Transcare Secure Services

Transcare Secure Services - Birmingham

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

We carried out an inspection of Transcare Secure Services - Birmingham using our comprehensive methodology under the core service framework of Patient Transport Services (PTS). The service has not been previously inspected.

Our inspection was announced. We gave the provider short notice of the inspection date to ensure their availability on the day. We undertook a site visit on 23 August 2022.

This was the first time we inspected the service. We rated it as inadequate because:

- The service did not provide mandatory training in key skills to staff or ensure staff had completed training through other employers. Safeguarding systems, processes and standard operating procedures were not effectively implemented to keep people safe. The service did not always control infection risk well. Processes were not in place to ensure the maintenance and use of facilities, premises, vehicles and equipment kept people safe. Risk assessments were not always completed. Assessments of the risks identified lacked detail and did not demonstrate how risks would be mitigated. Patient booking and transfer documentation was not fully completed by staff. The service did not always follow best practice when storing and transporting medicines. The service did not have an effective process for reporting, investigating and learning from incidents.
- The service could not evidence that it provided care and treatment based on the most up to date national guidance and evidence-based practice. Managers did not routinely check to make sure staff followed guidance. The service did not monitor response times. Systems to make sure staff were competent for their roles were ineffective. The service did not ensure all staff had received training in the Mental Health Act (MHA), Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The service did not have formal arrangements in place for working with other organisations to plan care. The service was not always inclusive of patients' individual needs. We could not determine if people could access the service when they needed it. The service collected information about times from journey referral to the time of patient collection, but this was not monitored. It was not easy for people to give feedback and raise concerns about care received.
- Leaders did not demonstrate they had the skills and abilities to run the service. Leaders did not always understand or manage the priorities and issues the service faced. The service did not have a clear vision for what it wanted to achieve or a robust strategy to turn it into action. There was no evidence the service promoted equality and diversity in daily work or provided opportunities for career development. Leaders did not operate effective governance processes, throughout the service or with partner organisations. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service. Systems were not in place to manage performance effectively. The manager did not collect and use data to understand performance or make decisions and improvements. Leaders did not actively engage with patients, staff or the public to plan and manage services. The service was not committed to continually learning and improving services.

However:

- Staff understood how to protect patients from abuse. Staff understood how to respond to a patient at risk of deterioration. The service employed enough staff with the right skills and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Records were generally stored securely.

Summary of findings

- Staff considered patients' food and drink requirements to meet their needs during a journey. Staff in the service worked together as a team to benefit patients. They supported each other to provide good care. Staff supported patients to make informed decisions about their care and treatment. They generally followed national guidance to gain patients' consent.
- The service provided care in a way to support local services in meeting the needs of local people and the communities served.
- 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.

We did not rate caring as we had insufficient information to rate. We did not observe any patient care.

We have taken enforcement action as a result of this inspection to promote patient safety. We served a notice of suspension to the provider on 25 August 2022 with immediate effect until 30 September, under Section 31 of the Health and Social Care Act 2008. We have told the provider that it must take some actions to comply with the regulations and a review of these actions will be completed at the end of the suspension.

We are placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate 	This was the first time we inspected the service. We rated it as inadequate because: • The service did not provide mandatory training in key skills to staff or ensure staff had completed training through other employers. Safeguarding systems, processes and standard operating procedures were not effectively implemented to keep people safe. The service did not always control infection risk well. Processes were not in place to ensure the maintenance and use of facilities, premises, vehicles and equipment kept people safe. Risk assessments were not always completed. Assessments of the risks identified lacked detail and did not demonstrate how risks would be mitigated. Patient booking and transfer documentation was not fully completed by staff. The service did not always follow best practice when storing and transporting medicines. The service did not have an effective process for reporting, investigating and learning from incidents. • The service could not evidence that it provided care and treatment based on the most up to date national guidance and evidence-based practice. Managers did not routinely check to make sure staff followed guidance. The service did not monitor response times. Systems to make sure staff were competent for their roles were ineffective. The service did not ensure all staff had received training in the Mental Health Act (MHA), Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). • The service did not have formal arrangements in place for working with other organisations to plan care. The service was not always inclusive of patients' individual needs. We could not determine if people could access the service when they needed it. The service collected information about times from journey referral to the time of patient collection, but this was not monitored. It was not easy for people to give feedback and raise concerns about care received.

Summary of findings

- Leaders did not demonstrate they had the skills and abilities to run the service. Leaders did not always understand or manage the priorities and issues the service faced. The service did not have a clear vision for what it wanted to achieve or a robust strategy to turn it into action. There was no evidence the service promoted equality and diversity in daily work or provided opportunities for career development. Leaders did not operate effective governance processes, throughout the service or with partner organisations. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service. Systems were not in place to manage performance effectively. The manager did not collect and use data to understand performance or make decisions and improvements. Leaders did not actively engage with patients, staff or the public to plan and manage services. The service was not committed to continually learning and improving services.

However:

- Staff understood how to protect patients from abuse. Staff understood how to respond to a patient at risk of deterioration. The service employed enough staff with the right skills and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Records were generally stored securely.
- Staff considered patients' food and drink requirements to meet their needs during a journey. Staff in the service worked together as a team to benefit patients. They supported each other to provide good care. Staff supported patients to make informed decisions about their care and treatment. They generally followed national guidance to gain patients' consent.
- The service provided care in a way to support local services in meeting the needs of local people and the communities served.
- 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.

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Summary of this inspection

Background to Transcare Secure Services - Birmingham

Transcare Secure Services Ltd is an independent ambulance service operating predominantly in Birmingham and the Midlands area. The service opened in 2018 and the current registered manager has been in place since opening. The registered manager is the owner. The service has never been previously inspected.

The service transports adults and children over 14 years of age and those detained under the Mental Health Act (MHA) or Mental Capacity Act (MCA). The service provides patient transport from local NHS trusts and independent health providers to other locations such as hospital and places of safety. There are approximately 20 to 25 active staff members working for the service. This includes the registered manager, an operations manager, an administrator and Registered Mental Health Nurses (RMN) and health care assistants.

The service has two patient transport vehicles in use. The service does not have a formal patient transport contract in place with a healthcare provider. From February 2022 to July 2022, the service undertook approximately 76 patient transfers.

The regulated activity delivered by the provider is transport services, triage and medical advice provided remotely.

How we carried out this inspection

We carried out an inspection of Transcare Secure Services - Birmingham using our comprehensive methodology under the core service framework of Patient Transport Services (PTS). Our inspection was announced. We gave the provider short notice of the inspection date to ensure their availability on the day. We undertook a site visit on 22 August 2022. The service has not been previously inspected.

During the inspection visit, the inspection team:

- Spoke with the registered manager.
- Inspected two vehicles.
- Reviewed 14 ambulance transfer records.
- Reviewed documentation in relation to the running of the service.
- Reviewed policies and procedures.
- Reviewed and observed the storage of equipment and records.

We were unable to observe a patient transfer as there were none booked in on the day of our inspection.

The team that inspected the service comprised a CQC lead inspector, a CQC inspection manager, a CQC mental health inspector and a specialist advisor with expertise in patient transport. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

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Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that the vehicles are clean, and a robust cleaning schedule is in place to ensure high standards of cleanliness and infection control practices and take appropriate actions where this is not met. Regulation 12(1)(2)(h).
- The service must ensure that all equipment is suitable for the purpose for which they are being used, in date, and staff are trained to use it. Regulation 12(1)(2)(e).
- The service should ensure a system is in place to log all electrical equipment and ensure they undergo relevant safety tests including but not limited to portable appliance testing. Regulation 12(1)(2)(e).
- The service must ensure risk assessments effectively assess the risk to the health and safety of the service user receiving care and detail what actions will be taken to minimise the risk. This includes, but is not limited to; transporting young people, aggressive and violence behaviour, self-harm, use of restraint, sexualised behaviour, mobility problems, disturbed behaviour. Regulation 12 (1)(2)(a) and (b).
- The service must ensure all patient medicines received by the service at the point of transfer are recorded on the patient transfer documentation and recorded where given to the receiving provider on arrival. Regulation 12 (1)(2)(g)(i).
- The service must ensure staff receive safeguarding training appropriate to their role and safeguarding policies and procedures support staff to raise concerns both externally and internally in a timely manner, and to the right organisation. Regulation 13(1)(2)(3).
- The service must ensure information about current procedures and guidance about raising concerns about abuse should be accessible to staff. staff must know and understand the local safeguarding policy and procedures, and the actions they need to take in response to suspicions and allegations of abuse. Regulation 13 (3).
- The service must ensure they operate a robust recruitment procedure, including undertaking any relevant checks to ensure all staff employed are fit and proper. The service must ensure robust procedures are in place for ongoing monitoring of staff to make sure they remain able to meet the requirements. This also includes ensuring DBS checks are undertaken prior to employment start and monitored ongoing and staff risk assessments are undertaken where required. Regulation 19 (1)(2)(3)(4).
- The service must ensure where there is a risk that restraint could be required, this is planned for in line with policy and the detail of the use of restraint is robustly documented, reported and investigated. Regulation 13(4)(b).
- The service must ensure there is an effective and documented system in place for managing and monitoring staff compliance with mandatory training and reviewing staff competency. Regulation 17 (1)(2)(b).
- The service must ensure complete and accurate records are maintained that support effective risk management and describe the care and treatment delivered to individual patients. This includes but is not limited to booking forms, patient transport reports, transfer summaries, staffing details, staff signatures, detail of risk, recording of mental health status and receipt of mental health documentation. Regulation 17 (1)(2)(c).
- The service must ensure effective systems are in place to identify, report, investigate and share learning from incidents to prevent further incidents from occurring. This includes but is not limited to incidents where restraint is used. Regulation 17 (1)(2)(b).
- The service must ensure it has a robust system to audit, review and monitor care delivery and outcomes. Regulation 17(2)(a).

Summary of this inspection

- The service must ensure effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care provided. This includes but is not limited to; quality and safety audits. Regulation 17 (1)(2)(a) and (b).
- The service must ensure it has an open, transparent and robust process for investigating complaints and incidents, and identify, share and make changes from learning. Regulation 17(2)(a)(e).
- The service must ensure effective systems and processes are in place to assess, monitor and improve the quality and safety of services provided. Regulation 17(2)(a).
- The service must ensure that all policies and procedures provide staff with clear and timely guidance, are regularly reviewed by a suitably qualified person, reflect national guidance and are communicated with staff. Regulation 17 (1)(2)(b).
- The service should ensure the provider governance frameworks outline in policies are fit for purpose and reflect the leadership structure and service provided. This includes but is not limited to leadership roles and governance groups and committees. Regulation 17(1)(2)(b).
- The provider must ensure there is a comprehensive record of risks associated with the service. Risks must be regularly reviewed, and mitigating actions are discussed with the whole team. Regulation 17 (1)(2)(b).
- The service must ensure duty of candour responsibilities are fully applied. This includes but not limited to being open and transparent with patients and notifying patients as soon is practicably possible that a notifiable incident has occurred. Regulation 20 (1)(2)(3)(4)(5)(6).

Action the service SHOULD take to improve:

- The service should ensure there is a formalised process for disposal of clinical waste. Regulation 12.
- The service should ensure there is an inclusion and exclusion criteria for the service which is communicated with all staff. Regulation 12.
- The service should ensure there is a clear process for allocating numbers of staff including specific skills sets to each patient journey and this process is communicated with all staff. Regulation 12.
- The service should consider how it collects feedback from patients and those close to them.
- The service should consider how it could work more effectively with other providers and organisations to collect performance data to help within internal monitoring and service improvement.
- The service should review its systems for collecting feedback from staff and other providers to help shape and develop the service.
- The service should consider implementing a mechanism to communicate with all staff.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Inspected but not rated	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inspected but not rated	Inadequate	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Effective	Inadequate
Caring	Inspected but not rated
Responsive	Inadequate
Well-led	Inadequate

Are Patient transport services safe?

Inadequate

This was the first time we inspected the service. We rated it as inadequate.

Mandatory training

There was no system in place for monitoring and recording staff training compliance or making sure everyone completed it. The service did not have mandatory training compliance targets. The service did not provide mandatory training in key skills to staff or ensure staff had completed training through other employers.

Systems to ensure staff had received statutory and mandatory training were not in place. When the service was first registered with the Care Quality Commission (CQC) in 2019, the registration assessment report stated 'staff in the organisation are given yearly mandatory training in a number of skills and competencies. The mandatory training for staff is monitored by a robust computer software which will alert line managers of the impeding mandatory training for staff'. However, during our inspection, we found the service did not set mandatory training requirements for staff dependent on their role. Managers were unable to provide evidence all staff had completed statutory and mandatory training as they did not record this. The provider did not align itself to the skills for health core skills framework and we were not assured staff had received all relevant statutory and mandatory training for healthcare professionals.

The service did not have a system for monitoring staff compliance with mandatory training. Managers relied on staff receiving training from their substantive NHS or independent health service employers, however, they did not routinely check this. During our inspection we reviewed eight employee personal files which indicated most staff had not completed statutory or mandatory training in line with the Skills for Health Core Skills Framework. Training requirements outlined in the employee employment contract we reviewed stated staff were required to complete handcuff training, first aid, basic life support automated external defibrillator training, manual handling and search training. However, the service did not provide these training modules and we did not see evidence in any of the eight staff records we reviewed they had been completed.

Managers told us all staff were required to complete Safety Intervention Training (SIT). The service sourced an accredited external training provider to deliver SIT. SIT provides staff with skills to de-escalate in crisis situations and prevent the need for more restrictive interventions. It teaches staff non-restrictive and restrictive interventions. During

our inspection, the service provided us with a list of 11 staff including two services managers, an administrator, two health care assistants and seven Registered Mental Health Nurses (RMN) who had completed this training. However, managers could not tell us which staff had not completed it. We were therefore not assured all staff working in the service were appropriately trained to manage patients who were at risk of violence and aggression.

Handcuff training was listed in the employee contract as a required training; however, the service did not provide this training to staff at the time of the inspection. The service was unable to provide evidence of staff who had completed this.

Staff were not required to complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Following our inspection, the service provided us with a list of mandatory training modules they intended to implement and an action plan outlining plans to commission this training to ensure all their staff had completed it by the end of September 2022. Furthermore, the service intended to implement two SIT workshops in September 2022 for staff members where this training had expired or was due for renewal.

Safeguarding

Safeguarding systems, processes and standard operating procedures were not effectively implemented to keep people safe. Policies did not support staff to safeguard patient's from abuse and harm. Not all staff had received appropriate training on how to recognise and report abuse. However, staff understood how to protect patients from abuse.

At the time of our inspection, the service could not demonstrate all staff had received training specific to their role on how to recognise and report abuse. The safeguarding children and adult policy did not outline what safeguarding training was required. The service could not provide evidence all their staff had completed both adult and children safeguarding level two training. The policy did not indicate how the service would assure itself training requirement were in line with Safeguarding Children and Young People Roles and Competencies for Health Care Staff Intercollegiate document 2019 and Intercollegiate Guidance for Adult Safeguarding 2018. The safeguarding policy stated there was a safeguarding module on the induction training for all staff to complete, however, we did not see any evidence this was completed.

The service did not provide safeguarding training to its staff. Managers relied on staff receiving safeguarding training from their substantive NHS or independent health service employers, however, they did not routinely check this. Personal records we reviewed showed two staff members had completed safeguarding children training and four had safeguarding adult training through a substantive employer. However, it was unclear what level of safeguarding this was and whether it was in line with Safeguarding Children and Young People Roles and Competencies for Health Care Staff Intercollegiate document 2019 and Intercollegiate Guidance for Adult Safeguarding 2018.

Following our inspection, we requested immediate assurance of intended actions to address safeguarding training compliance. The service told us they intended to implement a system to monitor training compliance moving forward and procure safeguarding training internally for their staff.

Safety was not promoted in recruitment practice. There was no system in place to ensure safe recruitment checks had been completed prior to a staff member starting their employment. Staff files we reviewed did not comply with schedule three recruitment requirements. Managers told us they were in the process of reviewing their recruitment process to

ensure all staff had relevant checks completed. We checked eight staff files and found evidence safe recruitment checks were not being completed at the point of recruitment. Records showed the service had started to complete these checks, however, in some cases there was a significant time between employment start and the checks being completed.

We found proof of identify checks were not routinely completed during the recruitment process before a staff member commenced employment. For example, a staff member who started in August 2021 had not undergone proof of identify checks until August 2022. Another staff member started in April 2022 and checks were not completed until August 2022.

Professional register checks were not routinely reviewed during the recruitment process before a staff member commenced employment. For example, we found an RMN who started in March 2022 did not have a check until August 2022. Another RMN who started in February 2022, was not checked until August 2022.

Reference checks were not completed routinely during the recruitment process before a staff member commenced employment. For example, a staff member who started in March 2021 did not have a reference check until April 2022. Another staff member started in February 2022 and references were not obtained until August 2022.

Right to work in the UK declarations were not routinely checked during the recruitment process before a staff member commenced employment. For example, a staff member who started in March 2021 did not have a right to work in the UK check completed until August 2022. Another staff member started in April 2021 and checks were not obtained until August 2022.

Disclosure and Barring Service (DBS) status, were not routinely checked at the point of recruitment. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. When the service was first registered with the CQC in 2019, the registration assessment report stated 'Transcare Secure Services have in place systems, processes and practices that are essential to keep people safe such as ensuring DBS checks are conducted prior to employment in order to safeguard children, young people and vulnerable adults'. However, during our inspection, we found there was no system in place for ensuring DBS checks were completed prior to employment starting and checked when renewal was required. The service did not routinely undertake their own DBS checks for new staff. The service relied on the employee providing evidence of existing DBS checks through substantive employers. However, we found DBS checks were not routinely completed by the service before recruitment started. For example, we found a staff member who started in August 2021, did not undergo a DBS check by the service until August 2022. A staff member who started in March 2022, was not checked until May 2022 and staff member who started in February 2022 was not checked until August 2022. Furthermore, a staff member who started in April 2021, had no evidence of a DBS check being undertaken until the day of our inspection, where it was identified the staff members substantive employer DBS had expired in March 2022. This meant there was a period of five months without a DBS renewal.

Systems to assess the potential risks posed to patients from staff who had previous convictions or where previous allegations of abuse had been made against them were not effective. We did not see that consideration was given to the appropriateness of recruitment where convictions or concerns had been noted on DBS checks. We saw no evidence where a concern had been identified that the risk had been assessed to mitigate risk to patient's.

Since staff checks were not consistently performed on recruitment for all staff, we could not be assured that recruitment processes promoted patient safety. Following our inspection, we requested immediate assurance of intended actions to address recruitment and employment checks. Managers told us they intended to review recruitment policies, pre-employment checks and implement a process to mitigate risks.

Safeguarding policies did not support staff to safeguard patients from abuse or harm. The provider had a safeguarding children and adult policy which had expired in March 2022. We reviewed the policy during our inspection and found it did not support staff in taking the actions required where safeguarding concerns were raised. The process map included in the policy was unclear. It did not clearly outline to staff to how to make a safeguarding referral if they had concerns about an adult or a child. The policy included a list of national 'duty team' numbers, however, the numbers were not up to date. For example, the service contact for Birmingham was the emergency out of hours safeguarding children team. It did not include the details for Birmingham safeguarding adults teams. The policy was not accessible to staff on vehicles and staff did not have regular access to the office or the service information technology so they could make a referral electronically if required.

The policy did not provide guidance to staff on consent and information sharing, what to do if the alleged abuser is a staff member, safe recruitment processes or provide staff with expectations around timescales for making a referral and who to escalate to internally should a concern be identified.

Documentation such as the service booking form and patient transfer forms did not include anywhere to record whether there were any safeguarding concerns identified at booking and upon transfer. Furthermore, there was nowhere to assess whether there were any personalised gender needs. However, there was a tick box on the booking form to select if there were any 'sexually inappropriate behaviour', but no reference to what safeguards were put in place to protect patients or staff.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. They were able to describe when to raise safeguarding concerns and could name the safeguarding lead. Most staff knew how to make safeguarding referrals and who to inform if they had concerns. Managers told us there was a registered RMN on each patient transfer who would be the initial point of escalation if a safeguarding concern was identified. However, records we reviewed did not demonstrate there was always an RMN on a transfer. A document sent to us following the inspection stated for informal patient transfers, there would only be three HCAs required on a transfer.

Managers told us they had not made a safeguarding referral since the service was registered in 2019.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection, however these were not always effective. They did not keep vehicles visibly clean.

There was an infection, prevention, control and decontamination policy in place which we reviewed during our inspection. The policy was issued in March 2020 and had expired in March 2022. It included staff requirements for personal protective equipment, cleaning, handwashing and staff training requirements. The policy did not reflect the service processes at the time our inspection. For example, we did not see evidence infection risk was assessed at the point of booking, there had not been an annual Infection, Prevention and Control (IPC) audit, the service did not offer IPC training to staff and mechanisms to monitor IPC cited as the 'quality and safety group' were not in place. Following our inspection, we were provided with another version of the policy which stated it was issued in March 2022 and was reviewed by an administrator who had recently been recruited. We were concerned there was no external, objective or qualified review of the policy. The policy had not been shared with staff.

Patient transport vehicles were found to be dirty. For example, we found crumbs and dirt on chairs and on the floor of both vehicles. We found objects left in the door compartments such as opened toothpaste, a sharp plastic object, a battery and water bottles. We found a straw underneath the seat on one vehicle. The front of the vehicle where the

driver sits also contained significant crumbs on the floor, chairs and at the back of the steering wheel. A vehicle guidance handbook was stored on each vehicle which stated, 'each vehicle should be kept tidy and clean at all times and rubbish/personal belongings should be removed at the end of each journey'. This meant staff were not following the service vehicle handbook.

The provider's operating base was a conventional office within a shared building and not an operational ambulance station. The office within the building was clean and tidy. However, both the rest room and kitchen were visibly dirty with lack of cleaning equipment. The provider told us they escalated this to the buildings manager.

Vehicle cleaning records were in place but not always effective in ensuring vehicles were regularly cleaned. Weekly vehicle cleaning records we reviewed demonstrated both vehicles underwent weekly IPC checks. However, cleaning schedules did not detail specific tasks to be completed and at what frequency. We did not see evidence of regular deep cleaning of the vehicle being scheduled. We did not see evidence of required daily cleaning tasks to be completed at the end of each shift or after a patient transfer. Patient transfer records included a section to document pre and post journey checks including cleanliness of the vehicle before and after. This included a prompt to clean the vehicle. Five out of 14 records we reviewed showed this had not been completed. A patient journey had occurred the day prior to our inspection yet both vehicles were not clean, meaning they were not effectively cleaned following the journey. The manager did not have a routine system of auditing completion of vehicle cleaning checklists or the standard of cleaning tasks performed. We were therefore not assured IPC risks were being fully mitigated and managed.

Vehicles had suitable furnishings which were well maintained. The chairs and floor were all wipe clean and in good condition.

Staff told us they cleaned equipment after use using antibacterial disposable wipes. For example, we saw equipment such as blood pressure machines and handcuffs were clean on both vehicles. However, we did not see evidence of regular cleaning of these documented.

Staff followed IPC principles including the use of personal protective equipment (PPE). There was a ready supply of disposable gloves and aprons for all staff if they required them. We saw PPE including aprons and gloves were available on both vehicles and stored in the boot. Both vehicles contained hand cleansing gel, decontamination wipes and clinical waste bins including sharps bins. Staff told us they always wore face masks on patient transfers to prevent the spread of COVID-19. As there we no bookings on the day of our inspection, we were unable to observe any patient transfer journeys so we could not observe staff wearing PPE or decontaminating their hands.

The registered manager told us they completed staff observations of care which included IPC techniques. However, there were no formal or documented IPC audits such as hand hygiene audits.

Staff were not made aware of specific infection and hygiene risks associated with individual patients. The IPC policy stated, 'the call handling staff will ascertain wherever possible, from anyone requesting transport, whether the patient is considered an infection risk'. This was not included the booking form or patient transfer forms.

Following our inspection, we requested immediate assurance that vehicles were clean and there was a system in place to record daily vehicle infection prevention and control checks. The service told us they intended to implement a robust cleaning schedule and auditing system for cleaning and sanitisation of vehicles. They intended to develop a daily cleaning checklist to be completed prior to and after use of vehicles and implement weekly audit of cleaning checks.

Inadequate

Patient transport services

Environment and equipment

Processes were not in place to ensure the maintenance and use of facilities, premises, vehicles and equipment kept people safe. The service did not have an effective system for clinical waste disposal. Processes were in place to induct staff on the use of equipment and vehicles, but these were not were routinely completed.

The service did not have a process in place for maintaining equipment servicing. There was no equipment asset log in place. The service had not undergone any equipment electrical testing since it was registered. There was no contract in place with an external company to conduct annual Portable Appliance Testing (PAT). Following our inspection, the manager told us they had arranged with the landlord of the building the service was based, to undertake electrical testing but this was not yet in place. This did not include equipment kept on vehicles such as blood pressure machines and body scanners.

Vehicle safety checks were in place, but these were not always effective or in line with best practice. The service had three vehicles but only two were operational at the time of the inspection. We inspected both vehicles which were generally in good condition. We saw each vehicle had a valid annual safety check including a service within the 12 months prior to the inspection and both had vehicle tax. Managers told us service activity was low therefore both vehicles were rarely in use at any one time. Therefore, in the event of a fault or breakdown, the second vehicle could be used.

Weekly vehicle checks were in place but were not always effective. Weekly checks included ensuring vehicles had equipment and consumables on board. For example: supplies of water; PPE; documentation; cleaning supplies; patient observation equipment; restraint and safety equipment checks. The weekly checks were regularly completed, however did not check vehicle roadworthiness. During our inspection, we found body scanners on each vehicle were not working. These were not identified as not working in weekly checks or patient journey checks. This meant weekly checks were not always effective in identifying equipment which was not in good working order.

There was limited evidence of daily vehicle safety checks. For example, daily checks of tyres, wiper blades, lighting, seatbelts, handcuffs, first aid equipment, satellite navigation and body scanners. Staff carried out basic safety checks of the vehicle before a transfer as part of the transfer documentation. For example, there were pre-set questions for staff to answer including whether the lights were working, whether tyres were inflated, whether warning signs were displayed and the level of fuel. We saw these were not completed in five out of 14 records we reviewed.

Faulty equipment was not logged. Where faulty equipment was identified, this was escalated to the manager who arranged for serving of to be replaced. The patient transfer documentation signposted staff to the manager should they identify any issues or faults. Staff told us they contacted the service manager if there were any concerns who arranged for issues to be fixed. However, there was no log for recording issues or faults with vehicles or equipment. This meant there was no process in place to evidence vehicles and equipment had been made safe after a fault had been identified.

The service did not have a robust process for disposing of clinical waste safely. They did not have a clinical waste disposal contract in place to ensure all clinical waste including sharps could be safely disposed of. Sharps bins and appropriate clinical waste bags were located on both vehicles. Managers told us staff were asked to safely dispose of used clinical waste bags and sharps bins at the provider they transferred a patient to. There was no contract in place for this. There was no clinical waste on vehicles at the time of our inspection.

The service generally had enough suitable equipment to help them to safely care for patients. During our inspection we saw each vehicle had equipment to use in the event restraint was required. Each vehicle had adequate PPE, clinical waste, spill kits and sharps bins. Each chair space had a seat belt in good working order; however, these did not accommodate for children.

Managers told us staff were trained to use all equipment, however, we did not see any evidence of this. Managers told us all staff underwent an induction to the vehicle, so they knew what was on board and where equipment was. This formed part of the induction checklist, however, we did not see evidence this were routinely completed wit staff in the records we reviewed.

The building where the provider's operating base was, had other business operating within it. Entry to the building was through a keypad lock. There was a buzzer for visitors to use to gain access. The provider`s operating base was a conventional office and not an operational ambulance station. The administrative office was based on the first floor and there was a kitchen/staff rest room on the same floor. The administrative office was accessed using a key. There were notice boards with minimal information displayed for staff to read. The building was alarmed, and the car park was secure.

Assessing and responding to patient risk

Risk assessments were not always completed. Risks identified lacked detail and did not demonstrate how risks would be mitigated. Staff understood how to respond to a patient at risk of deterioration.

Patient transport booking forms were not always completed prior to a transfer. The service accepted new referrals by telephone. Staff took information from the referrer and populated a booking form. The form included personal patient information, details of transfer, risks and mental health status. It included a summary of staffing required including the number of staff and skill set. However, we found four out of 14 records we reviewed did not have any evidence that a booking had been taken and the appropriateness of the transfer assessed prior to the booking.

There was no inclusion or exclusion criteria for the service. This meant there was no process for determining if a patient was appropriate to be safely transported. For example, staff told us they experienced challenges when transporting a patient with a very high body mass index and mobility issues as the vehicle was not equipped or accessible to manage these patients.

There was no protocol in place for transporting young people to ensure they could be safely transferred, and managers could be assured staff had the correct level of training and competence. Managers told us they did not transport young people under the age of 14 due to not having child safety seats or appropriate seat belts. Following the inspection, managers told us 'practical and feasible adjustments are made to accommodate the presence of a parent or guardian during the transfer booking process in order to appropriately safeguard the young person'. However, we did not see any evidence of consideration of young people's needs in the booking documentation we reviewed.

Procedures were in place to confirm a patient's mental health status prior to transfer. However, patient booking forms did not always confirm a patient's mental health status. For example, whether a patient is detained under the Mental Health Act (MHA) or subject to a Deprivation of Liberty Safeguard (DoLS). We reviewed 14 patient transfer records and found four records did not include the patient's mental health status. This meant staff did not have the most up to date information to plan the transfer, ensure adequate staffing and patient/staff safety.

Risk assessments were not always completed and lacked detail where a risk was identified. Patient risks were identified at the booking stage and point of transfer through a list of pre-populated risks indicated through a tick box. We reviewed

Inadequate

Patient transport services

14 patient transport records and there was no evidence of a risk assessment being completed in five records. We found where risks were selected, they generally did not include any further information. In the nine records where the risk assessment sections were ticked to indicate a risk present, there was no further detail about the risk. For example, the form asked staff to add further details if ticked 'yes'. We did not find evidence of any further details, so staff understood what the risk was, the triggers and how it was currently being managed by the referrer.

Risk assessments did not include a documented risk management plan to mitigate risk of harm to patients, staff or the public. We did not see evidence in any record where there was a risk, there was a plan in place to mitigate the risk. For example, we saw where patients were assessed as high risk of violence, aggression or self-harm, there was no information about triggers or how staff will safeguard the patient and themselves. This was not in line with the service management of aggression and violence policy which stated the risk assessment 'should identify which control measures are needed to eliminate or reduce the risk to the lowest level reasonably practicable'.

The use of physical interventions including restraint was not assessed or planned for where possible. The service physical intervention policy stated staff should plan for physical interventions if there is a known risk. We did not see evidence of detail where restraint may be required, what the plan would be for this based on the type of behaviour being displayed.

Patient transfer records did not include detail about whether restraint was required. We reviewed a recent patient transfer record of a young person where physical restraint was undertaken. Whilst the patient risks were highlighted through a tick box, this was not personalised and there was no plan for how staff will manage the risks. There were no details of measures to be used to safely transport the patient. There was no plan to mitigate the known high risk of aggressive behaviour. There was no detail of the type of restraint used or detail in the journey summary report. There was no body map completed before the journey or after the journey despite being told restraint had been used on route to the vehicle. The body map stated, 'pat searched' and no other detail. Timings of the restraint were not recorded and there was no evidence of observations being undertaken such as blood pressure in line with the service physical interventions policy. There was no incident reported. This meant we could not be assured staff took the most appropriate and safe action to manage and safeguard the patient in line with best practice and the service policy.

Staff understood what to do in the event of an emergency or sudden deterioration in a patient's health. Each vehicle had a folder with instructions about what to do in an emergency. Staff could describe the process. They would pull over and call 999 and notify the registered manager. However, we were not assured all staff had appropriate training in basic first aid including basic life support. Managers were unable to provide evidence all staff had undergone appropriate training.

Staffing

The service employed enough staff with the right skills and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers had a process to induct new staff, however, this was not completed in most staff records we reviewed.

The service had enough staff to keep patients safe. The manager told us there were approximately 20 to 25 staff working for the service. However, at the time of the inspection, were unable to provide most up to date numbers of active staff. Most staff working in the service were Registered Mental Health Nurses (RMN) and Health Care Assistants (HCA). Staff worked on a zero hours contract basis. The service did not have a rota as they did not have a contract in place at the time of the inspection and the activity of the service did not require this. The service transferred between five and eleven patients monthly at the time of the inspection.

Inadequate

Patient transport services

The service ensured there was sufficient staff to provide safe care. Staffing levels were determined by the level of risks identified at the point of booking. For example, patients who were informal and not detained would require three HCA's and if detained under the Mental Health Act 2003 would require a minimum of four staff which would include an RMN. However, there was no documented criteria for this. This meant there was a risk of insufficient staff being allocated in the absence of the registered manager. Staff told us they always felt staffing levels were safe and reflected the level of risk of the patient being transferred. Most records we reviewed showed there was always a minimum of one RMN on each patient transfer and staffing levels reflected the staffing ratio's outlined by the registered manager.

Patient transfer requests were not accepted unless safe staffing could be confirmed. The registered manager told us the service offered a quick turnaround of two hours from point of telephone booking. They relied on staff responding to an all staff mobile phone messaging service to check for availability. If required, the registered manager and operations manager would cover who both worked fulltime in the service and were both RMN's.

Managers did not ensure all new staff had an induction and understood the service. The service had an induction checklist and a newly developed induction workbook which was more detailed. However, they were not completed in seven out of eight staff records we reviewed. We were therefore not assured staff had undergone a structured induction to the service.

Records

Patient booking and transfer documentation was not fully completed by staff. Patient records audits were not undertaken by managers to ensure they contained all required information. Records were generally stored securely.

The service had a standard patient transfer document which staff were required to complete. It contained a transfer report detailing the outgoing provider details and incoming provider details, a pre- and post-transfer checklist, a patient information section, details of staff present and arrival times, a risk assessment, a body map and a journey report summary. These documents were in addition to the booking form. We reviewed 14 patient transfer records and saw they were not fully completed. For example, we found:

- Collection details were not recorded in three out of 14 records we reviewed. Referrers were requested to sign to say they had handed over the patient and was a declaration that all patient documentation was handed over. However, it did not specify what this information was.
- Destination details were not completed in two out of 12 records we reviewed.
- Transcare staff who were present on the transfer were not documented in four out of 14 records and only partially completed in ten records. For example, staff full names were not recorded.
- Risk assessments were not completed in four records and only partially completed in 10 records. Where risk was identified staff did not add any further comments as requested on the document.
- Body maps were generally not completed. Staff were required to complete this before a transfer and after to document body marks. Staff who completed these were required to record their name and sign. We reviewed 14 patient journey records and found no evidence of body maps being completed in four records and no rationale documented for not completing them. In the other 10 records, there was minimal information recorded with pen strikes through the body map with a comment 'pat searched'. There was no evidence staff completed a before and after body map and who had undertaken the search documented as required.
- Journey report summaries were blank in seven out of 14 records. In the other seven, the information was minimal. In one record where restraint was used the information was limited and did not record details of restraint.

We found there was nowhere to record what documentation had been taken from the outgoing provider such as mandatory Mental Health Act (MHA) documentation. There was no evidence in any record that MHA document which accompanies a patient was signed out by Transcare and handed over to the provider at the destination. Managers told us these were handed over; however, this was not routinely documented.

The manager told us there was no system of audit of patient records to ensure they met expected standards.

Records were stored securely. Staff provided all patient transfer documents to the manager at the end of their shift and these were kept in a locked filing cabinet. On transit, staff told us patient documentation was kept in a zipped bag and stored in the back of the vehicle which was locked.

Medicines

The service did not always follow best practice when storing and transporting medicines.

Due to the nature of this service, staff did not prescribe, administer or carry on-board medicines.

Patient medicines were kept securely on-board the ambulance when in transit. Staff told us medicines were kept in clear plastic bags and kept in the back of the ambulance for the duration of the journey.

Staff did not always accurately record each patient's medicines which they carried on board. Whilst there was a section on the patient transfer report to record medicines, this was not always completed to indicate whether medicines were being transferred and if there were what the medicines were. There was no process to sign medicines in and out once transferred to the receiving provider to safeguard the patient and service against loss of medicines. However, staff told us they did check medicines before taking them.

Incidents

The service did not have an effective process for reporting, investigating and learning from incidents. The service did not report or investigate known patient safety incidents. Staff recognised incidents but did not report them. Managers did not investigate incidents or share lessons learned with the whole team. When things went wrong, systems were in place for staff to apologise and gave patients honest information.

Staff understood the requirement to report incidents but did not report any incidents. Staff we spoke to including managers were able to describe incidents that would require reporting. However, staff did not report any incidents identified such as when they have used restraint during patient transfers. Staff told us they escalated incidents of restraint to managers, however, we found no evidence to demonstrate these incidents had been reported by managers. Most staff we spoke to told us they had never had to report an incident.

We were aware of at least two incidents where restraint had been used in May and July 2022. However, there had not been any incidents reported in the 12 months prior to the inspection.

Managers did not ensure all incidents were reported. At the time of our inspection, managers were aware of incidents that had not been reported but still had not reported them. Managers told us they understood they should have ensured incidents such as restraint were reported and told us they would ensure this happened moving forward.

Staff did not know how to report incidents in line with the service incident reporting policy. The service had an incident reporting policy in place. At the time of the inspection, the policy had passed its next review date of March 2022. However, following the inspection, the registered manager sent us a different version with next review date of March

Inadequate

Patient transport services

2023. Staff told us they would raise concerns or report incidents to managers. This is not in line with the incident reporting policy which stated 'the RMN or team leader in charge of the transfer in which the incident occurred is responsible for ensuring that an incident report form has been completed'. The policy later states all staff are responsible for reporting incidents, therefore the policy was unclear.

Staff did not have access to incident reporting forms. The service policy stated, 'incident forms can be found on each ambulance'. However, during our inspection, we did not see that incident reporting forms were on each vehicle. This meant staff did not have access to the appropriate tools to report incidents in line with the service policy and procedure. We did not see an incident reporting form having been completed.

Managers did not investigate incidents. There was no evidence known incidents such as recent use of restraint were investigated to ensure they were in line with service policies, best practice and so learning could be identified and shared. Managers told us they intended to ensure incidents were reported and investigated moving forward.

Managers did not share learning about from incidents with all staff within the service. Managers told us staff debriefed after every transfer to look at what went well and what could be improved. However, this was not documented and learning not widely shared. As incidents were not reported or investigated, there were missed opportunities for shared learning across the service to improve. There was no opportunity for staff to meet to discuss learning from incidents and look at improvements to patient care.

Duty of candour was not applied. The service incident reporting policy had a section on duty of candour with steps staff should take in the event of an incident. The duty of candour places a legal responsibility on every healthcare professional to be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress and to apologise to the patient or, where appropriate, the patient's advocate, carer or family. During our inspection we did not see evidence the service had followed the duty of candour process in response to known incidents such as use of restraint. Most staff we spoke to understood what duty of candour was. Any incidents were referred to the manager.

Following our inspection, we requested immediate assurance of intended actions to address incident reporting procedures. Managers told us they intended to review the incident reporting policy and share this with staff. They also advised us they intended to procure training for staff in the reporting of incidents.

Are Patient transport services effective?

Inadequate

This was the first time we inspected the service. We rated it as inadequate.

Evidence-based care and treatment

The service could not evidence that it provided care and treatment based on most up to date national guidance and evidence-based practice. Managers did not routinely check to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983 (MHA). The service could not demonstrate staff had received training in the MHA.

The service could not evidence it provided care and treatment based on national guidance and evidence-based practice. Policies did not always refer to current national guidance a or evidence-based practice.

Policies were not service specific and did not always reflect the service being provided. For example, we found:

- Specific roles within policies did not reflect the service staffing structures. For example, safeguarding vulnerable adults and children policy, incident reporting policy refers to a 'quality and assurance manager'. This role was not in existence.
- The 'transportation of detailed patients policy' stated patients who had been sedated before being conveyed will always be accompanied by a health professional. However, during our inspection, the manager told us they do not accept patients who had been sedated as they do not have appropriate equipment in the vehicle to ensure they were safe.
- The management of violence and aggression policy referred to a violence and aggression risk assessment which should be in place. The policy states the risk assessment will identify the risk and actions to be taken to implement effective control measures. However, the service did not provide evidence of a violence and aggression risk assessment being in place.
- The physical intervention policy stated staff should plan for physical interventions if known. However, there was no process in place to plan for physical interventions.
- Some policies referenced the service providing staff with training which was not in place. For example, health and safety training, safeguarding training and infection, prevention and control training.
- The service transported young people, however, did not have a policy or procedure in place so staff knew what to do when transporting children and young people.

Processes to review and update policies were not effectively implemented. During our inspection, the manager provided us with folders containing most up to date policies. This showed there was a wide range of policies, however, they had not undergone a recent review process. For example, the service had 19 clinical policies and procedures, 18 of which had surpassed their review dates from between September 2021 and March 2022. The service had 29 human resources policies all of which had surpassed the expiry day from Jan 2021 to March 2022. Furthermore, the health and safety policy did not have an issue or review date. We were therefore not assured staff had access to the most up to date information to safely undertake their duties.

Following our inspection, the manager provided us with a series of policies with different expiry dates to those we reviewed during our inspection. The manager told us this was because the front sheets which contained review dates had not been updated and were stored electronically on the computer. However, it was unclear what the updates to the policies were as these were not recorded. Managers were unable to provide evidence that staff had received updated policies, which meant staff did not have access to most up to date guidance.

Policies had not undergone professional or expert input. Policies were written by the registered manager. They did not go through a review or ratification process. Policies were signed off by the registered manager and the operations manager, although we did not see evidence of a formal sign off process. We were not assured that all policies were therefore appropriate or fit for purpose to enable staff to plan and deliver high quality care according to best practice.

Most staff told us they were aware of the service policies and where to find them. However, the service was unable to provide evidence of staff having read policies and procedures. A new induction was in the process of being implemented which provided staff with an induction workbook that covered specific and relevant policies and procedures. At the time of the inspection we did not see these were in place.

There were no set eligibility criteria. A patient's eligibility for the service was assessed at the point of booking. The manager told us they did not have an inclusion or exclusion criteria, however, reviewed on an individual basis. For example, we were told they did not take young people under 14 as they did not have appropriate seat belts/seats and

did not take patients who had been sedated as they only had seated transport. This meant there was a risk of patients being booked which the service could not accommodate as there was no set criteria. For example, we identified a patient with mobility issues being transported and there was no consideration given to level of mobility issues and whether the vehicle could accommodate their needs.

Patients' needs were assessed at the point of booking. The service had a booking form which was completed by the registered manager. Booking details were taken over the telephone and included personal details, patient information including level of risk, mental health status, pick up and destination details. The manager told us at the point of booking they assessed the level of risk and assigned appropriate staffing numbers.

There was no protocol in place for transporting young people to ensure they could be safely transferred, and managers could be assured staff had the correct level of training and competence. Managers told us they did not transport young people under the age of 14 due to not having child safety seats or seat belts. Following the inspection, managers told us 'practical and feasible adjustments are made to accommodate the presence of a parent or guardian during the transfer booking process in order to appropriately safeguard the young person'. However, we did not see any evidence of consideration of young people's needs in the booking documentation we reviewed.

The service did not undertake routine checks or audits of quality and safety to demonstrate compliance with policy and best practice. For example, infection, prevention and control or use of restraint. Managers told us they occasionally completed observations of staff practice although did not document this to demonstrate practice was compliant with the service policies and procedures.

The rights of people subject to the Mental Health Act 1983 (MHA) were generally protected. However, the service did not ensure all staff had received MHA training. We saw evidence staff were generally made aware of patients with mental health needs. Patients with mental health needs were identified at the point of booking. Where a patient was detained under the Mental Health Act 1983 (MHA), managers told us a Registered Mental Nurse (RMN) was always assigned to the journey. Dependent on the level of risk, the number of RMN's could increase. In records we reviewed we saw this was the case. Staff and managers, we spoke to had regard to the MHA Code of Practice when dealing with patients. Staff described ensuring relevant documentation accompanied the patient and was given to the provider at the destination. We were unable to see evidence this occurred as it was not documented. Staff were aware they can only receive handover from an approved mental health professional.

The service did not provide MHA training to staff and were unable to provide evidence of staff having completed it through other employers. Following the inspection, the service told us they intended to commission a training provided to facilitate this for all staff.

Nutrition and hydration

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

Patients nutrition and hydration needs were considered, and arrangements were in place such as bottled water in the vehicles, which could be given to the patient when required. Staff told us most journeys were local. Longer journeys were planned so where possible patients had eaten before the journey and had used the toilet beforehand. Safe stop points were identified beforehand which included police stations or accident and emergency departments.

Response times

The service did not monitor response times.

At the time of the inspection, the service did not collate or monitor response times. The provider was not commissioned or contracted and as such it had not been given key performance indicators such as response times by the service requesting the patient transport. Managers told us unless the job was pre-booked or requested for a specific time then the response time to the collection address was two hours within the West Midlands area.

Competent staff

Systems to make sure staff were competent for their roles were ineffective. They did not complete routine appraisals, supervisions or meetingsto provide support and development.

The service was unable to demonstrate all staff employed had the experience, right skills and knowledge to meet the needs of patients. The service did not have an effective system in place to ensure all staff had received appropriate training specific to their role. For example, not all staff had received training in the Mental Health Act (MHA), managing aggressive behaviour or use of handcuffs. At the time of the inspection, the service could not identify staff who had not received relevant training and we saw no evidence staff who did not have skills were appropriately supervised or restricted until they had received training. Following our inspection, managers told us they intended to review training requirements for the service and commission a provider to undertake training with all staff.

The service did not have an effective system in place to manage staff recruitment processes to ensure all necessary checks on new staff had been carried out. For example, work histories, identity checks, references, rights to work in the UK, driving assessments and Disclosure and Barring Service (DBS) checks were generally not obtained until after the employee had started with the service. On reviewing staff records, we saw three recent letters sent to staff who had already started working to provide evidence so that safe employment checks could be completed retrospectively. For example, a staff member who started in March 2022 was sent a letter in August 2022 requesting them to provide identification for verification of person, professional registration, driving assessment as well as providing evidence of most recent DBS. The application form in this case was not fully completed.

The service had a mixture of Registered Mental Health Nurses (RMN) and health care assistants. Professional registration checks of nurses were not routinely completed before employment started. However, the service was in the process of checking professional registrations of all staff to ensure they did have the right skills and experience to undertake RMN duties.

Staff inductions were not consistently completed. All staff we spoke to told us they underwent an induction. However, the staff records we reviewed did not demonstrate induction check lists were routinely completed. Staff told us they were provided with information about the service, the expectations and transfer process. Managers told us the induction process was an area for improvement and had designed a new induction workbook. The workbook was robust and covered all areas of the business, policies and training. However, we did not see evidence of these workbooks being implemented at the time of the inspection.

There was no process in place to assess staff competence of delivering patient care by managers.

Managers told us they provide appraisals to staff; however, we only saw evidence of one appraisal having been completed.

Managers told us they undertook supervision with staff but there was no set frequency, it was informal not documented. Some staff we spoke to said they had received supervision. Staff told us they debriefed following a patient journey to look at what went well and what could be improved but this was not documented, and learning was not routinely shared.

The service did not facilitate team meetings for staff. Managers told us this was because staff were on zero hours contracts and activity was minimal. Managers told us they provided informal and formal feedback to staff through email. However, we were not provided of any evidence of this.

Multidisciplinary working

Staff in the service worked together as a team to benefit patients. They supported each other to provide good care.

Staff received information about a patient before each journey. The manager provided staff with a booking form with information including staffing requirements. Staff told us the manager gave the information verbally before each transfer. Staff told us they received a handover at the NHS trust they collected the patient from before leaving. This meant staff had up to date information on patients care needs. However, information on patients care needs was not always accurate and comprehensive as patients transfer documentation was not always fully completed. Therefore, there were occasions where staff did not have full access to information about patient needs.

Staff told us there was always a RMN on each journey who was in charge and supported the team. The detail of the journey was discussed with the team beforehand and staff told us they debriefed afterwards, although this was not documented. The manager told us they regularly checked in with staff throughout the journey to offer support and advice where required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service did not ensure all staff had received training in the Mental Health Act (MHA), Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff supported patients to make informed decisions about their care and treatment. Processes were not in place to support staff to gain patients' consent in line with national guidance. However, staff understood their responsibilities for gaining consent. Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The service was unable to provide evidence of staff being trained in the Mental Health Act (MHA), Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, staff we spoke to understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

There was no guidance in place for staff to follow to ensure consent was gained in line with national guidance for adults or young people. Consent was not documented in patient transfer records for informal patients as well as those detailed under the MHA. However, staff were aware of their responsibilities for obtaining consent for both adults and young people. When patients did not appear to consent to journeys staff told us they worked with the referring provider to make decisions in their best interest.

Consent was not documented in any of the 14 patient transfer records we reviewed. Staff told us they gained verbal consent from patients for their care and took non-verbal cues as consent. For example, getting onto the vehicle willingly as consent. Staff were able to describe incidents where patient's had not wanted to be transported and how they supported them. Staff we spoke to understood how and when to seek support for patients to make decisions about their care.

Inadequate

Patient transport services

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, we did not see evidence of this in any of the 14 patient records we reviewed. There was limited evidence of consideration of a patients capacity on a journey and how patients who lacked capacity would be supported.

The service could not demonstrate where restrictive interventions were used, these were in the patients best interests and were least restrictive. Staff told us they promoted supportive practice that avoided the need for physical restraint. However, recording of patient transfer journeys was poor and we saw no evidence that where restraint was used, what type of restraint was used and whether it was the least restrictive measure possible.

Are Patient transport services caring?

Inspected but not rated

Insufficient evidence to rate.

Compassionate care

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

We were unable to complete any observations of patient care as there were no bookings on the day of our inspection. We therefore did not speak to any patients about their experience of care.

Staff described incidents of being discreet and responsive when caring for patients. For example, staff told us when searching patients before the journey, they took them to a private space in order to maintain their dignity.

Staff told us they interacted with patients and those close to them in a respectful and considerate way. Staff described being respectful and supportive to patients. For example, staff described making efforts to encourage patients when they were anxious about the transfer to avoid the need to use restraint.

Patient feedback was not actively sought. On the patient transfer paperwork, there was a document for patients to provide feedback. These were not completed in any of the 14 patient records we reviewed. In some records it stated patient refused. The service did not undertake any other form of patient feedback.

Staff followed policy to keep patient care and treatment confidential. Staff described maintaining confidentiality by keeping their records secure whilst in transit. Where body searches were required, staff told us they took patients to a private area.

Staff understood and described being respectful to individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Most staff who worked for the service worked with other independent health or NHS provider mental health hospitals.

Emotional support

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

We were unable to complete any observations of patient care as there were no bookings on the day of our inspection. We therefore did not speak to any patients about their experience of care.

Inadequate

Patient transport services

Staff described how they were focused on the emotional needs of patient's throughout the journey by building a rapport, offering encouragement and reassurance.

Staff told us they encouraged escorts where this supported a patient to feel relaxed. For example, where they transported young people, they supported the aren't or guardian to accompany the patient on the journey.

Understanding and involvement of patients and those close to them

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

We were unable to complete any observations of patient care as there were no bookings on the day of our inspection. We therefore did not speak to any patients about their experience of care.

Staff made sure patients and those close to them understood their care and treatment. Staff described how they built rapport with patients and involved them in decisions about their care during the journey.

Are Patient transport services responsive?

Inadequate

This was the first time we inspected the service. We rated it as inadequate.

Service delivery to meet the needs of local people

The service did not have formal arrangements in place for working with other organisations to plan care. The service provided care in a way to support local services in meeting the needs of local people and the communities served.

There were no formal arrangements in place for working with other organisations to plan care. This meant workloads could not always be planned and staff were employed on a zero hours contract.

Managers organised services so they met the changing needs of the local population. The service was flexible in responding to providers requests for patient transport services. The manager had developed relationships with local bed management teams in hospitals and offered support to them when required. The service did not have a rota in place but there were enough staff to respond to new bookings.

The service offered a UK wide service to accommodate the needs of those patients who required transfers to and from mental health units in any area. However, the service worked predominantly with midlands providers. The manager told us they supported local NHS trusts with bed capacity issues by being responsive to requests for urgent transfers to help release beds.

Resources were appropriate for the service being delivered. There were two vehicles used by the service so that they could be flexible to meet any increases in demand and provide adequate cover should they obtain a contract. This also meant in the event of one vehicle breaking down, they were able to continue to provide a service.

Inadequate

Patient transport services

Meeting people's individual needs

The service was not always inclusive of patients' individual needs. Staff made reasonable adjustments where possible to help patients access services.

When accepting a booking, managers considered the gender mix of staff required for a transfer. For example, if a woman was being transported, there would be at least one female staff member allocated to the job. Staff told us where a higher risk woman was being transferred, they would have two female staff members present.

The service did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service did not ensure staff had received training in the Mental Health Act 2007, dementia or learning disability awareness. However, most staff who worked for the service worked within other local mental health services and could describe how they supported patients living with mental health, learning disability and dementia. Some staff had a background in learning disability services. Patient booking forms had a box to record a patients mental health status, however, these were not always completed. There were no prompts to record whether a patient was living with dementia or a learning disability. However, during our inspection, we found three examples where a patient living with dementia, autism and mobility challenges were documented in the 'diagnosis' section on the transfer report or in a blank box at the end of the booking form. Having reviewed the documentation it was not clear what the patients' individual support needs were or how staff would support the patient. This meant that staff may not always be able to identify and meet any additional information, support and communication needs of patients with a learning disability, dementia or mental health.

The service did not have systems to help care for patients in need of additional support. For example, neither vehicle was accessible to a person using a wheelchair or with mobility issues that would prevent them getting onto the vehicle. Both vehicles required patients to take a high step up and the first step was very narrow. Managers told us they would be unable to cater for a bariatric patient or a patient requiring a more secure transfer in a locked cage. The manager told us they intended to look at obtaining a more accessible third vehicle in the future.

The service did not have a contract with a translation service, but managers told us they would book translators if needed. Some staff spoke multiple languages and could interpret if required. Most staff we spoke to said they had not needed to access interpreters.

Access and flow

We could not determine if people could access the service when they needed it. The service collected information about times from journey referral to the time of patient collection, but this was not monitored.

The service was not contracted or commissioned and therefore there was no formal service level agreement to manage access and flow. The booking of patient transports was through a phone call to the provider. The time and date of the transport was agreed between the service and the provider requesting patient transport. The manager told us they aimed to offer transport within two hours.

Managers did not monitor waiting times. Patient transfer records included a section for staff to record collection and arrival times. This information was recorded in most records we reviewed. However, this information was not collated, monitored or used by managers to make sure patients could access the service when needed.

Inadequate

Patient transport services

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received. The service did not have a complaints policy. The service did not have complaints information clearly available to patients. Systems for patients to feedback were not effectively implemented or monitored. The service had not received any complaints.

The service did not have a complaints' policy. When asked for the service's complaints' policy and procedure we were provided with a patient information document which outlined how to make a complaint and timescales for a response. The service had not received any complaints in the 12 months prior to our inspection.

The service did not clearly display information about how to raise a concern on the ambulance. The service had a complaint patient information document. This outlined the complaints process and contact details of the registered manager. Staff told us they would refer complaints to the registered manager should they have any.

Patient feedback was not actively sought. Patient feedback forms were included in the transfer documentation. These gave patients an opportunity to feedback on staff, dignity and respect, safety and whether they would be happy to use the service again. Patients had to select a response from poor to excellent with a section for additional comments. However, we did not see evidence these were visible or accessible to patients. We reviewed 14 records and did not see evidence these were routinely completed. Most of these forms were blank with comments such as 'refused to sign/ complete, did not have capacity'. Therefore, we were not assured, efforts were made to seek feedback or give patients opportunities to make a complaint.

Managers told us there was a process in place to investigate complaints, however, the service had not received any. Following our inspection, the registered manager provided us with a blank complaints log which would be used in the event of a complaint. They also provided a template complaint management and action plan which would be used to investigate individual complaints should they occur.

There were no processes in place at the time of the inspection to share any learning from complaints.

Are Patient transport services well-led?

Inadequate

This was the first time we inspected the service. We rated it as inadequate.

Leadership

Leaders did not demonstrate they had the skills and abilities to run the service. Leaders did not always understand or manage the priorities and issues the service faced. However, they were visible and approachable in the service for patients and staff.

The service was led by a full-time registered manager who was the service director and owner. The manager was a Registered Mental Health Nurse (RMN) who had worked in senior nurse positions and bed management previously in NHS trusts and independent healthcare. The manager had not completed any management or leadership training, however, told us he intended to do this. The manager was supported by an operations manager which had recently been made a full-time position. During our inspection, we were advised the operations manager led on company policies, recruitment and training and did not have any direct line management.

Staff identified the registered manager as the point of contact and spoke highly of the support provided. All staff described the manager as being visible and approachable. The manager supported staff on patient transfers where a patient was of particular high risk or where additional staff were needed. Staff told us the manager checked in with them regularly throughout a transfer.

The registered manager was the designated safeguarding and infection control lead. Company policies referenced a quality and assurance manager. At the time of our inspection this role was not in existence, but the registered manager told us the role was split between the registered manager and operations manager.

The manager did not have full oversight of the challenges facing the service. There were no systems for managing staff and service performance. This meant the manager was not always aware of areas for improving the service and ensuring it was safe.

Vision and Strategy

The service did not have a clear vision for what it wanted to achieve or a robust strategy to turn it into action. There was a statement of purpose for the service. The statement of purpose was not focused on sustainability of services or aligned to local plans within the wider health economy.

The manager told us their vision was to obtain NHS contracts within the midlands and nationally. However, the service did not have an up to date strategy document or plan outlining actions to be taken to achieve its vision.

The service statement of purpose outlined an aim to provide a range of specialist patient transport services to NHS and the private healthcare sector.

The registered manager was able to identify key pressures such as the number of competitors already providing contract services and local commissioning processes as impacting on the service securing a contract. The registered manager told us the development of the service vision and strategy was impacted by the COVID-19 pandemic. To date the service had not secured any contracts but had undertaken non-contracted patient transfers for local NHS and independent healthcare providers.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. There was no evidence the service promoted equality and diversity in daily work or provided opportunities for career development.

Staff we spoke to felt supported, respected and valued. Staff spoke highly of the registered manager and felt comfortable to raise concerns and seek support. Most staff were positive about working for the service and enjoyed their role. Staff told us they debriefed following transfers and found this a supportive process. They looked at what went well and what could have been improved.

Processes to support staff development were not fully implemented. For example, the service did not have an effective induction process. A new induction workbook had been introduced but was not in place at the time of the inspection. Managers told us they offered staff supervision and appraisals; however, we did not see evidence these were routinely completed. Managers told us supervision was informal and not documented.

Staff told us they worked well as a team on transfers and everyone knew their role before the journey took place. All staff felt safe and supported.

Inadequate

Patient transport services

During our inspection we did not see evidence the service promoted equality and diversity in its daily work. The service could not demonstrate staff had completed equality and diversity training.

Governance

Leaders did not operate effective governance processes, throughout the service or with partner organisations. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service.

The service did not have effective structures, processes and systems to support the delivery of good quality and sustainable services. There were no service level agreements or contracts with referring providers. This meant the expectations of both the patient transport service and referrers were unclear and they could not monitor satisfaction with the service provided.

The service had a 'good governance' policy and procedure. The policy included an outline of the service governance structure, audits, quality and assurance processes, staff roles and responsibilities and regulatory responsibilities. However, the policy did not reflect the governance structure we observed during our inspection. For example, a quality assurance lead was cited in the governance structure, yet this role was not in existence. When asked the manager told us this role was split between the operations lead and the company director. However, this was not reflected in the policy. The policy also referred to board meetings which we did not see evidence were in place.

The service had not implemented key aspects of the policy. For example, the policy stated the service caries out regular audits, reviews and spot checks. However, we did not see any evidence this was in place at the time of the inspection. During our inspection, managers told us they did not have a systematic programme of audits and the policy did not specify which audits should be undertaken. The policy stated that quality and assurance was monitored through scheduled meetings such as a monthly health, safety and risk group meetings; a monthly quality and safety meeting and a monthly employee forum. However, managers told us these meetings were not facilitated or documented. When asked, managers told us the health, safety and risk group did not meet because they were not mandated in the risk strategy. This meant policy and practice were inconsistent and the service could not demonstrate there were clear responsibilities, roles and systems to support good governance and management.

We were not provided with evidence of regular management meetings. The service did have a management meeting which managers told us met monthly. However, the last meeting was in June 2022. Managers told us they were not documented before April 2022. Following the inspection, the service sent us minutes of three management meetings in April, May and June 2022. The minutes provided a framework for discussing safeguarding issues, regulatory compliance, audits and quality compliance, staff management/recruitment, complaints, health and safety, infection control and service developments. An action document added to the end of the minutes dated August 2022 was included so progress with tasks could be monitored.

There was no system in place for managers to monitor that staff had completed mandatory training. This was also not reflected in the meeting minutes as a concern. Furthermore, there was no system in place to ensure staff had undergone appropriate recruitment checks prior to starting employment. Management meeting minutes did document concerns with this process with actions to improve the process. However, during our inspection, this had not been completed.

The governance framework did not provide assurance that Mental Health Act procedures were followed. There was no reference to how this is monitored day to day and no reference to processes to ensure use of restraint and mechanical restraint should be monitored.

There was no robust system for sharing learning with staff. Staff meetings were not held. Staff did not have access to the service electronic systems therefore did not have access to most up to date policies and procedures. There was a notice board in the office, but staff did not regularly visit the office and at the time of our inspection there was limited information stored there.

Policies for the service were devised and reviewed by the registered manager. There was a policy folder which we reviewed during out inspection. This showed most policies were overdue for review. Following the inspection, the registered manager sent us policies which showed the review dates had changed. The manager said this was because they had not updated the policy front sheets in the folder with the most up to date policies. We were therefore not assured staff had access to the most up to date policies. Managers told us there was no formal way of reviewing policies and procedures at the time of our inspection and most policies did not have professional or external input.

Management of risk, issues and performance

Systems were not in place to manage performance effectively. Risks were not effectively identified and escalated. Risks we identified during our inspection were not assessed or mitigated. The service did not have robust plans to cope with unexpected events. There was no evidence that staff contributed to decision-making to quality of care was not compromised.

There was no system in place to monitor service performance. The manager did not have a systematic programme of audit. Managers told us they occasionally observed practice, but this was not done in a constructive or routine way. There were no audits of vehicle cleanliness, staff hand hygiene, patient journey times, delays, use of restraint or handcuffs or oversight of incidents that required reporting. There were no key performance indicators at the time of the inspection and no formal contracts with referrers. This meant there was no process of review of the services performance. Management meetings minutes we reviewed did not discuss service performance.

The service did not have a governance process in place to enable effective oversight and review of risks. The service risk strategy policy stated the accountable committee for risks was the health, safety and risk group and the quality and safety group. However, managers told us these groups did not meet to review risks. We saw no evidence of risks being discussed during management meetings. The service did not have a risk register to record all risks and monitor them. This meant there was no management oversight of service risks.

Risk assessments did not clearly identify risks and were not completed in line with the service risk strategy policy. The risk strategy provided a risk assessment proforma to be completed for all known risk. However, these were not used. Following the inspection, we asked the service to provide us with their risk assessments. Seven risks assessments had been completed in August 2022 which covered health and safety, office work, patient escorting, staffing, use of physical intervention, vehicles and COVID-19 and Monkeypox. The proforma used was not in line with the service policy. Risks were not rated, there was no responsible person cited. Whilst there was a review date on the front page of August 2023, it was unclear how risks would be reviewed and monitored. The risks cited were none specific and unclear. For example, the health and safety risk assessment outlined two risks as ‘health and safety’ and ‘staff training’. No further information was provided to explain what the risk was. There was no risk score in line with policy. There was a column titled ‘action taken to minimise risks’ and another ‘contingency plan if risk event occurs’. It was not clear how these two columns were differentiated, and the actions were in some cases the same on both. The actions did not reflect what we saw on inspection. For example, there was an action to ‘audit training’, ‘training orientation’ and ‘staff with out of date training should not undertake any work until training is updated’. During our inspection, we observed these actions were not in place, therefore we were not assured actions to minimise risk wold be effective. Furthermore, ‘contingency plans if the

risk event occurs' column outlined actions the service did not have in place such as 'make use of our inhouse and external trainers' and 'update training matrix', neither of which were in place at the time of our inspection. This meant the service could not provide assurance risk assessments completed were robustly assessed and risks were adequately mitigated.

Risks we observed during our inspection were not identified as a risk by the service. For example, risks associated with the transportation of young people, not having a service level agreement or contract in place to provide transport on behalf of other providers, non-compliance with safe recruitment, risks of employing staff with DBS convictions and concerns, staff success to policies and procedures. Following the inspection, the service sent us management meeting minutes for April, May and June 2022. The notes referred to the new appointment of an administrator who had raised concerns about employee file compliance, training compliance and lack of auditing during. However, these were not escalated as a risk or included in the risk assessments provided to us. This meant the service could not be assured they had full oversight of all the risks and actions required to address them to ensure a safe service was being delivered.

Risk assessments about the service were made by the managers. There was no forum for staff to put forward ideas for service development or contribute to decisions about the service.

The business continuity plan was not fit for purpose. The business continuity plan provided an overview of human resource processes and did not identify crucial functions required to continue service delivery. For example, there was no consideration of the unexpected absence of the registered manager/business own in relation to staff. It did not address issues such as adverse weather which may impact the ability for vehicles to provide patient transfer or staff to get to work. Furthermore, there was no consideration of business continuity in the event of no contracts being secured.

Information Management

The service collected minimal data and did not review or analyse it. Staff did not have access to data to help them understand performance of the service. The manager did not collect and use data to understand performance or make decisions and improvements.

Managers did not collect data to understand the performance and safety of the service. There were no key performance indicators set by the service or the referring providers as there was no contract in place. Basic data in relation to time of booking, pick up and arrival times were recorded on patient paper documentation. However, this was not populated so that it could be analysed to assess performance and responsiveness. The service did not record data in relation to use of restraint or handcuffs so that it could be reviewed overtime to identify patterns and ensure patient safety. The service did not record mandatory training compliance and did not have an effective system to ensure staff recruitment checks had been completed.

During our inspection, managers were not able to easily provide information such as numbers of active staff, numbers of transfers undertaken, number of staff who had completed training and undergone appropriate recruitment checks as the information was not recorded in an accessible way. For example, managers did not collate number of transfers and provided this by counting records of telephone calls in a booking note pad. The note pad contained other service information; therefore, patient transfer services were not always easily identifiable.

Most staff with exception of the registered manager, operations manager and administrator did not have access to the service electronic system to enable them to access key information such as policies and procedures. Following the inspection, the registered manager told us they were setting up a system to enable access to key information.

Inadequate

Patient transport services

The provider kept patient records which were completed by staff in a locked filing cabinet. This meant patient information was kept secure when not in use.

Engagement

Leaders did not actively engage with staff or the public to plan and manage services. They did not seek feedback about their performance from providers who referred to them. There was limited engagement with patients.

The service did not actively seek feedback about its performance from the providers who referred work to them. Managers told us they had conversations with providers to discuss how the service could support with bed management challenges. These conversations were mostly informal and had not yet resulted in the service securing a contract.

Staff did not routinely seek feedback from patients to assess the quality of the service. There was a feedback form attached to the transfer documents. However, we did not see any completed. During our inspection we reviewed 14 records and did not see evidence these were routinely completed. We observed notes stating 'patient refused' or they were blank.

Processes were not established to engage and seek feedback from staff to help improve services for patients. Managers engaged with staff whilst on a transfer to offer support and implemented a debrief following transfers to discuss what went well or what could have improved. These were usually a transfer team discussion; the feedback was not recorded, and we did not see evidence of it being used in a meaningful way to improve services. The service did not undertake staff surveys. Managers told us staff feedback was usually informal and not recorded.

Learning, continuous improvement and innovation

The service was not committed to continually learning and improving services. Managers understood understand quality improvement methods but did not implement any. There was no evidence leaders encouraged innovation and participation in research.

The service did not have a focus on quality improvement. They did not actively monitor the service performance and did not strive to make improvements. There were no plans in place to implement quality improvement methods or monitor practice for quality and safety. We did not see evidence staff were encouraged or supported to develop themselves or the service.

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 20 HSCA (RA) Regulations 2014 Duty of candour Duty of candour was not applied. The service incident reporting policy had a section on duty of candour with steps staff should take in the event of an incident. During our inspection we did not see evidence the service had followed the duty of candour process in response to known incidents such as use of restraint.

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 • Effective process were not in place to assess, monitor and improve the quality and safety of the service provided. There was no programme of quality and safety audits in place. Whilst there were weekly vehicle safety and Infection Prevention and Control (IPC) checks in place, there were no daily checks and there was no process to audit for compliance. There was no process in place to monitor staff compliance with completion of patient risk assessments and patient journey logs. There was no apparent risk management system or risk escalation process in place. • There was no process in place for managing and monitoring staff compliance with mandatory training and reviewing staff competency. • The system to escalate and report incidents or near misses was not effective. During the inspection, you told us there had been incidents of restraint used yet these had not been reported as an incident so that any learning could be identified and shared. • There was lack of management oversight of the number of staff employed on zero hours contracts. When asked, managers were unable to provide an exact number of staff who were active within the service. • Systems for overseeing safe recruitment processes were not in place or audited for compliance. • All policies and procedures we reviewed had expired in March 2022, and there was no system in place to review them. We were not assured the policies and procedures we were given to review reflected the service provided. For example, there were roles cited in the policies that were not in place within the service. Policies did not have an expert of external input and were not always reviewed by a qualified person.

This section is primarily information for the provider

Enforcement actions

- There was no policy or guidance in place so that staff knew what their roles and responsibilities were from point of booking to end of transfer.
- Patient transfer documentation was not always fully completed.
- Systems to report incidents were not effective and known incidents such as use of restraint were not reported. There was no evidence of shared learning following incidents.
- The service did not have a complaints policy or robust process for investigating complaints and sharing learning from them.
- Service risks were not always identified by the service and risk assessments in place were unclear, did not have risk owner or risk rating to determine level of seriousness.

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 • There was no system in place to ensure staff had received the appropriate level of safeguarding training for both children and adults in line with Safeguarding Children and Young People Roles and Competencies for Health Care Staff Intercollegiate document 2019 and Intercollegiate Guidance for Adult Safeguarding 2018. • Safeguarding policies and procedures had exceeded the review date at the time of our inspection. Policies did not outline what level of safeguarding training was required and did not support staff to raise concerns both externally and internally in a timely manner, and to the right organisation. • There was no system in place to undertake due diligence when recruiting staff to the service. Personal folders we reviewed showed identify checks, references and Disclosure and Barring Service (DBS) checks were not always completed prior to the start of employment. Records did not demonstrate the service had checked

This section is primarily information for the provider

Enforcement actions

whether a DBS in place for new and existing staff were enhanced and children and young people checks had been included. The registered manager told us the service did not have a current DBS policy in place.

- The system to assess the potential risks posed to patients from staff who had previous convictions or where previous allegations of abuse had been made against them were not effective. In records we reviewed, the service could not demonstrate where there was a risk, they had safeguarded patients from potential abuse or harm.
- The service did not have a process to ensure where there is a risk that restraint could be required, this is planned for in line with policy and the detail of the use of restraint is robustly documented, reported and investigated.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Vehicles were not clean and there was not a robust cleaning schedule in place to ensure high standards of cleanliness and infection control practices were being met at all times. • Systems in place to check vehicle safety were not always completed or effective in identifying issues. • There was no system in place to log all electrical equipment and ensure they underwent relevant safety tests including but not limited to portable appliance testing. • Booking and transport records did not detail the patient individualised risks or how the risks will be mitigated. We saw where restraint was used, it lacked details about level of restraint used and there was no body map completed. • The service did not always document patient medicines received by the service at the point of transfer were recorded on the patient transfer documentation or recorded where given to the receiving provider on arrival.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing • There was no system in place to ensure staff had received statutory and mandatory training. You were unable to tell us what your staff training requirements were. Training requirements outlined in the employee employment contract you showed us included such as handcuff training, first aid, basic life support automated external defibrillator training, manual handling and search training were not provided. • Staff were not provided with role specific training such a handcuff training or Mental Health Act training. Whilst Safety Intervention Training (SIT) was provided, the service could not demonstrate all relevant staff had completed it. • There was a process for inducting new staff, but this was generally not completed in the eight staff personal files we reviewed. Staff did not undergo regular supervision or appraisals.