British Red Cross Society

British Red Cross Mitcham

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

British Red Cross Mitcham is operated by British Red Cross Society. The main service provided by British Red Cross Mitcham is events medical cover, which is outside the scope of regulation. However, they transport patients from event sites to local hospitals, which is in scope of our regulation.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 2 November 2017, along with an unannounced visit to an event where the service were providing healthcare on 4 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 areas of concern:

- Although safeguarding training was undertaken by staff and volunteers it did not meet the level of safeguarding training required by national guidance and there was no regular planned retraining. Therefore the provider could not show us staff or volunteers were kept up to date with how to recognise different types of abuse and ways they can report concerns.
- The system for managing and controlling confidential patient information was unsafe as staff and volunteers posted completed patient report forms through the royal mail postal system with no formalised or routine tracking.
- There was a risk that incidents were either not reported or not had their severity assessed, actions taken or learning documented.
- Medicines management did not always follow the provider policy which meant there was a risk of errors occurring. There was no Home Office licence at the time of the inspection for storage of the controlled drug diazepam; however an application was in progress.
- The were no robust DBS renewal process in place. The organisation did not comply with its own standards for DBS renewal and the majority of records we checked were past their DBS renewal date and two people had not have an enhanced check completed.
- Ambulance crew volunteers received no formal clinical supervision or performance appraisal with the service and competency was only reassessed every three years.
- There was limited training and support in the assessment of mental capacity and actions to be undertaken if a patient presented with limited capacity. Volunteers were not confident in being able to explain what actions they would take if they did not have support from a healthcare professional at an event.

However, we also found the following areas of good practice:

- The provider had undertaken a large scale national restructure in response to identified risk of consistency of service quality across the country. Managers at the Mitcham location supported the changes to improve quality despite the challenges of implementing large scale change. There were many methods used to engage volunteers and receive their feedback.

Summary of findings

- Despite the challenges for a service where a large proportion of the volunteer workforce worked remotely, the provider had a robust method of communicating clinical updates and learning through case studies. Volunteers were able to tell us about recent clinical updates and the multiple methods of communication used to pass on this information to them.
- Staff and volunteers followed evidence-based care and treatment and nationally recognised best practice guidance that was clearly colour coded to show what treatment could be carried out by different skill levels. In addition there was a robust system for ensuring that only volunteers with the required skill level were planned and assigned appropriately to an event.
- Patient feedback was collected using a survey. Although response rates were limited, it showed an overwhelmingly positive response about the care that patients received.
- Volunteers received training for psychosocial skills to support them in their communication with patients.

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 three requirement notices that affected emergency and urgent care. Details are at the end of the report.

Professor Ted Baker
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		British Red Cross Mitcham provided medical events cover. This included a regulated activity when patients were transported from event sites to local hospitals for further care and treatment. We found that systems and processes did not always ensure that staff and volunteers were supported in delivering quality care to patients.

British Red Cross Mitcham

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to British Red Cross Mitcham

British Red Cross Mitcham is operated by British Red Cross Society. The service moved to Mitcham in April 2017, from a local office in Wimbledon, where it was based since 2013. BRC Mitcham is an independent ambulance service in London providing events medical cover across London and the South East of England.

The service provides the following regulated activities:

1. Transport services, triage and medical advice provided remotely

2. Treatment of disease, disorder or injury

We inspected the service on the 2 November 2017 and visited an event site on 4 November 2017.

The service has a registered manager in post.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in ambulance services.

How we carried out this inspection

During the inspection we visited the base and an event site where the location was providing first aid including ambulance transport. We spoke with the site registered manager and logistics manager as well as two managers from other British Red Cross locations. As part of our inspection, we held a focus group for volunteer staff. We spoke with nine volunteers including paramedics and ambulance crew, and four sub contracted staff including paramedics, doctors and emergency medical technicians. We were not able to speak with any patients that were transported to hospital, however we reviewed four comment cards of patients left at other events and spoke with one patient who received care at the event by sub-contracted ambulance staff. We were not able to review any sets of patient care records where patients had been transported to hospital.

Facts and data about British Red Cross Mitcham

British Red Cross Mitcham forms part of the national Event First Aid Service of the British Red Cross. The

Detailed findings

purpose of this service is to provide first aid cover and ambulance transport from events at a wide variety of events throughout the United Kingdom as contracted by the private event organiser.

The British Red Cross had an organisational restructure within the last year. The Wimbledon site de-registered in April 2017 and was transferred to Mitcham. This new registered location focusses on providing event first aid services across London and South East England. The service is contracted through a variety of private event organisers, with ambulance support for transport from an event to a hospital emergency department (ED) provided at any medium to 'super-size' scaled events.

Fourteen emergency ambulances were managed by this location although they were not based there all the time as they were moved nationally to support events as required.

There were no ongoing special reviews or investigations of the service by the CQC during the 12 months before this inspection. This is the first inspection at either the Wimbledon or Mitcham location since registration with CQC.

Activity (October 2016 to September 2017)

- The service did not collect data on how many ambulance transfers from events they undertook. In the reporting period they covered 1569 events, of which 101 had ambulance transport provision.
- There were 11 ambulance crew volunteers were based at the Mitcham location. The location was also able to use volunteers based at other locations nationally for staffing events.

Track record on safety (January to October 2017)

- No never events
- One hundred and seventy clinical incidents; 45 no harm or near miss, 55 low harm, 10 as moderate harm and one as severe harm. The remaining 59 were uncategorised.
- No serious injuries
- No complaints

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

British Red Cross Mitcham provided medical events cover. This included a regulated activity when patients were transported from event sites to local hospitals for further care and treatment.

Summary of findings

We found that systems and processes did not always ensure that staff and volunteers were supported in delivering quality care to patients.

Emergency and urgent care services

Are emergency and urgent care services safe?

We do not currently have a legal duty to rate independent ambulance services.

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

- Not all volunteers had access to the electronic reporting system and this may have meant some incidents were not reported. Many incidents had not been categorised by severity or had any action or learning documented and this could mean that assessment of risk and learning from incidents was not being completed.
- There was no clearly identified timescale for refresher mandatory training in core subjects such as safeguarding, infection prevention and control, information governance and manual handling. This meant that some staff had not received update training in certain subjects for many years leading to a risk that some knowledge had been forgotten. Volunteers had not completed all modules of the annual continuation training which meant that there was a lack of consistency in training updates.
- Medicines management did not always follow provider policy which meant there was a risk of errors occurring. There was no Home Office licence at the time of the inspection for storage of the controlled drug diazepam; however an application was in progress.
- There was not an effective system for the management and control of patient sensitive and confidential information. Some patient record forms were sent through the Royal Mail postal system with no formalised or routine system of tracking that the information had been either sent or received. Volunteers and staff did not receive information governance training in line with the provider policy. There was no local audit of patient records.
- Safeguarding training for children and young people was not in line with national guidance. Some staff and volunteers had not received adult or children safeguarding training for many years therefore the provider could not demonstrate how staff and volunteers had up to date knowledge to recognise different types of safeguarding concerns and how to report them.

We found the following areas of good practice:

- The Mitcham base and the vehicles we saw were visibly clean and tidy, with evidence of regular deep cleaning of vehicles.
- National guidance was used to inform staff planning and there was a robust system to ensure only appropriately trained and competent volunteers were appointed.
- Continuation training was planned around patient case study examples and clinical memos provided up to date information and clinical support for identifying risks to patients. At large events, there was on site clinical advice that ambulance crews could access.

Incidents

- There were no never events reported in this service from January and September 2017. 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 provider had an incident reporting policy and procedure, updated in November 2016 that set out how incidents were learned from and acted upon to improve quality and safety. The policy set out the accountability, responsibility and reporting arrangements for all staff in relation to incidents.
- The provider introduced an electronic incident reporting system in November 2016. From January and October 2017, 20 non-clinical incidents and 170 clinical incidents had been reported for event first aid through the Mitcham location. Not all of these related to the regulated activity of transport to hospital. Out of the clinical incidents 45 were categorised as no harm or near miss, 55 as low harm, 10 as moderate harm and one as severe harm. The rest were not categorised which meant that the severity had not been assessed fully.
- Only half of the incidents had actions undertaken with details of the investigation and learning points. This meant that it was unclear how the service used incident reporting to learn and improve. We recognised that 23 incidents were reported in October 2017 so investigations may have been in progress.
- Serious Incident investigations were led by two reviewers who receive training in Root Cause Analysis

and are appointed by the Head of Quality. We saw the service had reported a serious incident to us for an incident that occurred as part of event first aid and did not form part of the regulated activity of transport services. This showed good practice and demonstrated the service was open and honest. The investigation into this incident had not yet been completed and so it was too early to identify the learning that had taken place and how it had been shared. No other serious incidents had been reported by the Mitcham location within the last 12 months.

- Not all volunteers were able to report incidents directly onto the electronic system. Some volunteers were not confident that incidents they had raised were reported by their line manager as they had not received any feedback. Others told us that they were not sure how to access the electronic reporting system.
- Feedback from incidents reported was sent to the person raising it as an email. This was forwarded to volunteers that did not have access to the system. We were told there were delays to receiving the feedback and it contained limited information. Some volunteers said it was then difficult to confirm what it related to.
- The British Red Cross maintained a central system for circulating updated clinical information and safety alerts to all relevant staff and volunteers. The memos were posted on the provider's intranet site, emailed directly to all relevant individuals and shared in newsletters and team meetings.
- We saw a clinical memo circulated in September 2017 as a result of incidents reported involving out of date medication being administered to patients. Although none of these incidents had occurred at the Mitcham location the information was cascaded to all staff and included an insert to be added to the clinical skills and standards pocket book as a reminder of a five point check used when administering medication. This showed that learning was shared across the provider and actions taken to reduce the risk of future incidents.
- Staff, volunteer and managers knowledge about the Duty of Candour had been identified as an area for improvement following a national audit in April 2017. We were told about actions taken following this were the circulation of learning pack about duty of candour and reviewing the requirement of the duty of candour at a quality workshop. Duty of Candour regulation is referred to in the Serious Incidents Procedure and managers were able to explain the fundamentals of the regulation. 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. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong.

Clinical Quality Dashboard or equivalent

- There was no clinical quality dashboard or equivalent system to monitor safety performance. There had only been one nationally led audit to monitor the quality and safety of the service being provided. This gave limited opportunities for the service to identify areas of strength or areas for improvement.

Cleanliness, infection control and hygiene

- Mitcham location was visibly clean. We checked five ambulances, four at the location and one on the event site and found them to be clean and tidy.
- An infection control policy included cleaning procedures for staff. This policy was created in 2016 and was next due for review in 2019. The policy was comprehensive and referenced relevant national guidelines for infection prevention and control.
- Foundation and ambulance orientation training modules included infection control. Update training had been offered in 2015 and 2017. We reviewed seven records of ambulance crew volunteers and found that only four had received infection prevention and control training in the last 12 months, two in the last three years and one five years ago. There was a risk that volunteers who had not received the 2015 and 2017 update training may have forgotten some skills and knowledge and their patients could be exposed to a risk of infection if good practice was not followed.
- A national audit run by the provider in April 2017 had reviewed each location infection prevention and control processes for premises and vehicles. The Mitcham location scored 83% compliance for the interior of ambulances and 75% for exterior ambulance cleanliness. This was slightly less than the national provider average compliance of above 90% interior and 84% exterior ambulance cleanliness. Waste disposal and personal protective equipment (PPE) audit results

were 90% which were only slightly lower than the 94% national average. The report that we saw did not identify what were the areas for improvement and there had been no follow up audits conducted.
- Deep cleaning of ambulances was undertaken every three months by an external company. We saw there was a record kept in the vehicle of the date done and the due date for the next deep clean. Swabs were taken before and after the deep clean to check that the process was effective.
- Cleaning materials were available for staff to use for daily cleaning. The service used colour coded buckets mop heads for cleaning the vehicles in line with best practice guidance.
- All vehicles were stocked with PPE including gloves, aprons, sanitising hand gel and wipes for decontaminating equipment in between patient use. We did not see any direct clinical care by volunteer ambulance crew however they were able to explain how they followed good infection control principles such as rolling up sleeves (bare below the elbow) and using hand gel appropriately. The service did not carry out hand hygiene audits.
- Vehicles were provided with single use disposable linen, including pillow cases, sheets and blankets.
- All staff were responsible for laundering their own uniforms. The infection control policy included instructions for all staff to follow for uniform cleaning or disposal in the event of heavy contamination. All staff we observed had visibly clean uniforms.

Environment and equipment

- The Mitcham location was in a large industrial unit. There were gates to the industrial park; however we were told these were not always closed or locked. Ambulances were parked outside of the unit and were kept locked. Keys were kept securely for volunteers to collect vehicles.
- Inside the unit was a large garage area used for storing event medical first aid equipment, consumables, oxygen and cleaning supplies. A door could be opened to the car park so there was easy access to the garage. Vehicles did not enter the garage.
- The Mitcham site had 14 vehicles used for transporting patients. Of these, 11 were frontline ambulances, two were Landrover defender ambulance and one was a 4x4 capable ambulance. Not all of these were at the location when we inspected as the service moved vehicles nationally when required for other events.
- No MOT records for vehicles were kept onsite however a spreadsheet indicated when a vehicle was due for an MOT. Records could be checked online using a government database. We checked the records for all 14 ambulances based at the location and found they were all in date for vehicle tax and MOT.
- Vehicle services were arranged by a fleet management company. Records of services were not held on site and we were told these records were kept by the management company.
- The fleet management company was used for repairs. Logistics staff at the site contacted the company who arranged a mechanic to fix the ambulance. We saw a mechanic fixing a vehicle while we were on site. Volunteers told us that if they found a fault with a vehicle on collection they contacted the on call manager to arrange for a replacement.
- We found that the interior of each ambulance was often different due to the age of the vehicle and where it had been sourced from. Location of equipment was not standard throughout the ambulances. We were told that this had led to confusion about where items were stored. For example, in some vehicles equipment was stored in bags, whilst in others it was within drawers or cupboards. We saw labels in some ambulances on cupboards to indicate what was stored inside and in one ambulance we saw a note identifying that kit layouts could be different. Volunteers told us that incidents had been reported where it was stated that equipment was missing when in fact the equipment was on the vehicle but the person may not have been familiar with the layout.
- We checked four ambulances on our site visit. All had fire extinguishers secured in the vehicles that were within service dates and equipment was secured appropriately inside. Equipment required for treating children was on all the vehicles we inspected.
- Each ambulance was fitted with an electronic suction unit and a portable defibrillator. In the three vehicles we saw, these had all within dates of service requirements. On the event that we observed a monitor was provided in addition to the defibrillator on one ambulance so that an electrocardiogram (ECG) could be taken by an appropriately trained member of staff.

- Each vehicle had a log book that included useful information and forms for crews to complete or refer to. A vehicle inspection checklist was provided so crews could document if the vehicle and equipment was fit for purpose. However one vehicle we saw at this event did not have this checklist so it could not be used.
- A logistics team worked at the location. All ambulances were returned to the location or to a local 'hub' and the logistics team organised collection of the vehicle and replenishment of equipment used.
- Within the main garage a large collection of shelves was dedicated to storing single use consumables equipment. Most equipment was stored on this in labelled plastic boxes that identified when items expired. Following the restructure all consumables from multiple sites had been sent to the Mitcham location as a central logistics hub. We were told that this consolidation of equipment had meant that there was a large surplus store or differences in equipment. The team were reviewing this equipment to ensure consistent stock was provided on ambulances. We checked five random items within the store area and found them all to be sealed in packets and within expiry dates.

Medicines

- An administration of medication policy clearly outlined the level of training staff and volunteers required to administer medications. The policy included operating procedures for the order, receipt, storage, administration and disposal of medicines. This did not include paramedics. Paramedics followed the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines for administration of medications.
- Most medications and medical gasses were ordered through one approved supplier nationally using a central ordering system. The approved supplier had authority from the Red Cross Chief Medical Advisor to supply prescription only medications to designated persons only. This was in line with the Human Medicine Regulations 2012. Stocks of these medications were stored securely at the location within a locked cupboard in an access controlled office.
- Another approved supplier was used for supply of paramedic medication. The policy stated that paramedic medication was supplied in sealed packs, however we saw the paramedic medication was in separate medication boxes within a locked safe which was not in line with the policy.
- Stocks and disposal of medication were tracked on a spreadsheet accessed by the logistics manager. There was no back up of this spreadsheet however we were told that paper records were held and paper check sheets could be completed if the computer was inaccessible. We checked five paramedic medications against the stock numbers showing on the spreadsheet. One of these, Ondansetron, showed as more stock on the spreadsheet than was in the cupboard. We raised this with the logistics manager who identified that a duplicated record had been made within the spreadsheet.
- The provider did not have a Home Office Controlled Drug License. A home office drug license is issued in accordance with the Misuse of Drugs Act 1971 to ensure stocks of certain controlled drugs could be held for use by healthcare professionals working on behalf of the provider. The service held diazepam, which is a controlled drug under the 1971 act and therefore the service was not compliant with the act. However, we saw the application for a licence that included morphine and diazepam had been submitted to the Home Office, a compliance visit had taken place in August 2017 and fees paid in October 2017. The provider was waiting for a final confirmation of the licence.
- The provider's policy was that paramedics were able to purchase morphine for administration to patients through an approved supplier and be reimbursed for the cost of this. The policy stated that paramedics were responsible for management of the morphine in accordance with legislation. We saw morphine held by a paramedic volunteer. This was securely held in a key-locked safe within the ambulance. We were told that each paramedic had a personal controlled drugs register where administration, stock and disposal of morphine was recorded, as well as administration on the patient report form (PRF). However this was unavailable during our inspection and we were therefore unable to ensure that this was completed accurately and in line with provider policy. The policy was due to change when the final confirmation for the home office licence required for possession and supply of morphine was received.

- The Red Cross had no medications requiring refrigeration. Medicines should not be stored in areas of excessive temperature variation and should not regularly exceed 25 degrees centigrade. Medications used by ambulance crew were stored in a temperature checked office. However the paramedic medications were kept in a separate office that did not have a temperature check. Medication packs that had been issued to ambulances were kept on vehicles outside. This meant that they could be subjected to a range of hot and cold temperatures and therefore the medication could lose its effectiveness. We were told by one volunteer that Glucagon, a medication that is more unstable if subjected to a range of temperature had a reduced shelf life set because of this. All medication that we reviewed held in the office at Mitcham location was within the expiry dates.
- Each ambulance had a small stock of medications stored on the ambulance within one of the emergency equipment bags. Staff told us they checked these when they collected the ambulance. On our event visit we were shown photos of out of date medication had been found within the ambulance that day as part of the checks. This medication had an expiry date of 2016, however a date of 2018 had been written on the box in permanent marker which could have contributed to the error. The volunteers had been able to change this medication prior to attending the event. We raised this issue with the service at the time and were told that the risk was known as writing dates on boxes was done at some locations prior to the restructure. We saw a clinical memo that had been issued to highlight to staff and volunteers that only the manufacturer's expiry date should be used, however this did not specifically state details about the practice of writing expiry dates on packets.
- The provider undertook a national audit in April 2017. This had included medication management, ordering, supply, storage and administration. The site report did not state what audit details or improvement actions were required, however listed the results were 100% for ordering, supply, transport, receipt and administration and 75% for storage and security. The medicine policy was that managers should have a system of reviewing the medicines management process with a minimum requirement for local audit and ensure records of checks were available. Apart from the national audit no local reviews were in place. We were told that it was planned for a peer review of medicines management to happen every one to two months however this had not yet started.
- Medical gas cylinders including oxygen and pain relieving gas were stored securely in a designated area within the garage and on vehicles. Full and empty cylinders were stored separately. The cupboard was appropriately secured and labelled to identify the gasses stored within it. We saw medical gases were stored securely on vehicles.
- National medicine recalls and alerts were initiated by the Medicines and Healthcare products Regulatory Agency (MHRA). We saw details of one recall notice in the September newsletter alerting staff and volunteers to this. Although medication administered was recorded on a PRF there was no system of review to ensure that medication used had been administered to patients and therefore no ability to follow up patients who may have been affected by a recall of medicine.

Records

- A policy was in place for the creation, storage, security and destruction of medical records. This policy followed NHS guidelines and complied with the data protection act for record retention schedules.
- Two versions of PRFs were completed by volunteers to record assessment and treatment. Ambulance crew volunteers used one version and paramedics a different PRF if they undertook a paramedic intervention. Volunteers told us that they sometimes used the PRF that was provided by the event first aid teams rather than completing a new one. This was different to the ambulance one. They told us there was no guidance on whether a new PRF was required when transporting a patient. We were told a copy of the PRF was left with the receiving hospital so that details of the patient care and treatment was provided to them.
- We were not able to view any completed PRFs as no journeys were competed during our inspection and all records were stored at a central facility. An audit of PRFs was completed in April 2017 as part of a national provider audit. The results for 10 PRFs audited at Mitcham location showed the average compliance score of 45% which was very low compared to the national average of 68%. Gaps highlighted included levels of observation and incomplete records. No further audits of records had been carried out by the location

following this audit and no action for improvement was listed however PRF refresher training was undertaken by all volunteers as a result of the audit . It had been identified as a risk that oversight of PRFs was limited as they were often sent straight for processing.

- Storage of completed records in ambulances was dependent on the type of vehicle that was being used. Some ambulances had a drawer that paperwork could be placed in. Others did not and an envelope was used to store PRFs. All ambulances we saw were able to be locked and therefore records were secure if the ambulance was left unattended.
- There were different systems for sending PRFs to a central scanning facility for archive. Some were returned to to a location secure drop box and these were sent by courier to the scanning facility. Other PRFs were sent untracked through the royal mail postal system and envelopes were provided on vehicles for this process. There was no formalised or routine system in place to ensure this information had been either sent or received. There was no formal risk assessment in place for this process, and the provider risk register only referred to a general risk that the personal data of volunteers and service users was not secured. A control measure was that no data was stored in ambulances and there was development of a PRF project, however there were no timescales for completion of this listed. We identified eight incidents where completed PRFs had been found in ambulances and one incident of a ripped envelope containing PRFs arriving at the archive centre leaving patient details on display. This demonstrated the risk that sensitive patient identifiable personal information could become lost.
- The information governance policy stated that all staff and volunteers with access to confidential, personal and sensitive information had induction and annual mandatory training in information governance. We reviewed nine records of staff and volunteers who worked within the regulated activity and found that no one had completed training within the last 12 months and four volunteers had no record of any training received. This was not in line with the provider policy and meant we were not assured all staff and volunteers were aware of managing sensitive patient information.

Safeguarding

- We were provided with a copy of the safeguarding children and young people policy. This had been endorsed in 2013 and was past the date of review of December 2016 at the time of our inspection. The policy was not specific to health services provided by the provider. It did not reference a named professional, a role that is required in national guidance for all healthcare organisations. The policy also did not outline the level of training, or frequency of updates that staff or volunteers, including the SPOs required.
- Initial safeguarding adults and children training was completed by staff and volunteers as part of their foundation level training. After this training no additional update training was undertaken on a regular basis. An update on safeguarding adults and children and young people was part of the continuation training for the second half of 2017. We reviewed the trainer's notes of this and found that it did not include all of the areas required for ambulance staff as part of level 1 and level 2 of the Intercollegiate document 'Safeguarding children and young people: roles and competences for healthcare staff 2014'. We were therefore, not assured all staff and volunteers had received the appropriate safeguarding children training for their role.
- We reviewed eight records of staff and volunteers who worked within the regulated activity. Of these only four had completed safeguarding training within the last three years. The remainder had not received training in the last four to nine years. National guidance for safeguarding children states that refresher training should be undertaken every three years. In not meeting this we were not assured that staff and volunteers were up to date in the skills and knowledge required for their role.
- Five national Safeguarding Protection Officers (SPOs) had extra training on safeguarding children and young people and 12 national Safeguarding Adult Officers (SAOs) had extra training for safeguarding adults. SPOs and SAOs were available for advice Monday to Friday between 9am and 5pm and were responsible for making referrals to the local authority. Outside of these hours there was a managerial 'on call' number, however this could be staffed by managers with no additional safeguarding training. We were told that it was intended for 24/7 safeguarding 'on call' advice to be available for staff and volunteers and were provided with a draft rota for this that was stated this was due to start the week after our inspection.
- We saw a course outline for extra training that was provided to SPOs. This consisted of a two day internal

course and included some knowledge that was required for level three. We also saw details of a one day refresher course outline; although it was unclear how often refresher training was planned and undertaken. We also saw details of a one day training session for SAOs that had been delivered in October 2017.

- Safeguarding incidents were reported by staff and volunteers through either the event control or the 'on-call' managerial support. They were also reported through the electronic incident reporting system, however not all volunteers had direct access to this. Volunteers and staff could describe the signs of abuse, knew when to report a safeguarding incident, and told us that in an emergency situation they called 999 for support if they were worried about the safety of an adult, child or young person. Volunteers had a pocket guide, which included an aide memoire to support staff in decision making.

Mandatory training

- Following completion of initial training, which for ambulance crew was the IHCD accredited BTEC Level 2 British Red Cross Ambulance Crew award or the Red Cross Ambulance Technician Programme, volunteers had to complete 12 hours of annual continuation training in order to undertake an annual assessment. Ambulance crew volunteers that did not have the annual assessment completed were not able to carry out duties.
- The content of continuation training varied each year and the content was set nationally by provider practice learning team and was based on incidents or case studies that had occurred in the provider. Although this was meant to ensure consistency of training when we reviewed the records of seven volunteers for the last 12 months we found that out of nine modules none had been completed by all seven. Completion of the modules varied between one person to five people and therefore the mandatory training was not consistently completed which meant the service could not be assured all volunteers had the knowledge and skills required to carry out their role.
- Volunteers were required to have an annual assessment for clinical competences including basic life support, use of a defibrillator and treatment of an unconscious casualty. It included a fitness to practice element that required evidence of safe practice and fitness to deliver the role. Of the seven ambulance crew records we reviewed five were in date for their mandatory assessment and two did not have a record of this completed.
- The provider told us that they were assured of the competence of volunteer paramedics as they only accepted paramedics who were employed in a practicing role by an NHS trust. However, there were no systems in place to seek assurance or evidence from staff or their NHS employers that staff were up to date with their mandatory training. An annual governance check was completed to check that paramedics were registered with the Health and Care Professions Council (HCPC) and had no restrictions in practice. Volunteer paramedics were able to upload certificates of training gained from other practice to the employee database so that this could be recognised as completion of training and knowledge of key subject areas but there was no set requirement of what this needed to include within the policy. We were told that the policy was under review following changes made in the restructure. There were no volunteer paramedics managed by the Mitcham location however paramedics from other locations attended as volunteers at their events.
- All staff and volunteers who carried out emergency driving duties were required to complete advanced driver training. The three members of staff qualified for this from the Mitcham location had undertaken training by driving instructors from an NHS ambulance service.
- The service wanted to train more volunteers in emergency driving however the current course offered by an external company was four weeks in duration and this was difficult for volunteers to attend around other commitments. We were told discussions were ongoing to adjust the course length so that more volunteers could be trained. However one volunteer told us they had been able to attend for the four weeks but the provider did not support the application as they were not employed staff.
- A national audit in April 2017 had identified that maintenance of driving records was low nationally. Mitcham location had scored 43% for maintenance of records which was average across the country. We were told that a change in policy was to check licences of emergency drivers every year. All staff had to report any penalty points to their line manager and if they had six penalty points then the insurance company was contacted to approve this.

Emergency and urgent care services

Assessing and responding to patient risk

- Ambulance PRFs, both for ambulance crew and paramedics, contained fields where vital signs could be logged. This included the response of the patient, pulse and breathing rates, blood pressure and oxygen saturation. Patients transported on an ambulance were attended to on a one to one ratio meaning that deterioration could be identified, recorded and treated early.
- Pre-alert calls were made by the ambulance crew to the receiving hospital via the event control to alert them of their arrival in the event a patient was critically unwell. This meant that the patient received a handover as soon as they arrived at the hospital.
- At large events doctors were employed by the service and could provide clinical advice for ambulance volunteers. We saw this at the event that we observed. At small events ambulance crew volunteers had no on-site support. There was a managerial 'on call' number, however this was staffed by managers, rather than clinicians and the support was described as variable by volunteers. Volunteers told us that in some areas of the country they were able to log the event with the local NHS ambulance service and access their clinical support however this was not consistent in all areas.
- On the back of the PRF provided to the patient was information on set conditions, such as paracetamol advice, ankle injury, head injury or tetanus immunisation advice. There were also instructions about what the patient should do if they felt unwell or things changed after they had left the care of the service.
- We saw a clinical memo dated October 2017 that informed staff about the treatment of corrosive substance attacks (acid attacks). This had been produced and circulated to all staff due to an increase in the use of these substances across the country. The memo highlighted treatment that may be required. This showed that the service had identified a potential new injury that staff and volunteers may come across and taken early action to guide treatment.
- Continuation training planning incorporated learning from case studies that had occurred within event first aid. Examples of subjects covered over the last two years included emergency childbirth, chronic conditions, drowning, sporting and endurance and psychoactive substances.
- Manual handling training was included as part of the mandatory training prior to volunteering on an ambulance. This included training specific to ambulance equipment. All seven of the records that we checked for ambulance crew members showed that they had completed manual handling training, although the length of time since this had been undertaken varied. This ensured that staff and patient safety was maintained and injuries avoided.

Staffing

- Events were prepared for by an event planning team who were responsible for resourcing. Minimum staffing and volunteering levels were based on industry guidance, risk assessment and best practice. The service used planning tools that reflected the Event Safety Planning (Purple Guide) and Guide to Safety at Sports Grounds (Green Guide) to promote best practice and ensure safe staffing levels when at events. Compliance with minimum staffing and volunteering levels was monitored by the service leads for planning and delivery.
- The national policy stated that all ambulances had a minimum crewing requirement of two ambulance crew. This could be enhanced for one ambulance crew to be replaced by a technician or paramedic. Volunteers could apply for an event on line and a robust system check meant that only those who were qualified could be booked onto that role.
- There were eight volunteer ambulance crew and no volunteer paramedics included as part of the Mitcham catchment area. However volunteers were able to apply for volunteer opportunities online nationally so Mitcham events could have ambulance crew or paramedics from other areas attending.
- We saw records which showed that four of the ambulance crew were out of date for their training; refresher training for ambulance crew was required every three years and therefore these people did not carry out ambulance crew duties. They could not sign up on the on line system and the co-ordinators were also aware of these staff members and made sure they weren't booked in that capacity.

- If ambulance staffing requirements could not be filled by volunteers then staff were sourced by employed British Red Cross staff from other registered locations. If these staff were not available then staff were contracted from outside agencies. We were not provided with the exact number of times that this had happened however managers told us that it happened a lot. Volunteer numbers, particularly ambulance crew, was listed as the highest risk on the national event first aid risk register and managers told us this was their biggest concern. We were told that the provider was working on establishing an approved contractors list; however this was not yet in place.
- A number of incidents had been raised relating to volunteers not turning up for events. However none of these incidents related to ambulance crew and transport provision. We were given an example by a volunteer of an event they had attended and found that they were missing one ambulance crew. They identified that they had contacted the on-call manager who had arranged a replacement and let the event organiser know there had been a delay.

Response to major incidents

- We were told the response to major incidents was co-ordinated by the local NHS ambulance service, with British Red Cross Mitcham co-operating as required. Ambulance crew volunteers did not receive specific major incident training, however we were told some information was included within a module entitled 'working with other services'. We saw an event plan that contained guidance on major incidents and actions to be taken by the ambulance crew if one was declared.
- At large events an event officer was present from the provider. This level of staff had completed training at the emergency planning college and was available to support ambulance crew and direct them if one was declared. We were told that event commanders attended table top exercises with other organisations as part of the planning prior to a large event. Triage packs were available on ambulances to be used in the event of a major incident.
- Contingency planning was carried out for events. An example provided to us was communication failure and an explanation given of a backup radio system used in this event.

Are emergency and urgent care services effective?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Staff and volunteers followed evidence-based care and treatment guidelines based on nationally recognised best practice guidance that was clearly colour coded to show what treatment could be carried out by different skill levels.
- Clinical updates were clearly communicated with volunteers through a variety of methods to ensure that they were seen. Volunteers were able to identify recent clinical memos and prompt cards were included in some of these that could be added to pocket books as a reminder. Training was developed from relevant patient case studies.
- We observed strong coordination with other providers at a large event. This involved working together with the local ambulance service to respond to 999 calls within the area and communicating with them for the status of hospitals in the event that any patients required transport.

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

- Patient's care and treatment outcomes were not routinely monitored. Service leads had recognised this and there was a plan to introduce an updated PRF with the ability to capture and interpret data more easily.
- Ambulance crew volunteers received no formal clinical supervision or performance appraisal although they did have to requalify every three years to maintain competency and registration.
- There was limited training and support in the assessment of mental capacity and actions to be taken if a patient presented with limited capacity. Volunteers were not confident in being able to explain what actions they took if they did not have support from a healthcare professional at an event.

Evidence-based care and treatment

- A clinical skills and standards pocket reference guide was carried by ambulance crew as a quick guide to information contained in provider training, policies and

procedures. The scope of practice for training and policies was collated from different evidence sources. These sources included the tripartite committee on first aid, JRCALC clinical practice guidelines, UK resuscitation council guidelines, the British Thoracic Society, the National institute for Health and Care Excellence (NICE) and the Royal College of Surgeons Faculty of Pre-Hospital Care.

- The most recent copy of the pocket book was dated as 2015 however updates were published on clinical memos for insertion in response to changes in practice or identified issues. The provider had plans to develop an online or telephone application based version that could be more easily updated.
- Paramedic volunteers used the JRCALC clinical practice guidelines.
- A national clinical and practice advisory group, made up of clinicians and professionals, recommended changes to practice and the responsibility for the scope of practice and clinical skills was held by the Chief Medical Advisor.
- Policies and procedures that were not clinically focussed were reviewed by provider leads who considered legislation and industry best practice. The service used planning tools that reflected the Event Safety Planning (Purple Guide) and Guide to Safety at Sports Grounds (Green Guide) to promote best practice when at events.
- Updates to clinical guidelines were issued by clinical memo and circulated by the national team. These were emailed directly to volunteers by the registered manager if relevant for their skill level. Clinical memos were also available to all staff and volunteers on the intranet and a list published in newsletters and ambulance crew said this was helpful. Volunteers told us of an update that had been circulated about croup (a respiratory illness usually found in children) and how guidelines had changed to reflect NICE guidance.

Assessment and planning of care

- All ambulance crew had a pocket version of the clinical guidelines. These had care pathways for patient groups including children to determine treatment. The guide was colour coded so that it was clear what treatment was within the scope of practice of volunteers' skill levels.
- However the clinical guidelines were not always clear to determine transport decisions following treatment of a patient. For example the asthma guideline did not give details for what to if a patient showed improvement following administration of a salbutamol nebuliser. (A treatment used for patients with specific breathing problems). Volunteers felt that this could lead to unsafe discharges from the event instead of transporting patient to hospital.
- Event plans included a list of local hospitals and their capabilities including specialist centres. All volunteers and contracted ambulance staff we spoke with were able to identify where they took patients with a suspected heart attack, stroke or a major trauma injury.
- We observed a briefing given to all event staff including ambulance crews. This included a description of the types of injuries that were expected at the event based on previous experiences. This meant that care was planned for in advance.

Response times and patient outcomes

- The service did not have any monitoring criteria for contracted providers however managers told us that they acted on feedback from their staff and volunteers if concerns about conduct or patient care were raised and they had stopped using certain ambulance companies following some received. The service was in the process of compiling a list of approved contractors.
- The event first aid service had an annual audit which used self-assessment, interview, hard audit and spot check as well as peer review and central oversight to share learning. The first of these had taken place in April 2017.
- Although we were told that the provider collected data on cardiac arrests and Return of Spontaneous Circulation (ROSC) we were not provided with any data on these outcomes related to patients treated by the Mitcham location events.
- We were told the PRF was being reviewed and a new version was being tested. It was planned that the new version would allow scanning and automated audit which would increase clinical audit capability. It was hoped that this meant the service could then begin reporting on clinical effectiveness indicators such as care bundles alongside the ROSC data. The project was planned to go live before the end of 2017 with the first reports being available in 2018. We were also told that the service was exploring opportunities for external comparison with other large providers to ensure appropriate benchmarking.

Emergency and urgent care services

Competent staff

- The service had a modular training package for volunteers and staff joining the provider. All volunteers and staff had to complete a foundation programme that included emergency first aid skills, communication skills and safeguarding training. Further modules were completed in resuscitation support, body anatomy, medical and trauma knowledge. All modules were valid for three years and there were clear expectations set in the training standards that competencies gained needed to be re-qualified before the end of the three year period. We were told by one volunteer that ambulance crew who worked with paramedics also had a set module so that they were familiar with extra equipment and medications used.
- As well as the mandatory continuation training, local areas, such as Mitcham provided additional training to all volunteers. Ambulance crew told us that this training was not consistent across the country and depended on arrangements by local training leads. They told us the level of training was often focussed on basic first aid and so was of limited value for their development.
- Ambulance crew volunteers received no formal clinical supervision or performance appraisal. In order to ensure clinical competency the service demanded a minimum of 50 hours volunteer work each year. Each volunteer was logged on a spreadsheet as active, or it was highlighted that they were suspended from duties if these hours were not completed.
- We were told there was ongoing development of a framework tender for sub-contracted providers. All third-party providers had been contacted to confirm that they were familiarised and competent in their own equipment. Where equipment was provided for contracted staff there was an agreement that their staff should familiarise themselves with the equipment.
- All contracted ambulance crew were sent a copy of the event plan prior to the event. Contracted staff we spoke with confirmed that this had been received five days prior to the event. This contained information on systems and processes for escalation. The contracted staff attended the event briefing and were informed of any changes or updates.

Coordination with other providers

- The ambulance service 'logged on' with the local NHS ambulance staff when they provided first aid and transport at events. At large events a multi-agency event control included an officer from the local NHS ambulance service. If a 999 call was made from within the event location this was passed to the service and they used their resources to cover it if they were able.
- At large events the decision for which hospital the patient were transported to was taken in conjunction with the local NHS ambulance service as they had information about the receiving hospitals.
- If a patient was critically unwell and required a 'pre-alert' then the ambulance crew could pass information to the receiving hospital through their event control room. A mneumonic reminder of what information was needed was listed in the event plan. For smaller events with no event control the ambulance crew could contact the local NHS ambulance trust if they had 'logged on' with them at the start of the event.

Multi-disciplinary working

- Volunteers and contracted ambulance staff told us of how clinical staff, including doctors, paramedics and ambulance crew worked together to assess, plan and deliver patients' care and treatment.
- We were not able to observe any hospital handovers with ambulance staff as no patients were transported during our inspection. However volunteers told us the PRF was used to assist handovers and a copy was provided to the hospital.

Access to information

- Ambulance volunteers only had access to special notes relating to patients or Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders if they were presented with these during treatment of a patient.
- Radios were provided at events to ambulance crew, including contracted crew as a link to the control room. Information was passed from the control room through the radio to the ambulances so that they were kept updated with developments.
- Satellite navigation systems were available in each ambulance. In addition event plans included a map of the event area which had a grid over it for references. This meant that the exact location of a patient on a large event area (such as a field) could be passed to the crew.

- All provider policies, clinical memos and other communications were stored on an intranet known as 'red room'. This was available to volunteers on their own computers or telephones. Support was also available from the event officers or a national 'on-call manager'.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Although the foundation training programme included training on good practice for disclosure, consent and confidentiality, there was limited specific training in the mental capacity act for ambulance crew and there were no annual refresher updates.
- A consent aide memoire was available in ambulances. This guidance had been produced in 2010. It did not include a toolkit for assessment of mental capacity or clear guidance on treatment in best interest. Volunteers said that they were encouraged to ask for assistance from a healthcare professional however they were not present at every event. This meant that volunteers may not be able to determine whether a patient had capacity and a risk that a patient without capacity may be left untreated if they refused treatment.A national audit in April 2017 had identified the location as scoring only one out of four for staff or volunteers being able to describe how they assessed mental capacity, following the audit, all services were issued with quick reference guidance on mental capacity and consent for dissemination to frontline staff and volunteers. There was also the development of additional mental health training although the service had not yet received this.
- The safeguarding adults' continuation training included a brief overview of capacity principles, and specified that volunteers were not expected to carry out a full capacity assessment. The training directed volunteers to a safeguarding adults officer (SAO) for support. However, at the time of our inspection this was only available 9am to 5pm Monday to Friday which meant this was not available out of hours. We reviewed the update training slides for the SAO refresher and found that there was limited training on capacity assessment and simply stated times when consent was not required with reference to the mental capacity act. It was therefore not assured that an SAO had the knowledge to remotely assist a volunteer in undertaking a capacity assessment.
- Volunteers were provided with reference information on do not attempt cardio-pulmonary resuscitation (DNACPR) within the consent guidance. Volunteers that we spoke with were able to explain what this was and the relevant paperwork that was required to support this.

Are emergency and urgent care services caring?

We do not have a current legal duty to rate ambulance providers.

We saw the following areas of good practice:

- Patient feedback was collected using a survey. Although response rates were limited it showed an overwhelmingly positive response about the care that patients received.
- Volunteers received training for psychosocial skills to support them in their communication with patients.
- Patients were supported to manage their own health when they were not conveyed to hospital.

Compassionate care

- Due to the nature of services provided we were not able to observe patient care by volunteers during our inspection. Volunteers, however, were able to describe events and situations which they thought provided examples of how they provided kind, and compassionate care.
- We reviewed four comment cards of patients who had received ambulance transport. All were positive and included comments such as 'Good staff, very patient and caring' and 'staff were caring. [I was] looked after well.'
- The service conducted patient feedback for event first aid using questions based on the NHS 'friends and family' test. It was not possible to identify which responses related to ambulance transport provision. The rate of responses varied each month from a low of one response in August 2017 to a high of 37 in September 2017. The percentage of positive response of those who were likely or extremely likely to recommend the service were between 89% and 100% over the five months of data reviewed.
- The feedback forms included asking if the person was treated with dignity and respect. The results of this were 97% to 100% positive responses received over the five months of data reviewed.

Emergency and urgent care services

Understanding and involvement of patients and those close to them

- Volunteers told us how they invited family and friends to join the patient when transporting them to hospital. This gave support to the patient and provided reassurance to the family member or friend.
- One comment card we reviewed stated 'I was spoken to and listened to'.

Emotional support

- Volunteers could receive training on psychosocial skills known as the CALMER framework. The framework included six prompts; consider, acknowledge, listen, manage, enable and resource. Volunteers told us the training for this framework helped provide a consistent and useful approach to providing emotional support to patients they attended.
- The feedback forms included asking if the person was received support that reduced their distress. The results of this were 93% to 100% positive responses received over the five months of data reviewed.
- Volunteers gave examples of how they had been provided with good support following a distressing event. They reported that an on call manager had come out to see them and that there was an external helpline that they could access if required.

Supporting people to manage their own health

- We were told that during events, the majority of patients were not taken to hospital. They were treated by on site first aiders and signposted to primary care, such as GP services or pharmacy facilities, depending on the nature of their injury.
- Advice was provided on the back of the PRF for patients who had certain conditions. This included advice about tetanus injections if they had sustained a cut.

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

We do not have a legal duty to rate independent ambulance services.

We identified the following areas of good practice:

- Feedback was requested and acted upon from event organisers to improve service provision.
- Volunteers were briefed on specific patient needs according to the type of event they were working at. In addition tools were available to assist in communication with patient's individual needs.
- The event planning ensured that the service was on site at the correct time to provide healthcare services and considered placement of ambulances for a rapid response across the area being covered.

We found the following areas of improvement:

- Although dementia and mental health training had been offered only limited numbers of volunteers had completed these. This meant that the knowledge of managing the needs of these groups of patients was not consistent across the volunteer group.
- As data was not collected on ambulance transfer numbers there was limited analysis for future planning needs.

Service planning and delivery to meet the needs of local people

- The service was contracted by event organisers to provide small to 'super-sized' event first aid provision within London and South East England. Post event feedback was requested from the organisers to review the service provision at these events. This did not ask specifically about ambulance provision but we were told the form was due a review. In addition feedback was responded to during events, for example at one event an extra ambulance was added for additional resilience at the request of event organisers. At each event the event officer conducted a 'hot debrief' to all volunteers and contracted staff in order to note any issues that needed immediate action. They were then able to liaise with the on-site event organisers if required to resolve these.

Meeting people's individual needs

- All volunteers spoken with were aware of different patient groups they encountered at different events. For example, at some events there was a prevalence of drug use which was a major cause for seeking medical attention. Staff were briefed on these groups at the event briefing and also information was contained in the event risk assessment.
- Each ambulance had a communication assistance book. This had pictorial aids that could be used to help patients with learning difficulties, or those, for whom

English was not their first language. The book also had the translated advice given on the back of the PRF for certain conditions in 37 languages so this was available for patients to read. Contracted providers told us that they had access to telephone translation if required for patients.

- The provider had provided the opportunity for staff and volunteers to receive dementia training in 2014. However of the seven records we reviewed only two volunteers had received this training and therefore the knowledge was not consistent across the service.
- Continuation training provision in 2016 had been mental health awareness. This module had covered information about mental health conditions, communication and assessment strategies that may have been useful when patients presented with mental health crisis. However only two of the seven volunteers whose records we reviewed had completed this training and therefore there was not consistent provision of this. We were told that a pilot had been undertaken of mental health first aid training and consideration was being given for this being offered to all volunteers.

Access and flow

- The service was contracted by event organisers specifically for the event they are organising. Ambulance crews took any patients requiring hospital care to the closest available hospital unless directed elsewhere by the event care plan or the local NHS Ambulance Service.
- The provider ensured resources were where they were needed to be at the required time by detailing this information in the event plan sent to volunteers and contracted staff prior to the event. When planning for events, two crew members were allocated to emergency transport vehicles. The number of emergency transport vehicles was dependent on the event size and nature. At the event, ambulances were placed on standby around the site so that they could respond quickly to incidents.
- The service did not collect data on how many ambulance transfers from events they undertook. This meant that they were not able to analyse if the amount of ambulance provision was sufficient or to use this information in future planning needs.

Learning from complaints and concerns

- We saw notices within the ambulances on how a patient or member of the public could raise a complaint. A national phone number was provided. The location had not received any complaints relating to care of patients on ambulances in the last 12 months we were unable to review the response of the location to complaints.

Are emergency and urgent care services well-led?

We do not have a legal duty to rate independent ambulance services.

We identified the following areas of good practice:

- The provider had undertaken a large scale national restructure in response to identified risks of consistency of service quality across the country. Managers at the Mitcham location supported the changes to improve quality despite the challenges of implementing large scale change.
- The provider used a number of different methods to engage volunteers, communicate information and updates and listen to their views.
- Volunteers were positive about the support provided to them by the service managers and the communication and engagement that they had locally.
- There was a clear national governance structure and a method of sharing information from these forums to location managers.

We found the following areas of improvement:

- The were no robust DBS renewal process in place. The organisation did not comply with its own standards for DBS renewal and the majority of records we checked were past their DBS renewal date and two people had not have their enhanced DBS completed.
- Out of hours managerial support was reported by volunteers to be inconsistent

Leadership / culture of service related to this core service

- The registered manager role is shared between the service delivery lead for South East England and the logistics manager for the Mitcham hub. They registered jointly with CQC earlier in 2017. Their role was day to day people management, equipment's, vehicles, medications and volunteers of the location.
- Overall provider operation including clinical management was provided at a national level by a

senior clinical manager; a healthcare professional manager and supported by a medical advisor. A national quality team supported the registered manager on quality issues.

- We spoke with the joint registered managers' who were both passionate about their leadership roles and were keen to ensure they had the appropriate knowledge and expertise to lead staff and volunteers. They spoke highly of the volunteers, describing them as 'amazing' particularly as they had continued to deliver a good service at events during a year of organisational change.
- Staff told us that there was always a national 'on call' duty manager, who could be contacted for advice and support. Volunteers had mixed feedback about this role and told us that although some were supportive and responsive, others were not able to provide the same level of support. Some volunteers told us that there was poor communication with the national leaders, however there was good local communication and they felt supported by line managers and local office staff.
- A volunteer told us of when they had raised an issue with the on call manager about an ambulance crew member not turning up to an event. They had been supported as a replacement had been identified and arranged and the on call manager had contacted the event organiser to update them of the situation as it meant there was a change in the skill level of the replacement volunteer..
- There were mixed views on the organisational restructure that had occurred over the last 12 months. Some staff and volunteers felt they were 'sold a story' of how it improved systems and processes for them that wasn't the case. However others felt that it had made practice more consistent across the country.
- Staff told us emotional support, de-briefing and counselling was available to them following a traumatic or distressing event.
- We saw copies of two monthly newsletters that were circulated nationally. These included positive feedback that been received from patients or event organisers for the service provided at events. We were told of other methods of providing positive support to staff and volunteers through volunteer awards, long service awards, and a recent introduction of an 'e-card' that could be sent to say thank you to someone.

Vision and strategy for this this core service

- As the location provided event first aid it followed the mission statement for event first aid that was set nationally. This was to support the Red Cross mission and become the provider of choice, providing safe, high quality, life-saving responses for the thousands of people seen at events each year. A further part of the mission was that the professionalism, care and compassion of staff and volunteers ensured that the people helped, along with visitors, spectator and participants at events leave with a positive impression of the British Red Cross.
- Staff and volunteers we spoke with told us how they aimed to provide the best level or 'gold standard' of event first aid which was consistent with the overall mission.

Governance, risk management and quality measurement

- Clinical governance was overseen by the Service Quality and Assurance committee. This committee met four times a year. A chief medical advisor (CMA) was employed and was a member of the committee. This advisor was a practicing consultant in emergency medicine. A clinical and professional advisory group chaired by the CMA reported to the committee. This was a national group which the national event first aid manager and ambulance advisor attended and was held three times per year. In addition further groups for equipment and standards and ambulance specification reported to the committee.
- The service delivery manager (SDM) for the Mitcham location had a meeting every six months with the other SDMs. This provided an opportunity to share information discussed at the quality assurance committee as well as other operational issues. The SDM then cascaded the information to six more local service delivery coordinators through a monthly teleconference. These co-ordinators had group leaders who received information through a teleconference and then passed it on to volunteers through a weekly or fortnightly group meeting.
- The location did not have its own risk register. However a national level risk register was held for event first aid and was managed by the national quality team and an individual risk assessment produced for each event attended. The risk register is reviewed at Director Management Team meetings. A quality and safety risk

register (across all service lines in the Red Cross) is reviewed at Service Quality and Assurance meetings. One of the highest risks identified was limited volunteer capacity, especially for ambulance crew.

- Safe recruitment processes were not in place to ensure patients were safeguarded against unsuitable staff. The disclosure barring service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. We saw records of nine staff and volunteers of when DBS had been completed. Six out of the nine records had passed the three year point of renewal required by the provider policy with three documented as renewal required in 2011. In addition two records we checked did not have enhanced DBS which is required for all staff and volunteers in healthcare. This meant it could not be assured that staff and volunteers were suitable to work with vulnerable people.
- The provider had undergone a recent national re-structure in the last 12 months. Logistics were now based at central warehouses which enabled kit and equipment supplied to events to be standardised. Logistics also oversaw the vehicles used at events including the ambulance fleet. Each local service had a delivery team with full responsibility for the volunteers ensuring that they were fully trained and compliant for first aid qualifications. We were told the change process had been proved challenging in implementation.

Public and staff engagement

- Public engagement was challenging, given the nature of this service. Patient feedback was gathered using handheld electronic tablets at events. The provider also requested feedback from event organisers on the service they provided, and provided us with an example where practice had changed following this.
- The provider had multiple methods of collecting staff and volunteer feedback. It had a national people survey. The last survey had been completed in 2015, which was prior to the establishment of Mitcham location. The survey collected information from staff and volunteers during October 2017 and the results from this were not available at the time of our inspection. In addition it had recently established a volunteer representative system and had requested nominations for the role. The elections for this had not yet been held at the time of our inspection.
- Additionally feedback from volunteers about events was collected from event debriefs and 'summer gathering events' held nationally. These were collated into a report that was used to inform planning for future events. One volunteer gave us an example of a debriefing event for a large event he had attended. He said that senior managers from the provider attended and that volunteers were encouraged to speak up and feedback about the event.
- We were told that ensuring that volunteers felt engaged and communicated with over the implantation of large organisational changes was important to the service. This was so that they were aware of these changes and were on board with the new processes and procedures put in place.

Innovation, improvement and sustainability

- The provider had identified risks to consistent quality of service delivery across the country. This had been a driving factor in the national restructure that had taken place over the last 12 months. This demonstrated a positive approach to improvement and this was reflected in the Mitcham location management who were positive that despite the challenges of the change it would improve working practices for volunteers and the clinical care that patients received.
- The national audit that had been conducted in April 2017 had established a national bench marking process and actions had been identified from this to improve quality processes. This included establishment of a system of driving licence checks and there were plans for a new PRF so that it could be audited more easily.

Outstanding practice and areas for improvement

Outstanding practice

- Despite the challenges for a provider where a large proportion of the workforce worked remotely and were volunteers, the provider had a robust method of communication of clinical updates and learning through case studies. Volunteers were able to tell us about recent clinical updates and the multiple methods of communication used to pass on this information to them.

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure there are effective systems and processes in place to maintain security of patient records.
- The provider must ensure staff and volunteers have undertaken the appropriate level of safeguarding training and evidence this.
- The provider must ensure that staff and volunteers are and continue to be suitable to work with vulnerable people.

Action the hospital SHOULD take to improve

- The provider should update its policies and procedures for the order, storage, administration, and disposal of controlled drugs held and ensure that these meet regulatory requirements.
- The provider should review its incident reporting procedures to ensure that all incidents are reported, assessed and actions taken to evidence learning.
- The provider should ensure that there is a consistent process for patient record completion and review.
- The provider should ensure that processes, training and audit follow the requirements set out in provider policies.
- The provider should ensure that all staff and volunteers understand the mental capacity act and their role in assessing and treating a patient who does not have capacity.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. 13(2) Systems and processes must be established and operated effectively to prevent abuse of service users. **How the regulation was not being met** Training on safeguarding children and young people, did not meet the level required by national guidance. Some staff and volunteers had not received adult or children safeguarding training in many years. Some staff were not kept up to date to recognise different types of abuse and ways they could report concerns.

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 Regulation 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements. Regulation 17(2)(d) Maintain securely such other records as are necessary to be kept in relation to— 1. persons employed in the carrying on of the regulated activity, and

This section is primarily information for the provider

Requirement notices

2. the management of the regulated activity

How the regulation was not being met

Staff and volunteers breached data protection by posting report forms, which included patient identifiable sensitive information.

There was no local routine process for tracking report forms had arrived at the scanning and archiving facility.

Staff and volunteers had no training in the last 12 months on information governance

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 Regulation 19 (1) (a) Persons employed for the purposes of carrying on a regulated activity must be of good character **How the regulation was not being met** Most DBS records had passed the three year point of renewal required by the provider policy with three documented as renewal required in 2011. Two staff did not have enhanced DBS which is required for all staff and volunteers in healthcare.