Meditransport Ambulance Service Ltd

Meditransport Ambulance Service

Quality Report

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

Ratings

Overall rating for this ambulance location	Inadequate
Patient transport services (PTS)	**Inadequate**

Summary of findings

Letter from the Chief Inspector of Hospitals

Meditransport Ambulance Service is operated by Meditransport Ambulance Service Limited. The service provides patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 12 March 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

This was the first time we had inspected this location. We rated it as **Inadequate** overall.

• The service did not have enough staff to care for patients and keep them safe. Staff did not have training in key skills. Not all staff had received training to enable them to understand how to protect patients from abuse and manage safety well. The service did not manage infection risk well. Staff did not always have enough information to assess risks to patients and act on them. Information contained in care records was not comprehensive. The service did not always manage safety incidents well. There was little evidence of lessons learned from incidents. Staff did not collect safety information to improve the service.

• Staff did not always provide good care and treatment. Managers did not monitor the effectiveness of the service or make sure staff were competent to undertake their role.

• There was little evidence of service planning to meet the needs of local people that took account of patients' individual needs. Staff did not gather feedback from patients, families and carers or make it easy for people to give feedback.

• Leaders did not run the service well using reliable information systems. Leaders did not support staff to develop their skills. Staff did not feel respected, supported and valued. Staff were not always clear about their roles and accountabilities. The service did not engage well with patients and the community to plan and manage services. Senior staff did not commit to improving services continually.

However, we also found:

• Staff ensured vehicles for transporting patients were serviced, received up to date MOT and used appropriate serviced equipment to keep people safe. Staff made sure they were competent drivers and undertook assessments to improve their skills and keep people safe.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with six requirement notice(s) that affected patient transport services. Details are at the end of the report.

We have taken enforcement action against this provider and have issued an urgent suspension notice because we identified significant concerns.

We will add full information about our regulatory response to the concerns we have described to a final version of this report, which we will publish in due course.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central Region), on behalf of the 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)	Inadequate	The main service was patient transport services. During our inspection on the 20 March 2020 we found concerns in relation to the training and competency of staff, a lack of quality auditing, governance and risk management. We rated the service as inadequate for safe, effective, responsive and well-led. We were unable to rate caring as we did not have enough evidence to rate this domain. • The service did not demonstrate if they had enough staff to care for patients and keep them safe. Staff did not always have training in key skills. Not all staff had the training and qualifications to understand how to protect patients from abuse and manage safety well. The service could not evidence controlling infection risk well. Staff did not have enough information to assess risks to patients and act on them. Information contained in care records was minimal. The service did not always manage safety incidents well. There was little evidence of lessons learned from them. Staff did not collect safety information to improve the service. • Staff did not always provide good care and treatment. Managers did not monitor the effectiveness of the service or make sure staff were competent. • There was little evidence of service planning to meet the needs of local people that took account of patients' individual needs. Staff did not gather feedback from patients, families and carers or make it easy for people to give feedback. • Leaders did not run the service well using reliable information systems. Leaders did not support staff to develop their skills. Staff did not understand the service's vision and values, and how to apply them in their work. Staff did not always feel respected, supported and valued. Staff were not always clear about their roles and accountabilities. The service did not engage well with patients and the community to plan and manage services. Staff did not commit to improving services continually.

Meditransport Ambulance Service

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Background to Meditransport Ambulance Service

Meditransport Ambulance Service is operated by Meditransport Ambulance Service Limited. The service opened in 2013 and this location was registered in 2018. It is an independent ambulance service in Wymondham, Norfolk. The service primarily serves the communities of the Cambridgeshire region and transported patients of all ages.The service has had two separate registered managers in post since registering the location in 2018.

The service employed two members of staff directly; this included the registered manager and the operational manager.

The service employed all other staff on zero hour contracts; this included emergency technicians and ambulance care assistants. The provider held one contract with a local NHS trust and was subcontracted by another independent patient transport service. They operated two types of non-emergency patient transport service vehicles, including two ambulances and one car from a dedicated ambulance station.

The provider did not hold any controlled drugs therefore no controlled drugs accountable officer (CDAO) was required.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two other CQC inspectors. The inspection team was overseen by Mark Heath, Head of Hospital Inspection.

Facts and data about Meditransport Ambulance Service

The service is registered to provide the following regulated activities:

• Transport services, triage and medical advice remotely.

During the inspection, we visited the Wymondham base. We spoke with seven members of staff including four emergency medical technicians one member of the management team. We did not speak with patients or carers because we had insufficient opportunity and evidence. Before our inspection we requested information from the provider through our routine provider information request. During our inspection, we reviewed eight sets of patient records in the form of interhospital transfer forms.

The service provided non-emergency patient transport services (PTS). At the time of inspection, the service had two contracts in place to provide PTS transportation covering the areas of Cambridgeshire.

Detailed findings

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once at a previous location. This was the first inspection at this location which took place in March 2020 which found that the service did not meet all standards of quality and safety it was inspected against.

The provider did not provide us with a completed provider information request prior to our inspection. This meant we were unable to demonstrate activity which included patient journeys undertaken.

The provider did not provide us with a list of their staff, which means we are unable to report the numbers or types of staff who worked for the provider. We were also unable to determine the number of incidents, never events or their track record on safety.

Track record on safety

The provider did not provide us with a completed provider information request form which means were are unable to report on track record on safety.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Not rated	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not rated	Inadequate	Inadequate	Inadequate

Patient transport services (PTS)

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

Information about the service

Meditransport Ambulance Service is operated by Meditransport Ambulance Service Limited. The service opened in 2013 and was registered at this location in 2018. It is an independent ambulance service in Wymondham, Norfolk. The service primarily serves the communities of the Cambridgeshire region.

Summary of findings

Patient transport services (PTS)

Are patient transport services safe?

Inadequate

This was our first inspection of this location. We rated safe as **inadequate.**

Mandatory training

The service did not provide mandatory training in key skills to all staff or make sure everyone completed it.

The provider did not provide us with a response to our request for information prior to our inspection. This meant we had no data or training information to demonstrate whether staff received mandatory training. An operational manager told us a training manager had been employed, however they had since resigned. Staff were unable to provide us with mandatory training compliance records. We found no evidence of systems to identify which staff had completed training. At the time of our inspection, there was no one in a position of responsibility who could provide us with details of staff's mandatory training compliance.

An operational manager told us they were unaware of any mandatory training systems in place and they could not provide us with evidence. We asked a manager for a list of mandatory training but they did not provide us with one. We looked at eight staff files, of which, none contained any mandatory training documentation. We spoke with two further members of staff who told us they were not aware of a mandatory training programme.

A manager provided us with a box containing miscellaneous folders. One folder in the box contained documentation with staff signatures relating to staff training from 2018 to April 2019. We saw that at least two active members of staff had signed to say they had received paediatric and adult resuscitation training, observations training and infection prevention control training in April 2019. This meant that potentially, two of the reported 20 active members of staff had received training. We were not assured that all staff were appropriately trained.

We were unable to verify the content or quality of any training which meant we could not say whether it met required standards. We could not see any documentation to verify competencies. This meant that staff may not have been safe to carry out their duties and may therefore put patients at risk of harm.

Safeguarding

Staff did not always understand how to protect patients from abuse. The service could not demonstrate that they worked well with each other or with other agencies to do so. Staff did not have training on how to recognise and report abuse or always demonstrate that they knew how to apply it.

Staff did not receive training on how to protect patients from abuse, identify and report concerns. All patient facing staff should have completed safeguarding adults and children level one and two training, in line with the intercollegiate document 'Safeguarding children – roles and competencies for healthcare staff' 2014 published by the Royal College of Paediatrics and Child Health (RCPCH). One of the eight staff files we looked at had up to date, appropriate safeguarding training certificate obtained during previous employment. One staff member's file had a safeguarding certificate; however, it was unclear whether it was accredited or at what level it was achieved.

We were not provided with any data to evidence whether staff were up to date with safeguarding adults or children training. Staff did not have access to a named safeguarding lead at the expected level 4 as outlined in the intercollegiate document 'Safeguarding children – roles and competencies for healthcare staff' 2014 published by the Royal College of Paediatrics and Child Health (RCPCH). This demonstrated that there was no qualified person with responsibility for ensuring the safeguarding standards were met.

Safeguarding policies were not available or accessible for staff to review either in hard copy form or electronically. A safeguarding folder providing information to staff on how to respond to safeguarding concerns was in an ambulance. However, one staff member we spoke with told us they were unaware it was there and had used their own initiative to manage potential safeguarding issues. We were unable to access a safeguarding policy to review. Staff could not provide evidence that they consistently escalated safeguarding concerns. We were not assured that people using the service were safeguarding from potential harm.

Patient transport services (PTS)

Staff were not provided with systems and process to help them safely manage safeguarding concerns. Staff provided us with examples of safeguarding concerns that required escalation however, there was no person in a position of responsibility to advise and manage incidents that arose. This meant there was scope for harm to people who used the service and staff. A member of staff provided us with an example of a safeguarding concern. They told us they were not provided with an induction and as a result, did not know the process to escalate safeguarding concerns. They used their initiative and contacted the local authority single point of contact to make a safeguarding referral for a vulnerable patient This demonstrated there was a lack of systems in place to support staff in making referrals appropriately to safeguard people and no evidence of shared learning.

Managers did not routinely carry out enhanced disclosure and barring service (DBS) checks as part of pre-employment checks. We saw some staff had completed DBS checks, however one member of staff told us they had been in post since January 2020 and had not had any pre employment checks, including DBS checks. They had not been required to submit an application form or provide references. We were therefore not assured that appropriate employment checks and safeguards were in place to ensure the person was not a risk to others.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. There were no consistent systems in place to demonstrate equipment, vehicles and premises were kept clean.

Staff did not routinely receive training in infection prevention and control. There was no systematic review of staff training or any demonstration of updates.

All vehicles we looked at were visibly clean, contained decontamination items, for example, hand sanitiser and disposable wipes and personal protective equipment, for example, gloves and aprons to help keep people safe. This helped prevent and control the spread of infection. Records demonstrated good oversight of cleaning schedules up until August 2019 at which point all checks ceased. We were unable to establish why this was the case. The service did not have a named infection prevention (IPC) and control lead. The service did not have an accessible IPC policy. This meant we could not be assured of good IPC practices to keep people safe from transmittable diseases.

Managers on site could not locate an IPC policy which meant we could not review the quality or standards set out IPC controls and procedures. Staff told us there were no IPC checks or audits to ensure IPC took place in an effective way to keep people safe. Staff told us there was no current deep clean system in place to help prevent and control the spread of infection. We saw records relating to deep cleaning up to August 2019. Since then there had been no deep cleaning of vehicles. This meant we could not be assured that people were kept safe from transmittable diseases.

Staff could access cleaning products for vehicles, which were securely stored following Control of Substances Hazardous to Health risk storage methods. For example, identifying and storing toxic substances in locked cupboards. This meant toxic substances were stored in a way to help keep people safe.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people safe. However, clinical waste was appropriately managed.

Staff had access to ambulances, cars and wheelchair accessible vehicles to transport patients. The vehicles were parked in a secured, barriered car park. Staff could also park the vehicles in a secure warehouse if necessary. Staff kept keys in a secure store in a locked area. Staff who were authorised could access them when needed.

Vehicles were maintained and serviced at regular intervals, in line with manufacturers recommendations. We looked at service records that evidenced compliance with vehicle maintenance, servicing, tax and transport safety checks.

Staff told us they had experienced vehicle breakdowns and did not always receive support needed to manage breakdowns. Staff described an incident of a vehicle breakdown when a patient was on board. Staff told us they were not supported by anyone in a position of responsibility to manage the situation. We were unable to

locate any information or guidance on the management of faulty vehicles during our inspection. Therefore, we could not gain assurances that the service proactively dealt with vehicles breakdowns in such circumstances.

Staff described how they would safely transport babies and children using specific seats and harnesses. However, we could not gain assurances that staff were competent in the use of this equipment as we found no records that demonstrated competency.

Clinical and non-clinical waste was appropriately managed. There was a clinical waste and sharps contract in place to ensure appropriate waste removal.

Staff carried out road speed driving assessments to improve their driving abilities to keep people safe. We looked at records and saw that there had been recent assessments for people who wanted to do blue light training. Staff were encouraged to provide feedback and we saw that crew members who observed the assessments regularly provided feedback on the driver's skills. For example, we looked at records for one member of staff who had received positive feedback by their colleagues for demonstrating good, safe driving skills.

Assessing and responding to patient risk

Staff did not complete and update risk assessments for each patient to remove or minimise risks. Staff did not always identify and quickly act upon patients at risk of deterioration.

Staff did not gather sufficient risk information to assess whether they were competent to provide safe care and support. We looked at patient information forms that followed the transportation of patients with complex needs. The information contained within would not have been sufficient to assess and respond appropriately to the complex needs of some patients using the service. We were therefore not assured that patients were fully protected from a risk of harm.

One staff member told us they had not received training to transport heavier patients. To keep the patient safe, they

to transport the patient. However, another staff member was given a journey request to transport a paediatric patient from intensive care at one hospital, to a children's ward at another hospital. They confirmed they had not received training in paediatric basic life support.

We looked at the paperwork given to staff about the patient. There was no information contained within the documentation to assist staff in carrying out a risk assessment to manage the paediatric patient safely throughout the journey. Staff did not have a system for carrying out further checks. For example, staff told us that a receiving hospital had raised a concern that observations had not been taken when a child had been transported and subsequently had a seizure on arrival. We were therefore not assured that staff had enough knowledge about the patient to provide safe care.

The service was unable to evidence that all staff had completed adult and paediatric basic life support training. In addition, we were not assured that staff had been adequately trained to responding to a patient who was at risk of clinically deteriorating.

The service was unable to evidence that it had an accessible deteriorating patient policy or procedure in place. Therefore, we could not gain assurances that staff knew the action to take in the event of patient deteriorating clinically.

Staff told us they sometimes felt under pressure to transport patients when they had not been given sufficient information or when they had said they were not suitably skilled to deal with patient complexities.

Staff told us they did not always receive important information from other providers before collecting the patients. We looked at paperwork and saw information was limited and would not have provided sufficient detail to keep people safe.

All staff we spoke with told us they were concerned about transporting patients that they felt they were not competent to transport. The service was not equipped to transport paediatric patients. They had recently had a near miss which prompted a halt on transporting patients under eight years of age. However, as there were no formal documented criteria set out or formal discussions with providers that indicated exclusion and inclusion criteria, we were not assured of that conditions would be applied to keep people safe.

Staffing

The service did not evidence if they had 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 regularly reviewed and adjusted staffing levels.

We were unable to establish the exact number of staff employed by the service. We did not receive a completed provider information request which had been requested in advance of our inspection which would have demonstrated staffing establishment details. The operational manager told us there were around 20 people working for the service, however was unable to provide us with detailed records despite our request.

The operational manager showed us rotas they used to manage day to day work. The operational manager completed the rotas a week in advance and work was offered to staff available. The manager told us they organised the rota to take into account staff skill mix. For example, ambulance care assistants for patient transport service jobs and emergency medical technicians for high dependency jobs. However, we were not assured staff received appropriate training to deal with varying levels of acuity of the patients.

Records

Staff did not always receive or keep detailed records of patients' care and treatment. Records were stored securely and available to all staff providing care.

Staff were provided with a personal digital assistant to take jobs from another independent provider. The system was password protected and only those staff authorised to do so could access confidential patient information. This helped keep patient information safe.

Staff deposited completed paper records and documentation in a locked storage box at the end of each day. Authorised staff were issued with a username and password to access confidential computerised information. All of these systems helped keep people's information safe.

Staff used interhospital transfer forms to record patient information. We looked at eight of these forms and saw that the quality of information contained within was variable. For example, we saw that the five records on a specific vehicle, written up by a specific member of staff contained clear and detailed information. Each form had allergies stated, observations recorded and evidence of when a safeguarding had been completed. However, the other three forms contained less detail.

We found no evidence of record audits to learn and make improvements to the quality of records.

Medicines

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

Medicines, including oxygen cylinders were not appropriately managed or stored. The manager on site gave us plastic bags that contained various types of unused oral and intravenous medicines. The manager told us they stopped using medications following the departure of the clinical lead. There were unused medicines found in rubbish bags which could have been accessible to those who were not authorised to do so. Oxygen cylinders were stored on a bed, in an out of service ambulance on the premises. The oxygen cylinders were not secured or stored upright. They were not stored in a well-ventilated room. This could present a serious safety hazard to staff and people in surrounding buildings.

The service did not carry controlled drugs.

Incidents

The service did not manage patient safety incidents well. Managers did not investigate incidents or share lessons learned with the whole team, the wider service and partner organisations. There was no system in place to apologise when things went wrong, give patients honest information or suitable support.

Prior to our inspection we requested routine information about the service. This service did not submit this routine data as requested. During our inspection we were unable to verify the number of incidents that had occurred due to a lack of systems and processes.

Staff did not have access to an incident reporting system. A manager who left the organisation in December 2019 had responsibility for previously overseeing incidents. However, there were no contingency plans or systems in place since that time. We found no evidence of a system that supported staff in incident reporting, reviewing, management and learning lessons.

Patient transport services (PTS)

Staff told us informal discussions took place, however there were no formal recorded investigations when incidents were reported. Staff could not provide us with an accessible incident policy. We could not gain assurances that staff had access to information to enable them to identify, report and escalate incidents in an effective manner.

There was no formal system in place to document and review incidents. We were aware of some incidents that had taken place for which there were no reports available. However, we did see evidence of informal sharing of incident information, learning and changes in practice as a result. For example, transportation of children under the age of eight was stopped following an incident however this had not been formally documented as an incident. The incident highlighted staff lacked training and skills to transport children. This demonstrated some learning, however without a system for reporting incidents we could not be assured that people were kept safe and that potential themes and trends incidents were identified in a timely manner.

Staff we spoke with understood the principles of duty of candour. For example, being open and transparent in the event there was an error. 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. However, there was no evidence of formal training or systems in place to ensure the process to notify patients or other relevant people when things went wrong. This meant managers and staff were not fulfilling their regulatory duty to share with others when things went wrong.

Are patient transport services effective?

Inadequate

This was our first inspection of this location. We rated it as **inadequate.**

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. Staff did not protect the rights of patients subject to the Mental Health Act 1983.

Managers did not carry out clinical audits as part of an audit programme to ensure safe and effective care and to monitor the quality and effectiveness of care delivery. There were no skills and competencies audits or audits of the quality of records for example.

Senior staff did not have knowledge of national guidance, best practice and evidence-based approaches to care delivery. Staff did not have access to policies and procedures whilst working remotely. This meant we were not assured that evidence based guidance was used to provide care and treatment.

The service did not independently transport patients held under the Mental Health Act 1983. Patients with mental health needs were escorted by clinicians from the receiving provider. There was no evidence of any consideration given to risk assessment in relation to keeping patients with a mental health condition safe. We were not assured that staff received training, to equip them with the skills or knowledge of the Mental Health Act 1983 or how to support or manage patients with a mental health condition.

Nutrition and hydration

Staff did not assess patients' food and drink requirements to meet their needs during a journey. This was due to the nature of patient transport services.

Staff did have a supply of water on one of the vehicles for patient use. Due to the nature of the service, staff did not routinely offer nutrition and hydration. This meant there was no standard process for providing nutrition and hydration to patient's using the service.

Pain relief

Due to the nature of the service, staff did not routinely offer pain relief.

Response times

Patient transport services (PTS)

The service did not monitor agreed response times so that they could facilitate good outcomes for patients. Therefore, they could not use the findings to make improvements.

Managers did not actively review journey times and therefore could not evidence response times.

There was no monitoring or audits of response times to improve the effectiveness of the service provided. The service did not have locally agreed standards or benchmarking to assess compliance against. This meant there was no learning relating to response times to help with improvements or developments in the service.

Patient outcomes

The service did not monitor the effectiveness of care and treatment. Therefore, they could not use the findings to make improvements and achieve good outcomes for patients.

There were limited systems to monitor patient outcomes. Whilst staff recorded journey times, we were not able to find evidence that senior staff used this information to make improvements or achieve good outcomes for patients. We asked to see evidence but were not provided with data or information.

Competent staff

The service did not make sure staff were competent for their roles. We were unable to see evidence that managers appraised staff's work performance and held supervision meetings with them to provide support and development.

During our inspection we found limited information to evidence that staff were assessed to be competent in their role. The service was unable to evidence that staff had received an appropriate induction prior to the commencement of work at Meditransport.

Staff were not provided with regular evidence based training, for example, to equip them to work with patients living with dementia or learning disabilities or basic life support.

Staff did not receive annual appraisals which meant potential learning needs were not identified. We found no evidence of staff appraisals in the eight files we reviewed.

There were no team meetings or one-to-one meetings with staff to discuss their learning objectives or development needs.

Managers could not provide us with staffing details, including the most up to date qualifications, evidence of skills, training details or whether staff had an induction. We could not verify qualifications, skills or training based on not knowing exactly who the staff group were in their entirety. Therefore, we could not gain assurances that staff were appropriately trained to provide a safe service to children of all ages.

We looked at a sample of staff files and saw that there was no way to determine whether the staff files belonged to all staff who worked there. Two staff members told us they had not received an induction since taking up post and two told us they did. This meant there was insufficient evidence to assured us that staff were suitably skilled, qualified or inducted to provide safe care to those who used the service.

Managers did not provide a system to ensure staff were competent to work with all types of patients who accessed the service. There was no framework in the form of strategies or policies to guide staff. There were no systems and processes to monitor staff competencies. Competencies defined applied skills and knowledge that enabled staff to successfully perform their work. Staff we spoke with were keen to work within their competencies but did not always feel supported in doing so. The operational manager was keen to ensure staff worked within their competencies but did not feel confident they were supported in doing so.

Managers did not ensure staff were competent to deal with risks relating to transportation of all types of patients. A manager told us that none of the staff were qualified or competent to transport paediatric patients. One member of staff, who had been tasked with transporting a paediatric patient told us they were not trained or competent to transport paediatric patients. The operational manager stopped all paediatric transfers as a result, however we were not assured that this practice would be adopted long term. None of the staff records we looked at demonstrated up to date staff training or competencies. This meant that staff could put themselves and patients at risk of serious harm.

Multidisciplinary working

Patient transport services (PTS)

Those responsible for delivering care did not always work together as a team to benefit patients. They did not always support each other to provide good care or communicate effectively with other agencies.

Managers and staff did not always work well together or with other providers. There were numerous examples given to us by staff spoken with of not feeling supported or provided with the resources need to benefit patients. For example, training in the use of equipment to safely transport patients. A manager gave us an example of where they attempted to work external stakeholders to benefit patients. The manager raised a concern with a commissioning NHS provider. The manager told us that no response had been received to work through the concern. This meant we were not assured that staff worked together to assess, plan and deliver care and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not support patients to make informed decisions about their care and treatment. They did not follow national guidance to gain patients' consent. They did not know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not use agreed personalised measures that limited patients' liberty.

The service could not evidence that it had any policies relating to mental capacity and consent. Patient information records did not have a section to record patient capacity to make decisions. Staff had not received any training relating to the Mental Capacity Act or Deprivation of Liberty Safeguards.

Are patient transport services caring?

Not sufficient evidence to rate

This was our first inspection of this service. We had insufficient evidence to rate caring as we were unable to speak with any patients**.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We did not have enough evidence to make a judgement about the level of caring within the service.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We did not have enough evidence to make a judgement about the level of caring within the service.

Understanding and involvement of patients and those close to them

We did not have enough evidence to make a judgement about the level of caring within the service.

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

We did not have enough evidence to make a judgement about the level of caring within the service.

Are patient transport services responsive to people's needs?

Inadequate

This was our first inspection of this service. We rated it as **inadequate.**

Service delivery to meet the needs of local people

The service did not plan or provide care in a way that met the needs of local people and the communities served. It also did not work with others in the wider system and local organisations to plan care.

We saw limited evidence of planning to meet the needs of the wider system and local organisations. Staff operating hours were flexible to meet the demand on patient transport services across the region. Staff worked flexibly where possible.

Patient transport services (PTS)

Managers supported delivery of service to ensure back up where staffing requirements were not met. However, we saw no evidence of wider system planning or engagement.

During our inspection we saw that the facilities and premises were appropriate for the service that was being delivered.

Meeting people's individual needs

The service was not inclusive and did not take in to account patients' individual needs and preferences. The service did not always make reasonable adjustments to help patients access services.

Staff could access equipment required to provide the planned care to patients. Staff could safely transport patients in their own wheelchairs. Child restraints for children and young people were used during transportation.

Staff could not access policies to help guide them in understanding equality, diversity and inclusion which would set out the protected characteristics from the Equality Act 2010. Staff did not have guidance on how to support patients who might need access to translation services or special communication aids.

Staff did not have access to a translation services for patients and families whose first language was not English. One staff member told us they used their phones to access search engines for online translation services. None of the vehicles had special communication aids. This meant staff could not always meet patient's communication needs which could impact on safe care and treatment.

Staff transported patients at the end of life. However, staff had no access to policies to help guide them when working with patients at the end of life. Staff received no specific training to help them work with people at end of life.

Staff did not have access to symbolised cards to promote communication with patients who had learning difficulties or disabilities to help them feel more comfortable and understand what was happening.

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received. The service did not treat concerns and complaints seriously. They did not investigate them and or share lessons learned with all staff, including those in partner organisations.

Prior to our inspection, managers did not provide us with a completed provider information request which would have shown the number of complaints received by the service.

The service did not have systems in place to enable patients or those close to them to make a formal complaint. Staff could not access a complaints' policy and the service was unable to evidence there was a complaints policy in place. Staff we spoke with were unable to tell us the process a patient should follow if they wished to make a complaint. There was no system in place to allow for independent review of complaints. We saw no evidence of learning from complaints.

Staff at the Care Quality Commission received a number of complaints from people who worked at or had formally worked for the service. The main theme being that staff were not appropriately trained, for example in safeguarding and concerns regarding delays in vehicle repairs.

Are patient transport services well-led?

Inadequate

This was our first inspection of this location. We rated well-led as **inadequate.**

Leadership

Leaders did not have the skills and abilities to run the service. They did not understand or manage priorities and issues the service faced. They were not visible and approachable in the service for patients and staff. They did not support staff to develop their skills and take on more senior roles.

The registered manager was not contactable at the time of our inspection. There was a clear lack of leadership, oversight and confusion about roles, responsibilities and accountability.

The registered manager had not been present at the location for over two months. They did not provide a formal

handover to ensure the business was appropriately managed in their absence and they did not follow processes to inform the Care Quality Commission of their absence.

To meet the requirements of regulation, the registered manager must inform the Care Quality Commission about any planned or unplanned absences from the service that are for a continuous period of 28 days or more. We were informed the registered manager had been absent from January 2020. The registered manager had not returned at the time of our inspection on 12 March 2020. We were not informed of the absence of the registered manager or informed of plans for how the service would operate while the registered manager was away.

There was one operational manager on site to run the service. They told us they had received no formal handover from the registered manager. They were unsure of their responsibilities beyond responding to daily to operational tasks.

There had been several senior resignations which left the operational manager without any additional support. Staff told us the operational manager was expected to be the responsible person at all hours. There was no back up, contingency planning or operational support for the operational manager. The operational manager also worked as an emergency medical technician and we saw that they had worked until midnight on the night before the inspection. This meant they were managing and working operationally, which impacted on their capacity to provide adequate leadership and management support throughout the service.

Vision and strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action.

Senior staff were unable to describe the key pressure, risks, goals and plans for the service going forward. This meant there was little of no evidence of structure to deliver good quality sustainable care.

Culture

Staff did not feel respected, supported and valued. The service did not promote equality and diversity in daily work or provide opportunities for career development. The service did not have an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they felt unsupported and did not always have their concerns responded to. Staff told us they did not have access to the resources they needed to safely carry out their role. For example, access to management for support in the event of an emergency and to keep people safe.

Staff understood the principles of whistleblowing. We had received a number of whistleblowing concerns from staff in the 12 months prior to inspection which related to lack of support and resources from the organisation.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff were not always clear about their roles and accountabilities. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service.

Governance systems were not robust to ensure effective delivery of service, to allow for improvements and to keep people safe. There were no regular, recorded governance meetings. Staff were not clear about their roles and responsibilities. There were no formal opportunities to meet and discuss performance. There were no records to evidence learning from performance.

Management of risks, issues and performance

Leaders and teams did not use systems to manage performance. Staff did identify some risks. There was some evidence that escalated risks and issues were not always managed to reduce their impact. Staff could not tell us what plans were in place to cope with unexpected events. Staff did not contribute to decision-making to help avoid financial pressures compromising the quality of care.

There were no systems in place to manage performance, issues or risk. The service did not have a risk register or other process for identifying, recording or mitigating risks.

Staff we spoke with were concerned that the service did not have robust systems in place to help them escalate and share concerns. Staff gave us examples of when they had identified risks and issues however there was no one to

escalate to and they had to rely on their own personal resources. This meant there was no consistent, accessible person or system in place with overall accountability managing risks, issues and performance.

Information management

The service did not collect reliable data or analyse it. Staff did not use data to understand performance, make decisions and improvements. We saw no evidence of data or notifications being submitted to external organisations as required.

The service did not have effective systems in place for storing information and staff were limited in what information they could access. The service held paper and electronic records. There was no system in place to use information to benefit the company or the people who used the service.

Policies and other information were kept securely and not available to staff either directly or remotely.

Managers did not collect or analyse data in relation to performance or patient feedback.

Public and staff engagement

Leaders and staff did not actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. We saw no evidence of collaboration with partner organisations to help improve services for patients. Managers did not routinely seek the views of staff and people who used the service to help develop and improve the service. We saw no evidence that the service engaged with staff, patients, the public or other organisation to plan and improve service delivery.

Innovation, improvement and sustainability

Managers did not commit to working with and supporting staff in continuous learning and improving services. We saw no evidence of quality improvement methods or the skills to use them. Leaders did not encourage innovation and participation in research.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

· The provider must ensure care and treatment of service users must only be provided with the consent of the relevant person. Regulation 11(1)

- The provider must ensure staff have the right skills and training to be competent in their roles. Regulation 12(2)(c)
- The provider must ensure the proper and safe management of medicines. Regulation 12(2)(g)
- The provider must ensure staff receive inductions to the service, access to a mandatory training with regular updates, safeguarding training appropriate to their role, safeguarding policies and procedures. Regulation 13(1)(2)(3)
- The provider must ensure that the service has robust cleaning schedules in place to ensure high standards of cleanliness and infection control practices and take appropriate actions where this is not met. Regulation 15(1)(a)
- The provider must ensure it has a range of evidence based policies and procedures that are fit for purpose. Regulation 16(2)
- The provider must ensure effective systems and processes are in place to assess, monitor and improve the quality and safety of services provided. The provider must ensure it has a robust system to audit, review and monitor care delivery and outcomes. Regulation. The provider must ensure it has a measurable strategy to ensure sustainability of the high quality care. Regulation 17(2)(a)
- The provider must ensure it has an open, transparent and robust process for investigating complaints and incidents, and identify, share and make changes from learning. Regulation 17(2)(a)(e)
- The provider must ensure effective systems and processes are in place to assess, monitor and mitigate risks relating to health, safety and welfare of patients and staff. The provider must ensure it maintains a comprehensive record of risks associated with the service. Regulation 17(2)(b)

Action the hospital SHOULD take to improve

- The provider should ensure staff receive support, professional development and supervision, and be engaged to share information and knowledge more effectively.
- The provider should ensure appropriate management and leadership cover for staff at all times.
- The provider should collect feedback from patients and those close to them.
- The provider should engage with other providers and organisations to collect performance data to help within internal monitoring and service improvement.

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 11 HSCA (RA) Regulations 2014 Need for consent

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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