Premier Rescue Ambulance Services Limited

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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location went down. We rated it as inadequate because:

There were no reliable systems to ensure staff were trained adequately for their roles to keep patients safe. There was very limited assurance staff had training in key skills, understood how to protect patients from abuse or managed safety well. The provider did not control infection risks well. Staff did not always assess risks to patients and the provider was not able to assure us staff were adequately trained to be able to safely monitor patient conditions. Staff did not keep good care records for patient monitoring of their physical or mental health conditions during transfer. There was a basic system for staff to identify, report, receive feedback or share learning about incidents and concerns but it was not accurate or embedded in the service. The recruitment process did not ensure safety checks about new staff were used to protect patients.

The provider did not monitor the effectiveness of the service or make sure staff were competent. The provider did not always meet and monitor agreed response times. The provider planned care to meet the needs of local people but did not take account of patients' individual needs. It was not easy for people to give feedback.

Managers of the provider did not have the capability to run services well. Staff were not supported to develop their skills. Managers showed little understanding of the safety and business priorities and how to manage them. There were no reliable and consistent systems to provide oversight of safety and quality of care delivered. Managers were not clear about their legal responsibilities of providing care under the regulated activities. Managers tried to support staff but opportunities for staff development were limited. Managers wanted to provide a safe service and wanted to put the patient at the centre of their service planning but were not clear on how to achieve this. There was no consistent, embedded system for gathering and reviewing feedback, incident reports or reviewing risks. There were electronic processes for gathering patient views which limited opportunity to feedback and there was no evidence of how these were discussed or actioned. The provider had no vision and values to apply them in their work.

However:

Staff assessed patients' food and drink requirements. People could usually access the service when they needed it.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate 	See the overall summary section above.

Summary of findings

Contents

Summary of this inspection

Background to Premier Rescue Ambulance Services Limited

Premier Rescue Ambulance Service Limited is operated by Premier Rescue Ambulance Service Limited. They provide a patient transport service to people living in Devon and Somerset and the surrounding areas. If required, the provider reaches further out into the south west and further afield to provide patient transport services. The service provides non-emergency ambulance transport for adults with mental health conditions, most of who are detained under the Mental Health Act 1983. The service also provides transport for non-detained adult patients, for example patients who are voluntarily going into hospital for referral or treatment. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 29 April 2021.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? We were unable to inspect the caring domain at this inspection.

The provider is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely.

The location has a registered manager in post since 2020. Registered managers have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

The provider employed 25 members of staff, 22 were on zero hours contracts. Staff were care assistants, drivers, management team and administration staff. The fleet consisted of two vehicles and between 1 March 2020 and 30 March 2021, the service provided 989 patient journeys.

The previous inspection of this service was February 2020 when the provider was rated overall as requires improvement.

The provider had 48 hours' notice of our visit to ensure staff would be available to give us access to the site, vehicles and observe routine activity. Before the inspection we reviewed information we had about the provider.

How we carried out this inspection

The team that inspected this location comprised of a CQC inspection manager, two CQC inspectors and a specialist advisor with expertise in ambulance services. During the inspection, we spoke with three staff of the management team. We reviewed documents and records kept by the provider and inspected the vehicles.

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 provider 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.

Summary of this inspection

We told the provider it must take action to bring services into line with five legal requirements. These actions related to the provider.

Action the provider MUST take to improve:

- Use systems and processes to ensure all staff have attended and are up-to-date with mandatory training and key skills for their roles. Regulation 18 (2) (a) Staffing.
- Improve the process to determine the risk to and from the patients it transports. All relevant information, including legal paperwork, must be available on the transport paperwork for staff to be aware of. Regulation 12 (2) (a) Safe care and treatment.
- Assess the risk of, and preventing, detecting and controlling the spread of infections, including healthcare associated infections. Regulation 12 (2) (h) Safe care and treatment.
- Ensure all equipment is clean and properly maintained. Regulation 15 (1) (a) (e) Premises and Equipment.
- Ensure all vehicles are roadworthy, clean and have a proper cleaning schedule. Regulation 15 (1) (a) (c) (e) Premises and Equipment.
- There must be an adequate system to report defects to vehicles. Regulation 15 (1) (e) Premises and Equipment.
- Monitor and assess the quality of the service provided. Records of patient's risk assessments, and actions taken to minimise risks, must be improved. Regulation 17 (2) (a) (b) (c) Good Governance.
- The incident management system must be improved to reflect accurate monitoring and management and evidence of shared learning with staff. Regulation 17 (2) (b) Good Governance.
- Ensure all policies relied upon are complete, contain details of assessing and monitoring, provide direction for staff and include best practice guidelines and national guidance. Regulation 17 (1) Good Governance.
- Insurance cover must be correct for the provider's business. Regulation 12 (2) (e) Safe care and treatment.
- The provider must have enough suitably trained, skilled and competent staff to carry out their duties. Regulation 18 (2) (a) Staffing.
- All staff employed by Premier Rescue Ambulance Service Limited should have an annual appraisal or direct supervision. Regulation 18 (2) (a) Staffing.
- The provider must conduct recruitment and keep records in accordance with Schedule 3, Regulation 19 (3) (a) Fit and Proper Persons Employed.
- The structures, processes and systems of accountability must be reviewed to support the delivery of the strategy and good quality, sustainable services. Regulation 17 (2) (a) Good Governance.
- The provider must appoint, or have access to, a freedom to speak up guardian and have a Whistleblowing policy. Regulation 17 (2) (e) Good Governance.

Action the provider SHOULD take to improve:

We told the provider that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- Consider a policy or an addendum to the infection prevention and control policy to effectively maintain cleanliness of uniforms.
- Provide access to pictorial cards to aid communication for patients who are not able to verbally communicate.
- Provide proper storage for cleaning fluids
- The provider should keep accurate records of the number of staff they employ.

Review the complaints policy to add in a process for what happens if the complainant is unhappy with the first outcome and to add in an independent review of their complaints.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Effective	Inadequate
Caring	Insufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate

Are Patient transport services safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided limited mandatory training in key skills to staff and did not make sure everyone completed it. Managers could not be assured staff were up-to-date with training.

The provider had a newly created staff training and development policy. This policy was not dated, did not identify the training needs of each staff group, specify what mandatory and statutory training was and how often it should be repeated. It also had no ratification process, was not signed off by any senior managers and had no review date. The provider was unable to confirm whether it had been shared with staff. This meant the policy was not fit for purpose.

We were unable to determine the correct number of staff employed as there were 29 staff on the training matrix and 22 on the supervision matrix. The provider had previously told us 22 staff were employed.

Training records did not provide assurance whether staff were trained as required. There was no system to assure the registered person mandatory training had been undertaken by staff. The provider did not align itself to the Skills for Health Core Skills Framework. This framework includes statutory and mandatory training relevant for all healthcare staff. Therefore, the provider could not assure itself staff had all the relevant mandatory and statutory training. We were provided with a list of 27 training subjects the provider required to be renewed yearly. We reviewed 11 staff personnel records, of which none had completed all the training on the list. We found:

- Training certificates for three members of staff did not match the renewal date on the providers training matrix.
- Two members of staff had completed one training session and three others had completed two training sessions, with other training expired.
- Two people completed training for the Mental Capacity Act 2005.
- No evidence of any training for the Mental Health Act 1983.
- Three people completed training for information governance and one person completed training for data protection.
- Ten people had completed prevention and management of violence and aggression training (PVMA) which also covered restraint.

- Six people completed training for safeguarding adults.
- Eight people completed training for basic life support.
- There were no records of driving competency checks in any of the personnel files. Copies of driving licences had been taken. However, the provider showed us a list of 18 driving assessments undertaken from August 2019 and October 2020.

Infection control and prevention training was completed online. However, a manager told us he also delivered it at induction but was an unqualified trainer. Therefore, the quality of the infection control training could not be assured and was not in line with the providers infection prevention and control policy.

The provider had a training matrix, which had four training requirements comprising infection control, basic life support, safeguarding and prevention and management of violence and aggression (PMVA). However, when we reviewed it, we found it was inaccurate when cross referenced with training certificates in personnel files. We found a personnel file of a member of staff who was not on the training matrix but was on the supervision matrix. Due to the system currently used by the provider, we were unable to establish if staff were actively employed and had completed statutory and mandatory training. This disorganised approach meant the provider was unable to assure themselves all staff received all relevant mandatory and statutory training. Following our inspection in February 2020, we had told the provider to provide an up-to-date training matrix. Although the provider had implemented this, at this inspection we found it was inaccurate.

The provider told us they currently had to check individual personnel files for other training completed, but this would be moving online shortly. They had recently engaged the services of an online training company where they could have access to employees training records. The provider did not have an action plan to increase uptake of training.

Safeguarding

Many staff did not have training on how to recognise and report abuse and the policy did not explain how to apply it.

The provider had a safeguarding policy which was not fit for purpose because; it was not dated, did not identify the training needs of each staff group or specify what level of training was required or how often it should be repeated. It also had no ratification process, was not signed off by senior managers, had no review date, no reference to best practice guidelines and was for adults only. The policy did include the process for reporting safeguarding concerns to the management team and local authority.

At the previous inspection in February 2020, there was a recommendation the provider trained a member of staff to level 4 safeguarding to support staff. One of the management team had completed this as required. However, the providers policy did not reflect the correct lead for safeguarding at the provider.

The provider was unable to assure itself how and when the policy had been shared with staff and whether staff had been trained in both children and adult safeguarding at the correct level. The provider told us all staff should be trained to level 3. In the 11 personnel files we reviewed, six members of staff had up-to-date safeguarding training, of which three included safeguarding children. This was not in line with Intercollegiate guidance for Safeguarding Children and Young People: Roles and competencies for Healthcare Staff (2019). Also, in management meeting minutes for 13 April 2021, a manager was tasked to devise an audit system for safeguarding, to make the process accessible to all staff. This had not been completed which meant the provider was unable to demonstrate how their staff were trained correctly and competent to deal with safeguarding issues.

Safety was not promoted in recruitment practice and ongoing checks. There was not a clear process to demonstrate Disclosure and Barring Service (DBS) checks were made. The provider told us DBS checks were carried out on all staff yearly. Of the 11 personnel files reviewed, one member of staff did not have an up-to-date DBS check and it was not enhanced to cover working with vulnerable adults and children. Another member of staff's DBS check was last completed in 2017. CQC expects providers to undertake recruitment safety checks at the correct level for staff who are eligible for them. This meant there were gaps in the processes to keep people safe.

Cleanliness, infection control and hygiene

The provider did not control infection risk well. Staff did not follow best practice to use equipment and control measures to protect patients, themselves and others from infection. Staff did not keep the vehicles visibly clean. Guidance for staff around infection prevention and control was not clear. Standards of cleanliness and hygiene were not maintained. There were no reliable systems to prevent and protect people from a healthcare-associated infection.

Before the inspection, we asked for a copy of the providers infection prevention and control policy. The policy was dated but had no evidence of a ratification process, was not signed off by senior managers, had no review date and did not include references to best practice guidelines. The policy referred to medical equipment that was not carried or required in patient transport services. The provider had told us their policy had been updated with precautions required for staff and patients regarding COVID-19. This had not been completed. Therefore, the policy was not fit for purpose. The provider was not able to assure itself how and when the policy had been shared with staff. The provider was unable to demonstrate how their staff were trained correctly and competent to deal with infection control issues. There was also no qualified infection control lead for the provider, which meant there was no responsible person to oversee the providers management and monitoring of infection prevention.

The provider did not make sure vehicles and equipment were correctly and safely cleaned and ready for use. We inspected both vehicles on site, which were considered ready to use.

In one vehicle we found;

- The seats were fabric with carpeted floors which were not compliant with best practice for infection prevention and control, as they were not easily cleaned.
- The inside of the vehicle was visibly dirty and untidy with staining on the fabric seats, carpet floors and there were open mouldy food products.
- The hand sanitising gel was almost empty; the bottle was dirty and growing mould.
- One size of gloves (large) were available.
- There was no cleaning spray.
- The first aid kit was dirty.
- Seat covers were visibly dirty.
- Soft cuffs and leg restraints for patient use were visibly dirty.

In the other vehicle we found:

- The seats were fabric with carpeted floors which were not compliant with best practice for infection prevention and control as they were not easily cleaned.
- The inside was visibly dirty and untidy with staining on the fabric seats with carpet floors and dirt and debris on high touch points.
- There was no hand sanitising gel.

- The first aid kit was dirty.
- Personal protective equipment (PPE) was stored in a drawer with a visibly dirty hand brush.
- Cleaning wipes were stored in a locker which was very dirty.
- There was no cleaning spray.
- Seat covers were visibly dirty.

There was no evidence of when vehicles and equipment were last cleaned and when they were due next. There were no cleaning schedules, guidance or checklists for staff to refer to for cleaning in vehicles. Managers told us disinfectant spray was kept on board the vehicles to clean with after each patient journey. However, there was no cleaning spray in either vehicle when we inspected them. The infection prevention and control policy stated at the end of the shift, the vehicle floor (which was carpeted) should be cleaned with medical sanitiser with a mop and bucket. There was no evidence this level of cleaning occurred.

At the previous inspection in February 2020, the provider was told to review the cleaning solutions used to make sure they met best practice guidance for cleaning of spilt bodily fluids. We found that this had been implemented. The provider was also going to undertake regular internal audits to ensure cleaning was taking place as recommended and carry body fluid spillage kits. Neither vehicle had an internal cleaning audit completed or carried a body fluid spillage kit.

Managers were unable to provide evidence the vehicles were deep cleaned to conform to best practice standards. The infection prevention and control policy outlined the requirements for a deep clean. However, cleaning contractors were used to clean the vehicles. This was a commercial mini valet, which did not include deep cleaning of the seats or floors. Managers were not aware of where cleaning was performed on the vehicles or what cleaning products the contractors used. We asked for audits of deep cleaning, but the provider was unable to provide these.

Crews were not always made aware of specific infection and hygiene risks associated with individual patients. Managers told us they did not transport patients with a positive COVID-19 test. In the action plan from the previous inspection in February 2020, the provider had said COVID-19 signs and symptoms were now incorporated in the initial assessment questions. We reviewed 13 random booking forms from January to March 2021. The booking form did not include a prompt to remind staff to ask for this information or any other infectious disease. We found one documented COVID-19 test and negative result. This meant 12 journeys had taken place without a COVID-19 test result recorded. A manager told us their expectation was the acute trust would alert the provider to any infection risks associated with the patient they wanted to convey. This was not in line with their infection prevention and control policy.

A manager completed 34 hand hygiene audits to check compliance from August to September 2020. Two further audits had been performed in January and March 2021. These all showed a high level of compliance. The timing of the audits was not in line with the infection prevention and control policy. This meant the provider could not be assured hand hygiene compliance was maintained and they relied on replacing the hand sanitising gel in vehicles to measure compliance. The policy also stated an annual infection prevention and control report would be compiled. When requested, the provider could not provide this.

The provider provided some uniforms for their staff. Before the inspection we asked the provider for their uniform policy, but they did not provide it. However, their uniform policy was referred to in the infection prevention and control policy. The provider was unable to assure itself how staff were able to effectively maintain cleanliness of their uniform.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment did not keep people safe.

Inadequate

Patient transport services

At the last inspection in February 2020, the provider was required to maintain records of the daily checks undertaken by staff to make sure the vehicles were safe for use. This action had not been fully implemented. There was evidence managers performed vehicle checks weekly. However, there were no records of essential equipment checks being completed prior to every journey.

We inspected the two vehicles on site that were ready for use and found:

- A rear offside tyre on one vehicle was visibly balding, had side wall damage and was unsafe for road use. We informed the provider of this at the time of our inspection who said they would attend to this immediately.
- On one vehicle the fire extinguisher was badly damaged and unusable. It had been stored on its side (should be stored upright) and had corroded. The rust had leached into the plastic storage drawer. It had no service date, no single use tag and was inaccessible, as it was stored in a locker in the boot of the car.
- First aid kits in both vehicles were out of date.
- There was no formal or established process for reporting vehicle defects.
- The vehicles did not have a security screen to separate the passenger area from the driver's compartment.
- The wheelchair in one car had rusty parts, was visibly dirty with no evidence of maintenance.

We saw both vehicles used for patient transport services had current MOTs, were taxed and regularly serviced. However, the insurance certificate we saw did not provide the correct level of insurance cover for business or commercial use. We informed the provider at the time of our inspection.

The office environment allowed for social distancing of the management team. The premises had two toilets, however, one of these was being used as a storage facility. The vestibule also served as a storage area for cleaning products and PPE. This was not a suitable storage area and items were stacked on the floor.

Inside the vehicle, staff could access equipment they were not trained or authorised to use, for example, restraint handcuffs. There were no systems to check this equipment was safe to use or maintained correctly.

Assessing and responding to patient risk

Staff did not fully complete and update risk assessments for each patient therefore risks were not removed or minimised. Safety was not a priority. There was no measurement or monitoring of safety performance. The information needed to plan and deliver effective care, treatment and support was not available at the right time. Information about people's care and treatment was not appropriately shared between staff.

At booking, a risk assessment should have been completed, and the information transferred to the transport docket for the crew (see Quality of records). However, the information collected was not always complete, consistent and not always transferred correctly onto the transport docket. This meant staff were not always prepared for the care of the patient during the journey.

The provider worked collaboratively with approved mental health practitioners (AMHP). The AMHPs were the point of contact for securing the transport for patients detained under the Mental Health Act 1983. Managers told us when booking the job, there was a joint discussion around the risks and the staff required. However, this was not evidenced in the 13 booking forms and transport dockets we reviewed.

Inadequate

Patient transport services

The provider had a conveyance policy which contained an escalation process for deteriorating or seriously ill patients. However, they were not able to assure themselves staff were capable of recognising and responding to patients who become ill during their journey. This was due to the disorganised process of recording training (see mandatory training section) and a failure to document if staff had read and understood the relevant policies.

Staffing

The provider did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers had no system to calculate staffing levels and skill mix.

The provider had not taken action to implement improvements from our last inspection. At the inspection in February 2020, we told the provider:

- It should undertake checks on the driving abilities of staff to make sure they were safe, and to maintain records of this as part of their assessment of staff competency to meet the requirements of their role. We reviewed records for July 2020 to December 2020 and found no, records they had been undertaken this year. The provider gave us a list of driving competency checks completed from August 2019 and October 2020. Therefore, this action has been partially implemented.
- To provide evidence staff were competent to meet their roles at interview, end of induction and ongoing. We reviewed 11 personnel files and found no evidence competency was being monitored. Therefore, this action has not been implemented.
- It must include information about staff conduct in previous roles, to determine if the applicant is suitable for the role as part of their recruitment process and must maintain records of their decision. It must also ensure staff with criminal convictions or lacking references were risk assessed and records of these kept. We found this action had not been fully implemented.

The provider recruitment processes were not in line with Schedule 3 Regulation 19(3)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Schedule 3 sets out eight categories of information required to be kept by providers about all persons employed in the provision of services. We reviewed 11 personnel files and found none completely complied with schedule 3 requirements. Missing information included;

- One file had no photographic proof of identity.
- Five staff had no references.
- Eleven had no full employment history.
- Five did not have information about any physical or mental health conditions.
- One member of staff did not receive any follow up for their declared health issues.
- There were no risk assessments of staff where references were missing.

This meant staff were not properly checked or vetted to ensure they were fit and proper mentally and physically to work in this environment.

Quality of records

Staff did not keep detailed records of patients' care and treatment. Records were not clear, not up-to-date and not easily available to all staff providing care.

Inadequate

Patient transport services

At the last inspection in February 2020, we told the provider to include more detail in the booking records. At this inspection we found the provider did not fully document patient details or have a clear criterion to assess eligibility to use the service, (except the provider did not take patients who could not partly mobilise into the vehicle and did not transport children). Therefore, this action had not been fully complied with.

Also, we told the provider it must have records of patients risks and actions to minimise these, provide information about patient's medical conditions and do not attempt cardio-pulmonary resuscitation (DNACPR) decisions for staff to refer to. We noted limited improvement however, this action had not been fully complied with.

Crews accompanying the patient were supposed to be made aware of patient's individual physical and mental health needs on the transport docket. This had a comments section where management could put information received at the point of booking relevant to the patient's individual needs. We were told a patient's eligibility was assessed at the point of booking and was called a risk assessment. However, there was no scoring system to decide if the patient presented a low, medium or high risk. Most of the risk assessments wereviewed did not have any form of risk level noted. We looked at 13 booking forms (the risk assessment) and the associated transport docket. We found both documents to be lacking in important details and there were significant inconsistencies in the transfer of information from the risk assessment to the transport docket.

For example:

- The provider transported patients who were detained under various sections of the Mental Health Act 1983. In nine cases, the legal status of the patient was not transferred from the risk assessment to the transport docket. This was important as legal paperwork had to be completed and required to accompany the patient.
- One patient had a documented COVID-19 test result.
- Eight patients did not have their risk of verbal or physical aggressive behaviour documented.
- Physical health was not always documented, details were not transferred to the transport docket in 13 records.
- There was no evidence up-to-date DNACPR orders were recorded or communicated to crews when patients were being transported.

The failure to document a proper risk assessment and complete the transport docket properly with all relevant information was not in line with the providers conveyance policy. This policy also failed to specify how the provider would manage bariatric (very overweight) patients.

Incidents

The provider did not manage patient safety incidents well. Managers sometimes investigated incidents but did not consistently share lessons learned with the whole team, the wider service and partner organisations.

There was no embedded system or policy for staff to recognise what constituted a near miss or an incident, or how to report these. Therefore, the provider could not assure themselves all incidents and near misses were being reported or acted upon. There was little evidence of learning from events or action taken to improve safety. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient and of poor quality. None of the management team had training in investigating incidents or root cause analysis. We found there was poorly documented evidence of identified actions and of shared learning.

At the last inspection in February 2020, the provider was told to maintain records of any learning shared with staff from incidents. During this inspection managers told us incidents were discussed at managers meetings and with staff on Wednesdays. However, we did not find evidence these meetings occurred consistently.

Inadequate

Patient transport services

The provider was asked, but could not provide, an incident management policy. They provided an incident reporting flow chart following our site visit. The provider kept a basic incident management spreadsheet, which was not in use at the time of the inspection. This recorded 36 incidents reported since April 2017 of which eight involved the use of restraint. It was difficult to gather learning from this information, or to identify which staff had been involved and whether they had been trained in restraint. The pages for near miss reporting, learning from incidents, safety assurance, internal audit and dashboard were all blank. Incidents were not number identifiable; did not have an activity status and we found a number of incidents which appeared to have not been investigated. The CQC were aware of two serious incidents that had occurred in the last 2 years. However, we could not find them included as incidents on the spreadsheet. This meant incidents were not consistently reported, investigated, managed correctly and learning shared as required.

The managers had a basic understanding of their responsibilities under the duty of candour legislation regarding informing patient and families in writing and the need to apologise when things go wrong. The managers were not aware of the more specific requirements of this legislation. Duty of candour is a regulatory duty which 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. The provider could not provide any evidence to show they had undertaken any duty of candour for the two serious incidents reported but did not appear on their incident management spreadsheet. Following both incidents, we asked staff whether the patients/ family involved in these incidents had been contacted to undertake duty of candour. They did not provide a response to us.

Are Patient transport services effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

Evidence-based care and treatment

The provider did not provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. There was no evidence to show that staff protected the rights of patients' subject to the Mental Health Act 1983.

People's care and treatment did not reflect current evidence-based guidance, best practice standards or technology. Care or treatment was not based on a full assessment of a person's needs, physical or mental. There was very limited or no monitoring of the outcomes of patient's care and treatment.

At the last inspection in February 2020, the provider was told to provide evidence policies and procedures were devised or reviewed using the latest and best practice guidance. We did not see evidence to demonstrate this had improved at this inspection. There was no evidence of a system to show staff had read or been made aware of new policies introduced or changes to current policies. We were told staff could access policies when they visited the office base although no records were kept about this. We reviewed various policies including; infection prevention and control, safeguarding, conveyance, information governance, use of soft/handcuffs and quality control. The providers policies and guidance were not tailored to the patient transport sector. Policies were not reflective of the scope of practice of the provider and contained irrelevant information. They were lacking in detail, had few review dates, had no ratification

process and did not refer to legal requirements. They also did not contain reference to best practice guidelines such as the National Institute for Health and Care Excellence or the Restraint Reduction Network training standards. Some policies provided for review were not in force at the time of inspection. Therefore, the providers policies were not fit for purpose.

There was no easy way to access protocols to guide staff when out in the vehicle. The managers we spoke with were aware of the requirements of documentation in relation to transport of patients detained under the Mental Health Act 1983. However, there was no checklist for staff to follow to ensure the paperwork was in order prior to starting the journey and was not always on the transport docket.

There were no effective systems to assess and monitor the service provision, which included the use of audits to help improve the quality and safety. The provider had a spreadsheet that monitored the numbers of transfers completed weekly.

The provider told us staff were trained in the Mental Health Act 1983. However, we were unable to identify the percentage of staff who had received training and whether it was current due to the lack of a reliable system to identify this information. Management stated staff were selected because they worked in a mental health setting. Review of 11 personnel files showed not all staff had experience of working in mental health settings.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey.

Journeys were planned to account for a patient's hydration nutritional and toileting needs, especially when journey times were long. Bottled water was held on the vehicle in preparation for a journey. The provider asked the hospitals where the patients were picked up to supply a packed lunch for the patient. We were told staff risk assessed the patients when stopping for a rest break but there was no documentary evidence on the transport dockets to support this.

Response times

The provider did not monitor agreed response times so they could facilitate good outcomes for patients.

The responsiveness of the provider was not monitored against any internal or contracted standards. The provider collected the number of patient journeys. No information concerning response times (time from collection of patients to their arrival at required destination, before or after their appointment time, and the time waiting for their return) was collected or monitored. Therefore, the provider could not benchmark and compare itself to other providers.

The provider was not commissioned by the local care commissioning group; however, it did have two service level agreements with mental health NHS trusts. The service level agreements were on an 'as and when required basis' resulting in approximately 80 patient journeys each month. The provider did not have regular review meetings with the trusts to discuss service improvements or incidents as specified in the contracts. However, the trusts were contacted daily to communicate capacity to convey patients. The limited feedback we received on the provider indicated it was flexible, however there were some difficulties during the pandemic where transfers were not accepted as the provider felt it was not able to ensure the safety of staff.

Competent staff

Inadequate

Patient transport services

The provider did not ensure staff were competent for their roles.

People received care from staff who did not always have the skills or experience needed to deliver effective care. Managers did not appraise staff's work performance but held one off/unplanned supervision meetings with them and did not provide support and development. Staff did not develop the knowledge, skills and experience to enable them to deliver good quality care. Staff were not supervised or managed effectively. There was a lack of coordinated recruitment, support and training.

At the last inspection in February 2020, we told the provider it must ensure there were processes to provide all staff at every level with an appraisal and regular supervision. We found at this inspection that the provider had not progressed this action. We were not provided with any evidence to show annual appraisals were undertaken for any staff. We were told there had been some supervision sessions undertaken. This was an issue at the previous inspections.

Staff employed by the provider must have an annual appraisal or direct supervision. The provider told us this action had been completed. However, when we reviewed 11 personnel files, we found no evidence any member of staff had had an appraisal. The provider told us 13 supervisions had been completed and provided evidence for four supervisory sessions. The supervision matrix maintained by the provider was inaccurate and showed a supervision rate of 45% of staff supervised this year. One member of staff was not on the supervision matrix. Informal, undocumented telephone supervision was completed for five members of staff. Therefore, we found this action has not been fully implemented.

New staff participated in an induction period; the staff handbook stated this had a 90-day timescale. At the end of this period, managers told us they signed off the induction checklist. We saw evidence of some staff having had the induction in their personnel files. However, most of the checklists were blank, not signed or dated to demonstrate completion or the staff member was competent to do the role.

The providers training matrix did not match the certificates of training contained in the personnel files. The provider could not assure themselves the training matrix system correctly collected employees training or non-training status. One employee file we looked at did not have any training certificates, but we saw evidence they had recently been sent on a job. We were told the provider had moved to e-learning system. However, on the training matrix there were still staff were listed as outstanding for a considerable amount of training modules. This meant staff were not properly trained to carry out their job effectively.

Staff had access to mechanical restraints and training in the use of these were covered in the prevention and management of violence and aggression (PMVA) training in order to use them safely. This was in line with the Mental Health Act Code of Practice, Mental Capacity Act 2005, Human Rights Act 1998 and common law. However, the providers policy for restraint was not fit for purpose.

We were told managers would accompany staff on their journeys to evaluate their competency. However, the provider could not provide evidence of records to demonstrate this.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care usually worked together as a team to benefit patients. They supported each other to provide care and communicated with other agencies.

The service provided non-emergency patient transport service for patients with mental health conditions. The provider and the local NHS mental health trusts usually worked together to deliver care and treatment to meet the needs of the

Inadequate

Patient transport services

patients they transferred. Care was sometimes delivered in a coordinated way and other services were involved. A mental health professional told us they usually had joint discussions with the provider regarding the risks and the staffing requirements. Managers told us staff spoke with the ward/unit staff responsible for handing over the patient but did not always discuss the patient's immediate needs and any changes in their condition or behaviour.

Staff had limited access to information about the patients prior to the transfer/journey as information was not always fully transferred to the transport docket. For example, we did not find any evidence in the 13 booking forms that do not attempt cardio-pulmonary resuscitation (DNACPR) was always considered and was not transferred to the transport dockets.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not follow national guidance to gain patient's consent. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The provider could not assure themselves staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and other relevant national standards and guidance. From our review of 11 training records, two people completed training for the Mental Capacity Act 2005. We requested the providers consent policy. Although they provided one, it was not in force at the time of the inspection.

The provider told us they promoted supportive practice that avoided the need for physical restraint in their PMVA and break-away technique policy. However, there was no evidence to suggest where physical restraint was necessary, it would be applied in a safe, proportionate, and monitored way and there was no evidence it was part of a wider person-centred support plan. There was a lack of documented evidence of care for restrained patients on care records and incident forms. We found people's mental capacity had not always been assessed and recorded.

There was no evidence of photographs of patient's wrists when the soft handcuffs were removed, no debrief sessions following incidents of restraint or feedback from the patient of their experiences. This was not in line with their PMVA and break-away technique policy.

Are Patient transport services caring?

Insufficient evidence to rate

We were not able to gather sufficient evidence and therefore cannot rate this key question.

Are Patient transport services responsive?

Inadequate

Our rating of responsive went down. We rated it as inadequate.

Planning and delivering services which meet people's needs

Inadequate

Patient transport services

Services were planned or delivered in a way that sometimes met people's needs. The facilities did not meet people's needs.

The provider provided non-emergency patient transport service for patients with mental health conditions. The provider was not commissioned by the local care commissioning group. However, it did have two service level agreements with mental health NHS trusts. The service level agreements were on an 'as and when required basis' resulting in approximately 80 patient journeys each month.

The provider did not have regular review meetings with the trusts to discuss service improvements or incidents. However, the trusts were contacted daily to communicate capacity to convey patients. The provider was called by the trust when a patient required transportation. Feedback on the provider indicated it was flexible, however there were some difficulties during the pandemic where transfers were not accepted as the provider felt it was not able to ensure the safety of staff.

The provider worked collaboratively with approved mental health practitioners (AMHP). The AMHPs were the point of contact for securing the patient transport. We had been told when booking a job there was a joint discussion around the risks and the staff required. However, this was not evidenced in the 13 booking forms and transport dockets we reviewed.

We were told when the transport request had been agreed the provider had a two-hour time slot to get to the location. Premier Rescue Ambulance Service did not monitor the service in order to make improvements.

Meeting the needs of people in vulnerable circumstances

The provider did not always identify and meet the information and communication needs of people with a disability or sensory loss.

At the previous inspection in February 2020, it was identified the provider should provide staff with access to pictorial cards to aid communication for patients who are not able to verbally communicate. At this inspection, we inspected the two vehicles used for transporting patients and the pictorial cards were not present. We raised this issue with management who did have replacement pictorial cards in storage and stated these would be put on the vehicles for staff to access as required. No written information was provided to patients about their journey or what they could expect from staff.

The needs of people who could not speak English were not being met. Management were not able to inform inspectors of the translation service used to provide support for staff when dealing with people who could not speak English. We were told some staff spoke several languages and different translation applications were used. There was no evidence of this.

Some staff did have training in how to deal with violent or aggressive patients. However, we could not identify the percentage of staff who had received training and whether it was current due to the lack of a reliable system to identify this information. However, feedback received from an AMPH said staff were "really experienced and calming in even the most difficult of situations" and staff were confident in managing complex mental health situations and they referred to an alternative provider when its services were not appropriate for the patient. When we discussed this with the management team, they confirmed the patients needed to partly self-mobilise in order to access the service. This was because the provider did not have suitable vehicles to support patients who could not mobilise in and out of the vehicle.

Inadequate

Patient transport services

Access to the right care at the right time

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

Patients accessed care and treatment in a timely way. The service provided a 24-hour, seven-days a week transport service for detained patients and other patients who needed transport between hospitals. Transport requests were dealt with by the managers during the week and out of hours/weekend by the on-call manager. They liaised with the provider requesting the transfer to see if they could meet the request.

When the transport request had been agreed the, the provider had a two-hour time slot to collect the patient. The provider did not monitor the service in order to make improvements.

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received. Although complaints were investigated, learning was not always shared with all staff.

At the previous inspection in February 2020, the we told the provider to review their complaints policy to add a process for what happens if the complainant is unhappy with the first outcome and to add in an independent review of their complaints. We asked for a copy of the complaints policy and found it had not been amended. Therefore, this action had not been complied with.

There was an up-to-date complaints policy. However, it was not easy for people to give feedback and raise concerns about care received. The policy did not mention how the provider provided information to patients about how to raise complaints. There was no information about making complaints on board the vehicle and no feedback forms. There was the facility to feedback through the company website. Three complaints had been made since the last inspection in February 2020. Copies were provided and reviewed. We found:

- No acknowledgement letter was sent to the complainants within five business days, this was not in line with their policy.
- No correspondence was attached to the complaint file, this was not in line with their policy.
- Complaints were logged on the providers complaints log.

There was no evidence to suggest complaints, the investigation outcomes and learning were shared with staff.

Are Patient transport services well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Managers had limited skills needed to lead effectively. There were no examples of leaders making a demonstrable impact on the quality or sustainability of services. The delivery of high-quality care was not assured by the leadership or governance.

Managers did not show a full understanding of the priorities and issues the provider faced or how to manage them. Managers had some understanding of the priorities of the service but lacked knowledge of how to be assured they were providing a safe service.

None of the management team had any formal qualifications in leadership or management. There was no leadership strategy or development programme available. Managers of the provider did not have full understanding of their responsibilities as to the CQC regulations or compliance. Managers did not understand healthcare governance and showed limited awareness of their accountability in law for the service they provided.

The leadership team comprised of two registered managers and one nominated individual. A registered manager and nominated individual were both directors for the provider and registered mental health nurses, the third manager had been a mental health support worker. The management team took turns to be on- call out of hours and were available to staff and other providers for advice and support and to arrange any transfer requests.

We were not assured the managers provided complete and open information about the services they provided. The responses to data requests and our questions were not always correct. For example; some policies had been created in response to our requests and management confirmed no appraisals had been undertaken but there was a supervision record.

There was no system to provide oversight of the service, identify and monitor risks, identify and share learning. Major risks to the service were not documented on the risk register and could not be fully explained by managers when asked about them.

Review meetings were supposed to be held every six months with the local NHS trusts to monitor the provider; none had been held. While the limited feedback had been mainly positive, there were some concerns with timeliness of the provider. However, there was no monitoring of the level of care provided for patients and whether this was within agreed contractual limits.

Vision and strategy

There was no current strategy, statement of vision or guiding values.

At the inspection in February 2020, the provider was told they should review the structures, processes and systems of accountability to support the delivery of their strategy and good quality, sustainable services. At this inspection, the provider told us about their vision for the provider but there was no documented vision or strategy in order to achieve this. Therefore, this action had not been implemented.

Culture

The provider did not have an open culture where patients, their families and staff could raise concerns without fear.

At the inspection in February 2020, the provider had a whistle blowing policy. We saw a document at inspection which the provider said was their policy but there was no guidance or mechanisms for staff to report concerns. We also requested a copy of the policy, but it was not provided. The provider did not appear to understand the concept of a freedom to speak up guardian or have access to one. Both are required if a service undertakes work for the NHS. This meant staff were not able to report concerns anonymously.

We were unable to speak with any of the staff on the inspection. Managers told us staff could approach them with any concerns they might have.

There was not a strong emphasis on the safety and well-being of staff. The provider did not have any risk assessments for safe systems of work including daily vehicle checks or equipment checks. We found one member of staff had completed health and safety training even though it appeared on the training list for all staff.

Governance

Leaders did not operate effective governance processes. There was a lack of systematic performance management of individual staff.

Policies the provider relied upon were either incomplete, unfit for the purpose of assessing and monitoring the provider and lacked any reference to national best practice and guidelines. There were no reliable systems of oversight of policies or monitoring to ensure staff were following policies to keep people safe.

At the inspection in February 2020, the provider was told they must monitor and assess the quality of the service, record patients risks and actions taken to minimise them, review incidents, record any actions needed and record evidence of shared learning, and undertake proper employment requirements to meet schedule 3. The provider had told us these actions has been completed. We found some evidence to suggest these actions had been partially implemented.

There were no systems and processes to assess, monitor and improve the quality and safety of the service provided. There was no formal audit structure or programme of audits. The managers did not understand or monitor how the provider was performing and the areas where improvements were required. The provider had few systems to support the delivery of good quality and sustainable services. They did not have a formal system or process to regularly manage governance of the provider.

The provider recorded some risks for patients at booking but actions to minimise them were very limited. Significant information taken at booking was not always relayed to the transport crews. For example, a patient had type 1 diabetes, but the crew were not told. This meant the patient would have been at risk if they had suffered a hypoglycaemic (low blood sugar level) attack.

There was little evidence of provider overview, effective or consistent process to review incidents, record actions and there were few records to evidence shared learning with staff.

At the inspection in February 2020, the provider was told they should risk assess staff with evidence of criminal convictions or no references before working with vulnerable people. The provider stated this action had been completed. However, at this inspection, we found no evidence to support this.

We reviewed 11 personnel files and found significant gaps in the governance of the recruitment process. We found;

- The providers application form did not request a full employment history which is required to meet the regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- Gaps in employment history had not been investigated.
- No references for four members of staff and one reference for four other members of staff. References are important for staff who deal with vulnerable people. There was no evidence to suggest missing references had been followed up.
- No pictorial proof of identity for one member of staff.

- There was evidence of four occupational health forms. However, two were incomplete and the two others did not have health issues followed up.
- Most files did not contain a signed contract of employment.
- A member of staff did not have an enhanced DBS check and another member of staffs' last DBS check was last completed in 2017.

Management of risk, issues and performance

The provider did not use systems to manage performance effectively. There was little understanding or management of risks and issues, and there were significant failures in performance management and audit systems and processes. The risk register and mitigating actions were basic.

At the inspection in February 2020, the provider was told they should devise a written risk register. This had been completed but was rudimentary in style. It failed to capture significant risks, for example, reputational risk, risk posed if vehicles were off the road for maintenance or had broken down, adverse publicity, lack of suitably trained staff, financial risks in relation to business, gap in business continuity, disruption to IT systems, failure to meet healthcare regulations, performance management and failure to comply with patient safety alerts from the Medicines and Healthcare products Regulatory Agency.

The risk register did not contain enough detail about actual risk, mitigating actions, action planning with no target dates set for completion. The owners for most of the risks stated 'Premier'. This meant risks were not actually owned by a manager, and there were no dates for review and all risks were ongoing.

A manager showed us a folder with all the incident reviews and sharing with staff. There was no consistency in these weekly reviews as reported in management meeting minutes. We had previously been provided with the incident record, investigation report and action plans for two serious incidents that did not appear on the incident management spreadsheet. Therefore, the provider could not assure themselves all incidents were properly recorded, investigated, monitored and acted upon.

Information Management

The provider did not collect reliable data and information systems were not secure.

There was inadequate assurance that electronic systems maintained the confidentiality of patient information. There were no effective arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. The provider had suffered a significant data breach when a company mobile phone had been lost containing patient identifiable information. This incident was not recorded on the providers incident management spreadsheet but was on the risk register. The provider had undertaken an investigation and planned actions for the member of staff involved. However, the action plan did not contain any detailed information such as who would monitor the action plan or a completion date. Also, the provider failed to check whether all staff had training in information governance and requirements of the General Data Protection Regulation (GDPR) Data Protection Act 2018. There had been no sharing of lessons learned with staff. We asked the provider if the company mobile phone been found and it had. We also asked whether the patients involved in this data breach had been contacted, they did not provide a response.

The provider had an information governance policy which was not fit for purpose. The policy had many elements that were not applicable to the service provided. It contained reference to:

- Events management of data. The provider did not cover events.
- Referred to the lead clinical auditor and the medical director, neither of these posts existed at the provider.
- Provision of "training for all staff members who handle personnel information and ensure access to further guidance and support and provide clear lines of report and supervision for compliance with data protection". However, information governance did not appear on the training list given to us by the provider.
- There was no further information on how clear lines of report and supervision were to be provided and by whom.
- We found that one member of staff had undertaken information governance training.

The provider told us they were not registered with the Information Commissioner's Office (an independent authority set up to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals). It was their responsibility to decide whether they should be registered with them, but they had failed to consider this.

The provider was not handling Disclosure and Barring Service (DBS) certificates in line with government guidance (July 2018). The provider had photocopies of DBS certificates in staff files. This was contrary to guidance which stated, "Once a recruitment (or other relevant) decision has been made we do not keep certificate information for any longer than is necessary". Guidance does state a record of the date of issue of a certificate, the name of the subject, the type of certificate requested, the position for which the certificate was requested, and the unique reference number of the certificate may be held on file. Five files had photocopies of DBS certificates.

Engagement

There was some engagement with patients and external partners.

There was a patient feedback form online which asked patients to comment about their experience of using the provider. There was no information on the vehicle for patients on how they could complain/provide feedback. Therefore, very little feedback was received. Managers attributed this to the clientele they conveyed.

Learning, continuous improvement and innovation

There was no innovation or service development, no knowledge or appreciation of improvement methodologies, and improvement was not a priority for leaders.

As no appraisals of staff had been completed, it was unclear how staff were supported and helped to develop. There was no evidence of learning and minimal reflective practice.

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
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983

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Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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	S31 Urgent suspension of a regulated activity