

# Keynsham Vehicle Base

## Quality Report

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

## Ratings

### Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Are services responsive?

Good



Are services well-led?

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Keynsham Vehicle Base is operated by Tascor Services Limited which is part of the Capita PLC group. They provide a patient transport service. They are located on a trading estate in Keynsham in the south west of England. The service provides non-emergency ambulance transport for people with mental health conditions, most of whom are detained under the Mental Health Act 1983. The service also provides transport for non-detained patients, for example patients living with dementia who attend day centre groups.

We inspected this service using our comprehensive inspection methodology. We carried out the short-notice announced inspection on 28 January 2020.

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

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

The main service provided was patient transport.

We rated it as **Requires improvement** overall.

- There was no safeguarding lead for the service to support and advise staff.
- The service did not control infection risks well.
- Equipment was not always within its use by date and stored securely whilst in vehicles.
- Staff did not always check vehicles to make sure any objects that could cause harm were removed.
- Managers did not use their information systems to monitor the quality of the service.
- Records of audits did not contain enough detail to provide assurance of safety on an ongoing basis.
- Patient paper records were not audited or kept in line with guidance for NHS patients.
- There were gaps in the process and records of recruitment of new employees.
- The managers had not devised a vision for staff to follow.
- Managers were aware of the risks to their service, but this was not recorded.

We found good practice in relation to patient transport:

- The service had enough staff to care for patients and keep them safe.
- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them.
- The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and gave patients enough to eat and drink.
- Managers made sure staff were competent.
- Staff worked well together with other agencies for the benefit of patients.
- The provider planned their service to meet the needs of local people and took account of patients' individual needs. They made it easy for people to give feedback.
- People could access the service when they needed it.
  - Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

# Summary of findings

- The service engaged with the community to plan and manage services and all staff were committed to improving services continually.

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

**Nigel Acheson**

**Deputy Chief Inspector of Hospitals (London and South), on behalf of the Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

### Rating

### Summary of each main service

#### Patient transport services

Requires improvement



Patient transport services was the provider's only activity. They provided services for a local NHS trust where they transported patients who were detained under the Mental Health Act and other patients with mental health illnesses. The service was for adults.

# Summary of findings

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Requires improvement 

# Keynsham Vehicle Base

Services we looked at

Patient transport services

# Summary of this inspection

## Background to Keynsham Vehicle Base

Keynsham Vehicle Base is operated by Tascor Services Limited. Tascor has been providing a service to a local mental health trust since 2007 and serves the communities of Avon and Wiltshire, along with north Somerset and south Gloucestershire. The service occasionally carries out transport to repatriate patients from or to elsewhere within the United Kingdom.

Two teams of specialist staff are employed by the provider. One group provides transport for patients who are detained under the Mental Health Act 1983. The other group provide transport for voluntary patients attending treatment at hospitals and a non-emergency patient transport service for people with dementia to attend day centres.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector and another CQC inspector. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

## Information about Keynsham Vehicle Base

Keynsham Vehicle Base is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

During the inspection we visited the base in Keynsham. We spoke with 13 staff including detained driver escorts, driver escorts, office staff and management. We spoke with the commissioners from the local NHS trust who contracted the service. During our inspection, we reviewed five sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in August 2017. At this inspection, the service was not rated. We found some areas of good practice and areas where improvements were needed.

Activity in the last 12 months:





In the last 12 months there were 8,876 patient journeys undertaken.

Staffing included 50 detained driver escorts, 14 driver escorts and six office staff.

Track record on safety:

- No never events
- No clinical incidents
- Five complaints
- Six compliments

# Patient transport services

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

## Information about the service

The main service provided by this service was patient transport services. The service provided transport for a local NHS Trust specialising in mental health. They transferred patients who were detained under the Mental Health Act and other non-detained patients with mental health illnesses. The service primarily served Avon and Wiltshire, along with north Somerset and South Gloucestershire and provided some transfers out of the county.

The service had 14 vehicles, which included cars, large people carrying vehicles (some with tail lifts) and one vehicle that could transport patients using a stretcher.

## Summary of findings

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

- There was no safeguarding lead to support and advise staff. The service did not control infection risks well. Equipment was not always within its use by date and stored securely whilst in vehicles. Risks to patients were not always removed as some objects were not always removed from vehicles which could cause harm to patients.
- Managers did not use their information systems to monitor the quality of the service. Records of audits did not contain enough detail to provide assurance of safety on an ongoing basis. Patient paper records were not kept in line with guidance for services working with the NHS. There were gaps in the process and records of recruitment of new employees. The managers had not devised a vision for staff to follow.

However, we found the following areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment and gave patients enough to eat and drink. Managers made



# Patient transport services

sure staff were competent to carry out their roles. Staff worked well together with other agencies for the benefit of patients. Key services were available seven days a week.

- The provider planned their service to meet the needs of local people and took account of patients' individual needs. They made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services using reliable information systems. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service engaged well with the community to plan and manage services and all staff were committed to improving services continually.

## Are patient transport services safe?

Requires improvement 

We rated safe as **requires improvement**.

### Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone had access to it.**

All staff received mandatory induction training.

The provider had a list of mandatory core training that had to be completed. This included Information security awareness, data protection awareness, financial crime, social media awareness and safety, and health and environment training.

At a local level, the service provided emergency first aid (this included infection, prevention and control), safeguarding, prevention and management of violence and aggression, tail lift & wheelchair operation, speed awareness and driving assessments. The prevention and management of violence and aggression included communication skills, control and restraint techniques and use of hard and soft handcuffs. This was renewed annually for all staff.

Training was also provided on the Mental Health Act 1983. This included information about sections and the actions which needed to be taken by staff when transferring a patient who was under a section from the Mental Health Act 1983.

All staff received a mandatory driving assessment upon commencing their employment. A practical driving assessment was carried out on the vehicles used for transporting patients. This was done by a qualified driving assessor. Staff were only re-assessed if a concern was raised about the standard of driving.

Most staff were up to date with their mandatory training. We were not able to get a percentage of how many. Mandatory training was recorded on a spreadsheet which showed when each topic was last done and when staff needed an update. The registered manager told us it was

# Patient transport services

his responsibility to update this spreadsheet and inform staff when training was due. The registered manager told us the provider's target was 100%. The registered manager told us the provider's target was 100%.

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it but not all staff were trained to the required level.**

As part of their mandatory training staff received safeguarding adults training to level 3 and children to level 2. At our last inspection, we issued a requirement notice for the service to provide ongoing refresher training for staff in safeguarding. The registered manager sent us evidence that staff received safeguarding training yearly. The training spreadsheet showed most staff were waiting on updated refresher training dates for safeguarding for this year. The safeguarding policy did not refer to the required level of training for staff. It did provide staff with information about abuse and a flow chart on how to report their concerns.

There was no dedicated safeguarding lead for the service to provide staff with advice or support. Following our inspection, the registered manager told us they would appoint a lead and two senior staff would undertake safeguarding training to level 4, so they would have the skills and knowledge to support staff.

The registered manager told us if they had any safeguarding concerns or referrals, these would be shared immediately with their commissioners. The registered manager shared with us a referral they made following an incident when transferring a patient. Staff had reported it to them, and they then contacted the commissioners who followed up this referral.

Managers ensured Disclosure and Barring Service checks were completed. Staff worked in a supernumerary capacity and were not left alone with patients whilst awaiting the return of the checks. Managers checked the photographic identification of all new starters.

## Cleanliness, infection control and hygiene

**The service did not control infection risk well. Control measures did not protect staff or patients and others from the risk of infection. The service did not keep vehicles visibly clean.**

In some cases, protocols for infection prevention and control were not in line with best practice. For example, when cleaning up bodily fluids the policy recommended hot water and detergent. The policy then referred to the use of spill kits, which were readily available in the vehicles. This needed to be reviewed to make sure it met current guidance and up to date best practice. Staff used household antibacterial spray to routinely decontaminate fabric items such as car seats and soft fabric restraints. Staff used a valeting machine to clean visibly soiled fabric seats. This was not in line with best practice guidance.

Staff used one mop to clean all the non-carpeted floors of the vehicles and the staff areas. Staff used household cleaning fluid for this purpose. There was no identified process for changing the mop head. There was also no system for different mops for cleaning different areas to prevent the risks of cross infection, for example clinical areas (vehicles), kitchen areas, and bathroom areas. Senior managers told us during the inspection they would address this as a matter of urgency and purchase additional different coloured mops and identify which would be used for bodily fluids only and the others for general cleaning. Following our inspection, the registered manager confirmed they had purchased additional coloured mops.

Managers told us blankets were taken to the laundrette twice a week for cleaning. However, there was no record of this process. Blankets stowed in vehicles were not labelled to indicate if they were clean. In one vehicle, we saw the blanket was stored in the same cupboard as a dirty dustpan and brush.

There was no process for routine deep cleans of the vehicles. When staff had information that a patient had an infection, we were told the vehicle was 'deep cleaned' by a contracted cleaner and staff could use 'fogging' cannisters to decontaminate the inside of the vehicle if lice were detected. However, staff did not keep records of these processes. Following our inspection, the registered manager sent us a new checklist for deep cleaning of vehicles that they were planning to start using.

We examined three vehicles, two used for transporting detained patients and one used to carry a stretcher. We

# Patient transport services

found all three to be dirty inside and out. The registered manager told us one had returned late the previous night, and staff did not clean vehicles in the dark. We were told the vehicle would be cleaned prior to use. Each crew was responsible for the cleaning of their vehicles at the end and beginning of each shift. Specialist cleaning wipes were provided. However, we found out of date specialist cleaning wipes in one of the vehicles we inspected. There were checklists to remind staff of the cleaning tasks to be completed daily. These checklists included brief references to cleaning the inside and the outside of the vehicle. We looked at these checklists and saw that staff consistently signed to say they had completed the cleaning tasks.

Crews were made aware of specific infection and hygiene risks associated with individual patients during the booking process. The registered manager told us, and this was supported by the crews we spoke with, they would contact the ward/unit prior to transfer to check if the patient had an infection.

Infection control and prevention training was provided as part of staff first aid training. Information about when staff had received this was on the training spreadsheet and monitored by the registered manager for when they were due updates. Staff had access to an infection prevention and control policy, however as mentioned above, this needed to be reviewed to make sure it provided staff with the most up to date guidance and best practice.

Staff had access to some personal protective equipment (PPE). Gloves were available on the vehicles. Staff could collect other PPE, including aprons and face masks from the office. Staff had access to hand gel.

Staff were responsible for laundering their own uniforms. Managers did not provide any guidance to staff regarding minimum temperatures of wash for effective cleaning.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment mostly kept people safe and staff were trained to use the equipment provided. Equipment stored in vehicles was not stowed safely. Staff managed clinical waste well.**

The service stored their vehicles in a parking area located on a business park where their office was based. This was a secure area and keys to the vehicle were stored securely at the office.

The service ensured all vehicles had a current ministry of transport (MOT) test, were serviced and insured. Records demonstrated all vehicles were safe to use on the road. Staff had access to a breakdown service for all vehicles if needed. A tracker was also fitted to each vehicle so senior managers could monitor their location. Staff had access to up to date satellite navigation systems.

Staff reported all faulty equipment to the registered manager or another senior manager. If this was minor it was dealt with by a member of staff at the location. However, if it was more serious and had an impact on how safe the vehicle or equipment was, the vehicle was withdrawn from use immediately. Action was taken to repair the vehicle or equipment as a matter of urgency.

Seatbelts were available in all vehicles. If they carried children, they also had access to child car seats. Most vehicles were used to transport patients detained under the mental health act. These were unmarked and had blacked out windows for privacy of the patient.

In each of the vehicle first aid boxes we checked, we found consumables which were out of date. Some also contained different consumables to others. Checking of the first aid boxes had been undertaken but this also varied between each vehicle. This system had proved to be ineffective as staff had not identified these out of date items. We found one consumable was out of date in 2015. During our inspection, a senior manager ordered 15 new first aid boxes for all the vehicles in use. We were sent evidence of this following our inspection. The registered manager said a new checking system would be implemented once the new first aid boxes were in use.

Items were not securely stowed in vehicles. There was no suitable equipment available for staff to use to secure these items effectively. For example, when the stretcher was not in use it was stored in a folded position in the seating area of the vehicle, directly in front of a passenger seat. Mechanisms to secure the stretcher did not include prevention of forwards/backwards movement, or vertical movement in the event of a collision. In one vehicle, we saw a folded wheelchair was stowed in a recess at the front of the seated area of the vehicle when not in use. The wheelchair was not secured to prevent movement in the event of a collision. In the same recess, other items such as an umbrella and wheelchair clamps were also not secured. In one vehicle, we saw several items were stowed in the rear of the vehicle using a bungee cord to restrict

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movement. The bungee cord was ineffective for this purpose. During the inspection the registered manager started to look at ways of securing this equipment to prevent unnecessary risks to staff and patients.

The vehicle used for stretcher patients was suitable for bariatric patients. Staff had been trained to use the stretcher and tail lift for detained bariatric patients. Alternatively, if the patient was mobile and could get in and out of the vehicle they could be transferred.

On the stretcher vehicle a defibrillator was available. This was checked weekly and staff knew how to use it.

Managers ensured restraint equipment was fit for purpose. For example, managers recorded the serial numbers of handcuffs. Every three months a senior manager checked each of these for wear and tear and checked the safety features were working correctly.

Clinical waste was disposed of safely. There were appropriate arrangements for this to be collected by an external provider.

## Assessing and responding to patient risk

**Staff completed risk assessments for each patient and mostly removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

The registered manager told us information about patients was shared with them by the local NHS trust who commissioned their services. The form used gave information about the associated risk with the individual patient, which had been assessed by staff from the trust. Specific information about the patient was also included. Senior managers were not aware of the risk assessment tool used by the trust, so they were not able to tell us what each risk level meant. For example, high, medium or low. Following our inspection, the registered manager told us they had contacted the commissioners who told them there was no set matrix and the risk assessment was down to the individual member of staff who assessed the patient. The registered manager said to mitigate this, staff will confirm an up to date risk assessment had been completed at the booking stage and before they commence the transfer.

Staff had not minimised all potential risks to patients. In one vehicle we saw an unzipped bag containing a pair of scissors and a box of lightbulbs was hung on the back of a

seat. These items could be used to cause harm. We also found cold and flu medicine which was used by staff that was not stored securely. This was reported to the registered manager and this was removed from the vehicle. After our inspection the registered manager told us patients had no access to the front of the vehicle and these were stored in the glove box. However, these medicines must not be stored in the vehicle and staff must make sure they keep their personal medicines away from the vehicles and patients.

Due to the nature of their work, staff did not always have a clear picture of risk associated with a patient who was detained under the Mental Health Act 1983. This was because there were times when they were asked to convey a patient who had been detained but had not been searched for equipment that could cause harm. Due to the time constraints of staff transferring patients who were detained, they may not have been fully assessed by the local NHS trust for their risks. This was because they needed to be transferred quickly to a facility. This also impacted on this service. Staff undertook a visual risk assessment when collecting a detained patient from their home. This was done to make sure it was safe for staff to enter the property and transfer the detained patient to a specified location. To help minimise the risks to staff they worked in a team of four, which included a team leader.

Managers had instructed staff to not convey the patient if they had any concerns that the patient might be concealing an item that could cause harm or injury. The registered manager told us they had a policy called 'walk away' in their escort tasks which contained details about the actions staff should take in this situation.

All staff were trained to use restraint if needed to protect themselves and the patient if their behaviour became too challenging or they were showing aggression and violence. All incidents of restraint were recorded.

When staff used restraint devices, staff monitored patients to make sure they did not come to harm. Every 20 minutes, staff checked patients' capillary refill, asked the patient if they were okay and visually inspected their wrists.

The registered manager told us if a patient started to deteriorate during the journey, staff would call for an emergency ambulance. However, there was no policy for managing the deteriorating patient. Following our inspection, the registered manager told us a deteriorating

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patient was most likely to happen during use of restraints. Instructions for staff to follow if this event was to happen was included in the use of force policy section three. There was not a separate policy for managing any patient who may deteriorate.

## Staffing

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

The service employed 74 staff in total including office and management staff. Of those, 50 were patient driver escorts, 14 were driver escorts, two were vehicle base coordinators, eight were team leaders and two were senior managers. During our inspection, we saw the required numbers of staff were available to transport and care for patients safely.

Most staff were employed on 48 hours per week permanent contracts. Some staff were employed on zero hours contracts. Bank or casual staff were employed to fill any vacancies on shifts. Senior staff told us they had received the same mandatory training as permanent staff. There were no staff vacancies at the time of our inspection.

For staff who transported detained patients, they were allocated in a team of four for safety. This included a team leader. This team worked together for all journeys.

The service had two staff members in the office who worked solely to take the transfer requests from their commissioners. They reviewed all requests, checked on timings and allocated to the crews. At the weekend and out of hours the team leader on duty would take the requests and follow these up before responding to the transfer.

The registered manager told us they had an 11% turnover rate for the period January to December 2019. They were not able to compare this to past performance as this was not monitored. Sickness and absences were monitored by the provider. The sickness for January to December 2019 was 2.2%. Whilst these were monitored, they were not compared to previous results. We did not see any evidence that shifts had not been filled during our inspection as bank staff were used to cover these.

We observed, and staff told us they were able to take breaks, but times varied depending on workload.

## Records

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

The service received a transfer form from the local NHS trust who commissioned their services with details of the patient, their risk assessment score, any specific details about their risk and where they needed to be taken to. Staff were also given a tasking sheet which contained details about the location etc. For non-detained patients, staff were given a tasking sheet and recorded details on a journey log. Senior managers then transferred all transfers and journeys for all detained patients to the monthly logs which was shared with commissioners. This contained, for example, journey details, patient details, staffing numbers and if the transfer/journey went ahead. We reviewed five patient records in total and saw they contained the details mentioned. These were clear, easy to read, signed and dated.

We did not see any audits of records by managers to demonstrate if records were being completed in full.

In each vehicle staff were given a blue box to store patient records.

Staff were given training on what section paperwork must be present to ensure the section was legal when the patient was detained. These were then transferred to the required location with the patient.

Staff were told when a patient had a do not attempt resuscitation order. If a patient had one in place this would be transferred with the patient.

## Medicines

**The service only administered oxygen based on strict guidance and stored it safely for transfer.**

Senior managers told us staff did not administer medicines. They would only administer oxygen to patients if they were already using it, and this would be on the directions of the ward/unit of the patient they were transferring. The service did not store any medical gases and if a patient was using



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any, they would need to bring the cylinder with them. Staff could transfer medicines for patients between locations if needed. These were stored securely and recorded on the patient records.

The provider had a health and safety policy which described how to administer the oxygen as directed by the unit/ward prior to transfer.

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff knew to apologise and to give patients honest information and suitable support.**

There was a paper system for reporting incidents. Staff knew the process for reporting incidents. There were incident forms available inside vehicles which staff could complete. Staff reported all incidents of restraint. These were reviewed by the senior managers and reasons for the restraint explored. For example, detained patients trying to abscond, or staff using restraint to protect themselves from aggression or violence. The registered manager was in the process of adding all restraint incident forms to a spreadsheet to help with monitoring. This was ongoing at the time of our inspection. The service had completed a review of all mechanical restraint used between January and November 2019 for their commissioners. We saw details of this.

The service had reported they had used restraint 67 times, in the last 12 months. Two staff had reported being assaulted by patients and these were shared with the commissioners from the local NHS trust.

The service had a duty of candour policy which detailed their responsibilities under this regulation. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Senior managers had not needed to initiate this requirement at the time of our inspection.

(for example, treatment is effective)

Good 

We rated effective as **good**.

## Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983**

At the last inspection we found staff followed best practice advice and worked in teams with an identified lead during restraint of patients. We saw incident reports that described staff working in this way. This practice was in line with the Department of Health guidance 'Positive and Safe' (2013) and National Institute for Health and Care Excellence guideline 'Violence and aggression: short-term management in mental health, health and community settings' published: 28 May 2015, Guideline 25. However, the policy did not include references to 'service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services' clinical guideline (National Institute for Health and Care Excellence CG136) December 2011 reviewed in 2016. We found this to be the same at this inspection. Senior managers told us they were in the process of reviewing all policies, procedures and standard operating procedures to make sure they were in line with the most up to national guidance.

Senior staff told us if mechanical restraint had to be used for some time, staff would try to change to soft cuffs as these were more comfortable for the patient. We saw staff had access to both.

Mechanical restraint is a method of physical intervention involving the use of authorised equipment, for example handcuffs, applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part(s) of the body of the patient. Staff had received training in use of restraint by an external training provider.

Staff had access to a folder of company protocols in each vehicle.

**Are patient transport services effective?**

# Patient transport services

## Nutrition and hydration

### **Staff ensured patients' food and drink requirements were met during a journey.**

Staff carried drinking water on board vehicles to give to patients when required. The service did not provide food for patients. However, due to the long distances they had been travelling to take patients to suitable locations, staff often had to stop and purchase food for patients. Some of the wards/units from the local NHS trust who commissioned their services provided food to be taken on the transfer. Staff would check if the patient required a special diet before purchasing any food.

## Response times/ Patient outcomes

### **The service monitored, and mostly met, agreed response times so they could facilitate good outcomes for patients.**

The service monitored response times as part of their contract arrangements with the local NHS trust. They only provided a service to this trust. Senior managers met in person with the commissioner every month to discuss performance against their key performance indicators (KPIs). The service told us they offered the local NHS trust a 24-hours a day, seven-days a week, 365-days a year bespoke service with agreed response times. This was confirmed by the commissioner for the local NHS trust.

All transfers/journeys were recorded on log sheets which were shared with the commissioners from the local NHS trust. These were used to monitor performance, for example how many transfers and costings.

Senior staff told us for detained patients the response time was two hours unless the crews were on other transfers. For out of area transfers it was by 2pm the following day. However, due to the increase in workload from the trust these were not always being met. The commissioners for the local NHS trust told us due to their increased workload this impacted on the KPIs they set for Keynsham Vehicle Base. This also meant they had to transfer patients out of the area more frequently which had an impact on the KPIs in their contract. They said about 95% of the time they met the target set for a certain section under the Mental Health Act 1983. The commissioners were happy with this response time.

## Competent staff

### **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Staff had the skills and knowledge to deliver effective care and support. Annual specialist training was provided in the prevention and management of violence and aggression and how to safely use control and restraint. As part of their induction training, staff also had access to information about the Mental Health Act 1983 and relevant sections used to detain patients.

New staff were provided with a handout explaining the different sections under the Mental Health Act 1983. Staff demonstrated a clear understanding of their roles in relation to patients detained under these sections.

Managers accompanied staff on their journeys to evaluate team competencies. This included observations of staff skills and adherence to protocols. For example, the evaluation included documentation, handover of information, completion of vehicle checks and communication with patients.

Managers ensured all staff who drove vehicles were competent to do so. All new staff met with an external driving assessor at the start of their employment who assessed their competence to drive the vehicles. This process was repeated if the managers received any complaints about the staff driving or if staff acquired points on their licence. None of the vehicles required a C1 drivers' licence. A driving licence check was recorded for all staff and this was ongoing. Staff had to report to the managers if they had any conviction in relation to driving.

All new staff worked in a supernumerary capacity for the first four shifts. During this time, the team leader explained all protocols to the employee and used an induction checklist to show this was completed. Managers told us they uploaded this checklist to the staff file. We checked three staff files and saw these had not yet been uploaded. Managers told us they were behind with this process.

New staff participated in a three-month probationary period. At the end of this period, senior managers told us they discussed staff performance and highlighted any areas for further development. At the time of our inspection, this process was not recorded.

# Patient transport services

Staff appraisals were at 100% completion for this year. Staff reported no issues with the system for appraisals.

## Multidisciplinary working

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

Staff and other services worked well together to deliver effective care and treatment to meet the needs of the patients they transferred. Care was delivered in a coordinated way when other services were involved.

The vehicle base coordinators recorded key information when they received the transport request, and this was also included on the transfer form received from the local NHS trust. Staff liaised with both the transferring and receiving hospital/unit about timings and bed availability.

Some patients required an escort from the departing NHS location to their transfer location. Staff told us they were able to travel with them in the vehicle.

We were shown several positive reports from different staff from the local NHS trust who contracted the provider's services. One was about how one crew helped the ward staff care for a patient who was displaying challenging behaviour.

Staff had access to information about the patients prior to the transfer/journey. For example, if a patient had a do not resuscitate order and any specific information about their needs. However, this was not always possible when collecting a patient who had been detained in their home.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment where able. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff had access to a safeguarding policy that referred to consent and the Mental Capacity Act 2005. This policy did not refer to Deprivation of Liberty Safeguards. We were told

staff received training on the mental capacity act and Deprivation of Liberty Safeguards as part of staff induction training. Staff also had training in mental health and the prevention and management of violence and aggression.

The registered manager told us they only transported children who were related to the detained patients they transferred. For example, if the parent had been detained and the child was being taken with them to a location like a specialist mother and baby unit. Therefore, staff didn't have training on the Gillick competencies. Gillick competence is a term originating in England and is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

## Are patient transport services caring?

We did not have enough information to rate caring.

We did not observe any transfers, so we were not able to speak with patients or their relatives/carers. Because of this we do not have enough information to rate this section.

## Compassionate care

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

Staff told us they involved patients in conversations and tried to make patients feel accepted. Staff told us that all members of the team had different interests and they tried to use this diversity to find common ground to share with the patients on the journey. Staff respected patients' individuality. For example, one patient liked to play guitar, so staff encouraged the patient to play to them during the journey.

Wherever possible, staff tried to respect patients' privacy and dignity. This was sometimes difficult and required the staff to be flexible and responsive to the risk levels. For example, staff accompanied patients to use a lavatory during long journeys. When managers purchased new vehicles, they ensured glass was darkened to provide privacy for the patients transported in the vehicle.

The commissioners from the local NHS trust told us they often received feedback from their staff about how the staff



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from Keynsham Vehicle Base showed compassion towards the patients they transferred. For example, how they took time to engage with patients living with dementia and not just hurry them into the vehicle.

## Emotional support

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

Staff told us how they used de-escalation techniques to minimise the impact of distressing situations for patients and their families. Staff told us how they showed empathy, for example offering patients a shoulder to cry on or a hand to hold.

Staff tried to relieve patients fears. For example, one patient was scared of travelling on the motorway. Staff sat next to the patient and positioned the seats, so the patient did not see the other cars.

When patients were anxious and confused, staff gave them reassurance. For example, staff told us how they helped a patient with dementia to understand they did not need to pay for the journey.

**Understanding and involvement of patients and those close to them.**

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

Staff told us how they only ever used restraint with caution. Staff constantly evaluated how they could reduce the level of restraint used during the journey whilst keeping the patient safe. Staff involved patients in this process wherever possible.

Feedback from the local NHS trust commissioners told us staff were always mindful of the relatives when they transferred patients who were detained and those who were not. They said they always involved them when they were able.

**Are patient transport services responsive to people's needs?**  
(for example, to feedback?)

Good 

We rated responsive as **good**.

**Service delivery to meet the needs of local people**

**The service planned and provided care in a way that met the needs of local people and the communities it served. It also worked with others in the wider system and local organisations**

Services were planned and delivered to meet the needs of patients using the service. The location of the vehicle base and vehicles was local to the NHS trust who commissioned their services. This helped to reduce the transfer time when collecting patients from the local communities. They also provided a 24-hour, seven-days a week service to the trust.

Keynsham Vehicle Base worked closely with the NHS trust who commissioned their services. They provided monthly transfers logs of all transfers undertaken with other relevant information included. For example, how many staff, time of collection and transfer.

The commissioners told us Keynsham Vehicle Base had held their contract for 12 years and they worked very well together in meeting the needs of their patients.

**Meeting people's individual needs**

**The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.**

Transport services were planned, delivered and coordinated to take account of patients with complex needs. We saw detained patients were collected in vehicles which were unmarked and had blacked out windows so were not identifiable as ambulances. This was to maintain patients' privacy and dignity. The service also had several vehicles with tail lifts for wheelchairs and one vehicle was able to carry a stretcher.

Staff had received training in mental health and the prevention and management of violence and aggression to meet the needs of their patients.

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Staff had access to a telephone interpreting system to support patients whose first language was not English. Senior managers told us they had not needed to use this service. Senior staff also told us they had a diverse staff group with some of the staff able to speak other languages.

The service was told about patients who had specific needs on the transfer booking form. The local NHS trust who commissioned their services were able to provide support for patients who had difficulty communicating verbally. There were no communication aids provided by the service to support staff, for example pictorial cards.

## Access and flow

### People could access the service when they needed it.

Patients accessed care and treatment in a timely way. The service provided a 24-hour, seven-days a week transport service to the local NHS trust. These included detained patients and other patients who needed transport to day centres etc.

Transport requests were dealt with by dedicated staff in the week and out of hours/weekend by team leaders. They liaised with the trust and location where the patient was being transferred to and the staff team to ensure a safe and timely transfer.

The service had Key Performance Indicators (KPI's) as part of their contract with the local NHS trust as mentioned above. However, these were not always being met due to high demand on the services of the trust and the impact this had on this service. For example, more patients were being transferred to out of area locations as the NHS trust had no beds.

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.**

Information about making complaints and sharing patient experiences was displayed within one of the vehicles we viewed.

There were five complaints received in the 12 months leading up to this inspection. These all came via the local NHS trust commissioners. The commissioners told us the

service was very open with them when they needed to investigate complaints and provided all required information. The outcome of these was shared with Keynsham Vehicle Base. We were told about shared learning from one of these complaints, which included a change to the risk assessment for detained patients to include a question about pregnancy.

The service had a complaints policy which covered how patients, or their relatives/friends could make a complaint. The policy did not mention how they would proceed if the complainant was not happy at the end of their local process. There was also no access to an independent review of a complaint.

Patients who made a complaint to the local NHS trust who commissioned the provider's services were able to be directed to Patient Advice and Liaison service (PALS) if needed. We saw one complaint had been investigated by PALS.

The service kept a log of all complaints as part of their monitoring. This also included compliments received about the service.

There had been six compliments received in the 12 months leading up to the inspection. All were about the conduct of staff. These were shared with the whole staff group.

## Are patient transport services well-led?

Requires improvement 

We rated well led as **requires improvement**.

## Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.**

In September 2019, there was a change in the leadership structure at this location. The new management team consisted of the contract manager, the operations manager, and an experienced member of administrative staff who was acting up in the office manager role. There had also been a change to the registered manager since our last inspection. A new registered manager was registered with CQC in December 2019. Following our

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inspection, the provider put forward a new nominated individual as the previous one had left the service. A nominated individual has overall responsibility for supervising the management of the regulated activity and ensuring the quality of the services provided.

At the time of our inspection, the new management team had been in charge for a relatively short period. They were committed to bringing energy and focus to the service. Managers recognised the need to develop links with the support and oversight functions of the parent company. For example, they were holding regular meetings with the corporate health and safety manager.

Managers supported staff to develop their skills and take on more senior roles. At the time of our inspection, a member of staff was temporarily covering the office manager role. This member of staff told us they had acquired a wide range of skills during this development period. The managers hoped to make this role permanent.

All staff told us local leaders were visible and approachable. This included staff being able to telephone the on-call managers for advice any time, day or night.

A requirement at our last inspection to send an updated copy of the provider's statement of purpose had been addressed. Following this inspection, the registered manager sent us a further updated statement of purpose and an organisational structure for local management arrangements.

## Vision and strategy

**The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.**

During our last inspection, inspectors found the service did not have a vision or strategy. At the time of this inspection, managers had not resolved this. The vision for the service was not written down. Due to uncertainties regarding the future of the service contract, managers had delayed the process of formalising a vision and strategy for the service. The registered manager was in the process of completing further training which would equip them with skills to complete this task.

## Culture

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

Leaders operated an 'open door' approach to management. One manager arrived at work an hour before staff started their early shift to ensure there was a member of the management team available for them should they wish to raise any concerns. Staff could contact the on-call manager at any time by telephone.

All staff told us they felt comfortable to raise concerns and leaders listened to them. For example, when staff raised concerns regarding unequal rates of pay, the managers followed this up with the parent company and the policy was amended and staff were reimbursed.

Staff told us there was a strong emphasis on staff well-being and that managers were supportive during times of personal crisis.

Staff understood the complex needs of their patients and tried wherever possible to meet those needs. Staff showed a commitment to providing compassionate care in often very difficult circumstances.

Managers frequently joined teams during their shifts to ride alongside them in vehicles. This ensured that teams remained open to observation and to feedback.

Staff told us they felt valued. For example, some staff had received 'local hero' recognition awards from Tascor head office. We saw this was included in an article in the Tascor newsletter. Staff told us leaders gave them positive feedback.

Staff had access to a speak up policy devised by the provider. This provided staff with guidance on how to raise issues with the company.

The commissioners from the local trust told us they felt the staff were open and transparent, especially following complaints which they investigated with the support of senior managers and staff at Keynsham Vehicle Base.

## Governance

**Leaders did not always operate effective governance processes to monitor service provision. Staff did not**

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**have regular opportunities to meet as a group to discuss and learn from the performance of the service. However, staff at all levels were clear about their roles and accountabilities.**

The management team was in the process of adding further structure to their governance framework. The team held their first governance meeting the week before our inspection. Managers were taking steps to add transparency and accountability to their processes by building links with the parent company. As this was in its infancy, we could not assess its effectiveness.

There were gaps in the governance of the recruitment process. Managers checked the identity, credentials and integrity of new employees during the recruitment process. This included checking of photographic identification, scrutiny of application forms, conducting an interview, and obtaining personal references. However, these checks did not include obtaining references from the applicant's most recent employer. Managers told us the parent company, Tascor, completed an additional checking process prior to commencement of employment that included obtaining references from the most recent employer. However, the provider was unable to provide evidence of this process during or after our inspection. Following our inspection, the registered manager sent us information detailing that references were not kept past six months due to The General Data Protection Regulation (GDPR) 2018. They told us the provider completed a certificate of screening, which in future would be made available to local managers. However, this certificate of screening did not demonstrate the references or information received was satisfactory, or if any concerns had been identified in relation to the proposed member of staff working with vulnerable adults or children.

The senior managers had several monitoring tools they were using, for example the monthly transfer logs. But these were not being assessed or brought together to demonstrate if the service they were providing was safe and responsive.

Senior managers met with the commissioners from the local NHS trust who contracted their services monthly to discuss performance and any other issues. They were also able to contact the commissioners at any time if needed.

Senior managers had access to a member of staff from the provider who reported directly to the board. They told us

they could pass on any concerns to them to be shared with the board. If they required any advice or support about mental health, they would direct this to the NHS trust they had their contract with.

At our last inspection, we issued a requirement for the provider to review all policies and procedures as they were not in date, relevant and staff did not have access to them. At this inspection, we saw review dates had been added to all policies and procedures. Staff had access to them in each vehicle. Senior staff told us they were in the process of reviewing them all again using the latest best practice guidance.

## Management of risks, issues and performance

**Leaders and teams did not use systems to manage performance effectively. They did not document how they identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

The senior management team told us they had to devise their own risk register at location level. We were told the overall provider Capita PLC group had a risk register which included risks for all their companies. But we were not able to see this as the staff had no access to this risk register. Senior staff were not aware of how their risks would be added to this register. However, senior staff were able to verbally detail each of their risks and the actions they had to minimise them. For example, failure to complete transfers due to demand placed on them by the local NHS trust who commissioned their services. They told us when they got too many requests for transfers, they worked with the trust to identify the most urgent and completed those as quickly and safely as they could.

The service had a business continuity plan to assist staff in managing an emergency. For example, severe weather and loss of IT systems. This detailed the actions needed to minimise any risks to them because of the emergency. We saw evidence this policy was reviewed last year, and amendments made.

## Information management

**The service collected information about service delivery. This information was securely stored.**

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**However, staff did not use this to understand performance, make decisions and improvements. Staff were aware of what needed to be notified to external organisations as required.**

Senior managers were not aware of the time frame patient records were to be kept in line with national guidance. Patient records were destroyed after 12-months, which was not in accordance with the retention periods set out in the 'Records Management Code of Practice for Health and Social Care' (2016). Following our inspection, the registered manager told us they were changing their retention of records to meet national guidance and this would include the transport logs, combined with the task booking emails containing the data required to be retained.

The service was collecting data but not using this to measure the quality of the service. They were monitoring key performance indicators (KPIs), such as collecting and transferring detained patients within a certain time frame. The commissioners from the local NHS trust who commissioned their services told us they were not strict with these KPIs due to excessive demand on their services, which impacted on this service meeting their targets.

The provider undertook audits but did not use them to identify the strengths and weaknesses of the service. For example, first aid box checking and the checking of vehicles. When audits were being used, we saw these were not effective. For example, checking of first aid boxes as they had not identified out of date consumables.

Senior managers had access to IT systems, and these were password protected. Staff were able to store patient records securely during transfer.

## Public and staff engagement

**Leaders engaged with local organisations to plan and manage services. Staff were not always included in the processes. They collaborated with partner organisations to help improve services for patients.**

Senior managers told us it was not always easy to engage with patients who used their service due to their medical conditions.

Commissioners from the local NHS trust who contracted their services told us they felt Keynsham Vehicle Base staff were open to both positive and negative feedback. They held monthly contract meetings where feedback was discussed as part of the agenda. We were told they both worked together to improve the service to patients and gave an example about changes to the risk assessment for detained patients and the use of soft cuffs.

Managers held meetings with team leaders every three months. These meetings had a standard agenda that included, for example, operational updates and news regarding the contract. Feedback was shared with other staff by the team leaders. Senior managers told us they did not hold full staff meetings due to the number of staff they employed. Following our inspection, the registered manager told us because of the shift patterns and operational demands it was difficult to hold full staff meetings. To mitigate this, they hold regular continuous development meetings with team leaders. This provided an avenue of two-way communication to all levels using the team leaders as intermediaries.

The provider had a quarterly newsletter that was shared so staff could find out what was happening across the organisation.

## Innovation, improvement and sustainability

**All staff were committed to continually learning and improving services.**

Following the last inspection and this inspection, we saw evidence senior managers were committed to improving the service. They had responded quickly to some areas we identified on our provider feedback letter demonstrating a keenness to learn and improve the services provided. For example, the infection control and prevention issues we mentioned in safe.

The provider received an award in 2018 from the Royal Society for the Prevention of Accidents for outstanding performance in health and safety over 10 years. The senior managers provided us with a copy of their certificate.



# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **MUST** take to improve

- As part of their recruitment process, they must include how they obtain information about staff conduct in previous roles to include working with vulnerable adults and children. This information must be kept and not destroyed.
- Review their destruction of paper records process to make sure they meet guidance based on records for NHS patients and original copies.
- Review and implement an infection prevent and control process and procedure based on best practice guidance to prevent the risk of cross infection.
- All equipment must be within its use by dates and when carrying equipment in vehicles it must be stored secured to prevent unnecessary risks to patients and staff.

### Action the provider **SHOULD** take to improve

- Appoint a safeguarding named professional trained to a minimum of level 4 to provide support and guidance to staff as needed.
- Ask for a copy of the trust risk assessment used to obtain a rating of high, medium and low so staff understand this.

- Make sure staff check vehicles at the end of each shift to remove any objects that could cause injury to any patients.
- Devise a policy for staff to follow about how they manage a deteriorating patient.
- Continue to review and update all policies and procedures in line with best practice and current guidance.
- Amend the complaints policy to include information on how a patient should proceed if they are not happy at the end of the internal complaints process.
- Introduce staff meetings so staff can give feedback regarding the quality of the service and to discuss service developments.
- Provide some communication aids for staff to use if needed. For example, pictorial.
- Keep all records of patient care and treatment for NHS patients as stated in the guidance for services working with the NHS.
- Devise a written risk register to document all risks and action taken to mitigate them.
- Review all governance tools used to bring them together to demonstrate how your service is performing.

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

Transport services, triage and medical advice provided remotely

#### Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

There was no evidence to demonstrate for proposed staff that; satisfactory evidence of conduct in previous employment concerned with the provision of health and social care or children and vulnerable adults had been obtained. Or whey they had left this employment.

#### Regulated activity

Transport services, triage and medical advice provided remotely

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Patient paper records were being destroyed after one year.

#### Regulated activity

Transport services, triage and medical advice provided remotely

#### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Vehicles were not clean.

Some consumables in the first aids boxes were out of date.

Equipment stored in the vehicles was not secured.

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.