Collingwood Services Ltd

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Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated this service as requires improvement because:

- Staff were not in date for training in key skills and safeguarding policies were not based on national guidance. The service did not control infection risk well. The maintenance of vehicles and equipment did not keep people safe. They did not have systems and processes to safely administer, record and store medicines. The service did not manage safety incidents well.
- Managers did not monitor the effectiveness of the service and did not make sure staff were competent. Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development.
- The service did not take account of patients' individual needs. The service had not received complaints in the two years prior to inspection. Therefore, we were unable to see evidence of learning shared.
- Managers did not always manage the priorities and issues the service faced. They did not complete appraisals which supported staff with their training needs. However, training courses, such as First Response Emergency Care (FREC) levels 3 and 4 were available for staff to improve their skills. There were not always effective governance processes. They did not collect and use data to make decisions and improvements. Staff did not meet regularly to discuss issues and service performance. The service did not collaborate with staff to help improve services for patients.

However:

- The service had enough staff to care for patients and keep them safe. The equipment and vehicles were visibly clean and staff recognised incidents and near misses.
- The service provided care and treatment based on national guidance and evidence-based practice. Staff gave patients practical support and advice to lead healthier lives.
- The service planned and provided care in a way that met the needs of local people and the communities it served. People could access the service when they needed it and received care in a timely way.
- Leaders were visible in the service for patients and staff. Most staff felt respected, supported and valued.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Requires Improvement 	See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Collingwood Services Ltd

Collingwood Services Ltd is an independent ambulance service based in Amesbury. They primarily provide medical cover for events nationally but also have a training academy. The Care Quality Commission (CQC) does not regulate activities that are undertaken on an event site. However, CQC do regulate activities involving patients being transported from an event to hospital, which was an activity that was carried out by the service.

The service was registered with the CQC in December 2017 to provide transport services, triage and medical advice remotely and treatment of disease, disorder or injury.

The service has had a registered manager in post since January 2018. A registered manager is a person who has registered with CQC to manage a service. They are 'registered persons.' Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2012 (Regulated Activities) Regulations 2014, and associated regulations about how a service is managed.

How we carried out this inspection

On 27 October 2021 we carried out a comprehensive inspection of the service. The service did not directly employ any staff in addition to the registered manager and two business partners. However, they recruited 20-25 staff on a flexible basis to deliver the service at events where they may be required to convey patients to hospital. During the inspection visit, the inspection team:

- inspected the premises at Amesbury and two ambulance vehicles
- spoke with the registered manager and business partner
- looked at the training files for 20 staff
- looked at the recruitment files for eight staff
- looked at equipment
- looked at a range of policies and other documents relating to the running of the service.

We were not able to speak with staff on the day of the inspection but subsequently spoke with seven members of staff on the telephone.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that all staff are compliant with mandatory training compliance (Regulations 12(2)(c).
- The service must ensure safeguarding incidents are reported in a timely way (Regulations 13(2)).

Summary of this inspection

- The service should ensure there are systems and processes to support an effective cleaning regime (Regulations 12(2)(h)).
- The service must ensure staff manage clinical waste in line with clinical guidance (Regulations 12(2)(h)).
- The service must ensure PPE requirements for staff are reviewed regularly in line with national guidance and comply with recommendations (Regulations 12(2)(h)).
- The service must have processes that demonstrate staff are trained and competent to use medicines (Regulations 12(1)(2)(c)(g)).
- The service must have a full audit trail of use of medicines and their storage (Regulations 12(1)(2)(g)).
- The service must have assurance controlled drugs are appropriately purchased and stored correctly (Regulations 12(1)(2)(g)).
- The service must have oversight and organisation of staff that can drive emergency vehicles with audible and visual warnings (blue lights) (Regulations 17(1)(2)(d)).
- The service must complete staff appraisals and supervisions (Regulations 18(2)(a)).

Action the service SHOULD take to improve:

- The service should continue to improve and embed processes surrounding recruitment of staff.
- The service should consider ways to improve storage of medical gases, medicines and equipment.
- The service should consider ways of improving staff competence.
- The service should consider introducing a central equipment asset register.
- The service should have clear options available for patients to make complaints.
- The service should improve oversight of staff COVID-19 vaccination status and COVID-19 test results.
- The service should consider ways in which the use of the risk register could be improved to inform the delivery of the service.
- The service should have safeguarding policies that reflect national guidance and risk assessments around DBS checks.
- The service should consider ways to improve the ways in which formal feedback is received from customers, staff and patients that use services.
- The service should work to improve its evidence that vehicle maintenance is carried out by people who are qualified to do so.

The service should consider ways in which incident reporting could be improved.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Requires Improvement	Inspected but not rated	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Inadequate	Requires Improvement	Inspected but not rated	Requires Improvement	Requires Improvement	Requires Improvement

Requires Improvement

Emergency and urgent care

Safe	Inadequate
Effective	Requires Improvement
Caring	Inspected but not rated
Responsive	Requires Improvement
Well-led	Requires Improvement

Are Emergency and urgent care safe?

Inadequate

Mandatory training

The service provided mandatory training in key skills to most staff. However, there was not a system for monitoring and recording compliance or making sure everyone completed it.

At the time of our inspection, the registered manager did not have effective oversight of staff completion of mandatory training. This meant there was an increased risk patients would be cared for by staff who had not received the right level of training to meet their needs. There was no established process to monitor training compliance on an ongoing basis. We were told by the provider the target for training compliance was 100%. They were unsure when staff were due training, whether they were out of date and what the current compliance was. The staff training policy stated the target had been set at 95% and this would be monitored. The provider was therefore not adhering to their own policy.

We reviewed 20 staff training records and found 14 completely blank forms. Of the remaining six records we reviewed we found them to be partially completed with gaps in annual refresher training. The service was in the process of transferring these records to an electronic system. At the time of inspection only six members of staff were on the system. We found some staff records contained notifications to advise training for staff was overdue due to COVID-19 working restrictions and this would be rectified over the coming months.

Following the inspection, the registered manager improved oversight of mandatory training and provided evidence of this improvement. However, it remained the case that mandatory training completion was poor.

Safeguarding

Not all staff had safeguarding training which was in date. Safeguarding policies were not based on current national guidance.

The service did not have adequate systems and processes for staff safeguarding training to prevent abuse of service users. The provider informed us all staff were trained at safeguarding adults and children level three. The safeguarding training was provided in-house by a level four instructor. However, they were not a healthcare professional. The service's policy on three yearly training subject matter stated staff may wish to complete an external level three safeguarding course as the in-house course did not offer a formal qualification. The training was not in line with the intercollegiate

documents 'safeguarding children and young people: roles and competences for healthcare staff' or 'adult safeguarding: roles and competencies for healthcare staff'. These state level three training must be multidisciplinary, inter-agency and delivered by a healthcare professional. There was a risk staff were not competent to recognise safeguarding concerns.

Safeguarding policies were not based on current national guidance. There was a safeguarding policy which included adults and children's safeguarding which was in date for review. However, the policy directed staff to report any safeguarding concerns to the company director rather than local authority directly, therefore it did not follow best practice. Some staff we spoke with advised they would report safeguarding incidents internally. This meant there was a risk of harm to patients if these were not raised to the local authority in a timely way.

Following the inspection, the registered manager sent evidence of safeguarding training completion for 25 staff. Seventeen members of staff had either not completed or were out of date for the annual safeguarding refresher training. The case remained that the training that had been completed had not been delivered in line with intercollegiate guidance.

Recruitment processes were not in line with the requirements of Schedule 3 of The Health and Social Care Act. The service did not have a written disclosure and barring service (DBS) policy. The provider informed us they asked staff for proof of a DBS check from their current or previous employer. We reviewed nine employment files. We found four out of the nine were dated between 2005-2017. One member of staff did not have a DBS certificate and the other four were dated between 2020-2021, but were from another employer. Following the inspection, the recruitment policy was amended to include a DBS check section. This stated certificates must either be completed in the last three years or staff must be registered on the subscription service. This meant certificates were transferable between employers. Oversight of all staff DBS certificates was improved and mitigations made to accommodate.

The recruitment process did not always take a full employment history of applicants. We reviewed the employment files of four members of staff. None of these included a full employment history with explanation of all gaps in employment. There was only room for current and previous role on the providers paper form. Following the inspection, the service worked to improve this issue and obtained full employment histories for staff.

The process for obtaining references when staff were employed was not always adequate. Since thorough staff checks were not consistently performed for all staff, we could not be assured recruitment processes promoted patient safety.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. However, the equipment and vehicles reviewed were visibly clean.

While ambulances were visibly clean and staff completed records of daily cleaning, there was a lack of oversight over deep cleaning of the vehicles. We inspected two ambulances that were in use. Deep cleans were performed using a deep cleaning policy that had not been recently reviewed. A microbial count was not taken before or after the clean. A microbial count indicates how many microorganisms are present in a sample. The deep cleaning policy stipulated vehicles should be deep cleaned monthly. The provider told us these cleans were undertaken weekly. However, there was no tracking system for deep cleaning schedules and although deep cleans were taking place we were not assured they were effective. Following the inspection, the registered manager completed level five commercial cleaning management training.

The service did not always maintain equipment to ensure it was clean and ready to use. We found an armrest in the interior cab of one ambulance was worn exposing sponge padding. This posed an infection risk. There was alcohol gel available in the front cab of the same ambulance, but the dispenser in the rear saloon was empty.

Staff did not manage clinical waste in line with national guidance. The sharps bins in both ambulances were in use but were not dated when opened. Therefore, there was no record of how long sharps bins had been in use for. There was no audit trail to ensure sharps bins were disposed of every three months in line with the National Institute for Health and Care Excellence (NICE) guidelines.

Staff did not have access to adequate personal protective equipment in line with national guidance. Filtering face pieces (FFP3) respirator masks are required as part of COVID-19 personal protective equipment worn in areas where aerosol generating procedures (AGPs) are undertaken. The service told us they carried out some AGPs and we found nitrous oxide available on vehicles. We reviewed 20 staff files and found only one had a fit test and that had been completed by another service. The respirator masks were not located on the ambulances close to the point of use for staff. We were told staff would be issued with these on deployment. Other personal protective equipment (PPE) including gloves, face shields and aprons, spillage kits and clean linen were available on the ambulances.

Environment and equipment

The maintenance and use of vehicles and equipment did not keep people safe and there was no assurance that staff were trained to use them.

Although records confirmed that both ambulances had been serviced regularly, there were no records which verified the work had been done. Following the inspection, the provider told us they had implemented processes to rectify the issue.

Defibrillators were not stored in a way which supported staff to be clear they were ready for use. This meant there was a risk that staff may rely on defibrillators that were not ready for use.

The provider did not always secure equipment safely. General cleaning products were stored in a plastic storage unit which was not locked, and ambulance cleaning equipment was stored in a statutory off-road notification (SORN) ambulance which had been de-commissioned and was non-operational. These were within the secure compound but in a shared car park. The ambulance was locked with a combination padlock. Cleaning materials were stored alongside five full medical gas cylinders. This did not follow the requirements of the Health and Safety at Work Act (1974) which stipulates storage of such containers must be sited away from storage areas containing highly flammable liquids and other combustible materials and any sources of heat or ignition. This did not provide assurance that COSHH products were safely stored. However, the provider had a folder detailing the control of substances hazardous to health (COSHH) which was accurate and up to date. Following the inspection, the provider purchased a separate storage container for the cleaning equipment.

The cage containing the medical gas cylinders was not padlocked or bolted to the ground, this meant it was not secure. This was raised immediately following the inspection and the provider secured the cage to ensure safe storage of these cylinders.

The ambulances were not equipped with necessary equipment to find the most direct route to the hospital. There were no maps or satellite navigation systems available for crews on the ambulances. This meant there was a risk that journeys to hospital could take longer as staff were not aware of the quickest route. Following the inspection, the provider has included directions (including maps) to hospitals inside the vehicles used for transferring patients.

Staff were responsible for noting deficiencies in stock levels, but the replenishment of supplies was undertaken by management staff based on the recorded levels. All sterile supplies we checked on the ambulances were in date. The registered manager had a digital copy of the inventory items the service required, stocked or issued with minimum stock level proposals and expiry dates. We checked 10 items in the stock room and found one item had expired, the provider removed this immediately.

We were told staff carried out daily safety checks of the vehicles and equipment stored on them. Ambulances were visibly clean with no signs of damage and both access ramps were in good working order.

Vehicle faults were reported by the crew to management, either after the initial vehicle check when another ambulance would be taken, or during a shift via telephone where we were told recovery of the defected vehicle and replacement would be arranged.

Vehicles had a valid annual safety check certificate, were taxed and insured when required. We checked the insurance cover against the vehicles we inspected that had been used for the regulated activity and vehicle daily inspections had been completed and insurance had been confirmed.

Assessing and responding to patient risk
There was not sufficient evidence to assess this during the inspection.

Staff followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical guidelines. Assessment for patients were carried out and recorded on patient report forms (PRFs). The documentation assisted in undertaking a rapid assessment and making the decision to convey to hospital. The provider told us they would send pre-alerts if they needed to send a patient urgently to an accident and emergency department.

Staffing
The service had enough staff to provide the right care and treatment. Managers reviewed and adjusted staffing levels and skill mix.

The service had enough staff to keep patients safe. Staff working in the service were emergency care assistants (ECAs), emergency medical technicians (EMTs) and paramedics. Staff worked for the service on a zero hours contract basis.

We were told there were two events that conveyed patients to hospital, one was a music venue and the other a motocross event. The music venue had two types of events - concerts and club nights. At a concert the minimum staffing would be two EMTs and two ECAs and a club night would also include a paramedic. At the motocross event the minimum staffing would be two ECAs, two EMTs and two paramedics.

Records
There was not sufficient evidence to assess this during the inspection.

The service used patient report forms (PRFs) which staff completed following their assessment and treatment of patients. We reviewed four patient report forms for patients that had been conveyed to hospital during the period April 2021 and July 2021. These were dated and timed observations were recorded. We found all forms to be legible and completed in full with patient identifiable information.

Medicines
The service did not have systems and processes to safely administer, record and store medicines.

Requires Improvement

Emergency and urgent care

There was no evidence of processes that supported staff to safely administer medicines nor processes which demonstrated staff were trained. However, there was a medication policy and medication training was available.

The service did not have a full audit trail of use of medicines. Paramedic and technician medicine bags were checked out to staff by the registered manager, who recorded the name of the staff member and the type of bag issued. Medicine bags were sealed with a serialised locking tag. However, the serial number was not recorded anywhere. There was a risk that medicines could go missing or out of date and not be accounted for in a timely way. We checked five sample medicines and found they were all in date.

The service did not hold controlled drugs, paramedics held their own controlled drugs. However, the service lacked systems to provide assurance the controlled drugs held by the paramedics were appropriately purchased or stored correctly.

Medicines requiring refrigeration were not stored safely. They were stored in a fridge alongside food. There were two thermometers in the fridge, fridge temperatures were recorded on a centralised spreadsheet twice a day and there were no gaps in recording history. However, minimum and maximum temperatures were not recorded. Therefore, the process did not provide assurance that if the medicines storage temperature was out of the recommended range it would always be identified. Following the inspection, the provider sent photographic evidence to show a dedicated medicines fridge was purchased and in use.

Incidents

The service did not manage patient safety incidents well. Staff recognised incidents and near misses but there were not systems and process available to report them appropriately.

Staff were not aware of the incident form paperwork to fill in after a near miss, accident or incident as per the service's incident reporting policy. However, staff told us they would report all incidents to the registered manager. This was in line with the service's incident reporting policy.

The service had reported no incidents from 2019 to 2021 so we were unable to review incident investigations and learning. The provider told us a meeting would be arranged to share lessons with staff should there be any incidents.

There was no process for the manager to share patient safety alerts with staff. However, the registered manager told us safety alerts were received and the management team discussed actions and implemented them. A recent example was for an Automated External Defibrillator (AED) that required a recall.

The service had no serious incidents or never events from 2019 to 2021.

Staff understood the duty of candour and the requirement to be open and transparent with patients if things went wrong. The service had had no incidents when they needed to apply duty of candour. The duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.

Are Emergency and urgent care effective?

Requires Improvement

Emergency and urgent care

Requires Improvement

Evidence-based care and treatment
The service provided care and treatment based on national guidance and evidence-based practice. However, managers did not complete formal checks to make sure staff followed guidance.

The service had a range of policies which provided guidance for staff to follow. We reviewed a range of policies and found most were in date for review. Policies were available for staff through an online portal. There was no evidence staff had read and signed these. However, the new HR system being implemented monitored who had read the policies.

Prior to the COVID-19 pandemic, staff had access to electronic tablets at venues for easy access to the online portal, joint royal colleges ambulance liaison committee (JRCALC) and national institute for health and care excellence (NICE) guidelines. There was a plan to reinstate these at the venues in weeks following our inspection. Staff had a copy of JRCALC in the vehicle.

We were told managers completed observations of staff practice, this included:

- duty of candour
- significant events
- staff competency assessment for the management of medications
- administration of emergency medical gases
- burns and scalds
- spinal injury
- limb trauma
- abdominal trauma
- hypothermia
- heat-related Illness
- asthma
- allergic reactions
- incident reporting
- recruitment: applicant process
- complaints

Following the inspection, the provider sent copies of the observation audits however they were incomplete.

We were told audits were completed. These audits included:

- stock checks of equipment at venues
- hand hygiene
- uniform
- clinical rooms at venues
- vehicle cleans
- vehicle equipment
- vehicle inspections
- medial gases form
- temperature checks

- patient report forms
- display screen equipment
- treatment
- caring
- environmental
- health and safety
- information governance.

Pain relief
There was not sufficient evidence to assess this during this inspection.

Competent Staff
The service did not make sure staff were competent for their roles. Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development.

There was a risk staff who were not trained to drive emergency vehicles with audible and visual warnings (blue lights) could be deployed to an event where they were commissioned to convey patients. The service did not provide this training to staff. It was assumed that paramedics had received this training from other employment.

The service did not have oversight of drivers that were trained to drive emergency vehicles with audible and visual warnings. We were told this information was known to the management team, but were not provided a written record of this. We were told nine members of staff were able to drive the car and six were able to drive the ambulance. We reviewed four driving licences for staff that were able to drive the ambulances and found they held the correct licence category.

Staff appraisals were not completed regularly. Managers did not provide support and development for staff. We were told this was due to the pandemic. Appraisals were due to be arranged between January and March 2022. We reviewed eight staff recruitment files and saw no evidence of appraisals, supervision, continuing professional development (CPD) portfolios, review of completion of mandatory training or other developmental meetings for their employment. This meant there was a risk that staff were not competent for their roles.

Staff did not receive a formal induction programme. We were told a formal induction programme had been devised but implementation had been delayed due to the pandemic.

All Emergency Care Assistant (ECA) and Emergency Medical Technician (EMT) staff were trained using the skills for health framework. This was a national framework for people delivering healthcare services. Staff were provided training on equipment and a 'medical devices and equipment assessment' form was completed.

Staff had requested further training for treating patients under the influence of drugs and alcohol which we saw had been delivered to 12 members of staff.

Multidisciplinary working
There was not sufficient evidence to assess this during the inspection.

Health promotion
Staff gave patients practical support and advice to lead healthier lives.

Requires Improvement

Emergency and urgent care

Managers told us they signposted patients to other organisations. We saw the service had supply of advice leaflets for patients about depression and anxiety and panic attacks. They treated a high number of patients with these suspected symptoms at the music venue events.

Consent, Mental Capacity Act
There was not sufficient evidence to assess this during the inspection.

The service had policies to support staff when considering the mental capacity act or deprivation of liberty in the course of their work. Staff told us they were aware of the content and discussed difficulties that could be experienced with specific patient groups. However, when we looked at staff files, 20 member of staff did not have up to date training records around the Mental Capacity Act 2005, or Deprivation of Liberty Safeguards.

Are Emergency and urgent care caring?

Inspected but not rated

We were unable to complete any observations of patient care. We did not speak with any patients about their experience of care. In the two years prior to the inspection, the service had only delivered the regulated activity to five patients.

Compassionate care
There was not sufficient evidence to assess this during the inspection.

We were told patient's privacy and dignity were maintained during transport and conveying to hospital, and staff described how this was achieved in different scenarios.

Emotional support
There was not sufficient evidence to assess this during the inspection.

We were told staff had received extra training around the subject of panic attacks, due to the high number of patients seen at music events with anxiety. This enabled staff to help patients by calming them, practicing breathing techniques and understanding their fears. The service offered further information and signposted patients to seek help from charities, their doctors or other professionals. We were also told of an example where a member of staff offered support and to chaperone a young patient who was nervous to talk with their relative.

Understanding and involvement of patients and those close to them
There was not sufficient evidence to assess this during the inspection.

Staff described how they talked to patients with respect and tried to build a rapport. We were told a lot of patients at the music events were with friends and they often requested to speak with the patients. Staff spoke with the patients first to see if they would like to talk with the people requesting to speak with them. Friends and family were restricted in the ambulance due to requirements around infection and control. The service was aware of the receiving hospitals COVID-19 policies and explained these to friends and relatives.

Requires Improvement

Emergency and urgent care

Are Emergency and urgent care responsive?

Requires Improvement

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities it served. It worked with others in the wider system and local organisations.

The service undertook five emergency and urgent care conveyance to hospital from events from March 2020 to September 2021. The registered manager ensured there were enough staff to meet the requirements of the work they had been requested to carry out.

Managers told us they transported patients to different hospitals based on their clinical needs and they were pre-alerted.

Meeting people's individual needs

The service did not always meet peoples individual communication needs.

While there was a communication assistance policy, staff we spoke with were not aware of this policy or how to access interpreting services. There were visual communication aides and pain score charts available for staff on vehicles and in the online portal.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers collected information about patient conveyance. They reviewed the time ambulance crews left the site, which hospital they transferred to and the time this ended. A music venue stipulated the requirement for two ambulances to enable medical cover availability if one ambulance had to convey a patient to hospital. This was usually arranged six to seven months in advance of the event. All events were loaded into the electronic portal which gave staff the opportunity to request to work. No work was subcontracted. By planning in advance, the service was able to meet the needs of people and manage demands on its capacity.

Learning from complaints and concerns

There was not sufficient evidence to assess this during the inspection.

Information on how to complain or raise concerns was not clearly available for patients.

The service had a complaints policy. Information for staff regarding complaints was available on the online portal, in folders in the ambulances and at venues. The registered manager told us complaint management would depend on the individual complaint and feedback timeline for response.

The service had reported no complaints from 2019 to 2021 so we were unable to review responses. Therefore, we were unable to see evidence of learning shared.

Requires Improvement

Emergency and urgent care

Are Emergency and urgent care well-led?

Requires Improvement

Leadership

Managers did not always manage the priorities and issues the service faced. They did not always support staff to develop their skills. However, they were visible in the service for patients and staff.

The service was led by a management team which included the registered manager, business partner and administrative officer who were employed full time. The management team also consisted of a clinical lead, fleet manager and security manager who did not work for the service on a full-time basis. There was no evidence that leaders in the service fully understood the challenges to quality. The lack of oversight of some key areas within the service such as training and recruitment created a risk that safety, quality and sustainability could be compromised.

Vision and strategy

The service had a vision and set of values, there was not a strategy to turn the vision into action.

The vision for the service was to “create a workplace that was incident and injury free with skilled medical professionals providing a quality service”. There was also a mission statement and values which included safety, effective, caring, leadership and responsive. All staff received a copy of these through induction and on a printout for easy viewing.

The service shared their strategy for 2021. There was a large focus on business continuity. It did not contain a strategy for how to develop or improve the experience of the patients that it looked after. There were no plans to develop the strategy with staff through wider engagement.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. There was no evidence the service promoted equality and diversity in daily work or provided opportunities for career development.

Most staff described a culture where they could raise concerns with managers and felt supported. The registered manager told us policy and procedure changes were sent via email to staff. Staff meetings were difficult to coordinate due to the large geographical area all staff lived. We were told a group had recently been set up through a smart phone application for key messages. This had made an improvement in communication between managers and staff.

There was no specific evidence that the service promoted equality and diversity in its daily work. However almost all staff had completed equality and diversity training and were in date.

We were told staff had radios and mobile phone contact details for managers and were able to contact them anytime.

Staff did not receive regular supervision or appraisals to identify any areas for learning and development within their role. This meant most staff had not had many conversations with managers about their learning and future development needs.

Requires Improvement

Emergency and urgent care

Governance
There were not always effective governance processes. Staff were not clear about their roles and accountabilities and did not meet regularly to discuss issues and service performance.

The service did not have effective structures to support the delivery of good quality services. Whilst they held long term contracts with event companies, there was no formal system for monitoring satisfaction with the service provided.

Systems and processes did not support effective oversight or governance. This risked a lack of foresight relating to a number of issues. At the time of the inspection, the provider was aware some staff had lapsed DBS checks and informed us this was mitigated as staff worked in pairs. However, there had not been any action taken to ensure DBS checks were completed in a timely way. There was potential for two members of staff without a recent DBS check to be working together. We raised this with the provider following our inspection, and urgent action was taken by them to rectify the problem. The recruitment policy was amended to include a DBS check section. This stated certificates must either be completed in the last three years, or staff must be registered on the subscription service. DBS applications had been submitted for all staff and there was oversight of all staff DBS certificates. Staff with outstanding checks were not in patient facing roles. Full working histories were obtained for all staff and the application form was amended for future applicants to provide this information.

There was a lack of oversight of mandatory training compliance and drivers of emergency vehicles with audible and visual warnings trained staff at the time of our inspection. Following the inspection, the provider sent evidence to demonstrate improved oversight of staff mandatory training. However there was not an action plan to demonstrate how the uptake of mandatory training would be improved.

We were provided evidence of how learning had been shared following adverse incidents because there had been no incidents recorded in the two years prior to the inspection. Furthermore, there was no formal system to assure staff were not working excessively or without scheduled breaks.

The provider did not have oversight of staff COVID-19 vaccinations or lateral flow testing (LFT). The service relied on staff using the NHS application on their smart devices and the venues checking these before commencing a shift. This meant that the service could not be assured all staff were taking precautions in relation to protecting patients against COVID-19.

There were a range of policies and procedures that were available for staff to view through the electronic portal that provided guidance for their roles. However, there was no evidence or oversight these policies had been read and were being adhered to. The safeguarding policy was not in line with intercollegiate guidance.

Management of risk, issues and performance
Managers did not always use systems to manage performance effectively. There was not a robust arrangement for identifying, recording and managing risks. However, the registered manager had identified some relevant risks and some actions to reduce their impact. The service had plans to cope with unexpected events.

There was no system for monitoring of service performance. There was a programme of audit, but we did not see that the results were used to inform practice, identify risk or improve service.

We reviewed the risk register. There were potential risks recorded such as needlestick injuries, knife crime, global oil prices and vehicle breakdowns. We saw these risks were given a risk score and a brief outline of mitigating actions were identified. However, there was no responsible person named for carrying out the required measures and no completion timeline. This meant there was a possibility that risks were not effectively managed.

While the provider had identified risks, they had not always acted to effectively mitigate them. A risk that sat low in the register for probability and impact was 'complete risk assessments on staff, who issues highlighted by DBS/Reference check'. There were no other entries on the risk register relating to DBS. A risk that sat at the top of the risk register was COVID-19 and staff should be reminded of infection prevention and control (IPC) however, only six members of staff had completed and were in date for this training.

We discussed current risks with managers and not all risks mentioned aligned with those recorded. We were told the fleet of vehicles had one to two years left and may need replacing soon. However, this did not appear on the risk register.

We saw minutes of weekly manager meetings which included discussion about suppliers. However, there was no standard agenda which included performance, governance or risks.

The service had specific major incident policies for each venue where the regulated activity took place. This meant they had considered the risks and devised a plan should a major incident occur.

Information management

The provider collected data but did not analyse it. Staff did not have access to data to help them understand performance of the service.

There was a programme of audit, but we did not see that the results were used to inform practice, identify risk or improve service. In addition, due to the lack of complaints and incidents it was not possible to understand how the service improved.

An electronic portal was used for staff to access policies, guidelines, training, staff forms and templates from their smart devices. This meant staff had access to these during their shift and completed forms were able to be seen immediately by managers. We were told prior to COVID-19 smart devices were provided by the service at the venues where the regulated activity took place. There was a plan to re-introduce these.

Engagement

Managers did not actively engage local organisations to plan and manage services. They did not collaborate with staff to help improve services for patients. There was limited engagement with patients about their experience of using the service.

The service did not seek formal feedback about its performance from organisations, staff or patients that used services. There was no formal collection of staff views, these were gathered informally when managers worked a shift with them. We were told the staff survey would be sent by the end of 2021. Patients and event organisations sent feedback to the service. However, this was not formally requested.

We saw the service had a 'wall of awesomes' which contained written thank you emails and letters from patients and venues where the service had provided medical support.

Requires Improvement

Emergency and urgent care

Learning, continuous improvement and innovation

There was not sufficient evidence to assess this during the inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The service did not ensure safeguarding incidents were reported in a timely way Regulations 13(2).

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service did not have oversight and organisation of staff that could drive emergency vehicles with audible and visual warnings (blue lights) Regulations 17(1)(2)(d).

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The service did not complete staff appraisals and supervisions Regulations 18(2)(a).

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Not all staff were fully compliant with mandatory training Regulations 12(2)(c). • The service did not have systems and processes to support an effective cleaning regime Regulations 12(2)(h).

This section is primarily information for the provider

Requirement notices

- Staff did not always manage clinical waste in line with clinical guidance Regulations 12(2)(h).
- PPE requirements for staff were not reviewed regularly in line with national guidance Regulations 12(2)(h).
- The service did not have processes to demonstrate staff were trained and competent to use medicines Regulations 12(1)(2)(c)(g).
- The service did not have a full audit trail of use of medicines and their storage Regulations 12(1)(2)(g).
- The service did not have assurance controlled drugs were appropriately purchased and stored correctly Regulations 12(1)(2)(g).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We issued a Warning Notice because the service did not comply with Regulation 12, (2) (c) (e) (h), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.