Northampton Emergency Aid Team

Northampton Emergency Aid Team - Fernie Fields Scout Centre

Quality Report

Fernie Fields
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Date of inspection visit: 25 August 2016 and 3 November 2016
Date of publication: 23/12/2016

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 know to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location	Not sufficient evidence to rate
Patient transport services (PTS)	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focused unannounced inspection on 22 August and 31 October 2016 to review the service's arrangements for the safe transport and treatment of patients as we received information of concern about this service. As this was a focused inspection, we did not inspect every key line of enquiry under the four key questions we inspected (safe, effective, responsive and well led). We did not inspect the caring key question.

Are services safe at this service

- There were robust systems in place to maintain the safety of volunteers less than 18 years of age.
- There were concerns that care and treatment was not being provided in a safe way for patients.
- There was no process in place for the safe management of medication, with staff providing their own medicines to administer to patients.
- Medical gases were not always secure and were at risk of tampering.
- There was no maintenance programme in place for equipment used, with gaps of several years between servicing.
- There was no evidence of regular audits to confirm compliance with infection control policies, and those that were completed had no actions associated with findings.
- Patients' records were not always stored securely, with instances where records containing personal identifiable information had been left on vehicles for several days.
- The service did not provide the NHS recommended level of safeguarding children training for staff treating patients less than 18 years of age.

Are services effective at this service

- The service did not measure any patient outcomes, or benchmark its service against any other providers.
- Mental capacity act training was not provided.
- The policies and guidance that were in place were outdated having been produced in 2013 and not reviewed.
- The service provided clear guidance on what levels of training were expected for each role, and offered staff the opportunity to develop.
- The service provided supervisors and mentors for all staff.

Are services caring at this service

- This was a focused inspection and we did not gather evidence for this key question.

Are services responsive at this service

- The service did not provide services for those patients who were partially sighted; hard of hearing, wheelchair user or those for whom English was not their first language.
- Although the service received few complaints, there was no evidence of shared learning. There was not a robust system in place to act upon complaints.
- The service planned to meet the needs of local people, and provided a service based on an external risk assessment.

Are services well led at this service

- We found serious concerns regarding the governance and risk management processes of the service. There were no effective governance arrangements in place to evaluate the quality of the service and improve delivery.
- There was no nominated individual and registered manager within the service. This meant there was no one in place to take regulatory responsibility for the health services being provided.

Summary of findings

- There were significant concerns about the way the service was managed and found breaches of regulations 7, 11, 12, 13, 15, 16, 17 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During the course of the inspection, senior managers confirmed that the service was no longer to provide the regulated activity of transport, triage and medical advice provided remotely and that the service was therefore planning to deregister,

The service must take action to:

- Ensure that a CQC registered manager and responsible person is in place.
- Ensure that the service has a strategy and updated statement of purpose.
- Ensure that staff have relevant safeguarding children level 3 training.
- Implement a system for monitoring compliance to policy.
- Implement a system to monitor patient outcomes.
- Implement a system to review service performance and benchmark against other organisations.
- Implement a risk register, which accurately reflects the service's risks.
- Ensure that patient feedback is collected, analysed and used to improve services.
- Ensure that there are robust systems in place to communicate and evidence learning from incidents and complaints across the team.
- Implement a process for the safe management of medications, which should include the purchasing, storage and administration.

Importantly, the provider must take action to ensure compliance with regulations 7, 11, 12, 13, 15, 16, 17, and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. When we immediately raised these concerns during the course of the inspection, senior managers of the Northampton scouts' association confirmed that the service was no longer to provide the regulated activity of transport, triage and medical advice provided remotely and that the service was therefore planning to deregister.

Professor Sir Mike Richards
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)	Requires improvement 	We have not rated the patient transport service for the four key questions we inspected (namely safe, effective, responsive and well-led). This was a focused inspection and elements of this key question were not inspected. We did not inspect the caring key question. We found that: • There were significant concerns about the way the service was managed and found breaches of regulations 7, 11, 12, 13, 15, 16, 17 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During the course of the inspection, senior managers confirmed that the service was no longer to provide the regulated activity of transport, triage and medical advice provided remotely and that the service was therefore planning to deregister. • There were robust systems in place to maintain the safety of volunteers less than 18 years of age. • The service did not have robust systems in place to maintain patient safety. This included poor management of medications and medical gases, lack of maintenance regimes for vehicles and equipment used, and poor management of patient records. • The service did not provide staff with the recommended level 2 or 3 safeguarding children training. • The service did not have audits in place to identify risks and maintained no risk register. There was no evidence of actions to be taken as a result of audit findings. • The service did not formally record action taken in response to concerns or complaints raised. There was no evidence of information shared across the team, either as part of team development or in response to any learning. • There was no system in place to capture patient outcomes, or benchmark the service against other providers. • The service did not complete their own risk assessments for events, and were dependent on

Summary of findings

those provided by the event's organiser. This meant that service did not always consider patients with partial sight, hard of hearing, wheelchair user or patients who did not speak English as their first language.

- Although the service received few complaints, there appeared to be no system in place for the investigation of complaints and the sharing of lessons learnt.
- The service did not have a registered manager in post for more 12 months.
- The service had no strategy or vision in place. There were no systems in place to monitor performance, risks or concerns.
- The service provided a clear structure for learning and developing staff, with tiers of learning dependant on staff roles. The service offered development opportunities and supported team members to achieve.

Northampton Emergency Aid Team - Fernie Fields Scout Centre

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Northampton Emergency Aid Team - Fernie Fields Scout Centre

Northamptonshire Emergency Aid Team - Fernie Fields Scout Centre (NEAT) was established in 1979 and provides patient transport services. They also supply first aid services to public events.

The aim is provide trained volunteer support to emergency services. Volunteer scouts and team leaders are trained to offer support in major incidents. The service developed and gained experience working alongside the local police and fire and rescue teams, offering support to major incidents within the local area, such as flooding.

NEAT consists mainly of scouts who have an interest in first aid and providing support to emergency services in the event of a major incident. The service does not provide direct emergency response services.

The service is registered for the regulated activity of transport services, triage and medical advice provided remotely.

At the time of our inspection, there was no registered manager in post.

We inspected the service on the 25 August 2016 and 3 November 2016. During the inspection, we saw one vehicle used and the main offices used by the service. The remaining vehicles were not available. We spoke with three members of staff.

Our inspection team

Our inspection team was led by:

Inspection Manager: Phil Terry, Care Quality Commission

Lead Inspector: Justine Eardley.

The team included three CQC inspectors.

How we carried out this inspection

This inspection was carried out following concerns raised about the cleanliness and suitability of equipment used. Due to the service being voluntary, we completed a short notice inspection on the 25 August 2016 and announced inspection on 3 November 2016.

We spoke with three members of staff. We also inspected all available equipment, 28 patient records and a range of information and documents provided by the service.

Detailed findings

Facts and data about Northampton Emergency Aid Team - Fernie Fields Scout Centre

Northamptonshire Emergency Aid Team was established in 1979, and consists of three ambulances, and one four-wheeled drive vehicle. Staffing is voluntary, with 25 adults registered with the service.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Not rated	Not rated	N/A	Not rated	Not rated	Requires improvement
Overall	Not rated	Not rated	N/A	Not rated	Not rated	Not rated

Patient transport services (PTS)

Safe	Not sufficient evidence to rate
Effective	Not sufficient evidence to rate
Caring	
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate
Overall	Requires improvement

Information about the service

Northampton Emergency Aid Team was established in 1976 and registered for the provision of patient transport services in July 2011. The service part of a registered charity and is affiliated to the Scouts Association. The service is wholly managed by volunteers, and has three team leaders who manage the service in their free time.

The service has three ambulances and one four by four response vehicle. The service offers support to events across Northamptonshire and provides initial medical assessments and first aid on site, and transfers of patients from events to local acute hospitals.

We completed a short notice inspection of the service on the 25 August 2016 and an announced inspection on the 3 November 2016. We spoke with three members of staff, and reviewed records of 28 patients.

There was no registered manager at the time of inspection. The service had not had a CQC registered manager in post for more than one year.

Summary of findings

We have not rated the patient transport service for the four key questions we inspected (namely safe, effective, responsive and well-led). This was a focused inspection and elements of this key question were not inspected. We did not inspect the caring key question. We found that:

- There were significant concerns about the way the service was managed and found breaches of regulations 7, 11, 12, 13, 15, 16, 17 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During the course of the inspection, senior managers confirmed that the service was no longer to provide the regulated activity of transport, triage and medical advice provided remotely and that the service was therefore planning to deregister.
- The service did not have robust systems in place to maintain patient safety. This included poor management of medications and medical gases, lack of maintenance regimes for vehicles and equipment used, and poor management of patient records.
- The service did not provide staff with the recommended level 2 or 3 safeguarding children training.
- The service did not have audits in place to identify risks and maintained no risk register. There was no evidence of actions to be taken as a result of audit findings.

Patient transport services (PTS)

- The service did not formally record action taken in response to concerns or complaints raised. There was no evidence of information shared across the team, either as part of team development or in response to any learning.
- There was no system in place to capture patient outcomes, or benchmark the service against other providers.
- The service did not complete their own risk assessments for events, and were dependent on those provided by the event's organiser. This meant that service did not always consider patients with partial sight, hard of hearing, wheelchair bound or patients who did not speak English as their first language.
- Although the service received few complaints, there appeared to be no system in place for the investigation of complaints and the sharing of lessons learnt.
- The service did not have a CQC registered manager in post for more 12 months.
- The service had no strategy or vision in place.
- There were no systems in place to monitor performance, risks or concerns.

However, we found that:

- The service provided a clear structure for learning and developing staff, with tiers of learning dependant on staff roles. The service offered development opportunities and supported team members to achieve.
- The service had robust systems in place to maintain the safety of volunteers who were under 18 years of age.

Are patient transport services safe?

Not sufficient evidence to rate

We have not rated the patient transport service for safety. This was a focused inspection and elements of this key question were not inspected. We found that:

- There was no process in place for the safe management of medication, with staff providing their own medicines to administer to patients.
- Medical gases were not always secure and were at risk of contamination.
- There was no maintenance programme in place for equipment used, with gaps of several years between servicing.
- There was no evidence of regular audits to confirm compliance with infection control policies, and those that were completed had no actions associated with findings.
- Patients' records were not always stored securely, with instances where records containing personal identifiable information had been left on vehicles for several days.
- The service did not provide the NHS recommended level of safeguarding children training for staff treating patients less than 18 years of age.

However, we also found:

- The service had reported no incidents.
- There were robust systems in place to maintain the safety of volunteers less than 18 years of age.

Incidents

- Staff reported that there was a system in place for the reporting of incidents. This was a paper reporting form, which was completed at the time of the incident and then investigated by one of the team leaders.
- Incident reporting templates were available as part of the equipment taken to events, which enabled all incidents to be reported at the time of occurrence by frontline staff.
- During inspection, we were informed that there had been no incidents requiring investigation, from July 2015 to August 2016. We were told that there was a process in place, which included investigations being completed within one week of the incident and

information shared with the reporter and the wider team. The service did not use a database for the recording or monitoring of incidents, the investigations, outcomes or learning. As there had been no incidents, we did not see any evidence of incident reporting, investigation or feedback to staff.

- The senior team reported that if incidents occurred they would be discussed as part of the senior team meetings. Any learning would be shared with the wider team.
- The service had an adverse incident reporting policy dated February 2013. This detailed the system for reporting and investigating incidents, and escalation to the district commissioner and scout headquarters.
- The service reported no never events or serious incidents. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic protective barriers, are available at a national level and should have been implemented by all healthcare providers.
- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- 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.
- Staff were not aware of the duty of candour and had no formal processes in place to meet this this regulation, this represented a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 20: duty of candour.
- Team leaders told us that due to the structure and involvement of team leaders at all events, information relating to incidents could be easily shared. All information sharing was completed verbally with no written communication across the team.

Mandatory training

- There was not clear evidence that staff had undertaken mandatory training since employment with the service. There was no definition of what training was mandatory and must be undertaken by staff. We did not see the service record of staff training, as the database held by the scouts' association was not updated with clinical training. This was of the breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 18 (2)(b); staffing.
- Staff who held professional registrations completed mandatory training and revalidation through their employed position and not through the service. These were not checked by the service, as individuals were expected to complete specified roles outlined by their service training and competence only, and not in the scope of their professional registration.
- The service had a system in place for monitoring the completion and compliance of external training undertaken by the team. This included a database that detailed skills or training completed, the date completed and expiry. This was monitored by the team leaders to ensure that staff were compliant with the external training required for their roles.
- The service did not provide mandatory training, as staff were expected to complete training external to the service relevant to their roles. All staff were expected to complete relevant training for the role, which they undertook. For example, ambulance first aiders were expected to hold a valid health and safety executive (HSE) first aid work certificate and complete 16 named clinical modules, which included managing unconscious patients, wounds and bleeding, manual handling and major incidents.
- We did not see a training policy for the service and staff reported that they did not have one.
- Staff were required to complete basic life support training (BLS) as part of their first aid training. This was mandatory for all staff working for the service.

Safeguarding

- The service did not have clear systems, processes and practices in place to ensure that people, both patients and staff, were safe.
- All volunteers were recruited through the scouts' association, which meant that all volunteers had to be interviewed, provide references, and have a clear disclosure barring service (DBS). There was a robust system in place to ensure that volunteers were suitable for the role they were to undertake. The service used the scouts' association policies and procedures relating to child protection.
- Safeguarding training was provided for all staff, which was completed at the scout's association standard.

Safeguarding training was not clearly identified in defined levels. The district commissioner informed us that this had been reviewed against NHS safeguarding levels, and did not meet level 1, stating that the training was "just above awareness". The district commissioner reported that the level of training was currently under review by the area team.

- No staff had been trained at safeguarding children level 2 or 3, which would be required for those staff transporting and treating children. This meant that there was a risk that staff would not be able to recognise and report potential safeguarding concerns. Not all staff demonstrated a clear understanding of safeguarding process. This was of the breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 13; safeguarding.
- There was a dedicated safeguarding lead for both adults and children, who was affiliated to the scouts' association. Staff could contact this person directly or using the dedicated scouts' safeguarding contact number.
- The service issued all staff with a safeguarding contact card. This was a 24-hour service managed by the scouting association. Staff could make contact with the safeguarding team and discuss any concerns confidentially. This was not specifically for patients, and could be used for concerns about patients or staff. During inspection, staff were able to describe the escalation of concerns and demonstrated awareness of types of abuse and actions that should be taken.
- The service had a robust system in place for managing volunteers under the age of 18 years. When individuals volunteered to work events, their parent or guardian would be contacted directly by one of the team leads. They were informed of the details of the event, its location, the number of volunteers attending, contact details of team leader in charge and start and finish times of the event. Parents or guardians were asked to confirm their consent for the event and confirm contact details for any emergency. We saw evidence of contact during inspection.
- We were told that an adult team member when patrolling event sites always accompanied staff members who were under 18 years of age. This ensured the safety of all younger team members during public events. The scouts' association policy required staff prevent a one adult and one child situation. We saw that rotas reflected a balance of adult and under 18 year volunteers, which supported a minimum of two adults on duty.
- Due to the nature of the service, the service monitored safeguarding processes and practices regularly. The safeguarding policy required all staff to renew disclosure barring service (DBS) checks every five years. This process was monitored by the scouting lead, and included updating staff records held in a secure database. The scouts' association had a robust system in place to review DBS checks. Staff were issued with a 90, 60 and 30 day warnings that the previous check was about to expire. Staff were required to complete their application with an external agency. The scouts' association headquarters received completed application reports and screened them, before sending to the district commissioners. Depending on findings, volunteers were either declined, referred to the district commissioner or a review group, where judgements were made as to suitability of volunteers.
- Staff that did not complete a DBS check within the specified time were suspended from the service until the checks had been completed.
- During inspection, we saw that all staff had valid checks in place.
- The service provided care for all age groups including children. We saw one patient record form for a child of 10, who attended the service with their parent.

Cleanliness, infection control and hygiene

- The service had an infection control and prevention policy dated 2013. We saw this detailed the responsibilities of individual staff in relation to wear appropriate protective equipment, reporting of illness, training, education, and handwashing.
- The uniform policy 2013 detailed the need for staff to be vigilant with personal hygiene and to ensure they were bare below the elbow when completing clinical roles.
- We saw one vehicle during the inspection on the 25 August 2016. This was identified to be clean and free from clutter. The ambulance had been cleaned the week prior to inspection, and we saw evidence that a cleaning contractor had completed this.
- There were no other cleaning records for this or any other vehicle. We were told that there had not been a

"deep cleaning" regime in place prior to inspection, however it was planned that a six monthly cleaning programme would commence, with the first cleans in progress.

- We were informed that equipment and vehicles used for events were checked prior to the start of event and on return to base. Any equipment used was cleaned and prepared for the next use. The service did not use a formal checklist to complete this and we did not see any records stating that vehicles were clean and fit for use before events.
- We saw that the vehicles had monthly spot audits completed, which reviewed the cleanliness of the vehicle. The overall scores were from 93 to 100%, with two occasions noted when bins had not been emptied and towel rails were dusty. There was no evidence to support any actions taken regarding the spot check findings. The service aimed for compliance above 90%.
- We were informed that the vehicles storage area had facilities to clean the vehicles when heavy soiling occurred. This included jet washing and appropriate cleaning materials such as disinfectants. There was no evidence that this was completed when vehicles were returned to base. This was of the breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 12(h); safe care and treatment as we were not assured robust systems were in place to decontaminate all vehicles after use.
- The service provided appropriate waste disposal systems, which included domestic waste, clinical waste and sharps. The appropriate containers were observed to be in place, during inspection.
- We saw that there was colour coded bins in place for both general and clinical waste. We were told that clinical waste was stored on site at the base car park, and was collected at prearranged times when necessary. We did not see any evidence to support this during inspection.
- Staff were responsible for their own uniforms; however, protective equipment was available. We saw that the vehicles were supplied with aprons and gloves to assist with the prevention of cross infection. Appropriate hand washing facilities and hand gels were in place to be used by volunteer staff.
- We were informed that between treatments the team used appropriate cleaning wipes for equipment used. These were observed to be in place during inspection.

Environment and equipment

- The service had systems in place to ensure the safety and maintenance of equipment; however, these were not always followed.
- We saw that the management of vehicles policy dated 2013 detailed the expectations of the maintenance of the vehicles used by the service. This included servicing, insurance, permitted drivers, annual driving license checks and individuals responsibilities.
- The vehicles were not stored at the registered address, and were held at a local secure council car park. We were informed that the car park was manned 24 hours per day; however, during inspection we found that the car park was accessible, with no security in place. We discussed the car park with the team leads and were told that they were in the process of organising a new provider for the safe storage of the vehicles and equipment.
- Three vehicles were not available at the time of inspection. One was in the process of being decommissioned, and the remaining two were receiving maintenance.
- We saw that all vehicles were registered with valid Ministry of Transport (MOT) certificates and maintenance logs were maintained.
- We were told that all equipment was stored on the vehicles at the base car park however; this was not observed during inspection.
- We observed that equipment used was old, but still functioned. Some equipment had received portable electric testing, and were labelled with the date of testing, which had been within the two weeks prior to inspection. Other equipment was not recorded as being tested and fit for use.
- There were no equipment service schedules in place at the time of inspection. Following inspection, we were provided with the service records of all equipment in use. This included blood pressure monitoring equipment, blood glucose equipment, defibrillators and suction equipment. We saw that annual checks had been completed in 2011, 2012 and 2016; however, there was no evidence of equipment checks in 2013, 2014 and 2015. This meant that equipment could have been used, when it was not suitable or safe. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 15 (1)(b)(c) (e); premises and equipment.

Patient transport services (PTS)

- Staff were trained on the equipment used by the service to ensure they were competent to use it. We were told that the team leader on duty would observe all new staff using the equipment until they had completed a competency. All observed practice was recorded in the service records.
- Equipment found to be faulty was escalated to a team leader who arranged for appropriate servicing and temporary removal from service. Equipment was labelled as not to be used and removed from the vehicles on return to base.
- We found that the defibrillator was not secure during inspection. This meant that in transit, patients could suffer a significant injury from the equipment falling off the shelf where it was placed. We asked for this to be corrected during inspection.

Medicines

- The service did not have systems in place for the safe management of medicines and medical gases. Appropriate processes for obtaining, prescribing, recording, handling and storing or medicines were not in place.
- We saw in 18 out of 28 patients' records reviewed that staff had administered medicines to patients. This included analgesia and anti-histamines. When we discussed this with the service, we were informed that staff purchased and brought their own medication. There was no tracking process in place to identify what medication was being provided or record of medication details (such as expiry/manufacture dates).
- We found aspirin in the cupboard of the ambulance inspected. There was no record of how many tablets were used or supplied, and no record of how medication had been sourced. We asked for this to be removed from the ambulance during our inspection.
- There was no individual responsible for the management of medicines.
- The service provided oxygen and nitrous oxide (Entonox, a medical analgesic gas), which was supplied by a local medical company. We were informed that this was delivered directly to the base car park and stored in the "gate keepers" lodge until staff could attend to place the supplies within the vehicles. This meant that medical gases were at risk of being tampered with or removed by unauthorised persons. We were not informed of the duration that medical gases were not being kept secured.
- We were told that volunteers with specialist skills such as paramedics brought their own medicines to events. Volunteer paramedic staff would take their own kit, for which they were solely responsible. We did not see this during inspection, and saw no evidence to specialist medicines had been used. There was no process in place to ensure the equipment bought to an event was safe or suitable for use.
- The service had a medicines management policy in place, which stated that medicines were not routinely dispensed by the service. The only exceptions recorded within the policy were oxygen, nitrous oxide (Entonox) and Aspirin for chest pain if instructed by the NHS ambulance service. The policy states that staff were able to administer the patient's own regular medication if it did not interfere with their condition or treatment. The policy gave clear guidance on the use of patients' own medicines and the grade of staff required completing this.
- The medicines management policy did not give guidance on the safe handling, storage and disposal of medicines.
- As there were no safe systems in place regarding the management and administration of medicines, this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 12 (g) safe care and treatment.

Records

- We found that patient's records were not always managed safely.
- Patient report forms (PRF) consisted of triple duplicate records, which detailed patients name, address, complaint and treatment received. They also included the details of the staff member assessing or treating the patient and any details of transfer to another provider. PRF's would be completed and handed over at patient's destination when transferring to an acute hospital. Patients were given one copy of the record at the end of their treatment if not transported to hospital.
- We found that PRFs were kept in a locked cupboard within the registered address.
- We were informed that patient records were stored within the ambulances at the secure council car park until they could be collected and transferred to the registered address. This meant that patient's personal information, including name, address and details of clinical conditions was not secure. Service leads could

not confirm how long records were left on ambulances however, did confirm it could be several days. This was of the breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 17 (2) (c) good governance.

Assessing and responding to patient risk

- An external agency completed the event risk assessments for the service. The event risk assessment was shared with the service, who then allocated staff to work in line with requirements. Copies of completed risk assessments and allocated staffing levels were reviewed during inspection.
- We saw that the risk assessments included maps of first aid treatment areas, the number of staff required and details of event risks. For example, one risk assessment included the use of horses (for a medieval themed event), and risks associated with falls and trampling.
- The service reported infrequent patient transport services, with seven transfers from June 2015 to August 2016. Team leaders told us that these were always as part of the contractual agreement with the event organisers, and local provision of staff included additional numbers to ensure patient safety on site when vehicles were not available. During inspection, we saw one patient record form, which detailed a patient transfer. This was completed following an accident, which required the patient to be treated for a broken leg.
- The service had a transfer of patients' policy, which clearly outlined the roles and responsibilities of staff. This included communication between the service and the planned destination, information to be given to patients and documentation. The policy highlighted links to the consent policy, reminding staff to ensure consent in place, prior to transfer.
- The services provided first aid and if patients' condition deteriorated, the service would call for emergency services. Stable patients needing further assessment and treatment were transferred to the nearest emergency department.
- People using the service were assessed using a national tool based on the ABC (airway, breathing and circulation) approach to assessment.
- Anyone requiring first aid was assessed and treated by the service. We saw 28 patient records that confirmed this.
- Ambulances were used to transport staff to events, complete patient treatments and to transport patients to emergency departments if necessary. The service had a transferring patients policy.
- Team leads were confident that staff were able to assess patient risks, and escalate concerns accordingly. Patient records confirmed that senior team members or team leaders reviewed patients with more complex conditions.
- Staff were encouraged to call the local ambulance service for assistance if patients rapidly deteriorated. This was outlined in the service treatment policy dated 2013.

Staffing

- All staff used by the service were volunteers and mainly consisted of scouts or scout leaders with an interest in healthcare. The current members of the team included, paramedics, first aiders and ambulance technicians.
- Staffing levels and skill mix was planned and reviewed to ensure that people were safe and received safe care and treatment at all times.
- When the service was booked to cover an event, a risk assessment was completed which determined how many and what grade of staff were required. This was based on the size of the event and the risks associated with the activity. For example, events, which included weapons (for example, historical battle re-enactments) required a higher number of senior staff in comparison to those that did not use weapons. When staffing levels were determined, the event was advertised on the service website and staff volunteered for the available shift. Team leads confirmed attendance. We saw copies of risk assessments and off duty during inspection and saw, that staffing number always met planned cover.
- During longer events, staff change overs occurred on site, with the staff attending the event at a specified time for handover.
- The service did not use agency, bank or locum staff to support the service.
- The service provided mentorship to new staff or less experienced staff during events. The service leads told us that during events, junior staff were teamed with more experienced members of the team. We saw that off duty reflected the supervision.

Patient transport services (PTS)

- Staff were able to take sufficient breaks during events, and these were allocated at the time of event to ensure adequate cover. We saw work sheets, which detailed breaks during the inspection.
- Due to the service being voluntary, there were often gaps between events, which enabled staff to rest appropriately.

Anticipated resource and capacity risks

- The service carried out 'ad hoc' work so would assess resource requirements and capacity on an individual basis when requested.
- Risk assessments were completed before any event covered by the service. An external company who were responsible for identifying the number of staff required and the risks associated with the event completed these. The risk assessments were shared with the service and agreed prior to acceptance of the event.
- The service did not have a business continuity plan.
- A change in event coverage or staffing was completed by the team leaders and an on-site assessment was completed at the time. This was not a formal process and was completed on clinical judgement. There was no written evidence of a formal risk assessment for changes to planned staffing, events or adverse weather.
- As the service was managed and staffed by volunteers. Payments for services were used to purchase any equipment, stock and travel costs.

Response to major incidents

- The service had an adverse incident policy dated 2013, which detailed actions to be taken by individual team members in the event of an incident, the reporting and communications expected and the escalation process.
- Service leads told us that staff regularly participated in the actions to be taken in the event of a major incident or emergency. These events included working collaboratively with the police and fire and rescue services to determine actions to be taken in an emergency. We saw that major incident practices were completed annually.
- All staff were aware of their roles and responsibilities in the event of an emergency. The expectations of each individual were determined by their role. The service leads told us the service conducted major incident rehearsals annually, with the last being completed in October 2016. This event was completed in conjunction with the local police and fire and rescue teams.

Are patient transport services effective?

Not sufficient evidence to rate

We have not rated the patient transport service for effective. This was a focused inspection and elements of this key question were not inspected. We found that:

- The service did not measure any patient outcomes, or benchmark its service against any other providers.
- Mental capacity act training was not provided.
- The policies and guidance that were in place were outdated, but evidenced some national guidelines and standards.

However we also found:

- The service provided clear guidance on what levels of training were expected for each role, and offered staff the opportunity to develop.
- The service provided supervisors and mentors for all staff.

Evidence-based care and treatment

- The service policies were based on evidence-based guidance, standards, best practice and legislation. For example, the driving and care of NEAT Vehicles policy dated 2013, refers to the Institute of Health Care Development (IHCD) Ambulance Driving Manual. The resuscitation policy refers to the UK Resuscitation Council guidance.
- We saw that the service had a central alerting system procedure, which required a designated member of the team to check the central alerting system website weekly to identify clinical or equipment alerts. We did not see any evidence of this being completed, or information gathered from the website being shared.
- The service had a clinical update standard operating procedure, which detailed how clinical updates were to be shared across the team. This included red-urgent updates, which were those requiring immediate changes to practice, and green-routine updates, which were pending changes to clinical practice. Updates were distributed via email and marked with their priority. We did not see any evidence to support this system being used during inspection.

- We saw a number of policies relating to clinical activity. This included the safer manual handling policy dated 2013 and a resuscitation policy (not dated). These gave clear instructions for staff on their roles and training expectations.
- The service undertook a limited number of local audits. Those observed during inspection included vehicle cleanliness and hand hygiene.

Assessment and planning of care

- The service provided an onsite first aid drop in service and walked around event sites to observe for anyone who may need help. If necessary patient transfer to acute services. Bookings were made in advance, and were completed by arrangement with the team leaders directly. We saw examples of bookings on the booking system, and were satisfied that they provided adequate information for staff to make appropriate arrangement.
- The service was equipped to manage a variety of health-related complaints. The service primary function was the provision of first aid at events. A planned patient transfer service was not provided. They provided transport for patients requiring transfer to acute hospitals from pre-arranged events, and not as bookings for patient transfers.

Nutrition and hydration

- Nutrition and hydration for patients was not routinely provided.
- The service had a nutrition standard operating procedure, which detailed that in suspected cases of dehydration, staff were able to give patients bottled water. It also stated that staff could administer glucose gel to diabetic patients with low blood glucose levels. Although we did not see a supply of water or glucose gel during inspection.

Patient outcomes

- Information about the outcomes of peoples care and treatment was not collected or monitored by the service leads.
- We saw that the NEAT assessment, treatment, patient report form and safety netting policy dated 2013 detailed the referral pathways for patients. There were eight possible patient pathways; see and treat, send patient home, advise to attend the emergency department, transport to the emergency department, advise for the patient to see their GP, advise for the patient to attend the minor injury unit or call for emergency backup. Each pathway highlighted the types of injury which may qualify for each pathway and outlined the need to seek assistance of staff were unsure.
- We saw that information captured during events detailed actions taken by the staff to address clinical findings and any actions taken by staff members. This included advice for follow up with GPs or other services. The service did not analyse this data to determine, the number of patients using the service, the treatment given or the patient outcome.
- The service did not routinely monitor the number of patient transfers completed. Service leads told us that the service had completed seven transfers to acute hospitals from June 2015 to November 2016.
- The service did not have any key performance indicators (KPIs) to monitor the time taken to transfer patients to emergency departments.
- The service did not benchmark against other providers.
- The service did not participate in national audits or accreditation processes.
- The service did not use patient outcomes to improve the service.

Competent staff

- Staff volunteered into the service were assessed for their role using a modular training programme. Each role had a specified number and type of modules, which needed to be completed to enable the staff member to complete that role. The modules required for each post was outlined in the training policy dated 2013. There were 20 different modules, which included heart and circulatory problems, choking, medical gases, patient report forms and duty leader.
- We were told that all staff working within the service completed the modules appropriate for each role, irrespective of their skills and competence. This meant that all staff completed the same training programme and ensured competence prior to completing the roles. Staff deemed competent at a role were able to continue to develop through the modular training if they wished.
- When completing the training modules, staff were assessed and supervised by senior staff holding the appropriate skills until competence could be assured.

We saw that appropriately qualified staff completed training. Mentorship and supervision of individuals practice was completed during events, by the team leaders.

- We were told that senior team members were able to supervise all staff to ensure that they completed tasks appropriately. Any poor practice was identified and addressed at the time of the incident and addressed by the team lead on site. If necessary, additional training or supervision was provided to ensure competence.
- The service maintained accurate records for the drivers of the vehicles. This included driving licence type, number, and expiry. Reviews of individuals' driving licences were completed annually and we saw that all staff able to drive the vehicles had their licences reviewed in July 2016.
- The service did not provide clinical supervision or appraisals for staff.

Coordination with other providers

- The service had a duty leader responsibilities policy dated 2013. This detailed actions to be taken prior to attending an event, during the event and at the end of duty.
- The team attending an event would introduce themselves to the event organisers on arrival to site. During this briefing staff were informed of event activities and allocated to a first aid area. The event organisers always predetermined the base, and we were told this was routinely advertised at the event. Once on site the team were divided into group. Some staff would remain at base whilst others patrolled the event.
- The service used the ambulances as a secure area to assess and administer treatment. If patient's conditions deteriorated, the service would either transfer the patient to the nearest emergency department or call the emergency services for support on site. The largest portion of patients required first aid treatment only.
- The service had two radio systems. One was used to communicate between individual team members, and the second had access to the emergency services radio system. This was used for emergencies only.
- When vehicles needed to leave site the team leader would allocate the most appropriate staff to continue to staff the event and transfer the patient. The service continued to provide cover at the base area, whilst the number of staff patrolling the event would be reduced. The nominated driver would always drive the vehicle.

Multidisciplinary working

- All staff were included in the assessing, planning and delivery of care and treatment. The team always had an allocated team lead that was responsible for the management of the team and all activities whilst on site. This individual was responsible for a number of staff, depending on the event.
- The service did not directly inform other services of treatment given, with the exception of patient transfers to the emergency department. Patients transferred to emergency departments were handed over to the department. The assessment and treatment provided were explained and a copy of the patient record sheet given to the accepting service. We saw that the process for handover was clearly outlined in the handover standard operating procedure dated 2013.
- All other patients were given advice on any follow up care, however no referrals were made. For example, we saw treatment card that advised patients to attend their GP for further advice or discharged following minor treatments.

Access to information

- Information gathered during patient assessment was recorded on the patient report form (PRF). These were signed and dated by the staff attending the patient, and the patient or guardian. The patient was provided with a copy of the PRF on discharge. A copy of the PRF was given to staff within the emergency department if patients were transferred between the services.
- All patient records were observed to be paper based.
- All staff records were electronically held by a central database belonging to the scouts' association. This was password protected and only accessible by senior members of the team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Senior managers said that staff understood their roles and responsibilities in gaining consent. Senior managers told us that staff were trained in gaining consent for treatment, but as providers of first aid, staff did not complete training in mental capacity assessments or deprivation of liberty safeguards. As there were no systems in place to ensure all staff fully

understood mental capacity and best interest decisions, this represented a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 11; need for consent.

- The service had consent to care and treatment policy dated 2013, which detailed the expectations of staff to consider consent with all patients and to detail that consent was to be sought before any treatment. The policy also gave guidance on the consent process for children, and highlighted the guidelines in the safeguarding policy relating to treating patients less than 18 years.
- Patients receiving care or treatment were asked to sign the treatment record to confirm they understood the advice or treatment given. Verbal consent was recorded on the chart using a tick box.
- We were told that vulnerable adults and children usually attended events with parents or guardians. Consent for treatment by the individual staff member was obtained prior to the completion of any treatment.
- The service had a mental capacity policy dated 2013, which outlined the Mental Capacity Act 2005, how capacity was determined and the need for staff to be aware of capacity assessments. The policy included a flow chart to assist with mental capacity assessments. We did not see any capacity assessments during our inspection.
- The staff did not restrain patients or require authorisation for deprivation of liberty safeguards. The service did not have a policy that referred to patient restraint.

Are patient transport services caring?

We have not rated the service for caring. This key question was not inspected.

Compassionate care

- We did not gather evidence for this as part of the inspection.

Understanding and involvement of patients and those close to them

- We did not gather evidence for this as part of the inspection.

Emotional support

- We did not gather evidence for this as part of the inspection.

Supporting people to manage their own health

- We did not gather evidence for this as part of the inspection.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Not sufficient evidence to rate

We have not rated the patient transport service for responsive. This was a focused inspection and elements of this key question were not inspected. We found that:

- The service did not provide services for those patients who were partially sighted; hard of hearing, wheelchair bound or those for whom English was not their first language.
- Although the service received few complaints, there was no evidence of shared learning. There was not a robust system in place to act upon complaints.

However, we found that:

- The service planned to meet the needs of local people, and provided a service based on an external risk assessment.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. For example, the size of the event being held determined the number of staff in attendance.
- Event organisers and their stakeholders were involved with the planning of the service. The team were hired to perform specific roles. This was either first aid on site, or first aid plus transfer of patients to emergency departments. The roles and responsibilities of the service was determined in advance through discussion with the event organisers and detailed in the event contract. We saw contracts between the service and event organisers, which stipulated roles, and expectations.

Patient transport services (PTS)

- The team were able to flex the service provided if appropriate time was given to arrange the volunteering staff. We were told that staff were very keen to assist with event cover and additional staffing could usually be arranged.
- Facilities and the premises used were not appropriate for the planning and delivery of the service. The car park was not secure which meant that vehicles were at risk of being tampered with. The service had no storage area for equipment, which meant that all equipment was stored within the vehicles. The base used by the service did not have storage facilities to support the delivery of the service.

Meeting people's individual needs

- The service planned to take into account the needs of different people through the initial risk assessment of the events covered. This was not completed by the service, but by the event planners.
- Service leads confirmed that they used accompanying family, friend or carers to assess and treat patients requiring additional support. This included, children, visually impaired, and patients whose first language was not English.
- Vehicles were not designed to meet the needs of wheelchair users or bariatric patients.
- There was no access to translation services, or aids for visual or hearing impaired.

Access and flow

- Patients had access to timely care and treatment. This was achieved by the patrolling of events by teams with medical supplies, and the use of ambulances. The service could attend a location at the time of incident, and assess patients. If necessary patients could be removed from the event arena by the ambulance.
- In addition to patrols, the service provided a first aid area, which was advertised by event staff. Patients were able to "drop in" for treatment, as they felt necessary.
- The service did not use an appointment system. Patient awaiting treatment were seen in a first come basis. Staff reported that number of patients varied; however, there were no occasions where patients waited for treatment.
- We were told that attendance on site was planned from half an hour before and after the event started and finished. This ensured that all patients were seen and allowed additional time for the event to open and close.

Learning from complaints and concerns

- The service did not have a complaints policy but did have a respecting and involving policy dated 2013, which detailed the need to gain feedback from patients and event organisers. The policy outlined that all feedback should be acknowledged within 48 hours, with an investigation completed within one month. Escalation of non-compliance was required to be escalated to the management team. The service did not have a robust system in place for responding to complaints and feedback and to ensure that lessons were learned and actions taken to make improvements when needed. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16: receiving and acting upon complaints.
- We did not speak to any service users. However, we were informed that the service had received one complaint from June 2015 to August 2016. This was received from an acute trust, complaining about the transfer of a patient to the incorrect department. An investigation was completed locally, which identified that the patient had been transferred to the location predetermined by the acute trust. The patient had been involved with the investigation and made aware of the outcome. Information regarding this incident was shared by the team, although this was verbally and not recorded formally.
- There were no displays showing staff how the business was performing in relation to complaints or concerns.

Are patient transport services well-led?

Not sufficient evidence to rate

We have not rated the patient transport service for responsive. This was a focused inspection and elements of this key question were not inspected. We found that:

- There was no CQC registered manager.
- The service had no vision or strategy.
- We found significant concerns regarding the governance and risk management processes of the service.
- There were not effective, robust systems in place to assess, review and monitor risks within the service.
- There were no systems in place to monitor and review safety and quality performance in the service.

Patient transport services (PTS)

However, we also found:

- Team leaders regularly worked with the teams.

Vision and strategy for this service

- The service did not have a clear vision or values.
- There was no strategy in place for the service and no current statement of purpose that reflected the services provided.

Governance, risk management and quality measurement

- We found significant concerns regarding the governance and risk management processes of the service.
- There were not effective, robust systems in place to assess, review and monitor risks within the service.
- The service did not have a risk register in place. There were no systems in place to assess and respond to risks in the service and for the delivery of safe care and treatment for patients.
- The service did not use key performance indicators (KPIs) to monitor performance and patient care.
- We were told that team leaders met regularly. Meetings reviewed planned events; training and the service in general however, these meetings were not recorded formally and did not follow a set agenda.
- Team leaders did not review performance, audits or identify areas for improvement.
- Staff were aware of their clinical roles however were not aware of their roles and responsibilities as service leads.
- There were no systems in place to measure performance, and consequently no systems in place to identify areas for improvement.
- The service did not have an audit programme in place. We saw some audits completed during inspection. However, there were no action plans to address findings, and no evidence of actions.
- As there were no systems in place to assess, monitor and improve the safety and quality of the care and treatment provided, this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 17(1) (2) (a) (b); good governance.
- The policies and procedures for the service were well written, however all were dated 2013, with no evidence of being updated at the specified times required. For example the resuscitation policy stated it was updated but gave no date, the respecting and involving policy, infection control and prevention policy and the adverse incident policy were required to be updated annually, however there was no evidence to confirm that this had been completed. We saw that policies linked well to each other identify where a policy should be read or implemented in conjunction with another policy or procedure.

Leadership of service

- The service did not have a CQC registered manager. The previous manager resigned from post in March 2015, and although requested to be removed as the registered manager, had not informed CQC of the need to be removed from the service for nominated individual. The nominated individual is the person responsible for the supervising and management of regulated activity within a service. The lack of CQC registered manager is a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 7: requirements relating to registered managers.
- Three team leaders managed the service in the absence of a registered manager. All had varied experience outside the service. One team leader worked within a mental health environment at a junior level. The remaining two did not have a medical background. The team leader reported experience managing teams within their day jobs, and within the scouts association. The team leaders were knowledgeable about the service and clearly passionate and dedicated to their business.
- No team leaders were familiar with the Care Quality Commission registration requirements for the service.
- When we immediately raised these concerns during the course of the inspection, senior managers of the Northampton scouts' association confirmed that the service was no longer to provide the regulated activity of transport, triage and medical advice provided remotely and that the service was therefore planning to deregister.
- Their service had a very flat structure, with three team leaders who shared roles and responsibilities regarding management of the service. Remaining staff were allocated to clinical roles depending on their training and competence.
- There were limitations to the management of the service because of all staff being volunteers. This meant

that staff availability and commitments outside the service affected the staff's ability to manage the team. Team leads were aware of the limitations of available time and the impact of this on the service.

- Team leads were available and visible with at least one team leader attending each planned event. Off duty, rotas confirmed this, although we did not speak to any other staff to confirm this during inspection.

Culture within the service

- We did not gather evidence for this part of the inspection.

Public and staff engagement

- We did not gather evidence for this part of the inspection.

Innovation, improvement and sustainability

- We did not gather evidence for this part of the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that a CQC registered manager is in place.
- Ensure that the service has a strategy and updated statement of purpose.
- Ensure that staff have relevant safeguarding children level 2 and 3 training.
- Implement a system for monitoring compliance to policy.
- Implement a system to monitor patient outcomes.
- Implement a system to review service performance and benchmark against other organisations.
- Implement a risk register, which accurately reflects the service's risks.
- Ensure that patient feedback is collected, analysed and used to improve services.
- Ensure that there are robust systems in place to communicate and evidence learning from incidents and complaints across the team.
- Implement a process for the safe management of medications, which should include the purchasing, storage and administration.
- Ensure all vehicles and equipment are fit for use.
- Ensure robust infection control procedures are in place.

Action the hospital SHOULD take to improve

- Update and review service policies to reflect the most current evidence based practice and national guidelines.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers **Why the service was not meeting this regulation:** • There was no registered manager in the service

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Why the service was not meeting this regulation:** • **Staff did not complete training in mental capacity assessments or deprivation of liberty safeguards.** • There were no systems in place to ensure all staff fully understood mental capacity and best interest decisions.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Why the service was not meeting this regulation:** • **Medical gases were not always secure and were at risk of contamination.** • **There were no safe systems in place regarding the management and administration of medicines.**

This section is primarily information for the provider

Requirement notices

- **There was no evidence of regular audits to confirm compliance with infection control policies, and those that were completed had no actions associated with findings.**
- There was no assurance that robust systems were in place to decontaminate all vehicles after use.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Why the service was not meeting this regulation:** • No staff had been trained at safeguarding children level 2 or 3, which would be required for those staff transporting and treating children. This meant that there was a risk that staff would not be able to recognise and report potential safeguarding concerns. • Not all staff demonstrated a clear understanding of safeguarding process.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Why the service was not meeting this regulation:** • **There was no maintenance programme in place for equipment used, with gaps of several years between servicing.** • The vehicles were not stored at the registered address, and were held at a local secure council car park. We were informed that the car park was manned 24 hours per day; however, during inspection we found that the car park was accessible, with no security in place.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Why the service was not meeting this regulation:** • The service did not have a robust system in place for responding to complaints and feedback and to ensure that lessons were learned and actions taken to make improvements when needed.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Why the service was not meeting this regulation:** • There were no systems in place to assess, monitor and improve the safety and quality of the care and treatment provided. • Risks were not assessed within the service. • Patient's personal information, including name, address and details of clinical conditions was not always secure. • The service did not meet to discuss service delivery or performance. • There was limited information captured by the service, to evidence compliance against policies. • Policies were outdated.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Why the service was not meeting this regulation:** • There was not clear evidence that staff had undertaken mandatory training since employment with the service.

This section is primarily information for the provider

Requirement notices

- There was no definition of what training was mandatory and must be undertaken by staff. We did not see the service record of staff training, as the database held by the scouts' association was not updated with clinical training.