Personal Security Service Limited

Personal Security Service

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Personal Security Service is operated by Personal Security Service Limited. The service provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 20 February 2017, along with an announced visit to the service on 21 February and 2 March 2017.

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.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

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

- We found there was no incident reporting system and no records maintained of any incidents.
- Safeguarding training was not to the recommended level as per national guidance. All staff should be trained to level two safeguarding training and the safeguarding lead to level three.
- We were not assured that the mandatory training was sufficient to ensure staff competence.
- There were no records to show vehicles were maintained on a regular basis.
- There was a general lack of understanding of Duty of Candour amongst all staff.
- There was no auditing of infection prevention and control practice and hand hygiene amongst staff when transporting patients.
- Records of patients and staff were not secured properly.
- The provider did not operate a safe recruitment process.
- There was no supervision or appraisal system in place.
- Staff understanding of the Mental Capacity Act and consent was varied.
- There was no system in place to monitor complaints and any recurring themes. There was no log kept of complaints.
- No support was available during journeys for patients with communication difficulties or who did not speak English.
- There was no dedicated training offered around supporting those with dementia or learning difficulties.
- There was no written vison or strategy for the service.
- There was no risk register in place.
- Disclosure and Barring Services (DBS) checks were not being completed appropriately and there were no assurances staff were safe to work with vulnerable patients.
- There was a lack of clarity about the role of the safeguarding lead and safeguarding training was not to the required levels.

Following this inspection, we urgently suspended the service from carrying out any regulated activities. We told the provider that it must take actions to comply with the regulations. Details are at the end of the report.

We returned to the service on 19 April 2017 to review what actions had been taken by the provider to respond to CQC's concerns about the governance of the service. As a result of improvements made the suspension of the service ended at midnight on 21 April 2017.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We do not currently have a legal duty to rate independent ambulance services. We always ask the following five questions of each service: **Are services safe?** We found the following issues that the service provider needs to improve: • We found there was no incident reporting system and very few records maintained of incidents. • Safeguarding training was not to the recommended level as per national guidance. All staff should be trained to level two safeguarding training and the safeguarding lead to level three. • We were not assured that the mandatory training was sufficient to ensure staff competence. • There were no records to show vehicles were maintained on a regular basis. • There was a general lack of understanding of Duty of Candour amongst all staff. • There was no auditing of infection prevention and control practice and hand hygiene amongst staff when transporting patients. • Records of patients and staff were not secured properly. **Are services effective?** • The provider did not operate a safe recruitment process. • There was no supervision or appraisal system in place. • Staff understanding of the Mental Capacity Act and consent was varied. **Are services caring?** • We did not observe any patients being transported or spoke with any patients during the course of our inspection and so cannot comment on whether the service was caring. • The service did not undertake any patient satisfaction surveys.

Summary of findings

Are services responsive?

- There was no system in place to monitor complaints and any recurring themes. There was no log kept of complaints.
- No support was available during journeys for patients with communication difficulties or who did not speak English.
- There was no dedicated training offered around supporting those with dementia or learning difficulties.

Are services well-led?

- There was no written vision or strategy for the service.
- There was no risk register in place. Risks were not identified and mitigated.
- Disclosure and Barring Services (DBS) checks were not being completed appropriately and there were no assurances staff were safe to work with vulnerable patients.
- There was a lack of clarity about the role of the safeguarding lead and safeguarding training was not to the required levels.

Personal Security Service

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Detailed findings

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Background to Personal Security Service

Personal Security Service is operated by Personal Security Service Limited. The service registered with the CQC in 2013. It is an independent ambulance service with the head office based in London, the service however provides patient transport service across the United Kingdom and abroad.

Personal Security Service provides a secure patient transport service to vulnerable adults with mental health problems. This includes transporting a patient sectioned under the Mental Health Act 1983. Most journeys involve the transport of a patient from one hospital to another. Depending on patient's needs and associated risks the transport is carried out in low secure or high secure vehicles fitted with a secure area (cage) in the rear section of the vehicle. The service provides a driver, escorts and nurse if requested by hospital staff registered mental health nurse (RMN).

The service has had a registered manager in post since 2013.

Our inspection team

The team that inspected the service comprised a CQC Inspection Manager, David Harris,two CQC inspectors, an assistant inspector and a specialist advisor with expertise in mental health.The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for North London.

Facts and data about Personal Security Service

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

During the inspection, we visited Personal Security Service office. We spoke with 16 staff including patient transport drivers, escorts, registered mental health nurses, administrative staff and management. We did not have the opportunity speak with or observe any patients being transported during the course of our inspection. During our inspection, we reviewed 33 staff records and 30 sets of patient transport records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. Personal Security Service has been inspected twice before. The first inspection was in October 2013 where we found that the provider did not have a system for regularly seeking the views of patients which meant the provider could not be assured about the standard of care provided during patient journeys.

Detailed findings

Systems in place to check the accuracy of patient journey records had failed to identify discrepancies and gaps. At the subsequent inspection in February 2014 we found that a system for obtaining the views of patients and staff accompanying them on patient journeys had been introduced. Feedback from patients showed they were positive about their levels of comfort on the ambulance journey and they were satisfied with the way they were cared for by ambulance drivers and escorts.

Activity (January 2016 to January 2017)

- The service was unable to tell us how many patient transport journeys they undertook in the reporting period

Track record on safety

- The service did not record clinical incidents
- The service did not record patient complaints

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Personal Security Service is operated by Personal Security Service Limited. The service provides a patient transport service.

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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.

Summary of findings

We do not currently have a legal duty to rate independent ambulance services.

We always ask the following five questions of each service:

Are services safe?

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

- We found there was no incident reporting system and very few records maintained of incidents.
- Safeguarding training was not to the recommended level as per national guidance. All staff should be trained to level two safeguarding training and the safeguarding lead to level three.
- We were not assured that the mandatory training was sufficient to ensure staff competence.
- There were no records to show vehicles were maintained on a regular basis.
- There was a general lack of understanding of Duty of Candour amongst all staff.
- There was no auditing of infection prevention and control practice and hand hygiene amongst staff when transporting patients.
- Records of patients and staff were not secured properly.

Are services effective?

- The provider did not operate a safe recruitment process.
- There was no supervision or appraisal system in place.

Patient transport services (PTS)

- Staff understanding of the Mental Capacity Act and consent was varied.

Are services caring?

- We did not observe any patients being transported or spoke with any patients during the course of our inspection and so cannot comment on whether the service was caring.
- The service did not undertake any patient satisfaction surveys.

Are services responsive?

- There was no system in place to monitor complaints and any recurring themes. There was no log kept of complaints.
- No support was available during journeys for patients with communication difficulties or who did not speak English.
- There was no dedicated training offered around supporting those with dementia or learning difficulties.

Are services well-led?

- There was no written vision or strategy for the service.
- There was no risk register in place. Risks were not identified and mitigated.
- Disclosure and Barring Services (DBS) checks were not being completed appropriately and there were no assurances staff were safe to work with vulnerable patients.
- There was a lack of clarity about the role of the safeguarding lead and safeguarding training was not to the required levels.

Are patient transport services safe?

Incidents

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were no never events reported for this service. We spoke with the registered manager about their understanding of never events. They told us it was an unknown expression to them.
- There was no formal incident reporting system and we found there was an under reporting of incidents. The provider was unable to monitor incidents for any themes and use this for learning and service development. Incidents usually only came to the attention of the provider when raised by the local authority or service users. The registered manager demonstrated a lack of awareness about what constituted an incident and acknowledged that there was no system in place at the time of this inspection to log and monitor incidents.
- A lack of documentation meant there were no action plans and learning from incidents. The registered manager told us how incidents were kept with job sheets and so she was unable to produce any record of incidents unless the related job numbers were known. She also told us that there was no record kept of use of restraint or use of handcuffs.
- From our discussions with staff, it was apparent that there was no sharing of incidents or learning from them. For example, most staff, apart from those directly involved, were unaware of two recent serious incidents we raised, both of which had a significant impact on patient safety.
- We spoke with the nominated individual about any learning from these recent incidents. He was unaware of the provider's responsibilities to report certain notifiable incidents to CQC. He demonstrated no level of understanding or appreciation of the value of learning from incidents.
- During interviews with staff, inspectors were told of incidents which had occurred during the transportation of patients but which had not been logged as an

incident. For example, a member of staff referred to a situation where a young person became violent in the back of the vehicle. We later raised this with the registered manager, who told us they were unaware of this.
- There was inconsistency amongst staff about if and when they reported incidents. Some staff told us they were required to report all incidents on the back of the booking form and hand this into office. They said whenever they did this, there was never any further information or discussion about the matter, either via e-mail or during staff meetings. Other staff told us they only recorded an incident when they themselves took the decision that it merited one.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The registered manager was unclear about DoC and the application. We found that when we questioned staff about the principles of duty of candour, this was not well understood by most of them.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The provider had no system in place by which to monitor safety and results.

Cleanliness, infection control and hygiene

- The Department of Health Code of Practice about the prevention and control of healthcare associated infections Health and Social Care Act 2008 (the Code) states that `all registered providers will need to have adequate systems for infection prevention (including cleanliness)
- We were told by the registered manager that no hygiene audits were carried out and no cleaning schedules were kept.
- Staff whom we spoke with told us they were provided with and used personal protective equipment as and when required. However, they said they were given minimal information about the patient whom they transported, including any hygiene or infection risks.
- Staff told us that crew members should ensure the vehicles were cleaned. This was not recorded anywhere for monitoring purposes.

Environment and equipment

- The provider had a variety of medium and high security vehicles. We were told that the nominated individual (NI) was responsible for ensuring vehicle maintenance was carried out. He was also responsible for ensuring equipment on the vehicles was regularly checked.
- We spoke with the NI who was able to explain to us how he checked the defibrillator batteries and oxygen cylinders. We saw that checks on these were in date.
- We found that the first aid kits located in vehicles were not regularly checked for the content and expiry dates. The NI told us that the checks were placed inside the first aid kits. However, the one kit that we checked showed that the last check was completed in November 2015. He told us it was staff responsibility to ensure that first aid kits were complete. However, he could not show us any evidence to assure us that such checks were carried out.
- We were able to confirm that some vehicles had insurance and MOT. However, due to an absence of record keeping, it was not possible for us to confirm that this was the case for every vehicle, since the registered manager was unable to locate these records.
- There was no schedule of vehicle checks to ensure their roadworthiness, and we could not be assured that vehicles were regularly checked for preventative maintenance. We were told that it was the driver's responsibility to carry out monthly maintenance checks on the vehicle. The NI could only produce one checklist for one vehicle, dated February 2016.

Medicines

- We saw the provider's medication management policy, which stated that no member of staff should handle or administer patient medication. Where a patient required medication during their journey, then it was the responsibility of the commissioning service to provide a member of staff to administer the medication.
- We pointed out to the registered manager that we noted during our interviews that some staff were unclear about their responsibilities in this area. For example, one told us that any member of staff could give medication as long as they had the correct information about the medication.

Records

- Service users' confidential information was not securely kept. We found paperwork which included patient confidential information was kept in boxes on the office floor which were not secure. We found this to be still the case on the third day of our inspection. We also found that filing cabinets, which contained sensitive staff and patient information, were unlocked. We saw a computer password stuck to the computer screen on the first day of our inspection. This was removed as soon as we pointed this out to the office administrator.

Safeguarding

- We were not assured that there was appropriate reporting of safeguarding incidents to CQC. The registered manager told us that the local authority had raised two safeguarding concerns with the provider, and she was unaware these should have been notified to CQC. She also told us that staff had never reported any safeguarding concerns to her or the nominated individual.
- We found that both the nominated individual and the registered manager had little understanding of the role of the safeguarding lead, or the training requirements to perform this role. The nominated individual (NI) told us both he and the registered manager were safeguarding leads. However, he was unable to differentiate between safeguarding children and safeguarding adults when we explored his level of understanding.
- We asked about training levels for the leads, who should have level 3 safeguarding training. The NI said they did not have it and indicated that this was not required. However, he told us that both he and the registered manager were qualified to deliver level 2 training, but was unable to substantiate this with any evidence of certificates.
- We spoke with the registered manager on the third day of our inspection. She told us she had previously completed training for her role as safeguarding lead for children, but she was not able to produce any evidence of this.
- On the third day of our inspection, the registered manager showed us her certificate and that of the NI as evidence of fitness for the role of safeguarding leads. These were evidence of e-learning, completed on the day before our third inspection day.
- However, these certificates which included the title of 'designated safeguarding officer' stated the course was designed to help people with a designated child protection role understand more about their responsibilities. There was no reference to the role in relation to safeguarding adults and we were told there was no further evidence available to us to substantiate any safeguarding training done in relation to safeguarding lead for adults and children.
- Whilst all staff should have level 2 safeguarding training, the registered manager was unsure about what level of safeguarding the current training provided staff with. They told us the safeguarding training was part of a one day training course which included many other topics.
- We had concerns that the safeguarding children training provided for staff did not align with the Safeguarding children and young people: roles and competences for health care staff Intercollegiate document: March 2014.
- This states that training, education and learning opportunities should include multidisciplinary and scenario-based discussion drawing on case studies and lessons from research and audit. This should be appropriate to the speciality and roles of participants, and in consideration of the needs of those patients being transported. We were told that safeguarding training was delivered via one DVD which included all aspects of safeguarding adults and children.

Mandatory training

- There was no training matrix maintained to monitor staff training compliance and flag up when refresher training was due. Therefore we were unable to see what percentage of staff were up to date with their mandatory training requirements.
- Mandatory training was delivered in one day and covered some 13 topics. This included equality and diversity, health and safety, control of hazardous substances, Caldicott principles, fire safety, infection control, food hygiene, manual handling, basic life support including CPR, safeguarding adults, safeguarding children, conflict management and lone working.
- We discussed this summary of training with the registered manager who agreed that it was a substantial volume of training items to fit into one day. She said that it would be more appropriately used as refresher training for staff.
- We were told that there was additional training run on occasion. However, there was no record available to show what this was.

- We were unable to confirm that the level of restraint training delivered to staff was at the appropriate level. Staff we spoke with could not describe the type of restraint training they had received. They were also unable to tell us about the different circumstances in which they would use restraint or whether they had refreshed their training.
- We saw a training sign-in sheet for cuff training which had 25 staff names on it, but with only six signatures to show the training had been completed. However, there were certificates issued for all 25 staff, signed by the NI. We found this to be the case for many other additional training courses, where despite no signature to confirm attendance; all staff were issued with a certificate of training signed by the nominated individual.
- We spoke with the NI about this who told us that staff had attended but it was always difficult to encourage them to sign the attendance sheet.
- There was variable feedback about the quality of training. Whilst some told us they felt it was adequate for their requirements, others told us they learned on the job.

Assessing and responding to patient risk

- When a job was booked, the commissioning service handed over details of the patient, which included a brief summary of patient risks. We looked at 30 patient booking forms and saw there was minimal detail about the patients and their requirements.
- Details included, 'risk of absconding', 'unpredictable', verbally abusive, threatening and 'he won't want to go'. Staff told us where there was requirement for a registered mental health nurse they were given patient notes and any risks in fuller detail. There was no further detail or assessment of risk on the booking forms to indicate how escorts and drivers would safely manage the patient.
- We spoke with staff about how they managed violent or aggressive behaviour. They told us they tried to engage with the patient in an effort to de-escalate the situation. They told us they applied hand cuffs as a last resort and said they always tried to engage with the patient in an effort to de-escalate a situation.

Staffing

- We spoke with the registered manager about staffing levels and how the provider met the commissioner's demands. She told us that they used a calendar to monitor which members of staff are available and where vehicles are. If necessary, they negotiated a later pickup time for the patient.

Are patient transport services effective?

Evidence-based care and treatment

- We spoke with those members of staff who managed transport bookings about how they assessed a patient's eligibility for the service. They told us they took a brief history of the patient's needs at the time of booking, which was then shared with the driver and escort.
- Where a patient had mental health needs, this was indicated on the booking form by the need for a registered mental health nurse.
- Staff did not have remote access to guidelines and protocols when out in the community escorting a patient. The registered manager told us staff knew how to access these when they were in the office. Staff we spoke with told us they would ring in for advice if they were unsure about how to proceed in certain instances.

Assessment and planning of care

- We spoke with office staff about whether they allocated work to people in relation to the needs of patients to be transported. They told us they were aware of the individual skills of escorts and drivers and tried to match on the basis of this. This would include a greater degree of competency and experience of working with children and young persons, older people and those with particular types of mental health presentation.
- However, there was no summary sheet of the individual skills of staff to hand and since all of the office staff involved in allocating work were relatively new, it was unclear how this could happen.
- We were assured that all patients who were under a mental health section were accompanied by a registered mental health nurse. We confirmed this to be the case when we looked at job sheet records. It was noted whether the RMN was provided by the hospital or by the provider. Where the provider supplied the RMN, we were able to confirm that they were NMC registered.

Competent staff

- There were 47 members of staff on the provider's staff list. There were no staff records to view on the first day

of our inspection. We were told that the registered manager had taken them to her home to audit them. We were provided with a total of 17 on the second day of our inspection, none of which included registered mental health nurses (RMN).

- On the third day of inspection, the registered manager showed us that she had made up files for each member of staff, including RMNs. She acknowledged that these files were incomplete and she was endeavouring to obtain all necessary documentation as soon as possible.
- We found that the service did not have recruitment procedures in place to ensure that all staff were appointed following a robust check of their suitability and experience for the role, together with robust pre-employment checks.
- We found that recruitment procedures were ineffective in establishing whether people employed for the purposes of carrying on a regulated activity were of good character and had the qualifications, competence, skills and experience which were necessary for the work to be performed by them.
- There was no evidence of any checks done for registered mental health nurses (RMN). On the first day of our inspection, we asked the NI to produce a list of all RMNs, including their names, surnames and NMC PIN number of their registration with the relevant professional body.
- The list that was produced included 32 RMNs, of which there were only 15 full names and five with their PIN number. On the third day of our inspection, we were given a revised list which had 18 RMNs with full names and PIN numbers recorded. The registered manager told us she had removed all those nurses from the list for whom they did not have a valid PIN number. A subsequent check of these PINS found that there was still one person on the list whose registration could not be found on the NMC registry.
- The provider policy required that for each employee two references were obtained as well as a Disclosure and Barring Service certificate [DBS]. We found no such documentation on any of the RMN records during the course of our inspection. The registered manager told us she had made the assumption that because the RMNs were already employed within the NHS, then the relevant checks done by the NHS would suffice. She acknowledged that this was an incorrect assumption to make.
- There were 47 staff members on the staff list, which included drivers, escorts and office staff. There were no staff records to view on the first day of our inspection and we were told the registered manager had taken them home to audit them. We were shown a total of 17 staff records by the second day of our inspection, 11 of which lacked evidence of references, DBS or previous work history. On the third day of our inspection, the registered manager showed us that there were incomplete records made up for each member of staff and it was her intention to make sure all staff records were completed as soon as possible.
- Of the records we were able to look at, it was apparent that most did not contain two references and some did not have any. On one record where the member of staff began work in 2015 there were two references from the same employer which covered a period of work between 2003 and 2006. There was no other evidence of an up to date work history from 2006.
- Where there were DBS certificates, most were copies obtained by previous employers. It is the provider's responsibility to make their own application for DBS certificates. We discussed this with the NI who was of the incorrect opinion that a DBS certificate from a previous employer could be used whilst a staff member awaited their DBS check.
- We noted there were at least five certificates which contained disclosures of past cautions and convictions including grievous bodily harm, actual bodily harm, battery, possession of Class A drugs, driving whilst under the influence of alcohol and driving without a valid license. We found that there was no risk assessment process in place to mitigate any potential risks to service users of staff with previous convictions.
- One staff record showed that a DBS check was made two months after the person commenced work. This check flagged up 'Enhanced disclosure not clear'. Despite this, there was no further evidence that any effort was made by the provider to acquire a full DBS certificate. However, there was an undated statement signed by the nominated individual which included '[staff name] has misplaced DBS and a copy has been requested. From previous knowledge, we are aware of the following offences……[staff name] is of good character….'. We spoke with the registered manager about this who confirmed they had no explanation about when or why this statement was written.

Patient transport services (PTS)

- Another member of staff commenced work some five month before their DBS was issued. The issued certificate showed a record of many offences, some of which necessitated substantial periods of time in prison.
- Whilst the above examples need not necessarily preclude the person from working, there is an expectation that the provider would have a robust discussion with the person and develop a risk assessment as mitigation. There was no evidence of any discussion or resulting risk assessment on the person's record.
- The registered manager told us it was her responsibility to induct new staff. She did this by going through the staff handbook with them.
- The registered manager told us there was no system in place for the supervision or appraisal of staff.

Coordination with other providers and multi-disciplinary working

- We did not gather evidence for this as part of the inspection.

Access to information

- Information concerning the patient to be transported was relayed to the escort and driver via text message or telephone call. Staff we spoke with told us the dispatcher highlighted any particular points to note, such as whether the person was at risk of absconding or had any particular health care conditions.
- Where the patient required a RMN, then their patient notes and relevant risk assessments were handed to the RMN by the discharging hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The registered manager confirmed that there was no Mental Capacity Act and Deprivation of Liberty Safeguards training provided for staff at the time of our inspection.

Are patient transport services caring?

Compassionate care

- We did not observe any patients being transported during the course of our inspection and so cannot comment on whether staff offered compassionate care to patients.
- The registered manager told us there was always a same gender escort allocated to the patient.
- Staff we spoke with told us they engaged with the patient as much as possible in an effort to offer them assurance.

Understanding and involvement of patients and those close to them

- We did not gather evidence for this as part of the inspection.

Emotional support

- The registered manager told us of a time when they permitted a family member to travel in the vehicle with their relative, who was in a state of high distress. This helped to reassure the patient and prevented them from self- harming.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The service had contracts with a local NHS hospital trust and a local authority to help them meet patient demand for their services. Regular quarterly planning and performance meetings were held with the trust.
- We saw copies of minutes from the previous two meetings and noted that clarification was sought from a representative from the NHS about the provider's use of restraint and handcuffs. The registered manager was in attendance and said the staff handbook would be updated to remind staff of the appropriate use of restraint.
- We also saw in the minutes a comment made by the commissioner that trust staff were generally pleased with the service and there had been good liaison with the police.

Meeting people's individual needs

- The registered manager told us that communication skills training was delivered as part of the one-day training which covered many other areas. She also told us that staff were referred to the section on communication in the staff handbook.

Patient transport services (PTS)

- We asked how the needs of those patients with learning difficulties or dementia were met and whether there was specific training for staff in these areas. The registered manager told us there was no specific training in these areas but that dementia awareness was touched on in the one-day training which covered many other areas. She also told us it was unlikely there would be patients with these diagnoses transported but in the event, the expectation would be that they would be treated with the same level of care and compassion afforded to other patients.
- We were told that the provider did not access translation services or, where the need arose, provide an escort or RMN who could speak the same language as the patient.
- We saw that no record was made of whether patients were offered food and drink when being transported. This was of particular relevance where the patients were transported on long journeys. For example, on two records, where the patient journeys took six hours, there was no record made of food and drink offered; other journeys were over four hours and had no evidence of the patient offered food and drink.
- Blankets were provided to cover the patient up when exiting the vehicle in a public place.

Access and flow

- We spoke with the registered manager about how the provider responded to the demands of the commissioner. She told us that they used a calendar to monitor which members of staff are available and where vehicles are. If necessary, they negotiated a later pickup time for the patient.
- Each vehicle was fitted with a tracker which enabled office staff to monitor its location. We were told that this assisted with planning work according to location.

Learning from complaints and concerns

- We were unable to clarify how many complaints there had been against the provider in the 12 months prior to the inspection. The registered manager told us there was no system in place to monitor complaints and any recurring themes. She said she dealt with any arising complaints as they arose, usually via e-mail.

Are patient transport services well-led?

Leadership and culture

- We found there was a significant lack of awareness with both the nominated individual and the registered manager of their roles and responsibilities. This included limited understanding of their safeguarding roles, unsafe recruitment practices, lack of auditing processes, no risk register to monitor and assess risk and absence of reporting to CQC.
- The registered manager told us the leadership of the service consisted of a nominated individual who was responsible for the operational side of the business, including vehicles and invoicing, and a registered manager who was responsible for staff and responding to complaints.
- There was no senior leadership team and no management meetings took place. The registered manager told us how there was regular telephone calls between herself and the nominated individual and also face to face meetings whenever both were in the office. None of these discussions were recorded.
- Staff we spoke with told us the registered manager was supportive of them.

Vision and strategy

- Whilst the provider had no written vison or strategy for the service, the registered manager told us she aspired to having the best patient transport service in the community. She told us she wanted the service to have a reputation of one which offered a safe and reliable service to patients.

Governance, risk management and quality measurement

- We found significant concerns regarding the governance and risk management processes of the service.
- There were no systems or processes in place for the registered manager to monitor the service against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- We were not provided with evidence that effective policies, risk management and control systems, including audits, were in place. There was no formalised system of governance to improve the quality and safety of the service and learn from incidents.

- The registered manager told us she was unaware of what the function of a risk register was.
- Disclosure and Barring Services (DBS) checks were not being completed appropriately and there were no assurances staff were safe to work with vulnerable patients.
- There was a lack of clarity about the role of the safeguarding lead and safeguarding training was not to the required levels.

Public and staff engagement

- We were shown no evidence to demonstrate that the provider sought patient feedback on the quality of the service provided.
- We were told that there was no staff survey to determine the views of staff.
- We were told that staff meetings took place every three months. We were shown a summary of points raised during meetings in June and October which we were told was e-mailed to staff. There was no record of staff attendance at the meetings.
- We saw two e-mails from local authority and NHS staff which were complimentary about how staff supported patients.

Innovation, improvement and sustainability

- On the third day of our inspection, the provider told us they had employed a consultancy firm to work alongside them to improve the service and initiate change.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Take prompt action to address a number of significant concerns identified during the inspection in relation to safeguarding, incident recording and reporting, and the governance of the service.
- Ensure care and treatment is provided in a safe way for service users.
- Ensure service users are protected from abuse and improper treatment.
- Ensure all equipment used is suitable for the purpose for which they are being used and is properly maintained.
- Ensure that good governance systems and processes are established and operated effectively.
- Ensure fit and proper persons are employed.
- Ensure there are sufficient numbers of suitably qualified, competent skilled and experienced persons employed.

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Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) states that systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. We found that systems and processes to monitor, assess, and mitigate risks relating the health, safety and welfare of people using services and others required improvement. Senior managers lacked oversight of the risk management process and were unable to provide assurance of how risks to people's safety and service delivery would be mitigated. The service's risk register was still in development and managers were not clear on how this would be used to manage and monitor risks going forward. As part of their governance, providers must seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders, so that they can continually evaluate the service and drive improvement. We did not find that effective systems and

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processes were in place to gather feedback from service users. The service's complaints policy was not available for people to view other than in hard copy format within the head office. Service users were not provided with a copy of the complaints policy. There were limited systems in place to allow people to provide anonymous feedback as feedback was requested from service users during transportation and was often completed by staff on their behalf.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 (1) states that persons employed for the purposes of carrying on a regulated activity must— (a) be of good character, (b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. (2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in— (a) paragraph (1), (3) The following information must be available in relation to each such person employed— (a) the information specified in Schedule 3, and (b) such other information as is required under any enactment to be kept by the registered person in relation to such persons employed. We found that appropriate recruitment checks had not been completed for all staff employed by the service. We were told that staff without valid DBS certificates or references would not be working for the service until these had been completed and that recruitment procedures would be completed for all new members of

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staff. However, this meant that only two registered mental health nurses (RMNs) from a list of 32 and 17 of 47 {cke_protected_1}[DL1]{cke_protected_2} other staff members were fit to work.