Heart Medical Limited

Heart Medical HQ

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.

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

Heart Medical HQ is an independent ambulance service operated by Heart Medical Limited. The service provides patient transport and emergency and urgent care service.

We first visited this provider in March 2019, due to a number of concerns raised with CQC about the cleanliness of vehicles and the culture within the service. Following this inspection, we carried out urgent enforcement action and served a notice under Section 31 of the Health and Social Care Act 2008 to suspend the registration of the service provider in respect of the regulated activities: Transport services, triage and medical advice provided remotely and Treatment of disease, disorder or injury. We took this action because we believed that a person will or may be exposed to the risk of harm if we did not take this action. Following this action, the service was not allowed to carry out any regulated activity until they had improved. We undertook two further visits to the location, in May and June 2019 which are covered in this report. At the May 2019 inspection, we did not receive assurance that services had improved sufficiently, and the provider agreed to voluntarily suspend regulated activity. At the June 2019 inspection we received adequate assurance and the provider was able to provide regulated activities again.

We inspected the patient transport service as this was the main service provided by this company at the May and June 2019 inspections. We did not inspect the urgent and emergency care service. We asked two of our five key questions, during these inspections, examining whether services were safe and well led.

We inspected this service using our focused inspection methodology. Our inspections were announced (staff knew that we were coming) to enable us to observe routine activity.

Following the March 2019 inspection, the service had closed one base station in Durham and was operating from its only base in Ossett, West Yorkshire.

Throughout the inspections, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005. However, at the time of the inspections the service did not transport patients detained under the Mental Health Act.

Due to the inspections being focussed we did not rate these inspections. Following the May and June 2019 inspections we found:

- Improved standards of cleanliness and hygiene; the registered manager had developed reliable systems to prevent and protect people from a healthcare-associated infection.
- The service had improved training requirements to ensure staff had the relevant qualifications, competence, skills and experience to care for patients safely.
- The service had improved record keeping in relation to mandatory training undertaken and appraisal records for staff members.
- The service had improved record keeping in relation to safeguarding training. Although, due to the lack of regulated activity we were unable to speak to staff during these inspections to gain assurance on their understanding of safeguarding and how Heart Medical would report, act on or monitor any safeguarding issues.
- Improved systems to ensure that equipment was routinely checked for safety.
- Improvements had been made in relation to record keeping.

However, the following issues still needed further improvement:

- Although the registered manager had plans to improve governance structures to monitor and improve the quality and safety of the services they provided; these had not been implemented

Summary of findings

- There were limited systems to identify risks and plan to eliminate or reduce risks.
- The service did not seek and act on feedback to evaluate and improve the services provided.
- We were not assured that medical gases were consistently stored in line with guidance.

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

Ann Ford, 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?
Patient transport services (PTS)		Heart medical HQ is operated by Heart Medical Limited. The service opened in 2016. It is an independent ambulance service in Ossett, West Yorkshire. The service primarily serves the communities of North East and North-West England. At the time of this inspection, the service was not providing any regulated activity due to it being suspended. We received adequate assurance that improvements had been made to recommence the regulated activities. The service also provides events cover and repatriation, which are outside of the scope of CQC regulation.

Heart Medical HQ

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Detailed findings

Contents

Background to Heart Medical HQ

Heart medical HQ is operated by Heart Medical Limited. The service opened in 2016. It is an independent ambulance service in Ossett, West Yorkshire. The service primarily serves the communities of North East and North-West England.

At the time of the inspections, the service was not providing any regulated activity. The service also provides events cover and repatriation, which are outside of the scope of CQC regulation.

We have inspected the Ossett location, twice before, the last occasion being March 2019, where we took urgent enforcement action to suspend the service and issued requirement notices.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and one assistant inspector. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Facts and data about Heart Medical HQ

The service has had a registered manager in post since 2016. The service is registered to provide the following regulated activities:

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

During the inspection, we visited the location, we spoke with three members of staff including; registered manager. We were unable to speak with any patients as the service was suspended.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice since its registration, and the most recent inspection took place in March 2019.

We requested activity data between April 2018 to March 2019, however this was not supplied.

At the time of this inspection, the service employed eight ambulance care assistants and six management staff. The service did not hold controlled drugs so did not have an accountable officer.

We requested data on the systems used to measure safety including the number of clinical incidents, serious

injuries and complaints. Data on clinical incidents was supplied but we were not able to interpret this data, due to a lack of information about dates of incidents being collected.

Patient transport services (PTS)

Safe	
Well-led	
Overall	

Information about the service

Heart Medical HQ is an independent ambulance service with an operational base in Ossett, West Yorkshire.

At the time of the inspection, the service was suspended from carrying out regulated activities, the service was only providing activity outside of the scope of regulation for example; event cover.

Summary of findings

During the inspection, we visited the location and we spoke with three staff.

At this inspection, we did not rate the service.

We found the following issues needed further improvement:

- There were limited systems to monitor and improve service quality and safeguard high standards of care.
- There were limited systems to identify risks and plan to eliminate or reduce risks.
- There was limited evidence that the service had a process to assess and respond to patient risk.
- There was not an effective incident reporting and management process in place.
- The service did not seek and act on feedback to evaluate and improve the services provided.
- We were not assured that medical gas cylinders were stored consistently in line with guidance.
- Due to the lack of regulated activity we were unable to speak to staff during this inspection to gain assurance on their understanding of safeguarding and how Heart Medical would report, act on or monitor any safeguarding issues.

However:

- Improved standards of cleanliness and hygiene; the registered manager had developed reliable systems to prevent and protect people from a healthcare-associated infection.
- All ambulances we inspected were clean, stocked appropriately and suitable for the purpose. Clinical waste and used linen were appropriately managed.

Patient transport services (PTS)

- The premises and equipment used by the service were suitable for the purpose they were being used for.
- The service had improved training requirements to ensure staff had the relevant qualifications, competence, skills and experience to care for patients safely.
- The service had improved record keeping in relation to mandatory training and safeguarding training.
- Improvements had been made in relation to the standard of patient record keeping and storage.
- Improvements in the record keeping in relation to recruitment procedures to ensure that staff working at the service had up to date disclosure and barring service checks.

Are patient transport services safe?

At this inspection, due to the inspection being focused we did not rate the service.

We found the following issues needed further improvement:

- Although improvements had been occurred following the inspection in March 2019, the provider needed to ensure that these were sustained now the suspension was lifted.
- There was limited evidence that the service had a process to assess and respond to patient risk.
- There was not an effective incident reporting and management process in place.
- We were not assured that medical gas cylinders were stored consistently in line with guidance.
- Due to the lack of regulated activity we were unable to speak to staff during this inspection to gain assurance on their understanding of safeguarding and how Heart Medical would report, act on or monitor any safeguarding issues.

However,

- Improved standards of cleanliness and hygiene, the registered manager had developed reliable systems in place to prevent and protect people from a healthcare-associated infection.
- All ambulances we inspected were clean, stocked appropriately and suitable for the purpose.Clinical waste and used linen were appropriately managed.
- The premises and equipment used by the service were suitable for the purpose they were being used.
- The service had improved training requirements to ensure staff had the relevant qualifications, competence, skills and experience to care for patients safely.
- The service had improved record keeping in relation to mandatory training, appraisal and safeguarding training.
- We found improvements had been made in relation to record keeping.

Patient transport services (PTS)

Incidents

- There was not an effective incident reporting and management process in place.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious harm or death but neither need to have happened for an incident to be a never event. We requested information from the registered manager in relation to the number of never events reported within the service in the reporting period April 2018 to March 2019, which was not supplied.
- The service had an incident reporting policy; Incident forms were available in the main office. Following the March 2019 inspection, we requested information from the registered manager in relation to the number of incidents reported within the service in the reporting period April 2018 to March 2019, this was not supplied. At the May 2019 inspection, the registered manager supplied a document listing the incidents that had occurred, however this did not contain dates of when each incident occurred or when it was reported. This report also did not provide the grade of incident, so we were unable to identify how many incidents occurred within a specific period of time, or whether they had been investigated appropriately.
- At the March 2019 inspection, incident forms we reviewed did not show evidence of lessons learnt or recommendations to prevent reoccurrence. At the May 2019 inspection, the incident log did not show how learning from incidents was shared with staff to prevent reoccurrence.
- Due to the lack of activity we were not able to speak with staff about the reporting system, or whether they felt confident in reporting incidents or received feedback on incidents reported.
- 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. Due to the lack of activity we were not able to speak with staff about their understanding about duty of candour responsibilities or training they had received on duty of candour.

Mandatory training

- The service had commenced providing mandatory training in core skills to all staff.
- At the March 2019 inspection, the service had stopped using an accredited training programme to train their staff. Following the inspections in March and May 2019, the service had re-commenced using accredited training programmes.
- Following the March, May and June inspections, we requested information from the registered manager on the ambulance driver training (including blue light driver training) provided to staff, this was not supplied. At the time of the May and June inspections, the service was not contracted to provide blue light driving.
- At the March 2019 inspection, six out of seven staff files we reviewed did not hold evidence of mandatory training, At the May 2019 inspection, copies of mandatory training certificates were stored in staff files currently employed. Improvements were also seen in that since the inspection in March 2019, the provider had started using an online tracker to document and monitor staff training, this system generated an automatic alert for when training was due.
- There remained no evidence that staff received manual handling or mental capacity act training.

Safeguarding

- The registered manager had commenced a programme ensuring that staff were trained appropriately to protect patients from abuse.
- We requested copies of the safeguarding children and protecting vulnerable adult's policy from the registered manager; this was supplied. Due to the lack of activity we were not able to speak with staff about access to the policy whilst away from base. We requested from the registered manager evidence of how staff accessed policies whilst away from the base, this was not supplied.
- A company director was the designated safeguarding lead for the company. We requested evidence of the

additional safeguarding training this person held, as detailed in the safeguarding children and young people: roles and competences for health care staff intercollegiate document, January 2019. Evidence showed that staff had received additional safeguarding training to enable them to hold this position.

- At the time of the March and May 2019 inspections, the registered manager was not able to confirm the level of safeguarding training staff received. At the June inspection, the service had commenced training with an accredited provider aligned or equivalent to level 2 safeguarding children and adults. We saw evidence to confirm that six out of ten staff members employed had received adult and children's level two safeguarding, this was also supported by in-house face to face training, and completion of a national care award. The remaining four staff all had a date of when the training would be completed.
- Due to the lack of activity we were not able to speak with staff about the safeguarding training they received or held, or whether they were aware of safeguarding referral protocols.
- We requested to review information on how many safeguarding referrals had been made and what actions had been taken April 2018 to March 2019; this was not supplied.

Cleanliness, infection control and hygiene

- The registered manager had developed effective systems to show how the service met the requirements of the Health and Social Care Act 2008; code of practice on the prevention and control of infections to ensure that patients are protected from the risk of infection.
- At the March 2019 inspection, we had serious concerns over the cleanliness of the vehicles and the premises used for regulated activity. At the May 2019 inspection, we remained concerned about the cleanliness of the vehicles, equipment and premises, however during the June 2019 inspection, we saw that systems had improved, and vehicles, equipment and premises were clean and fit for purpose.
- At the March 2019 inspection, a number of concerns around cleanliness and infection prevention and control had been identified at the Durham base station, following this inspection the service had closed this base.
- The service had a vehicle cleaning and infection prevention and control (IPC) policy. Due to the lack of activity we were not able to speak with staff about access to the policy whilst away from base. We requested from the registered manager evidence of how staff accessed policies whilst away from the base, this was not supplied. At the June 2019 inspection, the service had commenced improved training on infection prevention and control, cleanliness, decontamination and prevention of infection.
- At the June 2019 inspection, all ambulances we reviewed were visibly clean and ready for service.
- At the March 2019 inspection, cleaning materials and solutions were not consistently available, at the May and June inspections, we saw improvements with cleaning materials being available for use. We saw an improved supply of colour coded mops and cloths were available to enable staff to carry out cleaning as required.
- At the inspection in March and May 2019, we had concerns about cleaning solutions being decanted into unlabelled containers. At the June 2019 inspection, the registered manager had acted and ensured that the solution was only used as required for cleaning and then disposed of; solutions were no longer being stored in unlabelled containers.
- At the March 2019 inspection, there was no evidence to show when vehicles were last cleaned, or when the next clean was due. At the May 2019 inspection, the registered manager had implemented a new process for recording vehicle cleanliness. This included electronic recording and management assurance checks. Due to low levels of activity, we were only able to review limited evidence on the systems in place to ensure vehicles and equipment were appropriately and safely cleaned and ready for use. This evidence showed us that the provider had made improvements in the system and was now auditing cleanliness reports to provide further assurance.

Patient transport services (PTS)

- At the March 2019, we did not receive assurance that the provider accurately recorded when deep cleans of vehicles had taken place, At the May 2019 inspection, evidence we reviewed showed that the vehicles had recently been deep cleaned by an external cleaning company and further deep cleans were planned.
- During the previous inspections (March and May 2019), equipment we examined such as ambulance bags, stretchers and trolleys were not visibly clean, at the June 2019 inspection these were all visibly clean and ready for use.
- At the March 2019 inspection, there was no evidence of effective systems for management of waste. At the May and June 2019 inspections, we saw improvements in the systems for the management of waste. All clinical and non-clinical waste were segregated appropriately.
- At the March 2019 inspection, there was no evidence of effective systems for management of used linen. At the May and June 2019 inspections, we saw improvements in the management of used linen. No used linen was stored within the ambulance station.
- At the March 2019 inspection, there was limited amounts of personal protective clothing available. At the May and June 2019 inspections, we found improvements in the availability of personal protective equipment (PPE) for staff, PPE was available on the vehicles we inspected and was available in the storage and cleaning areas of the station.
- During the inspection, due to the lack of activity we were not able to observe that clinical staff were complying with 'bare below the elbow' guidance.
- At the March 2019 inspection, alcohol hand sanitiser was only available in one ambulance and staff did not have access to any hand wipes. At the May and June 2019 inspections, we saw improvements in the provision of alcohol hand sanitiser to enable staff to decontaminate their hands.
- At the March 2019 inspection, there was no evidence of the service carrying out infection, prevention and control audits. At the May and June 2019 inspections, the service had begun completing infection prevention control assurance audits. This meant the service had begun to develop a system to monitor infection prevention practices against their policy,
- There was no evidence the service carried out hand hygiene audits to confirm staff adherence to good hand hygiene techniques.
- Staff had access to waste containers for disposing of sharp equipment, at the inspections in March and May 2019 these were stored longer than good practice guidance; at the June 2019 inspection these were all stored appropriately.

Environment and equipment

- The registered manager ensured there was suitable equipment available for the delivery of the service.
- At the time of the March 2019 inspection, the service had 13 ambulances used for PTS, urgent and emergency care and events. At the May and June 2019 inspections, the service had three operational vehicles, two being ambulances and one being an event response bus.
- At the March 2019 inspection, the senior management team said that staff should check the vehicles were ready for service prior to leaving the base station using vehicle daily inspection forms, however records we reviewed did not provide assurance that this was occurring. During the inspections in May and June 2019, we observed that the service had improved record keeping and was now able to provide some assurance of an effective system.
- At all the inspections, resuscitation equipment was available on the in-service ambulances; however, we did not receive assurance about compliance with some safety checks; such as recording of battery discharges and charging of defibrillators. We discussed this with the registered manager, who was not able to supply further assurance of a safe system.
- During the March and May 2019 inspections, we were not able to review the standard equipment stored in all ambulances. During the June 2019 inspection, we saw that three operational vehicles were stocked ready for use. All equipment was appropriate, correctly stored and in date.
- During all the inspections, first aid equipment and dressings were available on the vehicles ready for use and ambulance equipment bags had a standardised list of contents. However; during the March and May 2019 inspections, we did not see compliance with the standardised list of what should be available in

ambulances, and ambulance equipment bags. At our June 2019, inspection we saw improvements and all ambulance equipment bags we reviewed contained the appropriate equipment.

- During the inspections March and May 2019, we were concerned that the service did not hold relevant stock to enable the safe treatment of patients. The registered manager said that in advance of events or contracts, he would plan and order the necessary stock, to ensure that the correct equipment was available for staff to use.
- At the June 2019 inspection, we identified a stretcher trolley mattress that was damaged, the registered manager immediately took it out of service and arranged for repair.

Assessing and responding to patient risk

- There was limited evidence that the service had a process to assess and respond to patient risk.
- Following the March 2019 inspection, we asked the registered manager to supply the current deteriorating patient policy and/or protocols; these were supplied. At the March and May 2019 inspections, training records did not provide assurance of training for staff specific to the recognition and management of deteriorating patients. We were also not able to speak to staff about their recognition and knowledge of actions required for the escalation of deteriorating patients during transfer.
- Since the March 2019 inspection, the service had taken steps to ensure staff were appropriately trained in first aid, cardiopulmonary resuscitation (CPR) and the use of oxygen in an emergency. At the May 2019 inspection, we saw evidence to confirm that seven out of ten staff members employed had received basic life support training, this was also supported by in-house face to face training, and completion of a national care award. The remaining three staff all had a date of when the training would be completed.
- Following the March and June 2019 inspections, we asked to review the Do Not Attempt Cardiopulmonary Resuscitation Policy; this was not supplied.
- At the March 2019 inspection, we asked to review evidence on the insurance, weight, Ministry of Transport testing (MOT) and tax of all the vehicles used within the service; this was supplied and showed that at the time of the May and June 2019 inspections, all three vehicles were taxed, insured and MOTs were in date.

Staffing

- The registered manager had commenced improvements to ensure that staff had the right qualifications, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- At the time of the March 2019 inspection, the service employed one registered paramedic, six ambulance technicians, 23 ambulance care assistants, three emergency care assistants and six management staff. At the time of the May and June 2019 inspections, the service employed, eight ambulance care assistants and six management staff. Other staff were available for events on a self-employed basis.
- Staff worked on zero hours contracts. They would be informed as to what shifts they were working in advance.

Records

- The registered manager ensured that records used within the service were stored appropriately.
- At the May and June 2019 inspections, we saw improvements in record keeping and patient records storage. Patients records were stored in a locked room, or whilst in use were stored in an occupied office.
- Following the inspections in March and June 2019, we asked the registered manager to supply information on the information governance policies and training of staff within the service; the policy was not supplied and training data on this specific policy was not available.
- At the time of the May and June 2019 inspections, the service was not carrying out regulated activity and did not currently hold any NHS contracts therefore we could not review any bookings from NHS ambulance control rooms.
- At the time of the March, May and June inspections, staff we spoke with said that the company did not carry out

any audits in relation to the quality of documentation or booking information. Following the inspections in March and June 2019, we asked the registered manager to supply this information, this was not supplied.

Medicines

- The only medicines held at the service was medical gases. We were not assured that the cylinders were stored consistently in line with guidance.
- At the March 2019 inspection, the registered manager did not manage medicines in line with national guidance and legislation Following the inspection in March 2019, the service had made improvements to ensure that no medicines were stored on site.
- Cylinders containing oxygen and nitrous oxide were stored in cages, affixed to the wall. The cages were not locked, so did not provide assurance that cylinders were stored consistently in line with guidance.
- The service did not hold any controlled drugs or emergency medicines.

Are patient transport services well-led?

We did not rate the service due to the inspection being focused.

We found the following issues needed further improvements:

- There were limited systems to monitor and improve service quality and safeguard high standards of care.
- There were limited systems to identify risks and plan to eliminate or reduce risks.
- The service did not seek and act on feedback to evaluate and improve the services provided.
- The registered manager was aware of the issues requiring improvement within the service but needed to continue to act with pace to improve the services provided.

However,

- Improvements in systems to prevent and protect people from a healthcare-associated infection.
- Improvements in systems to ensure that staff working at the service had undergone the necessary recruitment procedures up to date disclosure and barring service checks.

Leadership of service

- The registered manager was making improvements to the services provided.
- At the March 2019 inspection, it was clear that the service had deteriorated since the last inspection in January 2018, and the registered manager had not acted with pace to improve the services provided. At the May and June2019 inspection, we saw improvements in the services provided, however they still required a further period of embedding to show sustained improvement.
- The leadership team consisted of the managing director, who was the CQC registered manager. At the March 2019 inspection a restructure of the leadership team had occurred in the months prior to the inspection, this included a head of education and quality, a head of service delivery and a head of business and strategy. At the May 2019 inspection, the registered manager spoke with us about an additional re-structure they may have to make to ensure sustained improvements occurred.
- At the time of the March 2019 inspection, there was limited evidence of a system for managers attending regular leadership team meetings. At the May and June 2019 inspections, the registered manager had commenced leadership meetings, however these needed further time to be embedded.
- At the time of the March 2019 inspection, there were no mandatory training records available for six out of the seven staff files we reviewed, at the May 2019 inspection training records were available for all staff currently employed. Improvements were still required in recording appraisals undertaken with staff and at the May 2019 inspection. There were no appraisal records for staff members in six of the seven staff files we reviewed. The registered manager shared with a us an updated appraisal form which they were going to complete with staff in the future.

Vision and strategy for this service

Patient transport services (PTS)

- The service had a vision which was to support the development of community response, resilience and access to care when it's needed the most. We are "Here when you need us".
- The service mission statement was to provide high quality treatment, care, training and service to our patients, their relatives, our students and our commissioners when they need us most.
- The service values were; to care, C - Care for ourselves and others with compassion, kindness, dignity and respect, A - Awareness and openness, demonstrating a learning no blame culture, R- Responsive and reliable to the needs of our patients, their relatives, our customers and each other and E - Effective and safe in all we do.
- These were displayed on the service's intranet page.
- Due to the service suspension, staff were not on site to assess their understanding of the vision, mission statement or values.

Culture within the service

- At the March 2019 inspection, staff we spoke with described a mixed culture; some staff we spoke with said that they enjoyed their role and felt supported by managers and immediate colleagues. Other staff described different negative experiences. During the May and June 2019 inspections, no staff were not available on site to speak with about the culture of the service.

Governance

- There were limited systems to monitor and improve service quality and safeguard high standards of care.
- At the March 2019 inspection, there were no systems to improve service quality, at the May and June 2019 inspections, the registered manager had plans to improve governance systems, within the organisation, including weekly governance and performance meetings. At the time of the May and June 2019 inspections, these plans had not been put into place.
- At the March 2019 inspection the service did not carry out audits to measure the quality and effectiveness of the service delivered and the service did not have a system to routinely monitor key performance indicators (KPIs). At the time of the May and June 2019 inspections, activity was restricted, and historically information had not been collected on the quality of patient journeys, so we were unable to review KPI data. Information that was collected was used for finance purposes rather than quality improvement.
- Following the March 2019 inspection, we asked the registered manager to supply information on any systems they held to measure quality within the service, they supplied a quality report, but this was for January 2018, so was unable to be used as evidence for this inspection. The registered manager said that they planned to re-instate these reports. We requested this again post the June 2019 inspection, however the registered manager did not supply this.
- Following the March and June 2019 inspections, we requested to review records of governance meetings; These were not supplied.
- Following the March and June 2019 inspections, we requested to review information on the number of compliments and complaints within the service, this was not supplied.
- At the time of the May and June 2019 inspections, the service did not hold any contracts with service commissioners.
- At the March 2019 inspection, the service did not hold meetings with staff. At the May and June 2019 inspections, we were supplied with documented evidence to show that staff meetings had been recommenced.
- Following the March and June 2019 inspections, we asked to review the recruitment policy that detailed the standards required for recruitment of staff; this was not supplied. At the March 2019 inspection, we reviewed seven staff files for evidence of full disclosure and barring service (DBS) checks and found this information contained within six. During the May 2019 inspection, we saw improvements in the recording of DBS checks, we reviewed five staff files all had evidence of full DBS checks.
- The register manager was aware of the issues requiring improvement within their service and had begun to take steps to improve the service. However, they needed to continue to act at pace to ensure improvements to the quality of the service.

Management of risk, issues and performance

Patient transport services (PTS)

- There were limited systems to identify risks and plan to eliminate or reduce risks.
- At the March 2019 inspection, there were no systems to identify risk or plans to identify or manage risk.
- At the March 2019 inspection, we asked to review the risk register used within the service. This was not supplied. At the May 2019 inspection, we were supplied with a risk register, however this showed a large number of risks recorded, all had mitigating actions identified., It was unclear as to how long items had been on the risk register, or when each risk was last reviewed. The registered manager acknowledged this and planned to make improvements these were not in place at the June 2019 inspection.

Information Management

- At all the inspections, it was clear that the registered manager did not use information to inform service development.
- At all the inspections, access to electronic records was password protected. Since the March 2019 inspection, records were now stored securely, and the service had purchased lockable boxes to transport records between different locations if required.

Public and staff engagement

- There was no effective process to engage with the public, staff and stakeholders.
- At all the inspections there was no evidence of any public engagement. Following the March 2019 inspection, the registered manager had reinstated staff meetings to improve staff engagement.
- At the May 2019 inspection, the service shared with us, “station updates” these documents were used to share key information with staff, these were available electronically, on the intranet and in paper formats displayed on crew room notice boards. We reviewed three recent documents and found that they contained relevant useful information for staff to improve engagement and performance.
- At all of the inspections, the vehicles we inspected did not contain any notices or leaflets explaining how to provide feedback or make a complaint.
- At the March 2019 inspection, the service was not able to share with us any information from the local NHS or independent hospitals on the type of feedback the service was receiving, positive or negative. Therefore, no learning was being shared within the service to enable them to improve or to sustain current performance. At the May and June 2019 inspections, no contracts were currently held with other providers, so the company were not able to share any information.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that staff providing care or treatment to patients have the correct competence, skills, training and experience to do so safely. This includes ensuring that all staff receive an annual appraisal. This also must be centrally recorded. (Regulation 18 (2) (a and b))
- The provider must ensure that learning from incidents is centrally recorded and shared with staff to improve patient outcomes. (Regulation 17 (2) (a and b))
- The provider must ensure that audits are centrally recorded and shared with staff to improve patient outcomes. (Regulation 17 (2) (a and b))
- The provider must ensure that they continue to have the correct system and process in place to prevent abuse and protect vulnerable patients. Regulation 13 (2))
- The provider must ensure effective governance systems are in place. Including recording of key performance indicators. (Regulation 17 (2) (a and b))
- The provider must ensure that staff have access to equipment required to protect patients and comply with national guidelines and legislation (Regulation 15 (1)).
- The provider must ensure that the risks of the service are assessed, monitored, and mitigated to improve the quality and safety of patients and staff working in the service. (Regulation 17 (2) (a and b))
- The provider must ensure that staff are recruited in accordance with national guidance and regulations. (Regulation 19 (2))
- The service must ensure that all staff working for the service have a good understanding about their responsibilities and obligations to fulfil the duty of candour requirements. (Regulation 17 (2))
- The provider must ensure that staff have reviewed operational policies and procedures ensure they are in date and that staff they have signed to say they have reviewed. (Regulation 17 (2))
- The provider must ensure that all staff working away from the base station have access to current policies and procedures. (Regulation 17 (2))

Action the hospital SHOULD take to improve

- The service should continue to take prompt action to ensure that the service is able to meet the requirements of the Health and Social Care Act 2008; code of practice on the prevention and control of infections. (Regulation 12 (2) (h)).
- The provider should continue to ensure that all premises used by the service are clean and suitable for the purpose in which they are being used. (Regulation 15 (1)).

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider needs to continue to ensure that staff have the appropriate skills, experience and knowledge to provide safe care and treatment to patients.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider needs to continue to ensure that staff have the appropriate, skills, training to protect patients from abuse.

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 The provider needs to continue to ensure that the service has systems and processes in place to assess, monitor, mitigate and improve the quality and safety of the services provided. The provider needs to ensure that staff have reviewed operational policies and procedures ensure they are in date and that staff they have signed to say they have reviewed.

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Requirement notices

The provider must ensure that all staff working away from the base station have access to current policies and procedures.

The provider needs to continue to ensure that staff have training in the requirements of duty of candour.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider needs to continue to ensure that staff working in the service have the correct skills, training and competence to undertake the roles they were employed for.

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 The provider needs to continue to ensure that the service has recruitment procedures established and operated effectively to record pre-employment checks on staff.