Medisec Ambulance Service Limited

# Medisec Ambulance Service Limited

## Quality Report

Unit 1
Mount Pleasant Road
Southampton
SO14 OSP
Tel:0330-9994062
Website: www.medisec-ambulance.co.uk

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

## Ratings

### Overall rating for this ambulance location

| | |
|---|---|
| Patient transport services (PTS) | |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Medisec Ambulance Service Ltd. predominantly provides transport for adults and children with mental health disorders, as well as the transport and supervision of people in, section 136 suites whilst awaiting mental health assessment. The services are provided under contract with an NHS trust and a service level agreement with another NHS trust and they provide services on request from an ambulance NHS trust.

We undertook a planned comprehensive inspection of Medisec Ambulance Service Ltd on the 14 and 20 of September and again on the 6 and 7 of October 2016 and 10 October 2016, to follow up significant concerns.

The provider operates services from a single location, an ambulance station. There were no other locations as part of this business.

CQC does not currently have the power to rate independent ambulance services.

Our key findings were as follows:

- There were inadequate recruitment checks on employees prior to commencement of employment as detailed in regulation 19 (Fit and Proper Persons Employed) and Schedule 3 of the Health and Social Care Act (2008).
- There were inadequate and ineffective systems for identifying, assessing and monitoring the safety and quality of the service.
- There was insufficient attention to safeguarding children and adults. Some managers and staff lacked an understanding about safeguarding.
- Staff did not receive training about recognising mental health issues.
- There was recording of risk assessment but where there were risks identified, no actions taken as a result of the assessment.
- The service had no formal system for recording of complaints and there was no evidence of learning form complaints .
- There was no evidence of learning or changes in practice in response to incidents. Incidents were not reviewed on a regular basis and there was no system to review trends.
- There was no central recording of risk and no systems in place to reduce these risks.

However,

- Patient's individual needs were noted when the booking was taken and arrangements made to meet them.
- Staff were trained to talk to patients who were violent or aggressive to calm them down.
- Feedback documentation we reviewed from patients and relatives was positive and commented on the caring attitude of staff.

There were areas of poor practice where the service needed to make improvements.

Following the inspection we used out urgent powers to suspend registration of the service until 30 November 2016. This action was taken in response to our significant concerns of the immediate risk to vulnerable patients arising from the inadequate pre employment recruitment checks and lack of assurance that staff were suitable and safe to undertake this work. We told the provider what was required for the service to continue in relation to pre-employment recruitment checks, quality and safety monitoring.

# Summary of findings

The registered provider had to make necessary improvements and provide evidence of assurance on the following:

- Evidence that all staff carrying on the regulated activity for Medisec Ambulance Service Limited had full and complete recruitment files, to ensure they were fit to be employed in carrying out the regulated activity, in line with regulation 19 (Fit and Proper Persons Employed) and Schedule 3 of the Health and Social Care Act (2008).
- Confirmation that the level of service was viable in order that service users were not at put at risk because of insufficient resources.
- Governance processes were improved in line with Regulation 17 (Good governance) of the Health and Social Care Act (2008). This included systems and processes to assess, monitor and improve the quality and safety of the services are established and operated effectively.

**Action the service MUST take to improve**

The service must:

- Implement systems and processes to assess, monitor and improve the quality and safety of the services.
- Ensure incidents that affect the health, safety and welfare of people using services are investigated and actions taken to prevent recurrences.
- Implement and monitor systems to ensure children and adults are safe from abuse.
- Ensure all staff have a full understanding of duty of candour.
- Ensure the service has a business continuity plan in place.
- Ensure a system is developed and implemented to manage complaints that includes learning from complaints.
- Ensure staff receive training about recognising mental health issues.
- Design and implement a system to record and monitor risks.
- Ensure policies and procedure in place to detail what monitoring staff should do to manage deteriorating patients.

**Action the service SHOULD take to improve**

The service should:

- Consider implementing a Medisec Ambulance Service Limited  driver training programme.
- Ensure all staff receive regular updates on mandatory training.
- Review the medicine management policy and the controlled drugs policy to ensure they are relevant to the service provided.
- Ensure regular audits of compliance of vehicle daily inspection forms.
- Ensure potential risks when planning services are identified and mitigated.
- Consider implementing assurance systems taking into account relevant and current evidence-based guidance, standards, best practice and legislation to provide effective care.
- Ensure key performance indicators are identified and monitored so as to provide assurance the service was meeting the target it had been set.
- Ensure staff competency assessment and formal supervision meetings are recorded and monitored.
- Ensure staff have access to information on policies when working remotely.
- Consider designing and implementing systems to support people to manage their own health.
- Ensure all crews are provided with equipment to discharge their role effectively.

# Summary of findings

- Ensure systems are in place to monitor safety of staff whilst working remotely.
- Consider designing and implementing systems to engage with the public.

**We informed the service of our serious concerns immediately after the inspection and took immediate action.**

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) | | We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve. |

# Medisec Ambulance Service Limited

## Detailed findings

**Services we looked at**
Patient transport services (PTS

# Detailed findings

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## Background to Medisec Ambulance Service Limited

Medisec Ambulance Service Limited predominantly provides transport for adults and children with mental health disorders, as well as the transport and supervision of people in, section 136 suites while awaiting mental health assessment. The services are provided under contract with an NHS trust and a service level agreement with another NHS trust and they provide services on request from an ambulance NHS trust. We visited the ambulance service in order to speak to staff about the service. We also visited a patient at a section 136 suite manned by the service while awaiting mental health assessment. We inspected the service as part of our routine inspection.

## Our inspection team

The inspection team was made up of one inspection manager, two inspectors, one assistant inspector and a specialist advisor with a background in governance.

## How we carried out this inspection

During this routine inspection we spoke with managers and ambulance crew members. We reviewed records, including staff files, incident forms and patient recording forms.

CQC does not currently have the power to rate independent ambulance services. Therefore the reports will not contain any ratings.

We visited the service provider at their registered location. We also visited a patient at the section 136 suite that was being manned by the registered provider while they awaited mental health assessment. We inspected eight vehicles during our inspection. We undertook a planned comprehensive inspection of Medisec Ambulance Service Limited on the 14 and 20 of September and again on the 6 and 7 of October 2016 and 10 of October 2016, to follow up significant concerns

# Detailed findings

## Facts and data about Medisec Ambulance Service Limited

Medisec Ambulance Service Limited undertook 5600 journeys a year. It employed 50 staff and owned 18 vehicles.

**Notes**

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

# Patient transport services (PTS)

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |
| Overall | |

## Information about the service

Medisec Ambulance Service Limited provides transport for adults and children with mental health disorders, as well as the transport and supervision of people in, section 136 suites whilst awaiting mental health assessment. They have a contract with local NHS trust and a service level agreement with another NHS trust. They also provide patient transport services on request from the local ambulance trust.

## Summary of findings

CQC does not currently have the power to rate independent ambulance services.

We found that:

- There was inadequate recruitment checks on employees prior to commencement of employment as detailed in regulation 19 (Fit and Proper Persons Employed) and Schedule 3 of the Health and Social Care Act (2008).
- There were inadequate and ineffective systems for identifying, assessing and monitoring the safety and quality of the service.
- There was insufficient attention to safeguarding children and adults. Some managers and staff lacked an understanding about safeguarding.
- Staff did not receive training about recognising mental health issues. However, they received training about the Mental Capacity Act (2005) and the Mental Health Act 1983.
- There was recording of risk assessment of patients but where there were risks identified, no actions taken as a result of the assessment.
- Policies and procedures about the management of medicines did not relate to the service provided by Medisec Ambulance Service Limited.
- Out of seven crews on duty at the time of inspection, only three had communication devices. We observed these communication devices being tested from the control room and only one out of the three radios responded to the test call.

# Patient transport services (PTS)

- The service had no formal system for recording of complaints and no evidence of learning from complaints.
- There was no evidence of learning or changes in practice in response to incidents. Incidents were not reviewed on a regular basis and there was no system to review trends.
- Staff were not aware of which incidents needed to be reported for further investigation. Some serious incidents were not reported or investigated.
- There was no understanding or procedures for implementation of the duty of candour.

However,

- Feedback documentation we reviewed from patients and relatives was positive and commented on the caring attitude of staff.
- Patient's individual needs were noted when the booking was taken and arrangements made to meet their needs.
- Staff were trained to talk to patients who were violent or aggressive to calm them down.
- All staff we spoke with said the organisation and their team leaders were good to work for and the felt looked after.

Following the inspection we used out urgent powers to suspend registration of the service until 30 November 2016. This action was taken in response to our significant concerns of the immediate risk to vulnerable patients arising from the inadequate pre employment recruitment checks and lack of assurance that staff were suitable and safe to undertake this work. We told the provider what was required for the service to continue in relation to pre-employment recruitment checks, quality and safety monitoring.

## Are patient transport services safe?

CQC does not currently have the power to rate independent ambulance services. We found that:

- There was inadequate recruitment checks on employees prior to commencement of employment as detailed in regulation 19 (Fit and Proper Persons Employed) and Schedule 3 of the Health and Social Care Act (2008)
- Incidents that affected the health, safety and welfare of people using services were not always thoroughly investigated and actions were not taken to prevent recurrences.
- Staff were not aware of which incidents needed to be reported for further investigation. Some serious incidents were not reported or investigated.
- There was insufficient attention to safeguarding children and adults. Some managers and staff lacked an understanding about safeguarding.
- There was no understanding or procedures for implementation of the duty of candour.
- There were no policies or procedure in place to detail what monitoring staff should do to manage deteriorating patients.
- Policies and procedures about the management of medicines did not relate to the service provided by Medisec Ambulance Service Limited.

### Incidents

- Staff confirmed that incidents were recorded on patient transport report forms.
- Staff were not provided with a list of incidents to report. For example, there were times when the mental health assessment of the patient had been completed but there was no bed available for that patient. Medisec Ambulance Service Limited staff then had to provide on-going supervision of the patient. Staff were not aware that this could be considered an incident and reported to their team leader. Hence, they rarely did.
- Staff showed us details of a number of incidents reported to the provider by a local NHS trust regarding Medisec Ambulance Service Limited staff. The registered manager told us that each of these incidents would be investigated by an internal operational manager. However, there was no documentary evidence to show

investigations had taken place or were ongoing. Staff told us they did not receive information at their daily briefing meetings or in other ways such as emails or staff newsletter about incidents or learning from incidents.

- There was no evidence of learning or changes in practice as a result of incidents and when asked, the operational manager responsible for governance could not describe any. Incidents were not reviewed on a regular basis and there was no system to review trends.
- The service did not carry out trend analysis to ascertain the types of incident and whether there were any patterns relating to the incident, such as the same staff or the same team. This could patients at risk of harm, with the possibility of similar types of incident happening again, as neither they were formally investigated nor any learning from the incident shared with staff.
- Discussions with managers and staff showed they did not have a full understanding of their responsibilities towards the duty of candour legislation, beyond the principles of openness and honesty. 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.

**Mandatory training**

- The organisation recently appointed a training officer (May 2016). They restructured the training records, which made it easier to identify what training staff had completed, what they still needed to complete. There was a list of mandatory training programme that all staff had to complete.
- Staff were provided with ongoing mandatory training. All staff had received induction training, which included infection control, manual handling and first aid. However, a few staff had not received any updates. The organisation had introduced a new system for ensuring all staff had completed their training through a "catch up programme."
- Staff had also received training about de-escalation techniques and every week, the trainer who had provided the training came to the service to support staff who had used this training as part of their work.
- Training about medical gases was included in the basic life support training.
- Mandatory training data was reviewed at inspection, most staff had completed their mandatory training according to standards, for example, infection control training was completed every year. The training officer had created their own list of staff who had not completed their mandatory training and there were systems in place to ensure all staff had completed mandatory training.
- At the time of the inspection, there was no formal driver training programme in place. New drivers went out with the training manager for an hour to have their driving abilities assessed. The trainer had the necessary skills and qualifications in advance driving techniques provided by the local constabulary. However, this lack of formal training for drivers had been identified and training manager planned to introduce mandatory Medisec driver training programme.
- If staff failed the mandatory training courses they would have a formal conversation with the training officer and training rebooked. The purpose of this conversation was to identify any underlying areas of support the staff member required. The issue would be escalated to the managers.
- Several members of staff had only recently started with the organisation (two weeks before the inspection) and had not yet completed their work place training. However, they found the training offered to them invaluable hands-on experience of caring for patients and the vehicle.

**Safeguarding**

- Staff were provided with safeguarding training as part of their induction. All crew trained to level 3 safeguarding for adults and children. This training was an e-learning course. The local ambulance NHS trust had been consulted on the course and had identified that the e-learning course was not sufficient. The training officer was planning to arrange a classroom-based safeguarding training.
- The provider told us there were two members of staff trained to level 4 safeguarding for adults and children. However, the provider did not provide any documentary evidence that these members' staff had completed this training.
- Processes did not keep vulnerable people safe. The service transported children, patients with learning disabilities and patients with mental health disorders.

There were no systems or processes established or operated effectively to prevent abuse of service users, or to recognise and report concerns. There was no oversight or scrutiny of safeguarding.

- When inspectors asked the two operations managers about safeguarding, they told us it meant that the service was safe. Inspectors explained what safeguarding meant and asked what would happen if a safeguarding, concern was raised. The registered manager responded that the operation manager would inform the trust where the incident took place and it would then be upon the trust to investigate and take the necessary actions. We asked about notifications to CQC and the local authority who were the investigating authority. The registered manager did not know these were required.
- The incident reporting process did not give assurances that safeguarding would be appropriately investigated or escalated, if reported. The general process for investigation and learning was lacking, as detailed in the incidents section. There was no specific investigation or learning process for safeguarding.
- There were no procedures for staff to follow in the event of them having a safeguarding concern, and no guidance documents to support staff in identifying a safeguarding concern. We found there were examples of safeguarding concerns that had not been acted on and these have not been identified here as they might identify patients.

**Cleanliness, infection control and hygiene**

- We examined eight vehicles and they were visibly clean. The crews showed us daily cleaning sheets evidencing when vehicles and equipment were last cleaned and when cleaning was next due. We were told that no ambulances left the station without the correct cleaning on the inside and outside of the vehicle being completed. During the inspection we observed ambulances being cleaned. We noticed staff use alcohol gel. There was an infection prevention control lead and staff knew who it was. The implementation of the cleaning sheet was monitored by the station manager. They performed on a weekly basis a cleaning test on a vehicle to ensure it had been cleaned appropriately.
- The team leaders explained how they managed clinical waste. They said they used the hospital bins for disposing of clinical waste. Clinical waste that was as a result of transporting patients was disposed off at a local trust before the vehicle was brought on its in return to the station. It was subsequently cleaned. Bins for segregating clinical and non-clinical waste were apparent at the station.
- There were infection control and decontamination policies and team leaders were able to describe the process for ensuring all equipment was cleaned prior to use.

**Environment and equipment**

- We observed a driver carry out a vehicle check before using the vehicle. Staff told us vehicle daily inspection (VDI) forms were stored in the vehicle and given to team leaders at the end of the shift. Managers informed us that team leaders would check the VDI forms before the vehicles left. However, this did not occur when we observed the VDI check.
- There was a checking process in place whether the vehicle could be used for people with mental health conditions. Every time a mental health patient was transported, the second person in the vehicle would be with the patient.
- There was no audit of these forms to assess compliance with vehicle checks..
- All vehicles had a valid MOT test and vehicles were serviced every 6,000 miles or 6 months whichever came first. Vehicle keys were placed in a secure area. There was also a vehicle available specifically designed for transporting bariatric patients.
- All vehicles had resuscitation equipment.
- All equipment (including lifting equipment) was standardised across the service.
- The only medical devices the service had were oxygen equipment. These were managed by an external organisation. We saw certificates that confirmed recent checks undertaken.
- Any fault equipment on front line vehicles were reported to the team leaders for immediate actions. Until the faults were rectified, the vehicles were not used. During our inspection, we found a vehicle that was out use because the lifting equipment was not working.
- There were records of equipment maintenance and these schedules were completed in a timely manner.
- Patients of all ages were appropriately seatbelted.

**Medicines**

- Staff told us controlled medicines were not carried in the vehicles and that patients would carry their own

medicines. Conversations with staff showed they were not aware of what actions to take when patients were required to take their own medicines. However, following the inspection the provider told us patients did not manage their own medicines whilst being transported.

- Following the inspection the provider submitted their policies about medicine management to CQC. Review of these policies (medicine management policy and controlled drugs policy) showed they were both issued in 2011 and had not been reviewed since that date. There was information in both policies that did not relate to the service provided by Medisec Ambulance Service, such as a list of medicines carried on each vehicle, which included controlled medicines.
- Oxygen containers were stored in a safe manner in the vehicles and staff had received training on the use of the equipment as part of their induction training.

**Records**

- Staff completed records relating to the care and treatment of each person using the service were. However, there was no process followed to review records to ensure they were fully completed.
- Staff ensured records travelling with the patient were passed to the relevant health staff at a receiving end. Records were placed in the glovebox of the patient transport service that was securely locked.

**Assessing and responding to patient risk**

- We observed the control room operator taking details of risk factors when making a booking for secure transport and recording that a patient was at risk of absconding. The control room operator explained they would always follow the nurses instructions for the level of secure transport required. Where they were not given direct instructions Medisec staff would make their own judgement. There was no guidance in place for staff to follow when making decisions. Higher level safety vehicles were only used if nurses had requested them.
- Staff told us that when a patient was booked for a journey, the trust provided patient detail information included any pre-existing medical condition, any known infections, and any mental health risk assessment on the patient's condition. If the patient had any complex health needs, such as heart conditions, they would not be transported.
- Staff were always made aware of mental health needs of the patients. Such information was available on handover sheets.
- There were no policies or procedure in place to detail what monitoring staff should do to manage deteriorating patients. Following the inspection the provider submitted their observation and engagement policy to CQC. This document provided guidance to staff about how to engage with and observe the wellbeing of patients with mental illnesses. However, review of the document showed most information was relevant to hospital trust sites rather than an ambulance PTS service.
- Discussion with staff showed they were not aware that some physical illnesses have similar presentations as some mental illnesses. There was no process to support staff recognise these situations and seek medical support and advice for the patient.

**Staffing**

- The service employed 54 staff, of which 45 were drivers, six team leaders, two operational managers and one finance manager.
- We found evidence of inadequate recruitment checks on employees prior to commencement of employment as detailed in regulation 19 (Fit and Proper Persons Employed) and Schedule 3 of the Health and Social Care Act (2008).
- On 6 October, we reviewed 37 staff files. None of them had evidence that Medisec had carried out full recruitment checks. We discussed this concern with the registered manager. On 7 October, we reviewed the remaining staff recruitment files and found Medisec had not competed full recruitment checks for these members of staff. There were 54 recruitment files for the staff who were currently transporting patients. We inspected all of these files.
- None of the recruitment files contained evidence of all pre-employment checks required to provide a safe service as specified in regulation 19 and Schedule 3 of the Health and Social Care Act 2008.
- None of the recruitment files complied with the pre-employment checks specified in the recruitment policy of Medisec Ambulance Service Limited.

# Patient transport services (PTS)

- The application forms within the recruitment files were not fully completed, or were completed after the start of employment. There was incomplete information about the applicant, their previous experience, and their contact details.
- None of the files contained evidence of interviews or decisions that the person was suitable to be employed for the work of transporting vulnerable patients.
- Of the 54 files, 51 did not have a full account of the person's employment history
- 51 files did not contain suitable references to confirm that the person employed was of good character.
- 21 files did not contain evidence of current and active Disclosure and Barring Service check.
- 2 files did not have photographic identification
- Several employees had previous criminal convictions and there was no evidence of consideration of the employees fitness to work or a risk assessment to support the decision to employ them. One conviction was so serious that it was not spent.
- None of the files contained evidence of occupational health checks to ascertain that the employees were able, by reason of their health, to properly perform the work required.
- We wrote to Medisec Ambulance Service Limited on 7 October 2016, with details of the concerns. We advised them that we have the option of using urgent powers under Section 31 of the Health and Social Care Act 2008 ("the Act") which included the power to suspend or cancel the registration or to impose an additional condition on their registration. CQC may only take this action if it has 'reasonable cause to believe that unless it acts under this section any person will or may be exposed to the risk of harm'.
- We stated that in relation to Medisec Ambulance Services Limited urgent action under Section 31 of the Act could involve, but may not be limited to, suspending the registration for the carrying on of the regulated activity: Transport services, triage and medical advice. We could also cancel the registration or impose a condition to limit the staff working in the service, depending on the most appropriate course of action.
- We asked the registered manager take immediate action and provide the following evidence by 3pm Monday 10 October, 2016:
- Evidence that all staff working for Medisec Ambulance Service Limited have full and complete recruitment files. These files meet the requirements under schedule 3 of the Act . Each files will need to include up to date information on the following:
- Proof of identification including a recent photograph.
- Current enhanced DBS checks
- Two appropriate and satisfactory references of previous employment and the reasons for leaving this employment.
- Fully completed and signed application forms, including criminal conviction declarations, a full employment history, together with a satisfactory written explanation of any gaps in employment, and full details of qualifications.
- Information about physical and mental health
- In addition to this, confirmation of a current driving licence. Confirmation that the appropriate category of driving licence for an ambulance (C1) is obtained where necessary.
- Fully completed and signed application forms, including criminal conviction declarations, a full employment history, together with a satisfactory written explanation of any gaps in employment, and full details of qualifications.
- Information about physical and mental health.
- We returned to the service on 10 October 2016 at 3pm to assess whether this action had been completed. The registered manager told us that recruitment files for all staff working at the service, were now complete and up to date. We proceeded to inspect 12 recruitment files and found none of the files contained full and proper pre-employment checks. DBS checks were missing or were at inappropriate level; there were incomplete application forms and unexplained gaps in employment history; references were missing or insufficient detail for the provider to make a judgment about the person suitability for role. We extended our review to include the inspection of all recruitment files. The registered manager told us that since Friday 7 October 2016, four people had been dismissed, one person had left. We also found four files were unaccounted for, from our last check. We asked about these files. No explanation was given and we assumed they were missing.
- We found that the registered manager had not taken sufficient action to ensure that full and adequate staff recruitment checks had been undertaken, and acted upon, to ensure the safety of service users. There were

just staff two files, one administrator and one front line transport staff, with evidence of adequate recruitment checks to give assurance of the fitness of the staff to work in the service. We considered there continued to be an extremely high level of risk of harm to service users.

- Identification letters and recent photographs were now present in all files reviewed. However, there were still anomalies, for example, different addresses on the application form to the letters given as proof of identification.
- 20 files (40%) lacked current or appropriate level of DBS checks.
- There was no evidence of DBS checks for nine staff.
- Three staff had current DBS checks but not at an appropriate level of disclosure, that is, they did not have enhanced checks against the barring list for children and adults.
- Two staff had a DBS check from previous employment but not at an appropriate level of disclosure, they did not have enhanced checks against the barring list for children and adults.
- Two staff had evidence of a recent application for DBS check but these had not yet been received
- Two staff had a full DBS check from a previous employment. However, there was no evidence of a process for risk assessing portability of the DBS check from a previous employment.
- Apart from the two files mentioned above, the rest of the files lacked appropriate and satisfactory reference checks of previous employment; including reasons for leaving. There was no evidence that the provider had assured themselves that the jobs or referees given were bona fide. In all 50 files (100%) the references were not of an acceptable or satisfactory standard. Four files (8%) did not contain references at all. In 42 files (84%) the new references in the files did not relate to those given in the application form, or previous employment history and their source was not clear.
- Thirty (60%) files did not have a fully completed and signed application form.
- Thirty application forms ( 60%) had gaps in employment history and a lack of satisfactory information to verify these gaps
- There was no evidence to verify gaps in employment history where people have stated that they were from overseas (for example no overseas police checks). This applied to at least eight files.
- All files lacked information on personal details, next of kin or emergency numbers.
- There was no evidence of risk assessment for people with known criminal background and/or poor references (for example references stating they would not re-employ due to behaviours at work).
- All 50 files reviewed (100%) lacked robust occupational health screens or decisions if people where fit to work; in particular absence of immunisation history. There was no risk assessment or plans for any people who declared physical or mental health problems. There was no internal or external occupational health resource to screen and assist in decision making regarding fitness.
- All 50 files reviewed (100%) lacked information of evidence of shortlisting/interview or interview outcome/ decision.
- Staff were supported out of office hours by their team leader. There were systems in place to ensure appropriate escalation took place. Staff told us they were well supported when they raised concerns to their team leader.
- All new members of staff worked with an experienced member of staff for a period of four weeks.
- There were arrangements for handover to ensure people were safe. We checked five handover sheets and they were appropriately filled out.
- Staff told us they received adequate breaks and time off between shifts.

**Anticipated resource and capacity risks**

- The service had not identified any potential risks when planning services. There was no consideration to fluctuation in demand or adverse weather.
- There were no planned changes on safety assessed.
- There were business continuity plans in place.

**Response to major incidents**

- Medisec Ambulance Service Limited were not part of any local area agreements to respond to emergencies or major incidents.

## Are patient transport services effective?

CQC does not currently have the power to rate independent ambulance services. We found that:

- Staff did not receive training about recognising mental health issues.

- There was no recording of competency assessment of information undertaken and no actions taken as a result of this assessment.
- There was no overall performance reports on the booking times to assess what percentage of the times, the service was meeting the target it had been set.
- There were no records of formal supervision undertaken.
- Staff did not have access to information on policies (for example safeguarding policies) remotely when they were away from the Medisec ambulance station.
- There was patchy recording of documentation for seeking consent and best interest decisions.

However, we found that

- Staff were appraised every year.
- Staff received training in the Mental Capacity Act (2005).
- Staff had been trained in de-escalation and the supervision of patients in section 136 suites

**Evidence-based care and treatment**

- The service was unable to assure itself that transport was provided in line with local guidelines. These guidelines were in place.It was also unable to assure itself that staff assessed patient needs against protocols to provide care and transport.
- Staff who were remotely working (when transporting patients from one place to another) did not have access to guidelines and protocols. These guidelines and standard operating procedure were in place. However, there were no assurance systems in place that the service used relevant and current evidence-based guidance, standards, best practice and legislation to provide effective care.

**Assessment and planning of care**

- PTS staff were made aware of their patient's condition at the onset of their journey so they could plan their transport appropriately.

**Nutrition and hydration**

- There were arrangements in place in terms of food and drink for patients who were in the vehicles for over one hour. We spoke to a patient who had been transported from a local police station to a section 136 suite and they told us they were offered drink and snacks.

**Patient outcomes**

- The registered manager told us that booking times were monitored on the booking system.However, there was no overall performance report on the booking times to assess what percentage of the times, the service was meeting the target it had been set.

**Competent staff**

- Training, learning and development needs were reviewed. Staff were regularly assessed for competence. The team leaders appointed were responsible for this competency assessment undertook random checks. However, there was no recording of this information. This meant the service was not assured staff had the relevant competencies to carry out their roles effectively.
- New staff completed an eight day induction programme. The induction included an overview of the Medisec Ambulance Service Limited code of practice.
- Some staff had not fully completed their induction. The training officer had arranged catch up courses for the staff who needed to complete their induction.
- New recruits were paired with a more experienced member of staff who would be a mentor. The training manager planned to provide mentoring training but this was not set up at the time of the inspection.
- A serving police officer provided refresher training and an opportunity to update staff on skills. Staff told us they did not restrain patients. Staff also received de-escalation training.
- The training manager had not seen a job description for their current role or for the team leader role.
- Staff were appraised every year.
- Staff were regularly supervised. However, there were no records of formal supervision.
- All staff were trained in both secure transport and patient transport. Secure transport involved transporting patients experiencing mental health episode. Patient transport services involved transporting elderly or patients with disability.
- We spoke to a trainer from a local NHS trust who provided training to staff at an ambulance trust. They told us the registered manager of Medisec Ambulance Service was very supportive of training staff to ensure they had the necessary skills and knowledge to undertake the roles identified.

- However, we found staff did not receive any training about recognising mental health issues, but did have training about the Mental Health Act and the role of an Approved Mental Health Professional (AMHP). Training records provided by the service showed staff did not receive training about mental health conditions, other than dementia. This meant they may not be able to recognise suicidal behaviour or acute psychotic symptoms, which would require urgent intervention from a mental health professional. Records showed they received training about common medical conditions.
- Staff were provided with all the necessary information about the patient and their mental health condition so they could plan transport accordingly.
- We identified that over the past six months, 15 members of staff had provided supervision of patients at the 136 suites and found all these staff had completed a two day programme on how to supervise patients whilst they are in a 136 suite.

**Coordination with other providers**

- Managers told us they would keep hospitals informed if they were running late. We also observe a control room operator calling care home staff who had booked transport to tell them of a delay
- There was coordination with the NHS trusts they provided a service for and with police and with section 136 suites. This ensured the police were not kept waiting for long period of times whilst staff arrived to take the patient into the 136 suite.

**Multidisciplinary working**

- Staff told us how they worked in a multi-disciplinary manner with staff from local trusts.For example, they sometimes joined their team meetings where patient transport issues were discussed. We also spoke with staff from two local trusts who had recently received service from Medisec Ambulance Service Ltd and they told us how staff worked in partnership with them.

**Access to information**

- Staff had access to all information required for transporting patients. They did not have access to information on policies (for example safeguarding policies) remotely when they were away from the Medisec ambulance station.
- Special requirements were noted on the online booking system. Jobs were printed out for drivers with details of what was required for each patient

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- The operation manager understood the relevant consent and decision-making requirements of legislation and guidance. This included the Mental Capacity Act 2005 ( MCA) and the Children's Acts 1989 and 2004. The provider had policies and procedures that referred to obtaining consent from service users, or considerations which should be made with regard to the Mental Capacity Act 2005.
- Staff did not fully understand the difference between lawful and unlawful restraint. They told us they used handcuffs only as a last resort. This illustrated staff's limited knowledge or understanding of restraint. Hence handcuffs were not stored on vehicles as standard. Duty officers carried hand cuffs and could be called to a vehicle if needed. Soft cuffs were used as these cause less distress to the wearer. Managers reported that if the police wanted a patient to wear handcuffs they accompanied the patient.
- The Mental Capacity Act was part of Medisec mandatory training programme. Staff demonstrated an understanding of the MCA. There was documentation for seeking consent and best interest decisions. However, recording of this was inconsistent.

## Are patient transport services caring?

CQC does not currently have the power to rate independent ambulance services. We found that:

- Feedback from patients and relatives was positive and commented on the caring attitude of staff.
- Comments from one patient confirmed that staff ensured they were safe during the ambulance journey.
- Patients and their relatives were supported when experiencing distressing events.

However,

- We found no evidence as to how the service supported people to manage their own health.

**Compassionate care**

# Patient transport services (PTS)

- We reviewed the file of feedback that the service received from patients and their relatives, which included positive and appreciative comments about the service they had received and the caring attitude of staff.
- We spoke with staff about how they provided care for patients. Staff provided examples of positive feedback they had received from patients and their relatives who had used the ambulance service.
- Staff received training at their induction as to ensuring the patient's dignity was maintained during transport in and to and from a vehicle.
- We met one patient during this inspection and they confirmed that staff ensured they were safe and cared for during the ambulance journey.
- The provider ensured ambulances did not look like ambulances as it could exacerbate patient experience of their crisis.

**Understanding and involvement of patients and those close to them**

- Staff we spoke with explained how they maintained communication with patients to ensure they were safe and comfortable during the ambulance journey, and supported them when they arrived at the patient's home. Comments from patients and their relatives that we reviewed confirmed this.
- Staff were trained to talk to patients who were violent or aggressive to calm them down.

**Emotional support**

- We found evidence that patients, their relatives and others were well supported when experiencing distressing events. The NHS trusts that commissioned the service told us they had received positive feedback about staff and the support they provided to patients. For example, when they interviewed patients regarding their transport to the hospital, patients told them how staff provided emotional support to them during their journey.
- Staff were trained to communicate with patients who were violent or aggressive to calm them down. Staff gave examples of having communicating with patients for over half an hour in order to avoid having to use restraint to get a patient to enter the vehicle.

**Supporting people to manage their own health**

- There was no evidence provided by the service on how they supported people to manage their own health. For example, patient with diabetes could be supported to manage their own care of medicines.

## Are patient transport services responsive to people's needs?
(for example, to feedback?)

CQC does not currently have the power to rate independent ambulance services. We found that:

- There were no systems in place to monitor safety of staff whilst on the road.
- The service had no formal system for recording of complaints.

However,

- Patient's individual needs were noted when the booking was taken and arrangements made.

**Service planning and delivery to meet the needs of local people**

- Medisec Ambulance Service Ltd provided secure patient transport to four section 136 suites managed by two local trusts. Fifty percent of the work was directly related to section 136 suites. Medisec Ambulance Service Ltd had requested that the operating procedures were standardised across both trusts. Following a meeting in August 2016 the multi-agency operational policy was being re-written so there was no variation of the service provision between the trusts.
- Two local trusts had a contract with Medisec Ambulance Service Ltd (Medisec) to convey patients with acute mental health conditions to a health based place of safety in Hampshire. The police contacted Medisec if they were going to place someone on a section136. The two trusts had two different contract details with Medisec for the provision of this service. For one trust, Medisec conveyed the patient to the health based place of safety (section 136 suite) where trust staff admitted the patient and had overall responsibility for the patient. However, Medisec staff remained in attendance with the patient and contacted the trust staff at regular interval to ensure the trust the patient was safe. For the second

trust, Medisec conveyed the patient to the section 136 suite, admitted the patient to the 136 suite and remained with the patient with no support from the trust staff. Medisec told us this trust had plans to adopt the same admitting process as the first trust.

- Operation managers explained how the demand for section 136 secure transport fluctuated during the week and seasonally. We were not shown any plans on how the fluctuations in demands were met.
- Forty percent of the workload related to the transport of mental health patients from one trust to another. Only 10% of the workload related to patient transport. Most of this was on an ad-hoc basis when a local trust was not able to meet local demands.

**Meeting people's individual needs**

- Operation managers told us that secure cars rather than marked ambulances were used for informal patients and young people to reduce the anxiety and stigma.
- An operation manager told us that across the organisation there was access to staff who spoke languages other than English. This gave access to interpretation services for six different languages. One member of staff could communicate using Makaton. The resources within the team were used to support patients whose first language was not English.
- Patient's individual needs were noted when the booking was taken and arrangements made. A control room worker explained how they ensured appropriate equipment was available for bariatric patients at time of booking. The bariatric ambulance had appropriate equipment to ensure patients were transported safely.

**Access and flow**

- The operational manager was involved in planning the daily transport runs. The provider's vehicles were allocated to incoming work on a daily basis. Usually patients were collected from the local hospitals and transported to another hospital or transported to their homes. Work requests were received on a planned basis and the service responded at short notice.
- The operational manager confirmed that no emergency transfers took place and patients transported were usually clinically stable.
- A control room operator told us that the vehicle registration code and radio call out code should be recorded on the online booking system. On the day of the inspection, staff were not following this process. This meant the control room was not aware of which members of staff were operating which vehicle.
- Staff carried radios with tracking devices to identify their location. However not all staff carried these and for those that did, not all devices worked. Out of seven crews on duty during one of the days of inspection, only three had communication devices. When the devices were tested from the control room, only one out of the three radios responded to the test call.
- A control room operator told us that there were plans for a new communication system that would increase productivity and improve safety of staff. This system would link vehicle communication devices to an online system so the control system could see where vehicles were at all times on a map. No time scale for the implementation of this were provided.
- Operation managers described how demand for section 136 secure transport peaks on Friday afternoon. Medisec reported that patients were usually in the section 136 for the full 72 hours due to the workload of the Advanced Mental Health Practitioner (AMPs) who carry out the assessment of patients.
- The control room took calls from the Police and health professionals needing to organise secure transport for a patient. A local ambulance trust contacted Medisec to provide patient transport when they did not have enough resource.
- If a crew was not available for a patient transport request the control room operator kept the client updated regularly as to whether a crew would become available. For example, recently (August 2016) three patients were detained in police custody as the four places of safety were in use. We asked the service to provide us with average waiting times for a patient to be assessed and patients detained for more than 72 hours. We did not receive the information requested.

**Learning from complaints and concerns**

- There was a complaints leaflet in place but no complaint procedure. The service had no formal system for recording of complaints. We requested complaint

records (which were not available) and we spoke with nine members of staff. Staff told us a notice was displayed on each vehicle which explained what to do if the patient had a complaint.

- The operational manager informed us that no complaint investigations were in progress. They also confirmed verbally that they did not receive any complaints.
- The operational manager told us that staff received feedback from patients. Staff confirmed this and we observed during one handover session how patient feedback was shared with staff. This was not formally recorded.
- There were sharing of concerns and complaints from the commissioners, NHS trusts shared many complaints received about the service with Medisec. During the inspection the operational managers repeatedly told us they did not receive any complaints from the NHS trusts.
- There were serious untoward incidents (SUI) relating to Medisec staff that were recorded by local trusts. Medisec had no systems in place to record these SUI nor investigate them. During the inspection, operational managers did not share these with the inspectors.
- Patient feedback was positive.

## Are patient transport services well-led?

CQC does not currently have the power to rate independent ambulance services. We found that:

- There were inadequate and ineffective systems for identifying, assessing and monitoring the safety and quality of the service.
- There was no central recording of risk and no systems in place to reduce these risks.
- The management team comprised of the registered manager, two operational managers and five team leaders.
- There were no assurance systems in place that the service used relevant and current evidence-based guidance, standards, best practice and legislation to provide effective care.
- There were no systems in place to engage with the public.

However,

- All staff we spoke with said the organisation and their team leaders were good to work for and the felt looked after.

**Vision and strategy for this service**

- There was no document that identified a vision for the service.When we asked the registered manager and the operational managers what was their vision for the service, they told us it was the provision of section 136 suites for patients as they was a demand for them.However, there was no vision articulated for the service they provided at present.
- There was no written strategy for the development of a high quality service.

**Governance, risk management and quality measurement**

- There were no processes in place to assess, manage and reduce risks to patients. The inspection found staff were not reporting incidents appropriately. Any incidents reported were not being monitored adequately and there was no evidence of learning in response to incidents or action taken to prevent recurrence.
- There were inadequate and ineffective systems for identifying, assessing and monitoring the safety and quality of the service. This meant that failings in recruitment checks were not identified. For example, there were no systems or processes in place for the registered manager to monitor their service against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The provider did not undertake regular audits of the service, nor they did they use any other method to assess, monitor or improve the quality and safety of the service.
- There was not a robust process for the reporting analysing and learning from incidents to make improvements to safety.
- When asked about what were the risks to the organisation, the registered manager identified the key pressures within the business as the volume of Section 136 and the staff needed to carry out this work. Eight people were needed to be available for Section 136 at all times. An operation manager reported that the

communication between managers, team leaders and crews was on their 'worry list' as they had difficulties implementing new policies due to poor communication. The training officer identified that not having enough staff was their biggest risk as they were sometimes short on nights and weekends. However, none of these risks were recorded centrally nor were there any systems in place to reduce these risks. For example, there was no risk register or a similar model to record risk.

- When asked how confident he was about the safety of the service, the registered manager responded "we have not had an incident." This highlighted that they had no insight into what wads meant by 'risk' and how to mitigate these risks.
- Inspectors asked the registered manager how he actively managed the regulated activities. He said he "relied on the operational managers for everything and had regular conversations with them to ask if anything was wrong. The registered manager did not review whether the business was compliant with the regulations.
- There were no formal assurance processes in place. When asked about assurance processes the registered manager said he spoke with the team leaders regularly to ask if there were any issues. He said he trusted the team leaders and operational managers and he knew the service was running well because that was what he was being told. Inspectors asked the operational managers if they were aware of regulation to review the service's compliance and he advised he had not, but that the registered manager probably had. There was no evidence of this taking place, and no evidence this had been discussed by the management team.
- Neither the registered manager nor operational manager had good oversight of the quality of the service. The operational manager and the registered manager were only able to provide examples about transporting patients in a timely manner. There was no understanding or appreciation of wider quality or assurance issues.
- The training officer was tracking the number of speeding tickets drivers received to ensure staff were always eligible to drive vehicles. Driving license speeding tickets were checked. This assurance system was in place and checks were made on a monthly basis.
- We received a number of complaints from the trusts when we shared our concerns with them in a joint meeting organised between the CQC, the two trusts and Medisec Ambulance Service Limited.

**Leadership of service**

- The management team of the service comprised of the registered manager, two operational managers and five team leaders. One operational manager was responsible for governance and the other for the operations of the service. Five team leaders reported to an operational manager with the responsibility of the service. Staff we spoke with said they were clear about the roles of the team leaders and found them approachable and accessible. All staff we spoke with said the organisation and their team leaders were good to work for and the felt looked after. They were all very complimentary of the registered manager. The operational manager responsible for governance had a very rudimentary understanding of the Health and Social Care Act. For example, they failed to understand the importance of recording incidents. When we asked whether the service had a risk register, they did not understand why that would be important.
- When asked about his understanding of the Health and Social Care Act, the registered manager was aware of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, he had delegated the responsibility of how the regulations applied to the service to the operational managers.
- The training had introduced a professional leadership course for managers, team leaders and experienced crew members. Eight members of staff had completed this training. The course was introduced as team leaders did not have the appropriate leadership skills and were not clear what Medisec Ambulance Service required.

**Culture within the service**

- When the registered manager was asked how would he describe the culture of the organisation, he asked what is "culture.?" After this was explained, he told us he was very supportive of staff and felt they would feel able to raise any concerns. However, when asked how he was assured of it, he told us that he relied on the operational managers to let him know if there were any concerns.

# Patient transport services (PTS)

- Staff who told us they got on well together, they enjoyed coming to work and felt part of the team. A few staff had come from the local ambulance trust and they felt that the pressure was not the same as working for the NHS ambulance service.
- There was a whistleblowing policy to provide assurance to staff who wished to provide feedback internally or to external regulators about aspects of the service. Staff were aware of the whistleblowing policy.
- A few members of staff had very recently joined the service and they felt comfortable working for the organisation and really enjoyed their job and the training they had received.

**Public and staff engagement**

- The registered manager tried to engage his staff through surveys and found that only three members of staff out of sixty responded to the questionnaire. He then decided to approach it by engaging them on a one to one basis and found this to be more fruitful. However, there was no record of what action was taken as a result of the feedback given.
- Staff gave numerous examples of moral and financial support given to them by the registered manager during times like weddings, funerals of near relatives, and others. Staff had a sense of loyalty to the service and during the suspension period, a number of them continued to come to work without pay. They undertook completion of any outstanding training programmes, vehicle servicing and others.
- There were no formal system in place to engage with the public but they did collect ad hoc feedback.

**Innovation, improvement and sustainability**

- In 2014, the work Medisec Ambulance Service Ltd had undertaken in the transport of patients to section 136 suites, had helped a local constabulary's performance in the national league table to the top position. As a result, Medisec was recognised by the Home Office as an example of good practice.

# Outstanding practice and areas for improvement

## Outstanding practice

The joint working between the police and the service to coordinate the transport of patients to section 136 suites

## Areas for improvement

### Action the hospital MUST take to improve

- Implement systems and processes to assess, monitor and improve the quality and safety of the services.
- Ensure incidents that affect the health, safety and welfare of people using services are investigated and actions taken to prevent recurrences.
- Implement and monitor systems to ensure children and adults are safe from abuse.
- Ensure all staff have a full understanding of duty of candour.
- Ensure the service has a business continuity plan in place.
- Ensure a system is developed and implemented to manage complaints that include learning from complaints.
- Ensure staff receive training about recognising mental health issues.
- Design and implement a system to record and monitor risks.
- Ensure policies and procedure in place to detail what monitoring staff should do to manage deteriorating patients.

### Action the hospital SHOULD take to improve

- Consider implementing a Medisec driver training programme.
- Ensure all staff receive regular updates on mandatory training.
- Review the medicine management policy and the controlled drugs policy to ensure they are relevant to the service provided.
- Ensure regular audits of compliance of vehicle daily inspection forms.
- Ensure potential risks when planning services are identified and mitigated.
- Consider implementing assurance systems taking into account relevant and current evidence-based guidance, standards, best practice and legislation to provide effective care.
- Ensure key performance indicators are identified and monitored so as to provide assurance the service was meeting the target it had been set.
- Ensure staff competency assessment and formal supervision meetings are recorded and monitored.
- Ensure staff have access to information on policies when working remotely.
- Consider designing and implementing systems to support people to manage their own health.
- Ensure all crews are provided with equipment to discharge their role effectively.
- Ensure systems are in place to monitor safety of staff whilst working remotely.
- Consider designing and implementing systems to engage with the public.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>There were no policies or procedure in place to detail what monitoring staff should do to manage deteriorating patients.<br><br>Staff did not receive training about recognising mental health issues..<br><br>Incidents that affected the health, safety and welfare of people using services were not always thoroughly investigated and actions were not taken to prevent recurrences. |

| 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<br><br>There was insufficient attention to safeguarding children and adults. Some managers and staff lacked an understanding about safeguarding. |

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br><br>The service had no formal system for recording of complaints and no evidence of learning from complaints. |

| 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 17 HSCA (RA) Regulations 2014 Good governance<br><br>There were inadequate and ineffective systems for identifying, assessing and monitoring the safety and quality of the service.<br><br>There was no central recording of risk and no systems in place to reduce these risks. |

| Regulated activity | Regulation |
| --- | --- |
| Transport services, triage and medical advice provided remotely | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br><br>There was inadequate recruitment checks on employees prior to commencement of employment as detailed in regulation 19 (Fit and Proper Persons Employed) and Schedule 3 of the Health and Social Care Act (2008). |

| Regulated activity | Regulation |
| --- | --- |
| Transport services, triage and medical advice provided remotely | Regulation 20 HSCA (RA) Regulations 2014 Duty of candour<br><br>There was no understanding or procedures for implementation of the duty of candour. |

This section is primarily information for the provider

# Enforcement actions

## 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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br><br>We issued a section 31 notice of urgent suspension on the registered provider because we had reasonable cause to believe that a person would or may be exposed to the risk of harm unless we did so.<br><br>We found evidence of inadequate recruitment checks on employees prior to commencement of employment as detailed in regulation 19 (Fit and Proper Persons Employed) and Schedule 3 of the Health and Social Care Act (2008).<br><br>The notice of urgent suspension was in respect of patient transport services at Unit 1, Mount Pleasant Road, Southampton SO14 OSP.<br><br>The notice of urgent suspension was from 13 October 2016 until 30 November 2016 because we believed that a person will or may be exposed to the risk of harm if we do not take this action.<br><br>The registered provider had to make necessary improvements and provide evidence of assurance on the following:<br><br>• Evidence that all staff carrying on the regulated activity for Medisec Ambulance Service Limited had full and complete recruitment files, to ensure they were fit to be employed in carrying out the regulated activity, in line with regulation 19 (Fit and Proper Persons Employed) and Schedule 3 of the Health and Social Care Act (2008). |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Enforcement actions

Transport services, triage and medical advice provided remotely

Regulation 17 HSCA (RA) Regulations 2014 Good governance

We issued a section 31 notice of urgent suspension on the registered provider because we had reasonable cause to believe that a person would or may be exposed to the risk of harm unless we did so.

There were inadequate and ineffective systems for identifying, assessing and monitoring the safety and quality of the service.

The notice of urgent suspension was in respect of patient transport services at Unit 1, Mount Pleasant Road, Southampton SO14 OSP.

The notice of urgent suspension was from 13 October 2016 until 30 November 2016 because we believed that a person will or may be exposed to the risk of harm if we do not take this action.

The registered provider had to make necessary improvements and provide evidence of assurance on the following:

- Governance processes were improved in line with Regulation 17 (Good governance) of the Health and Social Care Act (2008). This included systems and processes to assess, monitor and improve the quality and safety of the services are established and operated effectively.
- Confirmation that the level of service was viable in order that service users were not at put at risk because of insufficient resources.