Medical Response Services

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Requires improvement
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Medical Response Services is operated by Mr Warren Bolton . It is an independent ambulance service which was first registered with the Care Quality Commission in July 2011. The service is located in Wigan, Greater Manchester and serves a number of regional acute NHS hospital trusts, local authorities and clinical commissioning groups. The service provides patient transport services which encompasses the transfer of mental health patients, including those detained under the Mental Health Act 1983.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 7 and 8 January 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.

We had not previously rated this service. We rated it as **Inadequate** overall.

We found the following issues that the service needs to improve:

- Staff did not always receive the appropriate training or support to enable them to carry out the duties they were employed to perform.
- Medicines were not always managed appropriately.
- Incidents, near misses and patient safety issues were not always managed well. Staff did not always recognise and report incidents and incidents were not always documented appropriately; in line with policy and best practice guidance.
- Patient outcomes were not always measured or monitored and policies did not always follow best practice guidance or standards.
- It was not always apparent that patients transferred and transported with mental ill health were managed safely or appropriately.
- Leaders did not always operate effective governance processes or use systems to manage performance effectively.
- Leaders did not always identify or escalate relevant risks and issues or identify actions to reduce their impact.
- Leaders and teams could not always access and find the data they needed, data was not always collected and was not always available in accessible formats to allow staff to understand performance, inform decisions and drive improvement.

However, we found the following areas of good practice:

- The service worked well with other agencies and all those responsible for delivering care to benefit patients. They supported each other to work effectively to provide good care.
- The service managed and controlled infection risk well. Equipment and control measures were used effectively by staff to protect patients, themselves and others from infection.
- Staff were focussed on patient care and treated patients with compassion and kindness.

Summary of findings

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 took enforcement action telling the service that it had to make significant improvements. This is detailed at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate 	Medical Response Services provided patient transport services from one ambulance base location which is situated in Wigan, Greater Manchester.

Summary of findings

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Inadequate

Medical Response Services

Services we looked at
Patient transport services

Summary of this inspection

Background to Medical Response Services

Medical Response Services is operated by Mr Warren Bolton and registered with the Care Quality Commission in July 2011. The service has had a responsible individual in post since July 2011. The service is available 24 hours a day, seven days a week, every day of the year.

The service is an independent ambulance provider which provides patient transport services including the transportation of mental health patients, including those detained under the Mental Health Act 1983.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, inspection manager and a specialist advisor with expertise in ambulance services. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about Medical Response Services

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

During the inspection, we visited the provider's ambulance base location, which is where the service was provided from. We spoke with 16 staff including; office staff, patient transport ambulance staff and management. We spoke with two patients. We reviewed information relating to the service both before, during and after the inspection including policies and procedures, meeting minutes and feedback forms. During the inspection, we reviewed 85 sets of patient records and 17 patient booking forms.

There were no special reviews or investigations of the service ongoing by the Care Quality Commission at any time during the 12 months before this inspection. The service has been inspected three times, and the most recent inspection took place in November 2017, which found that the service was not meeting all standards of quality and safety it was inspected against, we did not rate these services at that time.

Activity (October 2018 to September 2019)

- For the reporting period October 2018 to September 2019 we were not provided with the number of patient transport journeys undertaken because the service did not monitor or record this information.

There were 47 staff in total who worked at the service. There were two managing directors, an operations manager, an office manager, one mechanic, two office administration/call handling staff and 40 patient transport ambulance staff which included both permanent and bank staff.

Track record on safety

- There had been no never events reported by the organisation.
- There had been no serious incidents reported by the organisation.

There had been four complaints into the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We found the following issues the service needs to improve:

- The service did not always provide mandatory training in key skills applicable to the service provided, to all staff and did not always make sure everyone had completed it.
- Staff did not receive training in safeguarding children.
- Staff did not always complete or update risk assessments for each patient or remove or minimise risks**.**
- The service did not always use systems and processes to safely transport medicines.
- The service did not always manage patient safety incidents well. Staff did not always recognise incidents and near misses or report them appropriately. Managers did not always investigate incidents and did not always share lessons learned with the whole team, the wider service and partner organisations.

However, we found the following areas go good practice:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- Staff kept equipment and the premises visibly clean. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The service had enough staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

Are services effective?

Inadequate 

We found the following issues the service needs to improve:

- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. Staff did not always protect the rights of patients' subject to the Mental Health Act 1983.
- The service did not always monitor agreed response times so that they could facilitate good outcomes for patients. They did not always use findings to make improvements.
- The service did not always make sure staff were competent for their roles.

Summary of this inspection

- It was not always clear that staff supported patients to make informed decisions about their care and treatment or that staff followed national guidance to gain patients' consent. It was not always clear that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However, we found the following areas of good practice:

- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff assessed patients' food and drink requirements to meet their needs during journeys.

Are services caring?

Good

We found the following areas of good practice:

- Staff treated patients with compassion and kindness and respected their privacy and dignity.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition.

Are services responsive?

Requires improvement

We found the following issues the service needs to improve:

- The service was not always inclusive and did not always take account of patients' individual needs and preferences.
- Complaints were not always managed in line with policy and lessons were not always shared with all staff, including those in partner organisations.

However, we found the following areas of good practice:

- The service planned and provided care in a way that met the needs of local people and the communities served.
- People could access the service when they needed it and received the right care in a timely way.

Are services well-led?

Inadequate

We found the following issues the service needs to improve:

- It was not always apparent that leaders had the skills and abilities to run the service or that they understood and managed the priorities and issues the service faced.
- The service did not have a vision for what it wanted to achieve or a strategy to turn it into action.

Summary of this inspection

- Leaders did not always operate effective governance processes, either throughout the service or with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.
- Leaders and teams did not always use systems to manage performance effectively. They did not always identify or escalate relevant risks and issues or identify actions to reduce their impact.
- The service did not always collect reliable data or analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions or improvements. Data or notifications were not consistently submitted to external organisations as required.

However, we found the following areas of good practice:

- Leaders were visible and approachable in the service for patients and staff.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires improvement	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Overall	Requires improvement	Inadequate	Good	Requires improvement	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Requires improvement
Effective	Inadequate
Caring	Good
Responsive	Requires improvement
Well-led	Inadequate

Are patient transport services safe?

Requires improvement

We had not previously rated this service. We rated it as **requires improvement.**

Mandatory Training

The service did not always provide mandatory training in key skills, applicable to the service provided, to all staff and did not always make sure everyone had completed it.

We had concerns that staff were not receiving the appropriate training or support to carry out the duties for which they were employed to perform. For example, there was no training in mental health awareness, mental health legal frameworks and associated documentation, duty of candour, complaints, complex needs, whistleblowing, specific consent training or medicines management.

Following the inspection, we were told that the service had redeveloped the training matrix since the inspection, to identify what training was required.

Mandatory training was overseen by the service directors and there was a training matrix for all staff who were employed by the service including bank staff. However, training records did not always contain the associated certificates. For example, 22 out of 26 training records checked had missing mandatory training certificates. We were told that the training matrix had been revised and that the records were still being transferred online (from paper). However, the training courses had been completed in June 2019 and the certificates remained missing. This meant that it was unclear that there was effective oversight of staff training.

At the time of the inspection we saw that mandatory training compliance was over 90% for all staff. Mandatory training consisted of 19 modules which included; infection prevention and control, safeguarding adults and Mental Capacity Act 2005.

Training was facilitated both through online and classroom-based learning. Online learning was provided through a system-based programme which alerted staff when the training was due by message. Classroom based training was facilitated by an external instructor who provided face to face courses, for eight of the 19 modules. We saw that there was a designated training room at the site base which contained all relevant equipment to facilitate classroom training.

Safeguarding

Staff did not receive training in both safeguarding adults and safeguarding children. However, staff understood how to recognise, report and protect vulnerable adults from abuse and the service worked well with other agencies to do so.

At the time of the inspection we saw that safeguarding adults training compliance was 100% for all staff. However, it was not apparent that the service provided training in safeguarding children. During the inspection we were provided with the course overview and lesson plan which was used by the external instructor which stated that the course combined safeguarding for children, young people and adults at risk. However, training certificates were entitled 'safeguarding of vulnerable adults' and did not

mirror the course document or title. Furthermore, the training matrix specified that the module was for safeguarding adults. This was important because it meant that the service was not meeting the latest intercollegiate guidance which states that all clinical and non-clinical staff who may come into contact with children were to be trained to level two as a minimum requirement.

Following the inspection, we were told that staff had completed safeguarding children training but this was not printed on the certificates. However, new certificates were not provided to us.

There was a safeguarding policy which was in date and version controlled. This was available to staff within the policies and procedures file; located in the crew room, at the ambulance base location. However, the policy did not reflect current legislation or the latest best practice guidance. For example, the Joint Royal Colleges Ambulance Liaison Committee guidelines and intercollegiate guidance referenced were both from 2006.

There was a safeguarding referral procedure in place which was in date and version controlled. This was available to staff within the policies and procedures file; located in the crew room, at the ambulance base location. However, the procedure was not always clear, easy to understand or appropriate for the service being provided. For example, the procedure advised staff in urgent circumstances to refer to section 3.10 of the procedure; however, there was no 3.10 within the document.

Following the inspection, we were provided with documented evidence that since the inspection, the service had amended the clarity of the safeguarding procedure to support staff.

The operations manager for the service was the designated lead for safeguarding and we saw that this person was trained to level three. However, we saw that the training related to adults only and that the safeguarding training course did not contain any face to face training hours, which did not meet with best practice guidance. A deputy lead had been established in the event that the service lead was unavailable; which showed good practice. However, we saw that this person was also trained to level three in adults only and this course was completed online with no face to face training hours.

All staff we spoke with during the inspection were able to demonstrate a good understanding of safeguarding principles and were clear on the service process for making a safeguarding referral.

The safeguarding lead told us that there was a good safeguarding reporting culture within the service and we saw that this was reflected in the number of safeguarding concern forms which had been completed. The service had made a total of 17 safeguarding referrals; however, the service had not notified the Care Quality Commission of these incidents which was a statutory requirement.

During the inspection we reviewed four safeguarding referrals and saw that each had been referred appropriately and had had the appropriate action taken. It was apparent that the service had made significant improvements in relation to safeguarding and safeguarding processes since the previous inspection.

We saw that all safeguarding referrals and subsequent documentation was held securely. However, we saw that there was no tick box on the patient movement log to record that a safeguarding concern had been raised. Staff told us that they would detail this within the free text box on the patient movement log and we saw evidence that this was the case when a vulnerable persons concern form had been completed.

We saw that all staff received disclosure and barring service checks and these were appropriate to the role of employment. There was a system in place for monitoring when disclosure and barring service checks were due and we saw that the key information was recorded within an electronic spreadsheet including the disclosure and barring service number and the date the renewal was due.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All staff undertook infection prevention and control training and we saw that compliance was 100% for all staff.

There was an infection prevention and control policy which was in date and version controlled. This was available to staff within the policies and procedures file; located in the crew room, at the ambulance base location. The policy gave limited information and did not reference any best

practice guidance. For example, there was no information for staff in relation to hand hygiene or reference to National Institute for Health and Care Excellence quality standard; QS61. There was no indication within the policy that it should be read in conjunction with any other service policy or that there were associated documents; for example, the clinical waste procedure. There was no detail within the policy of how compliance would be monitored. This meant that it was unclear how the service planned to monitor compliance against the policy.

During the inspection we saw that both the patient booking forms and patient movement logs contained risk assessment questions which included if the patient was infectious. However, it was unclear what procedure staff should follow if a patient was infectious as the infection control procedure contained only a vehicle cleaning procedure.

All staff we spoke with during the inspection demonstrated a good understanding of infection prevention and control principles and hygiene standards. All areas we visited were clean and had appropriate hand wash basins, liquid soap, antibacterial hand gel. The service displayed posters of the World Health Organisation hand hygiene pictorial guides throughout the ambulance base location.

The service had a designated infection prevention and control lead and staff we spoke with were aware that the lead should be first point of contact for raising concerns or seeking additional advice or support; this showed good practice. We saw evidence that the infection prevention and control lead carried out spot check audits which resulted in a pass or fail for vehicles.

Personal protective equipment (PPE) was available on all vehicles for staff to use when needed. This included items such as gloves and aprons. We observed staff using best practice hand hygiene techniques during the inspection and following best practice infection prevention control guidelines in between patients. The service did not carry out hand hygiene spot checks at the time of inspection; however, we were told that this was due to be implemented, going forwards.

Staff took care of their own uniforms on a daily basis. In exceptional circumstances; for example, if there was heavy soiling of staff uniform, the operations manager would arrange for the uniform to be laundered off site.

We saw that staff completed daily cleaning checklists and deep cleans were carried out on all vehicles every six weeks. We saw that both the daily checklists and six-weekly deep cleans were monitored and overseen by the operations manager.

All paperwork relating to the cleaning of vehicles was scanned onto the system and as such there was effective oversight of the number of spot checks completed, deep cleans and daily cleaning logs completed by staff.

Cleaning equipment was available at the ambulance base location and we saw that this was kept appropriately. Mops were colour coded and there was clear guidance which told staff which equipment should be used to clean which area.

The clinical waste procedure was in date and was version controlled. This was available to staff within the policies and procedures file; located in the crew room, at the ambulance base location. The procedure covered all required areas and the relevant legislation; for example, requirements of the Environmental Protection Act (EPA) 1990. However, there was no detail within the procedure of how compliance would be monitored. This meant that it was unclear how the service planned to monitor for compliance against the procedure.

The service adhered to standards of the Department of Health Technical Memorandum 07-01 in relation to the safe standards of waste disposal; including clinical and hazardous waste. Waste bins were appropriate to the environment; for example, non-touch pedal operation. Waste was collected by an external company under a contractual agreement and was stored appropriately whilst awaiting collection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

All areas observed were tidy and well maintained. Access to all areas was restricted and entry gained through swipe card access.

We saw that all areas had warning signs as required; for example, areas containing cleaning chemicals and hazardous substances.

Inadequate

Patient transport services

The service had 21 vehicles which were used for patient transport services. Vehicles were predominantly standard patient transport ambulances; however, the service also had an ambulance car and one secure vehicle which was only used when specifically requested and deemed appropriate by the service.

All vehicles were checked for road worthiness at the start of each shift and we saw that staff completed a daily checklist. These were overseen and audited; as required, by the operations manager. Vehicle defects could also be recorded during these checks and we saw that there was an effective process in place to log vehicle faults.

All vehicles had valid MOT certificates and tax and we saw that there was effective oversight of this on a vehicle maintenance whiteboard. We saw that each vehicle underwent a six weekly safety check and regular servicing. The service employed a mechanic to undertake this work and the garage was adjacent to the ambulance base location. This showed good practice and meant that repairs on service vehicles and equipment could be carried out swiftly as required.

We saw that all vehicles had been equipped with satellite navigation systems which updated automatically, and all vehicles had the facility for hands free communication, which showed good practice.

All equipment that was serviceable was serviced according to a schedule and all equipment checked during the inspection was within service date.

We saw that all equipment relevant to the vehicle was checked using a daily check sheet and there was a system in place which allowed effective oversight and audit, as required.

Basic emergency first aid kits and automatic external defibrillators were stored within the crew room at the ambulance base location for staff to retrieve for their vehicles at the start of their shift. First aid kits were tagged to let staff know that they were ready to be taken out and there was a system in place to make sure that expiry dates were logged and kits were restocked when items had been used or had expired.

Stores such as blankets and consumables such as vomit bowls, spill kits and gloves were readily available for staff and we saw that these were overseen effectively and managed appropriately.

Assessing and responding to patient risk

Staff did not always complete or update risk assessments for each patient or remove or minimise risks. However, staff identified and quickly acted upon patients at risk of deterioration.

We had concerns that the service did not have effective systems in place to ensure that only patients who were suitable for transportation with the service were transported. We were told by the management team that the service did not transport patients who had been sedated or medicated, or patients with complicated clinical needs or who were clinically unstable, without a clinical escort. Furthermore, we were told that the service did not transport children. However, these exclusions were not documented in the form of a procedure or as an exclusion/inclusion list for staff to follow.

Following the inspection, we were provided with documented evidence that since the inspection, the service had implemented an inclusion and exclusion list for staff to follow.

Initial risk assessments formed part of the booking request form and were completed by the office staff who took telephone bookings for the service. We saw that the service had three separate booking forms: a standard booking form, a bariatric booking form and a secure mental health transport booking form. Once complete the information from the form was sent securely to the relevant vehicle and ambulance crew via an electronic system. The form was then scanned into the system and then confidentially shredded within the office. This was good practice and ensured that the paperwork did not leave the office and could therefore not be lost or misplaced.

The secure mental health booking form mirrored the risk assessment questions on the mental health patient movement log. For example, it asked if the patient was at risk of self-harm or if they were at risk of absconding. We had concerns that mental health patients who did not require secure transport had their booking recorded on a standard booking form. This meant that key questions relating to risk were not being assessed or recorded until the ambulance crew were in attendance at the transferring hospital. This meant that there was a risk that a crew could be deployed when they were not appropriately skilled or able to safely transport the patient which could result in a delay for the transfer.

Inadequate

Patient transport services

Following the inspection, we were provided with documented evidence that since the inspection, a standard mental health booking form which mirrored the mental health patient movement log had been introduced.

The standard patient movement logs mirrored the risk assessment information which was documented on the standard booking form. This meant that there was documented evidence that the attending ambulance staff were confirming risk assessment information given at the booking stage; for example, if the patient had a do not attempt cardio-pulmonary resuscitation order in place or if the patient was infectious.

The leadership team told us that neither the booking forms nor patient movement logs were audited. This was a risk because the service was not able to demonstrate that staff were capturing risk assessment information accurately and the service was unable to highlight areas of concern, promote best practice or make improvements.

Following the inspection, we were provided with documented evidence that since the inspection, the service had implemented an audit process for all types patient records, going forwards.

At the time of the inspection there was no deteriorating patient policy or standard operating procedure for staff to follow if a patient became acutely unwell. We saw from reviewing records that on two occasions staff took safe and appropriate action in such circumstances and all staff we spoke with were able to articulate taking some form of action, dependent on the situation. However, answers differed, and staff were unclear if there was an actual service procedure or process for them to follow, which there was not. We had concerns that as there was no exclusion/inclusion criteria staff would be placed in a situation which fell outside of their scope of practice or competencies.

Following the inspection, we were provided with documented evidence that since the inspection, the service had put a deteriorating patient process in place to support staff.

Staff received training in basic adult life support and how to use an automatic external defibrillator (a portable electronic device with simple audio and visual commands, which through electrical therapy allows the heart to re-establish an organised rhythm so that it can function properly). We were told that the service did not transport children and as such there was no basic paediatric life support training provided by the service.

Staff did not carry out any clinical assessments or interventions in their day to day work. Staff received a one-day course in adult emergency first aid and as such, emergency first aid was administered, as and when required.

We had concerns that neither management nor staff had an understanding of the documentation required to transport patients detained under the Mental Health Act 1983. We asked six staff about confirming with the transferring hospital that the relevant paperwork would be travelling with the patient. One staff member was able to articulate that they would confirm that section papers and any transportation forms were travelling with the patient; however, five told us they did not check or confirm this and were unsure what some of the documentation was. There was a tick box on the mental health patient movement log for staff to confirm the presence of a H4 form; however, there was no requirement for confirmation of section papers or any other transportation authority form or documents. The H4 transportation form is a statutory form which gives authority to lawfully convey a patient detained under the Mental Health Act 1983 from one hospital to another; for treatment of their the condition, where the receiving hospital is managed by a different hospital trust. Patients being transferred or transported from one hospital to another for medical emergencies or medical appointments detained under the Mental Health Act 1983, where the receiving hospital is managed by a different hospital trust would require a Section 17 leave of absence authority form.

Following the inspection, we were provided with documented evidence that since the inspection, the service had put processes in place to support staff, in relation to transporting patients with mental health needs, including relevant documentation checks.

Staffing

The service had enough staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

Patient transport services

The service had 47 members of staff in total including directors, managers, a mechanic and office staff. The service employed 40 patient transport ambulance staff; 27 drivers and 13 non-drivers. These staff were a mixture of bank staff (11) and permanent employees (29).

The office manager was responsible for producing the staff rotas and we saw that there was an effective system in place to do this. There was effective oversight of staffing and numbers of staff required and we saw that the service managed the staff assigned to the regular pre-planned work alongside additional ad-hoc work efficiently. Another member of office staff had been trained to complete this task in the event that the office manager was unable to do so. This was good practice as it showed succession planning.

We saw that rotas were allocated fairly, a month in advance and that staff received a minimum of 11 hours between shifts; in line with working time directives. Staff we spoke with confirmed that they always received 11 hours between shifts and never felt pressured into working additional hours.

We saw that the service was able to alert staff electronically that rotas were available and this also detailed any vacant shifts which required covering. Staff told us the system worked well and we saw that it was highly effective during the inspection.

We were told that bank staff would be offered full time positions in the first instance before recruitment campaigns took place and this was confirmed by ambulance staff we spoke with. Bank staff understood that if the service lost any of the regular pre-planned work for the acute NHS hospital trust's, the service would look to streamline staffing which meant bank staff in the first instance. However, this risk was not detailed on the service risk register.

We discussed other risks in terms of staffing with the leadership team and were told that another key risk related to a number of staff being non-drivers. This meant that if a driver was absent and the ambulance crew consisted of a driver and a non-driver it could be difficult to find a replacement at short notice. We saw this to be the case during the inspection; however, there was no impact as the vehicle was for any ad-hoc work for that day. In order to mitigate the risk, going forwards, we were told that the service had elected to recruit only ambulance staff who were able to drive. However, this risk and mitigating action was not detailed on the risk register.

We saw that sickness rates were low in the service; however, leaver rates for the previous 12 months had been high. The leadership team told us that this was due to the service recruiting in large numbers (two intakes) and the role had not been as the candidates expected. The service had sought feedback from leavers and as a result had made changes to the recruitment process. For example, the service had implemented a "ride along" day as the final stage of the application process. This enabled the service to check the suitability of the candidate but also allowed the potential candidate to see what the job involved and see if it was something they felt they could commit to. This showed good practice as it reduced the future risk of staff leaving because the role was not as expected; however, neither the risk or the mitigating action were detailed on the risk register.

We saw that staffing was discussed as a standard item at each management meeting and a staffing report was produced each month which detailed a number of items including sickness, non-attendance and lateness. The service used these reports to inform future recruitment and this showed good practice.

Office staff worked on a rotational basis and we saw that there was an effective system in place to ensure that cover was provided between the hours of 730am to 10pm Monday to Sunday. Outside of these hours there was a management on-call rota and we saw that there was an effective telephony system and process to facilitate this. All staff we spoke with during the inspection told us there was never any issue with contacting either the office or management for support, advice or assistance.

Following the inspection, we were provided with documented evidence which showed the risks relating to staffing highlighted during the inspection had been added to the service risk register.

Records

Staff kept records of patients' care and treatment. Records were up-to-date, stored securely and easily available to all staff providing care.

Patient transport services

The service did not have a document or record management policy to provide guidance for staff in relation to documentation completion. However, we were told that record completion formed part of the training during induction day and staff we spoke with confirmed this during the inspection.

The service had two types of documents which made up the patient records; a patient booking form and a patient movement log. There were three types of patient booking form a standard form, a bariatric form and a secure transport form. There were two types of patient movement logs a standard patient movement log and a mental health patient movement log.

The paperwork completed varied based on what type of transfer was being undertaken and which NHS trust the transfer was required for. For example, two acute NHS hospital trusts the service worked for allocated the work to the ambulance crews directly and as such booking forms were not used. The third acute NHS hospital trust completed bookings through the service's office and as such booking forms were completed. This also applied for ad-hoc work.

Office staff completed booking forms, when required, and information was relayed to the ambulance staff securely via the online system. All completed documentation was stored securely both on vehicles and at the ambulance base location.

During the inspection we reviewed 85 patient movement forms including 17 mental health patient movement logs and 17 booking forms. We saw evidence that details of care provided during the patient journey was recoded appropriately, including where applicable, adverse incidents. Patient details were completed accurately including mobility, whether the patient was prescribed oxygen and other key risk information. However, we saw that the section which detailed the number of patient bags which were picked up and dropped off was not completed in 37 out of 85 patient movement logs reviewed. This was a risk because if a bag was reported missing, the service would be unable to evidence from the records whether the bags had been transferred with the patient or not.

There was no oversight or audit of the completion of any form of patient records. This meant that there was a risk that patient documentation was not being completed correctly and that there was an increased risk that improvements would not always be made in a timely manner, when needed.

Medicines

The service did not always use systems and processes to safely transport medicines.

The service kept oxygen on vehicles and both oxygen and nitrous oxide at the ambulance base location. The leadership team told us that they were not currently using nitrous oxide and we did not see any evidence of nitrous oxide on vehicles which were in service.

There were no other medicines in use or being kept by the service. We saw that medical gas cylinders were stored appropriately; in a purpose-built cage, within the garage area. The cage was locked, had appropriate signage and there was evidence of cylinders being checked each day.

We saw that information relating to oxygen requirements was detailed both as part of the booking form and on the patient movement log records. We were told both by the leadership team and ambulance staff that the service only administered oxygen when it had been prescribed to the patient by the transferring hospital. However, there was no medical gases policy or procedure in place to confirm this.

Following the inspection, we were provided with a documented process which had been put into place since the inspection, to support staff in the administration and transportation of oxygen.

There was no formal training for staff in the administration of medical gases. We were told that the use of oxygen flow meters and oxygen administration formed part of the training undertaken by staff at the induction day. Staff we spoke with confirmed this during the inspection; however, there was no documented evidence of this.

There was no standard operating procedure or policy in place which guided staff in the transportation of the patient's own medication. This meant that it was unclear where the patient's own medication was to be stored or if this could be administered by staff during the transfer. Staff we spoke with told us they would not administer medication and that medication would be transported in the patient's bags. However, the number of bags was not always recorded and it was not clear that medication was being transported safely by the service.

Patient transport services

Following the inspection, we were provided with a documented process which had been put into place since the inspection, to support staff in transporting patient's own medication.

We had concerns that the service was not able to transfer or transport patients who had been sedated or medicated safely. Both the secure transport booking form and the mental health patient movement log requested information about whether the patient had been sedated; however, the information was not mirrored. For example, the mental health patient movement log asked if the patient had been sedated. The secure transport booking form asked if the patient had received any sedation in the last four hours. We were told that the service did not transport sedated patients without a clinical escort. However, this was not detailed on either form and there was no exclusion/inclusion criteria for staff to follow or documented procedure to provide guidance. We did not see any evidence of sedated patients being transported without an escort during the inspection.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise incidents and near misses nor report them appropriately. Managers did not always investigate incidents and did not always share lessons learned with the whole team, the wider service and partner organisations. However, when things went wrong, staff apologised and gave patients honest information and suitable support.

The service did not have an incident management policy and the incident management procedure available was limited, not always clear or relevant to the services being provided. For example, the procedure instructed staff that faults with medicinal products be reported to the pharmacy the product was obtained from. However, the service was not carrying any medicinal products obtained from pharmacies.

Incidents were not managed in a way that would reduce the risk of a similar incident happening again. The incident management procedure did not include a process for investigating, reviewing or taking action when an incident had occurred. We saw that the service was completing incident check sheets, for each incident reported and these included tick boxes for information such as if further staff training was required, whether the office was informed straight away and if any disciplinary action should be taken. However, the checklist did not include any investigation, identified learning or outcome. Furthermore, the incident check sheets did not include the name of the reviewer or a date of review. This meant it was unclear if the reviewer was a manager and had the necessary experience to review incidents or if the incidents were being reviewed in a timely manner.

During the inspection, four out of six staff we spoke with were unclear on what to report as incidents or could not give examples beyond safeguarding or vehicle faults. It was therefore not always apparent that incidents were being reported appropriately. Two staff members gave separate examples of incidents which had occurred during their shifts, neither incident had been reported or documented as an incident. We also saw an incident when a patient had become aggressive which was detailed in the free text on a patient movement log. This was not recorded as an incident. This meant that there was an increased risk that incidents were not being reported, were not always being recorded correctly and that there would be no documented evidence of what actions had been taken to prevent similar incidents.

There was limited oversight of incidents. We were told there was no incident oversight log and we saw that one incident was located in the safeguarding folder as it involved a safeguarding issue and was not cross referenced within the incident folder. This meant that the service had to manually look through individual folders to ascertain the overall number of incidents for the service.

Following the inspection, we were provided with documented evidence that since the inspection, an incident log had been put into place and incidents were listed as a standard agenda item for discussion, at monthly management meetings.

There was no process for grading incidents and therefore no resulting requirement for differing levels of investigation; in line with best practice guidance. There was no reference to moderate harm or above incidents, that such incidents were notifiable to the Care Quality Commission or outlining the provider's responsibility to discharge Duty of Candour. 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 including any incident with a patient harm level of moderate or above.

The service did not have a Duty of Candour policy or provide any training for staff in relation to it. Five out of eight staff we spoke with were unclear on what the term meant; however, all staff were clear that they should be open and honest with patients, their families and carers.

Following the inspection, we were told that since the inspection, the service had put online Duty of Candour training in place for staff.

Are patient transport services effective?
(for example, treatment is effective)

Inadequate

We had not previously rated this service. We rated it as **inadequate.**

Evidence-based care and treatment

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

We had concerns with all the policies and procedures which we reviewed both before and during the inspection. The service had a number of policies and procedures for staff to follow in the course of their work; however, policies and procedures were not always clear, did not reference the latest guidance, were not always available or appropriate to the services being provided. For example, the mental health policy stated that management must make sure that copies of the company Mental Capacity Act 2005 standard operating procedures were available for all staff for guidance; however, these did not exist. Similarly, the policy guided staff to an appendix containing a national ambulance protocol for patients detained under Section 136; however, the protocol referenced was out of date and was not actually present within the appendices.

Following the inspection, we were provided with documented evidence that since the inspection, the service had put in place policies and procedures which followed best practice guidance to support staff in transporting those with mental health needs.

We had concerns that there was no documented process or procedure which made it a mandatory requirement for staff to read and sign a declaration of understanding for service policies or procedures. This was highlighted to the leadership team during the inspection and we were told that this would be written into the induction programme, going forwards.

All staff we spoke with knew where the policy and procedure file was located within the crew room, at the ambulance base location. However, there were no policies and procedures on the vehicles and there was no way for staff to access them electronically when they where out of the ambulance base location. We were told that if staff were unsure whilst out during their shifts they would need to contact the office for advice.

All staff we spoke with told us that if there were any changes to practice, they would be advised via the team intelligence brief. However, as there was no designated lead for policies and procedures and all policies and procedures were written by different authors, it was unclear that policies or procedures were being updated, when required.

Nutrition and hydration

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

During the inspection, staff we spoke with informed us that they gave patients enough food and drink to meet their needs and journeys were planned in a way that met the needs of patients including stops as necessary. During the inspection we saw that all vehicles carried bottled water for patients, if required.

Response times and patient outcomes

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

The service did not monitor or record the number of patient journeys they completed. We were not provided

with information to identify the number of journeys undertaken in the reporting period October 2018 to September 2019 and therefore could not establish how many patient transport or mental health transport journeys took place.

We saw that there was no requirement on any of the service paperwork for an agreed response or target time for each patient journey. We saw that there was a space for ambulance staff to record four sets of times relating to each patient on both the patient movement log and the mental health patient movement log, these included the pick-up time, the time the patient was loaded, the arrival time at the destination and departure time of the ambulance crew from the destination. We saw that in most instances, these times had been recorded. However, as there was no recorded response or target time there was no way to provide assurances that the service was responding quickly enough to meet patient's needs or find ways in which to seek improvement.

We saw that the service used a tracking system for all vehicles. This enabled the service to have effective oversight for ad-hoc bookings as to whether there was capacity to facilitate the booking when requested. We were told that if the service did not have the capacity to accept the request, they would refuse it. Office staff were able to articulate few occasions were this had happened and told us that generally the service was able to facilitate most ad-hoc requests.

Competent staff

The service did not always make sure staff were competent for their roles. However, managers appraised staff's work performance and held supervision meetings with them.

There was a recruitment and induction process in place which was in date and version controlled. During the inspection, we saw that this process was followed. This included Disclosure and Barring Service checks and driving licence checks. However, the recruitment and induction process did not outline what would happen if the required checks did not clear or if a risk assessment would be carried out in such cases.

We saw that personnel files included information as specified in the documented recruitment and induction process. For example, application forms, health questionnaires, right to work forms and references. We reviewed 15 personnel files and found one file was missing a work reference and another file was missing a character reference.

There was an induction policy which was in date and version controlled. However, the policy was not always clear, easy to follow and did not always make sense. For example, the policy stated that the induction procedure aimed to provide more detail and clarity to the induction programme, the support provided and the responsibilities of those involved in the process. However, we were told that both the induction procedure and programme were incomplete and in draft format, at the time of the inspection. There was a current induction procedure which was detailed at the end of the policy; however, this lacked clarity when reviewed in isolation and in relation to the rest of the policy.

During the inspection, all staff we spoke with told us that they had received an induction, had completed "shadow shifts" in which they had accompanied an experienced crew for a number of shifts and had undergone a three-month probationary period. At the end of the probationary period staff reported having received an appraisal and the leadership team established if there were any areas of concern from either party.

The service completed driving assessments for staff as part of the induction process. These assessments were completed internally by the operations manager who had a Royal Society for the Prevention of Accidents (RoSPA) advanced driving certificate. There were no ongoing assessments for staff; however, we were told that poor performance would be addressed if necessary and we saw that the tracking system enabled the management team to have effective oversight of vehicle speeds and the use of braking systems.

We saw that all staff had received an appraisal in the last 12 months. The service used a standard appraisal form and this required the signature of both manager and employee. The form included a declaration that the employee had not incurred any criminal convictions or driving offences since the last appraisal; this was good practice. We reviewed 24 appraisal forms and saw that five had not been countersigned by the manager conducting the appraisal. It was not always clear that the service supported staff with poor performance or areas of concern. For example, we

saw that one appraisal form annotated that the staff member's written paperwork was not to a satisfactory standard. There was no detail of how the staff member would or could be supported to improve this.

Multidisciplinary working

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

During our inspection we saw that office staff, ambulance staff and management worked well together.

Staff told us they felt they worked well with all levels of staff from other organisations and would have no hesitation in raising issues or dealing with any issues raised if they were able to do so. We saw this in practice during the inspection both at the local acute NHS hospital trust and a local hospice which a patient was transferred to.

We saw that the service had developed good working relationships with the three acute NHS hospital trusts for which the regular pre-planned work was being provided for. This was corroborated in the form of emails and meeting minutes between the service and the acute NHS hospital trusts.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

It was not always clear that staff supported patients to make informed decisions about their care and treatment or that staff followed national guidance to gain patients' consent. It was not always clear that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

We saw that the service had a control and restraint policy and this was in date and version controlled. However, information within the policy was not always clear, did not follow best practice guidance or current legislation and did not always make sense to the services being provided. For example, the policy used outdated terminology, discussed restraining patients in the prone position and did not include recommendations around maximum length of time restrictive interventions should be used for. This did not meet with National Institute for Health and Social Care Excellence guidance; NG10 or the Department of Health (DH) guidance, Positive and Proactive Care or the Mental Health Act code of practice. Furthermore, the policy stated that every effort should be made to use skills and techniques that did not use the deliberate application of pain. This was not appropriate for healthcare services and would be suited only for secure escorting; for example, security companies or police services.

We had concerns that as there was no restraint procedure and the restraint and control policy was not clear; it was not apparent if staff should or should not be restraining patients. Staff completed both a conflict resolution and a physical intervention course as part of mandatory training and we saw that compliance with both was 100%. The conflict resolution course was appropriate and comprehensive. However, it was not apparent that the physical interventions training course was suitable or appropriate for the service being provided. The course was aimed at staff working within the private security sector; for example, security door staff and as such did not meet with, or reference, any best practice guidance such as the Department of Health (DH) Positive and Proactive Care.

The policy did not state that staff should document restraint incidents either as an incident or on the patient movement log. Furthermore, the policy stated that the company had systems and processes to review all incidents where restraint was deployed; however, these were not documented anywhere within the policy. The management team told us that there had been no incidents of restraint within the service that they could recall; however, it was not clear that if restraint was used, incidents would be reported, investigated or that there was effective oversight in line with best practice guidance (National Institute of Care and Excellence; NG10). We had further concerns that the policy stated that compliance against the policy would be monitored through the number of patient or staff harm incidents which were a result of restraint.

During the inspection, we asked four staff if they would restrain a patient if required, two staff members told us that they would and were able to restrain patients and two told us they would not and were not able to restrain patients. One staff member told us that if a patient was aggressive and required restraining they would be transported in the service's secure vehicle. However, there was no procedure or policy which stated this. We did not see any evidence that any patient had been restrained within the records checked during the inspection. One staff member was able

to give an example of an aggressive patient whom the staff member felt unable to transfer safely as the transferring hospital was not providing an escort. This showed good practice and corroborated that staff felt able to raise issues with the acute NHS hospital trust's they provided services for. However, this was a risk as there was no exclusion or inclusion criteria and no documented procedure; therefore, it was unclear what staff should do in such situations and that patients could be transported safely by the service.

We saw that the control and restraint policy detailed the use of mechanical restraints and we saw that basic handcuffing was a separate training module within mandatory training. We also saw that staff had handcuff training certificates within their training files. However, we were told that the service did not carry mechanical restraints or use them. The leadership team told us that the handcuff demonstration was to give staff an awareness of handcuffs so that they were aware should the service transport a patient who was handcuffed. Eleven out of twelve staff we spoke with confirmed that they had received a demonstration at the end of the physical interventions course in handcuff techniques but did not use or carry them. It was therefore unclear why the service policy referred to the use of mechanical restraints.

Staff received annual training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We saw that staff compliance was 100% for both modules. However, there was no training specifically in relation to consent. We saw that consent in relation to mental capacity was discussed within the Mental Capacity Act 2005 training module and completing capacity assessments was also discussed. However, it was unclear if staff were expected to assess capacity or not.

We had concerns that there were a lack of policies and procedures for staff to follow particularly in relation to mental capacity, consent and best interest decisions. Information around consent, capacity and the Mental Capacity Act 2005 was annotated in the safeguarding referrals procedure, safeguarding policy, mental health policy and the control and restraint policy. Information within these policies and procedures was not always clear, did not cross reference, did not always make sense or was not always applicable to the service being provided. For example, the safeguarding referral procedures advised staff that if a vulnerable patient refused transport to hospital, consideration must be given to the capacity of the patient and that a capacity assessment may be required. Staff were advised to refer to the consent and capacity procedure. However, we were told the capacity and consent procedure did not exist and there was no capacity assessment document or procedure for staff to follow or reference for guidance.

The leadership team told us that ambulance staff would not be expected to complete capacity assessments on patients and that they would expect staff to refer to a qualified Health Care Professional at the transferring hospital for assistance or contact the office if the crew were at a home address. However, this was not documented anywhere in the form of a procedure for staff to follow and as such it was unclear what staff were expected to do.

Staff we spoke with during the inspection could articulate what they would do if a patient withdrew consent during a patient transport journey or before transportation to good effect and this mirrored what we were told by the leadership team. However, it was not clear that the relevant training and guidance where in place within the service for staff, should they require it. This was a risk as documentation was not being routinely checked in relation to patients detained under the Mental Health Act 1983 who were being transported.

Following the inspection, we were provided with documented evidence that the service had put in place a policy and process to support staff in relation to consent and capacity issues.

Are patient transport services caring?

Good

We had not previously rated this service. We rated it as **good.**

Compassionate care

Staff treated patients with compassion and kindness and respected their privacy.

During the inspection we observed two patient journeys and saw that staff treated patients kindly and made sure that patients were well looked after. Both patients were

transferred onto service equipment safely, ensuring patient comfort and the crew made sure that the patient's dignity and privacy was maintained in both instances with the use of cubicle curtains and blankets.

We saw that patient confidentiality was maintained during handovers at the receiving hospital and hospice.

Staff we spoke with during the inspection were able to give good, solid examples of compassionate patient care and it was apparent that staff saw this as the most important aspect of their role.

We saw evidence of, and were given examples of, when staff had made sure patients were safe before leaving them at home addresses and took account of individual needs and preferences. For example, staff had returned a patient to the acute NHS hospital ward that the patient had been discharged from because the home environment the patient was being discharged to was unsafe.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

All staff we spoke with during the inspection were able to articulate the importance of providing emotional support to patients, their relatives and carers. It was evident that staff wanted to look after patients and provide a high level of emotional care as part of their role.

During the patient journeys we observed staff demonstrating patience and understanding when it was unclear how access to the patient's property would be obtained. The crew did not try to rush the patient and allowed the patient the time to think through the access issue and obtain a solution.

Staff were able to give specific examples of when they had emotionally supported patients during transfers and discharges and we saw that staff were committed to ensuring patients felt supported and at ease.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition.

During the inspection we saw that both patients had everything explained to them clearly and in a way that they could understand.

Staff we spoke with during the inspection were able to give good, solid examples of how they would involve patients and those close to them and ensure understanding. This was particularly evident for transferring patients with mental health needs.

Staff were able to give specific examples of when they had recognised that the patient would feel more comfortable being transported with a carer or relative and if possible, this was accommodated.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We had not previously rated this service. We rated it as **requires improvement.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Patient transport services were the main service offered and this was a UK-wide service to accommodate the needs of patients including hospital discharges, inter-hospital transfers and those who required mental health transportation.

The service worked with regional and national acute NHS hospital trusts to support demand and provide both pre-planned and ad-hoc patient transportation.

The service currently had three regular pre-planned transportation workstreams with three acute NHS trusts. The service had draft contracts which they had submitted to the acute NHS hospital trusts; however, these had not been returned or signed. The draft contracts included information regarding how performance could be monitored and what level of transportation could be provided. We saw that the service was keen to discuss requirements and what could be provided with the acute NHS hospital trusts; however, we saw that this could not always be facilitated due to pressures within the system.

The service had established systems to provide and manage the regular pre-planned transportation by working

closely with the acute NHS hospital trusts. The management methods appeared to work well and we saw that there was flexibility within this. For example, over the Christmas period the acute NHS hospital trusts had been supported with additional vehicles at peak times when this could be facilitated by the service.

We saw that the ad-hoc work was also managed effectively and there was flexibility within this area to facilitate more urgent work; for example, end of life care transfers could be facilitated at short notice due to the tracking system which enabled the service to have oversight of all vehicle locations.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. However, staff made reasonable adjustments to help patients access services.

There was no procedure in place for transporting patients whose first language was not English. However, both staff and management told us that a translation application could be utilised and were able to demonstrate this on their mobile phones. Neither staff nor management were able to recall any occasions were this had been used since the service began.

The mental health policy stated that staff having direct contact with patients would receive training in mental health conditions including dementia awareness. However, this was not included within the mandatory training programme. There was no training for staff in relation to other potential complex needs; for example, learning disabilities. Furthermore, there was no requirement within the booking form, patient movement log or the mental health patient movement log which specifically requested whether patients were living with complex needs such as dementia or learning disabilities. This was important as we were told and saw evidence that the service had transported patients living with these conditions.

We saw that the service had given considerable thought to ensuring that they were able to safely transport bariatric patients. All service stretchers were bariatric, over half of the ambulances were equipped with a bariatric winch and slide aids for bariatric patients were available. We saw that there was a separate booking form for bariatric patients which included a set of risk assessment questions. We were given examples of when a member of the management team had completed on site risk assessments and this showed good practice as the service was making sure they could safely transport the patient before agreeing to the advanced booking. We saw evidence that staff were given training in bariatric equipment as part of the induction process and had signed for their understanding of it.

Access and flow

People could access the service when they needed it.

The service was available 24 hours a day, seven days a week across the year. Bookings could be made on the day of transfer or in advance.

Bookings were taken by the office staff, at the ambulance base location and senior management support was available 24 hours a day for both office staff and ambulance staff.

All vehicles were tracked by a navigation system and this allowed office staff to see where a vehicle was and who the crew were. This meant that office booking staff had oversight of vehicle availability and could allocate the nearest available vehicle should a new ad-hoc booking come in.

As the service did not monitor or record the total number of patient journeys, we were not able to establish if any patient journeys had been cancelled due to the service being unable to facilitate the transfer. However, the leadership team could not think of any recent occasions when this had occurred.

Following the inspection, we were provided with documented evidence that since the inspection, the service had begun to record all monthly patient journey numbers.

As the service did not document target times for collecting patients, we were not able to establish if the journeys were made in a timely manner. However, we were told that the service aimed to respond within an hour of receiving the booking and we saw that whilst the service did not routinely monitor times, they were able to run reports from the tracking system to establish if there were delays or issues.

Learning from complaints and concerns

Complaints were not always managed in line with policy and lessons were not always shared with all

staff, including those in partner organisations. However, it was easy for people to give feedback and raise concerns about care received and the service treated concerns and complaints seriously.

There was a complaints policy in place which was in date and was version controlled. This was available to staff within the policies and procedures file; located in the crew room, at the ambulance base location. The policy outlined timeframes for responding to complaints and a procedure for management to do so. However, the policy did not contain any reference to the Parliamentary and Health Service Ombudsman or other external bodies such as the Independent Sector Complaints Adjudication Service. These are independent bodies that can make final decisions on complaints that have been investigated by the provider and have not been resolved to the complainant's satisfaction.

Furthermore, the policy did not detail how complaints would be investigated with other provider's if needed. This was important because all patient journeys were undertaken on behalf of other providers, such as acute NHS hospital trusts.

There was no evidence that staff received training or were given an overview of complaints as part of the induction process. The complaints policy stated that complaints were discussed as part of the induction programme; however, we were told that the induction programme was in draft format and had not yet been completed.

We saw that all vehicles contained laminated information for patients, their relatives and carers about how to make a complaint, or give feedback, if required. Feedback forms were also available for patients to take from vehicles.

Complaints were not always managed in line with policy. The service had received four complaints. There was no evidence of an acknowledgment for one complaint and no evidence of a final response for another. Three out of four complaints did not advise the complainant about what to do if they remained unsatisfied with the complaint response.

There was no evidence that the compliance process within the complaints policy was followed. The policy stated that managers would discuss complaints and look for themes and trends; however, there was no evidence of complaints being discussed at any management level meetings or learning specifically relating to complaints being shared with staff within team intelligence brief letters.

Following the inspection, we were provided with documented evidence that since the inspection, complaints and learning had been discussed at a management level meeting.

Are patient transport services well-led?

Inadequate

We had not previously rated this service. We rated it as **inadequate.**

Leadership

It was not always apparent that leaders had the skills and abilities to run the service or that they understood and managed the priorities and issues the service faced. However, leaders were visible and approachable in the service for patients and staff.

The leadership team consisted of two managing directors, an operations manager and an office manager. Collectively they were responsible for the planning and operational support for the service's day to day work.

The responsible individual who was a managing director, was unable to supply information relating to themselves as specified in Schedule 3; either as part of the provider information return, or during the inspection. For example, information such as insolvency and bankruptcy checks. Furthermore, there was no appropriate process for assessing and checking that the responsible individual held the required qualifications and had the competence, skills and experience required to undertake the role. Consequently, there were no associated records to show the process had been followed.

It was not clear from the evidence provided that members of the senior leadership team had the managerial experience and leadership skills to effectively run the service. This was important because they were responsible for undertaking all aspects of management, including developing policies and procedures.

Inadequate

Patient transport services

Following the inspection, we were told that members of the management team had enrolled on a level 5 management course.

All staff we spoke with during the inspection spoke highly of the leadership within the service. Staff said that leaders were approachable and available at all times for them.

Vision and strategy

The service did not have a vision for what it wanted to achieve nor a strategy to turn it into action.

The leadership team were able to articulate how the company had grown over the last nine years and they told us they wanted to continue to grow in a phased approach whilst remaining focussed on delivering good, solid patient care. However, there was no formal documented vision, business plan or strategy for the service.

During the inspection staff we spoke with were unsure what the service vision or strategy was; however, some staff were able to articulate that the service ethos was about delivering a high standard of patient care.

We were told that the service was not looking to provide any services within urgent and emergency care.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

During our inspection all staff we spoke with told us that this was a good place to work. They felt supported by all levels of staff from colleagues to office staff and the leadership team. Staff told us they were happy to raise concerns, issues or make suggestions for the service, at any time.

There was no whistleblowing or raising concerns policy in place within the service. We saw that there was a small section within the employee handbook in relation to whistleblowing and a contact telephone number for an external independent whistleblowing charity. However, two out of five staff we spoke with were unable to recall this and were unfamiliar with the term whistleblowing.

Following the inspection, we were provided with documented evidence that the service had put a whistleblowing policy in place.

Governance

Leaders did not always operate effective governance processes, either throughout the service or with partner organisations. Staff at all levels were not always clear about their roles and accountabilities. However, staff had regular opportunities to meet, discuss and learn from the performance of the service.

During the inspection it was not clear that the leadership team understood or had the appropriate knowledge of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), relevant best practice and guidance or understood the consequences of failing to take action on set requirements. For example, meeting the requirements of the Duty of Candour regulation or notifying the Care Quality Commission of certain incidents such as safeguarding incidents.

We saw that management meetings happened monthly on the first Thursday of each month. Management meetings were not documented in a way that could be clearly followed. There were no minutes and the management meeting action plan did not make it apparent if there was a set or standard agenda and it was not always clear what had happened during these meetings. On occasion, the language annotated within the management meeting action plan was offensive and inappropriate.

We saw that office meetings happened once a month and were chaired by the office manager. It was unclear from the meeting minutes who attended these meetings as this was not documented. The meeting followed a set agenda, confirmed the previous meeting minutes and action log and detailed any new actions including owners and deadlines. There was an item for open floor suggestions and/or issues. This was good practice. The minutes also detailed the date and time for the next meeting.

There were no staff team meetings. We discussed this with the management team and were told that this had been attempted but did not elicit a good response in terms of staff turnout. As an alternative, the management team produced a team intelligence brief each month, with detailed key information for staff. For example, information on equipment was included, such as reminders to charge batteries from the ambulance stretchers at the end of the shift. On occasion, the tone and the font of text within the team intelligence briefs could be perceived as aggressive and/or threatening. Four out of six team intelligence briefs

we reviewed had at least one section giving staff information which was in bold, capital letters and highlighted red. For example, staff were advised that lateness would not be tolerated and that staff would be disciplined if they continued to be late for shift.

We saw that when the service had been able to facilitate meetings with external partners such as the local acute NHS trust, these had resulted in improvements within the service and the relationship between providers. For example, the service had implemented the secure request booking form as a result of these meetings as it had been established that the secure vehicle was being requested when it may not necessarily be required. This had resulted in a reduction in inappropriate requests which the service had mapped out.

The service had no effective oversight or a designated lead for policies and procedures. Therefore, it was unclear who staff would approach should they have a query with a particular policy or procedure. Furthermore, neither policies or procedures had a named author. For example, the control and restraint policy was written by the general manager. It was not apparent from the documented company structure who this individual was as the title was not annotated against a name.

Following the inspection, we were told that the service had appointed the operations manager as the designated lead for all service policies and procedures.

There was a lack of policies for staff to reference for guidance. For example, there were no policies in relation to patient deterioration, medicines management (patient own medications), medical gases, incident management, duty of candour, whistleblowing or capacity and consent.

There was a lack of procedures for staff to follow or reference for guidance. For example, there were no procedures for staff to follow in the event of patient deterioration, capacity issues, use of restrictive interventions, inclusion/exclusion criteria for transport or documentation checks for transporting patients detained under the Mental Health Act 1983.

Policies and procedures were not always clear, were not always easy to understand and were not always appropriate to the service being provided. Policies and procedures did not always follow best practice guidance or standards and did not always include the latest guidance or current legislation. We reviewed nine service policies and four procedures both before and during the inspection and had concerns with each policy we reviewed and three of the four procedures. For example, the training policy contained information about staff the service didn't employ and work the service didn't undertake; for example, paramedics and urgent and emergency work. The policy did not include any details about mandatory training and it did not outline staff responsibilities or cross reference to the service induction policy.

Compliance processes within policies and procedures were not always clear or present. This meant that it was unclear how the service had planned to monitor staff compliance against policies or procedures. When compliance processes were clear, there was no evidence that they were being followed. We reviewed nine service policies and four service procedures both before and during the inspection and we had concerns around the compliance processes within seven policies and two procedures. For example, the mental health policy did not state how compliance against the policy and the requirements set out within it would be monitored.

Policies and procedures did not always cross reference when required and did not always include references as to where the information within them had come from. We reviewed nine policies and four procedures both before and during the inspection and found concerns within seven policies and three procedures. For example, the induction policy did not cross reference to the training policy, capability policy or employee handbook.

Following the inspection, we were provided with documented evidence that since the inspection, the service had begun a programme to review and amend all service policies and procedures.

We saw that the service had arranged for appropriate insurance policies to be in place. This included motor insurance for all vehicles and employer's liability insurance. We saw that the certificate was displayed within the site base.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify nor escalate relevant risks and issues nor

identify actions to reduce their impact. However, the service had plans to cope with unexpected events and staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was no evidence of an effective risk management system. The risk register did not contain any of the key risks which were highlighted and discussed with staff either during the inspection process or during interview. The risk register had no risk identified date, mitigating actions, risk owner or risk review date. There was no evidence to suggest that the risk register was discussed as part of management meetings. This was important because the risk register contained risks which were high scoring. This meant it was unclear when or if these risks were reviewed and how they would be monitored.

We were not assured that incidents were being recognised, reported, graded, documented or investigated appropriately. The incident folder contained four incidents in total, we saw that a further incident was filed in the safeguarding file and we saw evidence of incidents recorded within the patient movement logs which had not been documented as incidents. This meant there was a risk that the service was unable to highlight areas of concern, seek improvement or prevent similar incidents from reoccurring.

The service had systems in place to monitor compliance and give oversight for certain areas. For example, daily vehicle checks, daily cleaning schedules and safeguarding concerns/referrals. We saw that there was good oversight and that staff told us they received feedback if the leadership team thought there were areas for improvement. However, we were not assured that other areas of the service were monitored for compliance because there were no systems in place to audit these areas. For example, the use of restraint, completion of records or compliance with service policies and procedures. This meant that there was a risk that the service was unable to seek improvement, highlight areas of concern or good practice.

The leadership team were not monitoring overall performance including target times, journey numbers or types. However, the leadership team told us they could investigate performance issues if there were concerns raised. For example, an issue had been raised in relation to a patient being late for an appointment. As the service used a vehicle tracking system and were able to capture arrival times and departure times, they were able to investigate this incident and acknowledge that the crew had been waiting at the transferring hospital in excess of 45 minutes due to the patient not being ready for transfer; we saw that this was documented on the patient movement log. The service had also completed a piece of work for a local acute NHS trust whereby they had looked over a four-week period at how incorrect information given at the booking stage had resulted in increased costings. For example, if a booking had been requested for one patient on a stretcher and one patient in a wheelchair but when the ambulance crew arrived both patients required a stretcher then an additional ambulance had to be provided. We also saw that the team were able to provide other performance and cost analysis data as part of the pack put together for new contracts. However, there were no systems or processes to routinely monitor existing performance.

The service had a business continuity policy which in date and version controlled. It gave clear definition and guidance on what the procedures would be in the event of an emergency and other key incidents.

Following the inspection, we were provided with documented evidence that since the inspection, the service had implemented an audit process to highlight areas of concern and drive improvement across the service.

Information management

The service did not always collect reliable data nor analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions or improvements. Data or notifications were not consistently submitted to external organisations as required. However, the information systems in use were secure.

The service did not use collected data for analysis or audit. Patient records were scanned into the computer system; however, the data within the records was not collected or used. For example, performance data such as journey numbers and journey types. This meant that it was unclear how the service could highlight areas of concern or make improvements easily.

The service used manual files to collect and store safeguarding concerns, incidents, feedback and complaints. The files did not contain any oversight sheets

and there was no associated electronic oversight document. This meant that it was unclear how the service could use the data within the files to map trends and themes or highlight areas of concern or make improvements easily.

It was not clear that data or notifications were being submitted to external organisations as required. For example, safeguarding referrals had not been submitted as notifications to the Care Quality Commission which was a statutory requirement.

During the inspection we saw that both paper and electronic information systems which were in use at the service were secure.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They worked collaboratively with partner organisations around the service model.

The leadership team told us that they encouraged staff to give feedback and make suggestions on a regular basis. The team had begun "pop in" sessions for staff every Thursday where they encouraged staff to highlight any areas of concern to them, raise issues or share good practice. Staff we spoke with confirmed this. Going forwards, we were told the team would be introducing "pop up" sessions at the acute NHS hospital trusts for whom regular pre-planned work was being facilitated for. This was further opportunity for staff to raise concerns or share information.

A monthly team intelligence brief was produced for staff which gave information and we saw that staff were asked for their input to make suggestions about the briefs to the leadership team. Intelligence briefs contained different kinds of information including operational information, clinical information or could relate to reminders about issues or something of concern which had been raised. For example, we saw one bulletin was advising staff that the annual mandatory training was coming up within the next two months and that dates for training would be sent out via email.

We also saw that the team intelligence briefs gave praise to staff and shared "good news" stories when appropriate. For example, one bulletin gave praise to two staff members who had noticed a staff member from another ambulance service had become acutely unwell and offered assistance. We also saw that staff were congratulated and thanked by the leadership team through the briefs. For example, when the service had moved premises staff were thanked for their commitment in assisting in the transition, often at short notice.

We saw evidence that staff received feedback and praise and that these were kept in a feedback folder within the office. For example, a member of the acute NHS hospital trust staff had contacted the service to comment on the professionalism of the ambulance crew during a particularly difficult transfer.

Feedback forms for the public, relatives and their carers were available on all service vehicles and we saw that contact information and details about giving feedback were included on all vehicles on a laminated poster. However, the leadership team acknowledged that the feedback received as a result of the forms had been limited. The service was looking to trial freepost envelopes for feedback forms in the future.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that all staff receive training in safeguarding children, to the appropriate level, in line with the latest best practice guidance. This was a breach of Regulation 13(2).
- The service must ensure that they have an effective system and audit process in place to make sure that only suitable patients are transported. This was a breach of Regulation 17(2)(a).
- The service must ensure that there are appropriate and effective policies and procedures in place to support and provide guidance for staff to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 17(2)(a).
- The service must ensure that there are systems and processes in place to support staff when managing medicines. This was a breach of Regulation 17(2)(a).
- The service must ensure that all policies reference and reflect up to date legislation and national guidance. This was a breach of Regulation 17(2)(a).
- The service must ensure that all policies and procedures are clear for staff to understand and follow and appropriate to the services being provided. This was a breach of Regulation 17(2)(a).
- The service must ensure that all policies and procedures cross reference when appropriate and contain all referenced material. This was a breach of Regulation 17(2)(a).
- The service must ensure that there is an effective risk management system in place and that the risks detailed are reflective of the service being provided. This was a breach of Regulation 17(2)(b).
- The service must ensure that there are effective governance systems in place, including assurance and auditing systems or processes so that areas for improvement can be identified. This was a breach of Regulation 17(2)(b).
- The service must ensure that there is an effective system in place to manage incidents so that they are managed in a way that would reduce the risk of a similar incident occurring again. Furthermore, there must be a process in place outlining the provider's responsibility to discharge Duty of Candour and to notify the Care Quality Commission of incidents of moderate harm or above. This was a breach of Regulation 17(2)(b).
- The service must ensure that there is an effective oversight process and designated lead for service policies and procedures. This was a breach of Regulation 17(2)(f).
- The service must ensure that compliance processes within policies and procedures are present, clear and followed as detailed within the policy or procedure. This was a breach of Regulation 17(2)(f).
- The service must ensure that complaints are managed in line with policy. This was a breach of Regulation 17(2)(f).
- The service must ensure that there is an appropriate process in place for assessing and checking that the responsible individual holds the required qualifications and has the competence, skills and experience required to undertake the role. This was a breach of Regulation 4(3)(ii)(5).
- The service must ensure that information relating to the responsible individual as specified in Schedule 3, can be made available to view or be supplied; to the Care Quality Commission, when requested. This a breach of Regulation 4(4)(c).
- The service must ensure that persons employed by the service provider in the provision of a regulated activity receive the appropriate training and support to enable them to carry out their duties. This was a breach of Regulation 18(2)(a).
- The service must ensure that all incidents which require notification to the Care Quality Commission are made, without delay. This was a breach of Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

Outstanding practice and areas for improvement

Action the provider SHOULD take to improve

- The service should ensure that hand hygiene audits are completed in line with best practice guidance.
- The service should ensure that both booking forms and patient movement logs for mental health patients are reflective of each other.
- The service should ensure that all personnel files include both character and previous employment references, in line with policy.
- The service should ensure that when areas of poor performance are identified, documented plans are put into place to support staff to improve.
- The service should consider that the safeguarding leads undertake face to face training hours as part of their safeguarding training; for both adults and children, in line with the latest best practice guidance.
- The service should consider having access to a level 4 trained safeguarding lead, in line with best practice guidance.
- The service should consider how it can effectively monitor performance to improve services.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met;** Neither the safeguarding lead nor any staff employed by the service were trained in safeguarding children, at any level. Regulation 13(2)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **How the regulation was not being met;** The service failed without delay to notify the Care Quality Commission of incidents as specified in Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009 which occurred while services were being provided in the carrying on of a regulated activity or as a consequence of the carrying on of a regulated activity. Regulation 18(2)

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met;** The service did not have an effective system or audit process in place to make sure that only suitable patients were transported by the service. There was a lack policies and procedures within the service for staff to reference for guidance. The service did not have a medicines management policy in place to provide guidance for staff in relation to the administration of medical gases or the transportation of patients own medication. Policies and procedures which were in place in the service were not always clear, easy to understand and were not always appropriate for the services being provided. The service did not make sure that all policies and procedures referenced best practice guidance or the most up to date legislation and national guidance. Compliance processes within the policies and procedures were not always clear or present and were not always followed. Policies and procedures did not cross reference to other appropriate policies or procedures when required and did not detail where references were obtained from. The service had no effective oversight or designated lead for policies and procedures. The service did not have an effective risk management system and risks were not annotated as discussed at any management level meetings. The risk register did not contain all risks relevant to the service and did not annotate a risk owner, mitigating actions or dates for identification or review.

This section is primarily information for the provider

Enforcement actions

Management level meetings were not documented in a way that could easily be followed, language was inappropriate and there were no minutes annotated from the meetings.

Incidents were not managed in a way that would reduce the risk of a similar incident happening again. There was no process for investigating, reviewing or taking action when an incident had occurred. There was limited evidence of investigation and action taken as a result of incidents. It was unclear that the service understood their responsibility to discharge duty of candour, grade incidents or make notifications to the Care Quality Commission.

Complaints were not managed in line with policy.

The service did not have effective systems in place to monitor the service provided so that improvements could be made when needed.

Regulation 17(1)(2)(a)(b)(f)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 4 HSCA (RA) Regulations 2014 Requirements where the service providers is an individual or partnership **How the regulation was not being met;** There was no appropriate process or associated records for assessing and checking that the responsible individual held the required qualifications and had the competence, skills and experience required to undertake the role. There was no evidence to suggest that the responsible individual had the appropriate knowledge of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), relevant best practice and guidance or understood the consequences of failing to take action on set requirements. The responsible individual was unable to supply information relating to themselves as specified in Schedule 3.

This section is primarily information for the provider

Enforcement actions

Regulation 4(3)(a)(i)(ii)(4)(c)(5)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met;** Staff were not receiving the appropriate support or training to enable them to carry out the duties they were employed to perform. It was not always clear that staff had an understanding of areas in which they did not receive training or in which there was no documented policy or procedure. Regulation 18(2)(a)