respiratory arrest, major trauma and severe pain not relieved by nitrous oxide or nitrous oxide contraindicated.
- 100% of staff members we spoke to were aware of the red flags. They confirmed that they would call 999 in the case of a deteriorating patient.

Staffing

- All members of the RRT worked and held full time positions on the business park and were volunteers for the RRT. Staff registered their availability four weeks in advance. The station officer used an availability tracker on a weekly basis to ensure that there was a minimum of four people available and that there was a suitable skill mix.
- The team consisted of 11 members. Four were trained to first person on scene (FPOS) enhanced level, three were FPOS intermediate and four were FPOS basic. All were registered community first responders with the local ambulance trust.
- In a situation when insufficient staff were available the station officer told us that they would notify the control room and any calls to the service would be diverted immediately to the 999 service. However this had never happened in the time that the service had been established.

Response to major incidents

- The business park had a major incident plan in place. Major incident simulation training took place annually and had taken place two weeks before our inspection. The simulation scenario was a building collapse with two injuries. The station officer had coordinated the response and had used a helmet camera to record the training. The team had reviewed this at the next training session. Areas of learning were identified including a review of the skill mix of staff allocated to each casualty and the working relationship with the fire crew. These learning points were recorded on the learning log submitted after the inspection.
- When the vehicle was not available for example if it was having an annual service, control were advised and the 999 service was automatically called in an emergency.

Are patient transport services effective?

Evidence-based care and treatment

- The service had policies in place including an operational policy, a vehicle and equipment cleaning policy, a clinical policy and a driver assessment policy. The policies had implementation dates and review dates. Policies referred to current guidelines and best practice. All policies we checked were in date at the time of inspection.
- Policies were accessible via the provider's intranet. Two members of staff confirmed that they knew how to access policies. Staff did not have remote access to policies and protocols but this was mitigated by discussion of changes at fortnightly training sessions.

- Everyone on the business park was eligible to use the service. Assessments were made as to the appropriateness of using patient transport according to patient need.

Assessment and planning of care

- There was an on-site emergency number which staff from the business park called in the case of a medical incident. This number was printed on all phones and staff passes. Staff employed on the business park were informed of the system during induction.
- Calls were answered by staff in the control centre and available members of the rapid response team (RRT) were contacted using a group text and pager alert.RRT members contacted the control centre via a dedicated line and were given details of the incident. One responder would be dispatched on foot and a second responder would attend with the ambulance.
- We saw a list of available rapid response team (RRT) members in the control centre for the week commencing 15 October 2017. This meant that the control room operator was aware of which team members were available to respond to any call.
- A triage prompt sheet was available to determine the nature of the medical emergency to assist control staff in sending the appropriate response.
- A member of staff told us that they used a pain score to assess a patient's pain. They told us that they would use non-verbal cues to assess pain level if a patient was unable to communicate.

Response times and patient outcomes

- The service had responded to 10 incidents from 1 January 2017 to 17 October 2017. The service kept a vehicle call log. The information recorded included incident number, date, call time, arrival time and patient outcome.
- The call log showed that two patients were transported to the local hospital via blue light transfer, one person was transported to hospital, one was taken to their GP, one person went home and five returned to work.
- The clinical policy stated that an RRT member should be with the patient within three minutes. The vehicle and call log recorded the time that the call was made and the time that the vehicle arrived. It did not record the time that the first member of the RRT arrived on foot. Therefore we could not confirm if this target had been met.
- Vehicle and call log response times showed that for the 10 calls received since January 2017 the vehicle arrived within 5 minutes of the call time for eight of the calls. In one case the vehicle arrived in eight minutes and in one case the vehicle arrived in fifteen minutes.
- The service it did not participate in any benchmarking or national audits.

Competent staff

- Formal appraisals were not undertaken. Due to the small nature of the service there was a different process in place to review staff performance. Every patient attendance was reviewed and staff competencies were assessed at team training sessions. However these were not formally recorded. The training officer told us that if there were a concern about an individual's performance they would organise additional training but this had not happened since the service had been running.
- All members of the rapid response team were trained as community first responders (CFRs) by the local ambulance trust. We saw the training schedule from April 2017 to March 2018. Training sessions included safeguarding, dementia awareness and patient assessment.
- The service training officer and senior members of the team delivered extra training in addition to the CFR training. External paramedics also delivered training. Topics included choking, burns and scalds, respiration problems, seizures and shock and the unresponsive casualty. Staff could also identify training needs and these were included in the regular sessions.
- The station officer had recently introduced the requirement that each member of the team completed a continued personal development (CPD) folder. Folders contained qualification certificates, DBS certificate, training attendance and advanced driver certificates where applicable. They also contained reflective pieces about incidents staff had attended. We reviewed 11

folders. Two were completed appropriately. We raised this with the station officer. They confirmed that the folders were new to the team and were a focus for future training sessions.

- Staff were encouraged and supported to do enhanced training. Seven members of the team had qualified in intermediate or enhanced level FPOS.
- New members of the team had a mentor and were supported through their training. They were supported by a senior member of the team when attending a call.

Coordination with other providers and multi-disciplinary working

- The service has a memorandum of understanding in place with the local ambulance trust. This outlined training that the service received from the local ambulance trust and the response that the service provided as community first responders.

Access to information

- The vehicle had an accurate and up-to-date satellite navigation system. There was a map in the vehicle detailing locations on the business park.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an internal memo outlining details of the Mental Capacity Act 2005. It contained details of the five principles of mental capacity and how to assess capacity. All staff we asked were aware of this document and could describe their responsibilities in relation to an individual's capacity to make decisions.
- The protocol stated that if a member of the team were in any doubt about their patient's ability to consent or were concerned about making a decision then the ambulance service would be contacted via the 999 system.
- We spoke with two staff members about their understanding of consent. Both were able to explain the principles of consent and implied consent.

Are patient transport services caring?

Compassionate care

- A service user described the service as "amazing". They said that they were made to feel comfortable and the person providing their care was very reassuring and made them feel at ease.
- Another service user told us that they had burned their hand at work and that the rapid response team (RRT) member had arrived quickly was very competent and managed to keep them calm.
- A service user described the RRT member as helpful and caring. A female service user described how a male RRT member stepped out of the vehicle when ECG leads were attached to protect her dignity.
- A former employee of Adastral Park Business Park came from home to tell us about the care they had received. They described how they had collapsed at work and how members of the RRT had saved their life by recognising what had happened and continuing with CPR until the trust ambulance crew arrived. They could not be more thankful and appreciative of the team and what they had done for them and their family.

Understanding and involvement of patients and those close to them

- A service user told us that they were listened to and were told exactly what was happening during their treatment.
- Another person who had used the service told us that they felt the responder "had their health in mind in every decision".

Emotional support

- A patient told us that the rapid response team member who cared for them accompanied them to hospital. They told us that the team member also contacted their relative so that they could meet at the hospital to offer support.
- Another service user told us that the team were very reassuring and they felt emotionally supported whilst they received treatment.
- A relative of the employee who had collapsed at work said that members of the RRT had offered emotional support during a very distressing time.

Patient transport services (PTS)

- A member of staff described the team are supportive. They told us team training sessions offered a safe place to share experiences and offered support to each other.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The service was planned to meetthe first aid needs of the people working on and visiting the business park and to provide access to treatment and transportation in case of an accident or ill health.
- The commissioners were the local businesses on site and were invested in providing the service.
- The facilities and premises were appropriate for the service provided.

Meeting people's individual needs

- Staff had completed dementia awareness training. One staff member told us what adaptations they would make to support a person living with dementia.
- The staff could accommodate those needing wheelchair accessible transport.

Access and flow

- There was a colour coding system ensuring that the control centre was aware of the status of the ambulance at any time. Red meaning emergency blue light journey, blue indicated an urgent journey, white a non-urgent journey and green meant the ambulance was available. In a situation when an urgent response was required and the ambulance was not available the 999 service was automatically be called.
- The service monitored on scene turnaround times. We saw the vehicle and call log which recorded details of the 10 calls that the service had attended between January 2017 and September 2017. The vehicle arrival and departure times were recorded with notes explaining any delays. Staff told us that each call out was discussed at the next team training session after the call. Any learning or areas for improvement were highlighted. However this was not formally recorded. After our inspection the station officer sent a copy of a learning log where learning from incident attendance could be logged and shared.
- Due to the secure nature of the work that is carried out on the business park some areas had restricted access. The rapid response team had members with varying levels of security clearance to enable them to access all areas of the park quickly in an emergency.

Learning from complaints and concerns

- The service reported they had not received any complaints between September 2016 and September 2017.
- There was a complaints process in place within the operational policy. This outlined how to respond to complaints including a letter of acknowledgement to the complainant, an investigation to be completed and a timeline for a response.
- We saw an internal memo which outlined duty of candour and how this would apply in relation to complaints.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The Adastral Park (Martlesham) rapid response team (RRT) operated under the guidance and governance the business park's Chief Medical Officer. The service was managed by the station officer who reported to the Adastral Park location manager.
- Leaders were clearly visible. The station officer and training officer attended and led the fortnightly training sessions. Staff confirmed that the leaders worked alongside them and were part of the team. They told us that everyone worked well together.
- Staff described the team as being like a family; it was evident that the team were passionate about the service they provided and that the whole team supported each other.

Patient transport services (PTS)

- One staff member told us that members of the team were reluctant to retire from their full time jobs because of the enjoyment and satisfaction they got from being part of the RRT.
- Team members were very proud of the service they provided and felt that they did contribute to making the business park a safer place to work. This was evident when the ex-employee who had had the collapse at work came to speak with us. Team members were visibly moved when they recalled the contribution the team had made to save his life.

Vision and strategy for this this core service

- The rapid response team aimed to provide fast, safe and effective enhanced first aid and transport to the local hospital if required, to anyone on the Adastral Park business park.
- Within the Rapid Response Team (RRT) operational policy there were goals set for the RRT members. These included attending the required number of training sessions, upholding their ability to provide safe and effective, prompt care by attending externally verified training sessions. It also detailed how the RRT member would contribute to making the site a safer place to work and benefit the local community via the community first responder scheme.

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

- There were no governance processes in place to effectively monitor the service, reduce risk and provide quality assurance.
- The service did not have a risk register in place at the time of our inspection however the station officer was able to identify the current risks to the service. We raised this on site and the service responded. Data provided post inspection showed that a risk register had been implemented. Five risks were identified. Action to be taken and the person responsible were recorded.
- There were no systems in place to monitor equipment maintenance and servicing. The issue we noted with the equipment servicing had not been identified by the management team. After our inspection we received confirmation that the equipment annual service had been booked for 6 November 2017.
- There was no audit or oversight of stock control of consumable items. We found a number of out of date consumables both in the vehicle and in staff grab bags.
- Although incidents were identified and discussed at training sessions these were not formally recorded and learning was not shared with team members who had not been in attendance at the training session. Following our inspection the station officer provided a copy of a learning log that recorded incidents and outlined learning and actions and how learning would be shared.
- There was a central training record in place to monitor staff training and competency compliance and renewal dates. This meant that we were assured that there was oversight of staff training requirements.
- There were risk assessments carried out in line with the Control of Substances Hazardous to Health (COSHH) Regulations to determine how to prevent harm to health from cleaning chemicals and implement control measures to reduce harm to health. Comprehensive operational and clinical risk assessment was completed.

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

- The station officer had conducted a survey of staff on the business park to gain their feedback on the service provided by the rapid response team. 95% of respondents felt that the RRT promoted a positive image and made the business park a safer place to work.
- In addition to the patient transport service the rapid response team provided on site first aid cover for events held on the site including family fun days.
- The rapid response team were trained community first responders (CFR) who operated in the local community on behalf of the local ambulance trust. This meant that when an emergency call was received via the ambulance 999 system the members of the rapid response team were mobilised by the ambulance dispatch. Being based in the local community they could offer treatment to the patient quickly whilst the 999 ambulance service was in transit.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure there are effective governance processes in place to review risk and ensure effective monitoring of incidents and learning to improve practice.
- The provider must ensure that records are kept of meetings where staff competencies and incidents were discussed.
- The provider must ensure there are effective processes in place to monitor equipment including processes to ensure consumables are in date and all equipment is serviced and maintained.
- The provider must carry out local audit for quality assurance.

Action the hospital SHOULD take to improve

- The provider should formally record and investigate incidents and ensure that any learning is shared with the whole team.
- The provider should ensure that the clinical waste bin is locked.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (Regulated Activities) Regulations 2014 Good governance: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulation activity, which states: (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (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; f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). How the regulation was not being met: The provider did not formally record risks, incidents, or share learning from incidents. The provider did not conduct any audits to assess the effectiveness or safety of the service. The provider did not have systems in place to maintain oversight of equipment servicing. The provider did not have systems in place to maintain oversight of consumable items.