Mr Nicholas Stefen Pridden

SNP Medical

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?	Requires Improvement
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We carried out an inspection of SNP Medical using our comprehensive inspection methodology on 24 May 2021. The inspection was carried out due to concerns raised during the last inspection in January 2020. Routine engagement with the provider indicated that not all required improvements had been carried out by the service. We inspected the five key questions of: safe, effective, caring, responsive and well led.

Our inspection was an unannounced inspection (the provider did not know we were coming). Following our inspection, and review of the evidence, we issued two Section 29 Warning Notices for breaches of Regulation 15 and Regulation 17. We also issued a Requirement Notice for a breach of Regulation 19.

This service was placed in special measures in April 2020. Insufficient improvements have been made such that there remains a rating of inadequate overall. Therefore, we are taking action in line with our enforcement procedures to drive improvement. 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 six months, and if there is not enough improvement, we will consider the need to vary the provider's registration to remove this location or cancel the provider's registration.

Our rating of this location stayed the same. We rated it as inadequate because:

- We found that although cleaning schedules were completed, the vehicles we saw during our inspection were dirty. We were not assured that the cleaning processes used were sufficient to control infection risks and protect patients.
- There was no clinical waste contract for the provider to dispose of clinical waste and the service relied on being able to dispose of clinical waste at other provider sites.
- There was no COSHH information for one of the cleaning products meaning staff did not have information available about how to safely manage this cleaning product.
- We found a full oxygen cylinder stored on a spare stretcher in the area leading to the storage yard. There was no medical gas warning sticker displayed so staff and emergency services would not know of the potential risk in the event of a fire. The oxygen cylinder was not stored securely meaning it could be accessed without authorisation.
- The non-patient transport vehicle was used to collect supplies, including any replacement oxygen cylinders. There was no process to secure the cylinders in the vehicle during transportation. There was no medical gas warning sticker displayed on the vehicle. This meant that the public or emergency services would not know of the potential risk in the event of an accident.
- We found that pre-employment recruitment checks were not robust. Some staff files did not have evidence of references, appropriate Disclosure and Barring Service checks, or identification documents.
- Although staff compliance with training had improved, there were still gaps in completion of required training. It was not clear what core training topics staff needed to complete
- Staff, including the registered manager, were not trained to the appropriate level in adults or children's safeguarding.
- Although we were told that staff received an annual appraisal, there was no one to one or supervision process to monitor staff performance, competence and wellbeing outside of the annual appraisal process.
- There were limited outcome measures used by the service and there was no system of routine audits to monitor performance.
- The service did not have a contractual arrangement or service level agreement in place with the referring services. There was no requirement for any formal review of activity or performance of the service SNP provided to third parties.

Summary of findings

- We saw a range of policies which were within date for review, however the policies were not always fit for purpose. Policies were developed by the registered manager and an administrator but did not have clinical or expert input. Policies did not always reference appropriate guidance.
- There was a devolvement of responsibility by the registered manager to third party providers for investigating incidents. There was no evidence of a process for regularly feeding back any learning from incidents and complaints to staff in the service.
- The service did not have a measurable strategy to ensure sustainability of the delivery of high-quality care.

However:

- Since our last inspection the service had developed a system for identifying and managing risks, meaning the registered manager now had oversight of the risks in the service.
- Staff we spoke with described a positive culture within the service and told us they were happy in their work there.
- We saw there was a communication booklet in each vehicle which facilitated staff to be able to communicate with patients who had additional communication support needs.
- We found the registered manager to be accepting of areas identified during our inspection that required improvement. They demonstrated an appetite to get things right and make improvements following our inspection.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to SNP Medical

The provider, SNP Medical is an independent ambulance service working within Leicestershire and Rutland. It opened in 2016 and the current registered manager has been in place since opening. The registered manager is also the owner.

SNP Medical provides patient transport services in and around Leicester and Leicestershire. The service transports adults, children and those detained under the Mental Health Act 1983. The service provides transport services to the local NHS Trust and works with other local independent providers. There are five staff working for SNP Medical as non-clinical ambulance care assistants in addition to the registered manager. All these staff worked in patient transport service attendant roles. Additionally, there is one administrator working in the service. From May 2020 to April 2021, 2268 patient transport journeys had been undertaken.

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

We last inspected SNP Medical in January 2020 when we rated the service as Inadequate. Two warning notices and two requirement notices were issued following the inspection. An action plan was submitted by the provider. As we were unable to revisit the provider to check compliance due to COVID-19 restrictions, evidence was submitted remotely to inform us of improvements in August 2020. However, we were unable to fully confirm that all required actions had been fully completed.

How we carried out this inspection

The service was inspected using comprehensive inspection methodology under the core service framework of Patient Transport Services (PTS). During our site visit on 24 May 2021 we inspected three patient transport vehicles (ambulances). We spoke with the Registered Manager for the service and four members of staff. We were unable to speak with patients as observations of care were not permitted in line with COVID-19 restrictions. However, we did review patient feedback forms received by the service. In addition, we reviewed 50 patient transport record forms and a sample of staff files. We reviewed service policies including the safeguarding, incident reporting, complaints and clinical waste policies. Following our inspection, we requested further data and information to support the evidence collected onsite during the inspection.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust 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:

We told the service that it must take action to bring services into line with legal requirements. This action related to patient transport services.

Summary of this inspection

- The provider must ensure that reliable systems are used to maintain standards of cleanliness and hygiene in the vehicles used to provide patient transport in order to prevent and protect people from infection. (Regulation 15: Premises and Equipment (1)a).
- The provider must ensure they have systems and processes, such as regular audits of the service provided, and must assess, monitor and improve the quality and safety of the service. (Regulation 17: Good Governance (2)a).
- The provider must ensure they actively seek the views of stakeholders about the quality of care delivered by the service. They must be able to show how they have analysed and responded to the information gathered, including taking action to address issues where they are raised, and that they have used the information to make improvements and demonstrate that they have been made. (Regulation 17: Good Governance (2)a).
- The provider must ensure that governance systems are effective. They must have a process to ensure all staff receive information, updates and best practice guidance. Policies and procedures must be appropriate to the service and be based on current guidance. (Regulation 17: Good governance (2)f).
- The provider must ensure their pre-employment recruitment checks are robust. All staff must have effective recruitment and selection procedures that comply with the requirements of Schedule 3, before they are employed. (Regulation 19: Fit and proper persons employed (2)).

Action the service SHOULD take to improve:

- The provider should consider developing the service vision and strategy so that it can be used to monitor progress against plans to improve the quality and safety of services.
- The provider should consider if the current arrangements for management of clinical and hazardous waste are robust and sustainable.
- The provider should review how staff are supported to deliver effective care and treatment and encouraged to develop.
- The provider should consider if complaints information is widely available to all service users and review if there is a process for sharing learning from complaints investigations with staff.
- The provider should consider if the current patient feedback processes are sufficient and should actively encourage feedback about the quality of care patients receive.
- The provider should consider if the leadership structure within the organisation is sustainable in the event of any unexpected absence of the registered manager.
- The provider should consider reviewing how they learn and improve the services using quality improvement methods.
- The provider should take action to comply with their legal duties to store all hazardous substances under the control of substances hazardous to health (COSHH), safely.
- The provider should consider if the incident management process includes a robust method of sharing learning from incidents investigated by third party providers. The provider should review if the current incident management process provides evidence of completion of actions identified for learning and improvement.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Requires Improvement	Insufficient evidence to rate	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Insufficient evidence to rate	Requires Improvement	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Effective	Requires Improvement
Caring	Insufficient evidence to rate
Responsive	Requires Improvement
Well-led	Inadequate

Are Patient transport services safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to most staff. However, there was not a robust system for monitoring and recording compliance or making sure that everyone completed it.

During our inspection, we saw documentation that indicated not all staff received and kept up to date with their mandatory training. We reviewed the training records for all members of staff and the registered manager, but not for the administrator who did not work in a patient facing role.

Although we found that all training sessions listed as completed were in date for renewal, we found that not all staff had completed all required training sessions. The registered manager explained that staff had access to an e-learning system which offered a range of training sessions, not all of which were mandatory. The manager told us that eight priority training sessions had been identified to staff and they had been expected to complete these by 2 February 2021. The priority training included infection prevention and control, moving and handling, safeguarding adults and children level two, prevent radicalisation, Mental Health Act (MHA), Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), and dementia awareness. In addition, all staff were expected to complete emergency first aid and oxygen administration training.

Training records provided for staff (including the registered manager but excluding the administrator) indicated that there was an overall compliance rate of 60.4% completion for the eight required training sessions. Two staff members had only completed two training sessions; emergency first aid at work and oxygen administration, but none of the eight priority training sessions. The registered manager told us this was because these staff members had only recently started in employment with SNP Medical. Following our inspection, the manager provided evidence that some staff had updated their training. We saw that five members of staff (including the registered manager) had completed all eight

required training sessions. The remaining member of staff had only got one outstanding training session to complete. Overall training compliance for the identified priority training sessions, based on evidence provided following our inspection had improved to 98%. We saw that 100% of staff had completed the emergency first aid and oxygen administration training sessions.

The e-learning training sessions available to staff were comprehensive and met the needs of patients and staff. However, not all staff had completed the full range of training sessions available. Staff were advised to concentrate on completing the eight priority training sessions and access the other training sessions when they were able.

Staff were required to complete training on recognising and responding to patients with mental health needs through the completion of Mental Health Act (MHA) training. There was no requirement to complete any training for learning disabilities or autism. However, staff were required to complete a mandatory session on dementia awareness. At the time of our inspection, data provided by the registered manager indicated that 66.6% of staff had completed MHA training and 50% of staff had completed dementia awareness training. Following our inspection, some staff had updated their training and we saw that 100% of staff had completed MHA training and all but one (87.5%) had completed dementia awareness training.

Managers monitored mandatory training and alerted staff when they needed to update their training. The registered manager explained that the software system used to provide staff training alerted them when staff were due to update training sessions. They told us they would highlight this to staff by email or in person to prompt them to complete the required training updates. We saw that the registered manager kept a list of staff training showing sessions completed and expiry dates. However, this system was not robust, as the manager was unable to provide an accurate up to date list of training compliance at the time of our inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff, at the time of our inspection, had training on how to recognise and report abuse, although this did improve following our inspection. Safeguarding policies were not based on current national guidance.

Some, but not all staff, at the time of our inspection, had received training specific for their role on how to recognise and report abuse. Staff were required to complete level two safeguarding training in adults and children but only three out of five staff had achieved this. In addition, the registered manager, who was the named safeguarding lead, had completed level three safeguarding training. We raised our concerns about safeguarding training completion to the manager following our inspection. They provided evidence that following our inspection, all staff (100%) had completed level three safeguarding training and the manager was booked on to level four training.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They were able to describe when they may need to raise safeguarding concerns and could name the safeguarding lead. Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were safeguarding pathways and flowcharts for referring services in each patient transport vehicle to inform staff what action to take and who to contact. There was no process for staff to receive feedback from any safeguarding concerns they had raised, to enable learning.

There were safeguarding policies for both adults and children's safeguarding which were in date for review, however, the guidance referred to within the policies was relating to outdated documents. There was no reference within the policies

to the intercollegiate guidance Safeguarding Children and Young People: Roles and Competencies for health care staff intercollegiate document 2019 or Adult Safeguarding: Roles and Competencies for Health Care Staff 2018. The safeguarding adults policy did include reference to all types of abuse such as domestic abuse, female genital mutilation, modern slavery and radicalisation. However, the safeguarding children policy did not mention child sexual exploitation. We were not assured that safeguarding policies were fit for purpose.

Safety was not consistently promoted in recruitment practice. Not all staff files complied with schedule three recruitment requirements. We checked all staff folders and found that although all staff had evidence of enhanced disclosure and barring service (DBS) checks with barred list checks, not all DBS certificates were relevant to the staff member's current job role. We raised this with the manager following our inspection who provided evidence that new DBS applications had been submitted for these staff. The DBS policy described the process for risk assessing the safety of individuals to work in the service when a disclosure was identified, however, we were not assured this was being implemented. There was no copy of a driving licence or identification photograph for one staff member. Four out of five staff records did not have the right to work in the UK declaration signed by both the staff member and the registered manager. There were no references on file for three out of the five staff members, nor for the registered manager. There were no completed medical questionnaires for three out of five staff, to indicate that they were fit to work in their role. There was no evidence of driving licence checks for three out of five staff. Since staff checks were not consistently performed on recruitment for all staff, we could not be assured that recruitment processes promoted patient safety.

Cleanliness, infection control and hygiene

The service did not 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 all equipment and the vehicles visibly clean.

Patient transport vehicles that we inspected were found to be dirty. We inspected three patient transport vehicles and concerns with the cleanliness of all vehicles. For example, we found dirt and dust on ledges and equipment such as stretchers and chairs. On one vehicle we wiped the dirty stretcher with a cleaning wipe and removed a significant amount of dirt and dust from it. There was evidence of ingrained dirt in the stretcher tracking on the vehicle floor. We found dirt and dust on the stretcher base indicating that the stretcher had not been raised in order to thoroughly clean it. There was a discarded thermometer cover, hair and dust found down the side of a chair in one of the vehicles. We saw used blue paper roll and debris (litter and leaves) in a cupboard containing patient equipment. There was a patient belt used to assist with patient moving and handling that was visibly dirty. The material inside the belt was not wipeable meaning the belt could not be effectively cleaned between each patient use. There was a tear in the fabric of one of the ambulance stretchers which had not been covered or repaired meaning that it was not possible to effectively clean this.

Cleaning records were up-to-date and identified a list of required daily cleaning tasks to be completed at the end of each shift. Staff had initialled against each listed task to indicate it had been completed. However, we found that despite cleaning schedules being marked as completed for that day, vehicles were not clean. The registered manager told us the system was that staff would leave the completed cleaning schedules on the manager's desk once they had been completed at the end of the day. The manager would then review forms to ensure they had been completed and would scan them into the computer system. The manager told us they did random checks on vehicle cleanliness following completion of cleaning checklists and would raise any concerns with individuals as required. The manager did not have a routine system of auditing completion of the vehicle cleaning checklists or the standard of cleaning tasks performed.

In addition, to daily vehicle cleaning, there were scheduled deep cleans. The registered manager explained to us these had recently been taken back in house having previously been outsourced to an external company. The registered

manager completed the deep cleans themselves every four to six weeks. We saw records that each vehicle had received three deep cleans from February 2021 to May 2021. The manager told us that they used an adenosine triphosphate (ATP) swab meter to evidence the vehicles had been appropriately cleaned. The manager used a system of random swabbing of an area of the vehicle, taking swab meter readings of the same area before and after cleaning. Swab meters use relative light units (RLU) to detect levels of ATP. High RLU readings indicate high levels of ATP, which indicates the presence of biological matter such as bacteria or food. Although an RLU is not a standardised unit of measurement the swab meter came with pre-set pass/fail thresholds of 10 RLU for pass and 30 RLU for fail which the manufacturer had set. All post cleaning swab meter readings we saw were at least 50 RLU. The pre and post clean swab meter readings on the deep clean sheets, indicated that there was a small reduction in the RLU readings following cleaning. We saw on average there was a 27% reduction in the meter readings following deep cleaning. This did not provide sufficient assurance that deep cleans had been completed effectively.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff wearing facemasks whilst on the vehicle. There was a ready supply of disposable gloves and aprons for all staff if they required them. Hand gel was freely available, and staff told us they used it between each patient contact or used hand wash sinks when available. Due to COVID-19 we were unable to observe any patient transport journeys so we could not observe if staff regularly decontaminated their hands. The registered manager told us they completed staff observations of care which included infection prevention and control (IPC) techniques. However, there were no formal or documented IPC audits such as hand hygiene audits.

Staff told us they cleaned equipment after patient contact using disposable antibacterial wipes. They wiped down stretchers and chairs used by patients in between each journey. However, we found that ambulances were not always visibly clean

There was an infection prevention control policy which identified Covid-19 procedures for staff to follow. This included staff requirements for personal protective equipment and processes for cleaning vehicles and equipment between patients. We were unable to observe any patient journeys due to Covid-19 restrictions, so we were unable to observe if staff followed these. All staff were required to complete lateral flow tests for COVID-19 twice weekly. The results were recorded in a book stored in the locked control of substances hazardous to health (COSHH) cupboard. The manager told us they checked that staff had completed this record of testing.

Environment and equipment

The design, maintenance and use of vehicles and equipment kept people safe. Most staff were trained to use equipment. However, staff were not always able to manage clinical waste well as there was no evidence of a clinical waste contract or agreement.

Staff carried out daily safety checks of the vehicles and equipment stored on them. These checks included looking at tyres, wiper blades, lights and seatbelts for example, as well as checking that first aid equipment was in date and any emergency equipment was in working order. We reviewed ten random daily vehicle checklists from February 2021 to May 2021 and saw all had been fully completed. We saw that on two occasions issues had been identified by writing these on the checklist form. The registered manager told us they fixed any identified issues before the vehicle was taken out on patient journeys. However, there was no log for recording when vehicle faults were identified nor that they had been fixed. This meant that there was no evidence that vehicles had been made safe for use after a fault had been identified. If issues were identified whilst the vehicle was in use, the registered manager told us they would travel to fix it

at the roadside. In the event of a vehicle not being able to be fixed before a journey or repaired at the roadside there was a third vehicle available that could be used for patient transport. We inspected the three vehicles belonging to the provider during our inspection and found them to be in generally good condition. We saw that each vehicle had a valid annual safety check certificate, was taxed and had been serviced within the last 12 months.

There was a process for maintaining equipment servicing. We saw that all equipment requiring electrical testing had a sticker evidencing that it was in date for testing. The registered manager kept an asset log and arranged for an external company to visit and test all electrical equipment annually.

During our inspection, we saw that each vehicle carried an in-date fire extinguisher which was carried in an appropriate holder. Vehicles had spill kits on board for use in the event of spillage of any bodily fluids, and sharps bins were available. Sharps bins were only used for disposal of clinical waste since no sharps were being used or disposed of by the service. However, we found out of date bandages in the first aid kit on one vehicle. In addition, one of the vehicles did not have a child restraint. We raised this with staff who told us that as it was rare for them to transport children, they could source a child restraint from another vehicle if necessary.

We saw that most staff received training on equipment used on the vehicles. Four out five staff had a completed induction checklist which recorded they had been shown how to use wheelchairs and stretchers and manage clinical waste and consumables. There was no emergency equipment kept on the vehicles as the process was for staff to call 999 in the event of a patient becoming unwell.

Staff did not have a robust process in place for disposing of clinical waste safely. The provider had an arrangement where staff disposed of any clinical waste at the local NHS trusts. Staff would dispose of clinical waste at the local hospital at the end of the day or at the beginning of the next day's shift. All of the vehicles had the appropriate bags to dispose of clinical waste appropriately, along with used and soiled linen. There was no clinical waste on the vehicles at the time of our inspection. There was an informal agreement that referring services would be responsible for clinical waste that had been generated during the care provided by SNP Medical. We saw there was a disclaimer on the booking referrer forms which stated this. However, at the time of our inspection, the manager did not provide evidence of a clinical waste disposal agreement. When the service was first registered with the Care Quality Commission (CQC) in 2016, the registration assessment report identified that the registered manager intended to set up a formal clinical waste contract. However, following our inspection, the manager provided evidence of an agreement for clinical waste from SNP Medical to be disposed of at a local NHS trust. This email was dated 19 July 2021 which was after our inspection. There was no evidence that this agreement was in place at the time of our inspection. We were not assured that clinical waste disposal arrangements were sufficient, at the time of our inspection, to ensure that clinical waste could always be disposed of safely.

The provider had a folder detailing assessment for products that were subject to the control of substances hazardous to health (COSHH) regulations. Substances were stored in a locked cupboard in line with requirements, and copies of the COSHH assessments were kept with the products. However, since COVID-19 the service had started using a powerful combined cleaner and disinfectant and we found there was no COSHH assessment for this product. This meant that staff did not have information available about how to safely manage this cleaning product, which was a risk to their health and safety.

Assessing and responding to patient risk

Staff had access to journey booking forms for each patient which identified any known risks. Staff identified and quickly acted upon patients at risk of deterioration

Inadequate

Patient transport services

The service required referring providers to complete booking forms for each patient prior to journeys being agreed and completed. These forms identified patient's mobility needs, medication details, oxygen requirements, medical conditions, COVID-19 status and MRSA status. This meant that key information was shared between providers to keep patients safe when their care was handed over.

There were inclusion and exclusion criteria for the service meaning that staff only accepted patients who were appropriate to be safely transported based on the available equipment and skill level of the staff working in the service.

Staff responded promptly to any sudden deterioration in a patient's health. All staff were trained in emergency first aid which included basic life support training. The service had a deteriorating patient procedure which included a deteriorating patient flowchart providing guidance to staff on what actions they should take. Staff were aware of the policy and told us they would pull over and call 999 if they had any concerns about a patient who became acutely unwell during a transport journey.

Staffing

The service employed enough staff with the right skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers had a process to provide new staff with an induction; most staff had completed this.

The service had enough staff to keep patients safe. All staff working in the service were technicians or assistant staff and did not require professional registration. Staff worked for the service on a zero hours contract basis. Most staff worked regular shifts for the service each week. Shifts were between nine and eleven hours long and all staff had a planned break of 30 minutes within each shift. Staffing rotas provided by the manager for March to May 2021 showed that all shifts were covered with a minimum of three staff working each day. If required, the manager would cover a shift on one of the transport vehicles. Staff told us that one staff member was willing and able to cover any unfilled shifts due to sickness at short notice. This meant that there were always two staff members available to work on each patient transport journey. Staff did not work alone.

Managers made sure most new staff had an induction and understood the service. We saw the service used an induction sign off form which was signed by the employee and manager to evidence that staff had completed the induction to the service. The induction covered roles and responsibilities, patient mobility, driving styles, manual handling (including use of equipment such as wheelchairs and stretchers), handover information, and infection control. We reviewed staff files and found that four out five staff had a fully completed and signed induction form.

Records

Staff kept records of patients' care and treatment. Records were stored securely. However, patient discharge journey sheets were not fully completed.

The service had a standard patient discharge journey sheet which staff were required to complete prior to the patient journey. These sheets were in addition to the booking request form completed by the referrer. The forms had sections for SNP Medical staff to complete to identify any patient support or care needs such as skin integrity, nutrition, mobility, and communication requirements. However, we reviewed patient discharge journey sheets for the month of May 2021 and saw that they were not fully completed. There were several sections which were not consistently completed. This

included the medicines, past medical history and allergies sections. We raised this with the registered manager who recognised that there was missing information and agreed to discuss with staff the importance of fully completing these documents. Following our inspection, the manager provided evidence that this had been discussed with staff in a team meeting.

The manager told us there was no system of audit for patient discharge journey sheets.

Patient records were stored securely. Staff provided all patient discharge journey sheets to the manager at the end of their shift each day and the manager uploaded these to a secure electronic system.

Medicines

The service used systems and processes to safely administer medicines such as oxygen. However, the service did not always store oxygen safely. The service did not always record medicines on patient journey sheets. The service did not prescribe, administer or store any other medicines but did transport medicines with patients.

Staff followed systems and processes for safely administering oxygen. There was a documented oxygen administration procedure which identified when and how staff should administer oxygen. Staff were only permitted to administer oxygen prescribed by health professionals, during the patient journey. All staff were required to complete oxygen administration training and we saw that all staff had completed this.

Staff did not always store oxygen safely. We saw that oxygen for use on the patient transport vehicles was safely and securely stored on the vehicles. However, we found a full oxygen cylinder stored on a spare patient trolley in a corridor. There were no medical gases warning signs to indicate the potential risks to staff and emergency services in the event of a fire. This oxygen cylinder was not stored securely meaning it could be accessed without authorisation. There was a non-patient transport vehicle which was used to collect supplies, including any replacement oxygen cylinders. We found there was no process to secure the cylinders in the vehicle during transportation. There was no medical gas warning sticker displayed on the vehicle. This meant that the public and emergency services would not know of the potential risk in the event of an accident. We raised this concern with the registered manager during our inspection who immediately ordered a medical gases warning sticker and we saw evidence that this had been displayed on the vehicle.

Medicines were not consistently recorded on patient discharge journey sheets. We saw staff did not complete the patient medication section of the journey sheet. None of the records we reviewed listed the medicines patients were transported with. In addition, there was a section for staff to record numbers of medicines collected and deposited at the start and end of patient journeys. We saw that this section was inconsistently completed by staff.

Incidents

The service did not manage patient safety incidents well. Managers did not investigate incidents and did not have a system for sharing lessons learned with the whole team. Managers did not have a system to ensure that actions from patient safety alerts were implemented and monitored. However, staff recognised incidents and near misses and reported them appropriately. When things went wrong, systems were in place for staff to apologise and give patients honest information.

Inadequate

Patient transport services

Staff knew what incidents to report and how to report them. Staff we spoke with were aware of the service incident reporting paperwork and understood when to complete one; they were able to give us examples of when they had reported incidents. Staff told us they would report all incidents or near misses to the registered manager. This was in line with the service's indent reporting policy.

The service had reported 13 incidents from May 2020 to April 2021.

Managers did not investigate incidents involving patients reported by staff. Instead they devolved responsibility to the referring provider. The registered manager told us that any patient incidents reported were escalated to the relevant referring service for formal investigation. This was in line with the incident policy but meant that SNP Medical did not take ownership or have systems in place to investigate incidents involving patients in their care. However, the manager told us that they would participate fully in an investigation if required.

Staff did not routinely receive feedback from incident investigations. Staff meetings did not have incidents as a standing agenda item. The manager told us they completed an incident log of all incidents reported. We saw that this had a section for identifying any actions taken and lessons learned. However, there was no information on how any learning had been shared with staff or if any required actions had been completed. We were not assured that there was a robust system for sharing incident investigation findings with staff to ensure that learning was implemented.

There was no opportunity for staff to meet to discuss learning from incidents and look at improvements to patient care.

There was no process for the manager to share patient safety alerts with staff. There was no evidence of a system for implementing and monitoring any required actions identified in patient safety alerts.

The service had no serious incidents or never events.

Staff understood the duty of candour. They understood the requirement to be open and transparent with patients when things went wrong. The service had no incidents when they had needed to apply Duty of Candour.

Are Patient transport services effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service could not evidence that it provided care and treatment based on national guidance and evidence-based practice. However, managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service had a range of policies which provided guidance for staff to follow. We reviewed a range of policies and found they were all in date for review. However, we found many of the policies to be brief and lacking in detail. Policies did not always refer to current national guidance and we found that policies were not referenced to national guidance

or evidence-based practise. We asked the manager how policies were developed, and they told us the manager and administrator had devised all the service policies. There had not been any professional or expert input into the policies. 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 and national guidance.

Staff were aware of the service policies and knew where to find them if required.

Managers completed observations of staff practice which documented their compliance with service policies such as infection prevention and control, completion of vehicle checklists and driving standards. We saw evidence of this process, but it was unclear how regularly observations of staff were completed.

Staff protected the rights of patients subject to the Mental Health Act (MHA) and followed the Code of Practice. We saw that staff were required to complete MHA training online and that this was one of the priority training sessions. At the time of our inspection, records showed that three out of five staff had completed this training. Following our inspection, the manager provided evidence that all staff had since completed this training. When asked about transporting patients detained under the MHA, the manager told us the service had transported patients detained under the MHA. The service required any patient detained under the MHA to be accompanied by an escort from the referring service. If any patient restraint was required, this would be the responsibility of the escort. The manager told us that staff, therefore do not complete restraint training and restraint equipment was not carried on the vehicles. The service did not have a restraint policy.

Patient outcomes

Managers did not monitor the effectiveness of the care and treatment provided by staff. They did not complete routine audits and were therefore unable to use any findings to make improvements and achieve good outcomes for patients.

The service did not routinely collect patient outcomes data in order to monitor the effectiveness of care provided. The manager told us the only outcome information collected by the service was in the form of patient feedback forms and staff observations. There was no collation of any data collected to provide an oversight of service performance.

Since the service did not collect patient outcome information, managers and staff were unable to use any results to improve patients' outcomes.

Managers did not carry out a comprehensive programme of repeated audits to check improvement of the service performance over time. There was no evidence of any audit data being used to improve care to patients.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance. However, there were no supervision meetings held with staff to provide support and development.

Staff were experienced and had the right skills and knowledge to meet the needs of patients. Staff completed training appropriate to their role and completed an induction at the start of their employment. The manager gave staff the time to complete relevant learning. Staff we spoke with confirmed they had completed an induction process which also included completing a trial shift. We saw evidence that induction checklists had been signed off by both staff members and the manager.

The manager told us they supported staff to develop through yearly appraisals of their work. We saw that only one staff member had received an annual appraisal since the other staff had worked for the service for less than one year.

Staff told us they did not receive any form of supervision or regular review of their training and development needs outside of the appraisal process. However, the manager told us they identified any development needs for staff through an observation process. They told us they went out with each staff member on patient journeys two or three times a year and observed their performance and behaviour. This was recorded on a template and discussed with staff in order to identify any areas for required improvement. However, there was no evidence staff had the opportunity to discuss training needs with their line manager or were supported to develop their skills and knowledge.

Managers made sure staff attended team meetings or had access to meeting notes when they could not attend. A team meeting was held every month where relevant issues were discussed, and any conversation was documented. The minutes were available to all staff. In addition, there were daily conversations with staff at the start of each shift where relevant information was shared.

The manager told us that if they had any concerns with poor staff performance, they would address this promptly on an individual basis.

Multidisciplinary working

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

The manager held daily meetings with staff to discuss the workload for that day in order that all staff were fully informed about their duties and responsibilities.

Referring services handed over relevant patient information to SNP Medical staff through completion of patient booking forms prior to each journey. This meant that staff always had access to up-to-date information on patients' care needs. However, information on patient's care needs was not always accurate and comprehensive as patient discharge journey forms were not always fully completed by SNP Medical staff. There were, therefore, occasions when staff did not have full access to information about patient needs.

The manager had regular communication with a named link person at each referring provider to discuss caseloads and capacity and any concerns raised about the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how to support patients to make informed decisions about their care. 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 understood how and when to seek support for patients to make decisions about their care. When patients did not appear to consent to journeys staff told us they worked with nursing staff from referring providers in order to made decisions in their best interest. They explained that when there were concerns such as a patient refusing to be transported, they would involve healthcare staff in making the decision. They gave examples of when they had not transported patients due to concerns about their ability to consent to the journey.

Inadequate

Patient transport services

Staff told us they gained consent from patients for their care through verbal communication and the use of body language to indicate they agreed to the journey.

Staff understood the legislation and guidance around consent and had completed training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The service had information and guidance about capacity and consent in their safeguarding policy and staff knew how to access this policy.

The patient discharge journey sheet used by the service had a section for staff to document that the patient consented to the journey and to their information being shared with the service. There was also a section entitled mental capacity assessment which prompted staff to consider if the patient was orientated and able to follow commands. If the answer was no to any of the questions, staff were prompted to discuss concerns with staff from the referring provider before completing the journey.

Are Patient transport services caring?

Insufficient evidence to rate

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 saw that the service had a customer service charter which set out customer service principles and standards that SNP Medical aimed to meet. The principles included being polite and courteous, treating all people with respect, and recognising individual's needs.

Patients said staff treated them well and with kindness. We requested to see patient feedback about the service. The manager provided two examples of patient feedback from the 12-month period leading up to our inspection. Both examples indicated that patients were satisfied with the care they had received. They described staff as 'helpful', 'caring', 'kind' and 'thoughtful'.

We were unable to complete any observations of patient care during our inspection due to COVID-19 restrictions. We therefore did not speak to any patients about their experience of care.

Emotional support

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

Staff described how they always tried to keep patient's calm and offer them reassurance if they were anxious. They explained that there was always a member of staff sitting in the back of the vehicle with patients so staff could talk to patients and allay any fears.

Inadequate

Patient transport services

We were unable to complete any observations of patient care during our inspection due to COVID-19 restrictions. We therefore did not speak to any patients about their experience of care.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood the care they provided. Staff described how they talked to individuals with respect and tried to build a rapport. They described how they tried to involve patients in any decisions about their care during the journey.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw that each vehicle had access to a comprehensive communication support book. The book contained different pictures and symbols to assist patients to express their needs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient feedback forms were available to patients on all vehicles. The manager told us that all patients were given the opportunity to provide feedback, but also stated that patients had to request feedback forms if they wanted one. The feedback response rate was very low. The manager was only able to provide two examples of patient feedback in the period from May 2020 to April 2021. However, we saw that this feedback provided by patients was positive.

We were unable to complete any observations of patient care during our inspection due to COVID-19 restrictions. We therefore did not speak to any patients about their experience of care.

Are Patient transport services responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided patient transport journeys in a way that met the needs of local people. However, it did not have any formal arrangements for working with other organisations to plan care.

The managers planned and organised patient transport services so they met the changing needs of the local population. There were arrangements to cover regular work from two different referring providers and the manager planned staff rotas to ensure sufficient crews were available to deliver this work. However, there were no formal contractual arrangements in place with the referring providers meaning that workloads could not always be planned far in advance and staff were employed on a zero hours contract basis.

Resources were appropriate for the services being delivered. There were two main patient transport vehicles used by the service plus a third 'standby' vehicle for use in the event of additional work or in the event of a vehicle breakdown. This enabled the service to have capacity to cope with differing levels of demand from the referring providers.

Inadequate

Patient transport services

The service had systems to help care for patients in need of additional support. Each transport vehicle was able to convey patients who needed to travel on a stretcher or in a wheelchair.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were required to complete training in the Mental Health Act 2007 and dementia awareness. We saw that patient discharge journey sheets had sections to document if patients had any additional communication support needs, mobility issues, any mental capacity or mental health problems or if they had a diagnosis of dementia. However, we found that these sections were not always fully completed. This meant that staff may not always be able to identify and meet any additional information, support and communication needs of patients with a disability or sensory loss.

There were no arrangements in place to access interpreters or signers when needed to ensure patients could communicate with staff. However, communication support books were available to staff which provided a range of tools to facilitate communication with individuals with communication difficulties or whose first language was not English.

The provider had made reasonable adjustments to make sure people could access the service. All vehicles within the service were adapted to transport patients with physical disability or mobility problems. All ambulances were fitted with a ramp and could accommodate a wheelchair.

Access and flow

We could not determine if people could access the service when they needed it and received the right care promptly. The manager collected information about times from journey referral to the time of patient collection but did not monitor this.

Managers collected information about the time the crew received the referral, the time the crew arrived and departed the patient pick up point, and the time the crew reached the patient drop off location. We saw a patient log which captured this data and identified if there had been any delays. We saw that from February to April 2021, 72 of 751 journeys completed were identified as having a delay. However, the main reason identified for this was cancellation of the journey. The next most common delay factor identified was the patient not being ready. However, even though the manager collected this information, there was no evidence they reviewed the data or monitored waiting times to make sure patients could access services when needed.

The manager told us they did not review activity data for any trends such as delays or reasons for delay. Data was not used to identify any areas for improvement to access and flow of the service. The service was not able to demonstrate patients were able to access the service promptly.

Learning from complaints and concerns

Inadequate

Patient transport services

It was not always easy for people to give feedback and raise concerns about care received. The service did not have complaints information clearly available to patients. The service had evidence of following an investigation process for a complaint received, but there was no evidence of a response to the complainant. There was no system for routine sharing of lessons learnt from complaints with staff.

Patients, relatives and carers were not always provided with information on how to complain or raise concerns as information was not widely available on patient transport vehicles. The manager told us that contact details for themselves were available for patients on all vehicles. However, we found that information about how to complain was not clearly displayed in the ambulances.

The service did have a complaints policy, however the version in the policies folder was out of date. The email address was for a different company and there was no contact telephone number. The manager told us that there was an updated policy, however, this was not provided.

Staff, we spoke with were unable to provide any complaints information and told us if any patient was unhappy and wished to raise concerns, they would advise them to contact the registered manager.

The service had only received one complaint from May 2020 to April 2021. The concerns had also been reported as an incident through a staff member at the time. The manager investigated the complaint by meeting with the staff involved to gain statements and identify any failings. However, there was no evidence of a response to provide findings of the investigation.

Managers did not have a system for routinely sharing feedback from complaints with staff. Complaints were not part of the meeting standing agenda items for discussion. The manager told us he discussed any complaints with staff, but this appeared to be an informal discussion and there was no documented evidence of this. We were not assured that there was a process where learning from complaints was used to improve the service.

Are Patient transport services well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Not all staff identified as leaders had the skills and abilities to run the service. They did not understand and manage the priorities and issues the service faced. They did not support staff to develop their skills. However, they were visible and approachable in the service for staff.

The service was led by a registered manager. The manager told us they had worked in a previous job role requiring leadership and people management skills for 16 years. However, there was no evidence that the registered manger had completed any leadership training specific to developing the skills required to manage and deliver an ambulance service. The manager was supported by one staff member who was identified as a supervisor. The manager told us the

supervisor was a point of contact for staff if they were not available. When asked about any leadership training, the manager told us the supervisor had not received any as he was simply a point of contact for staff. The manager confirmed that the supervisor did not have access to any of the organisations online systems. There was no contingency plan for leadership in the event of the registered manager being unavailable.

The manager did not have full oversight of the challenges facing the service. There were no systems for monitoring staff and service performance. This meant the manager was not always aware of areas for improvement or development.

Staff told us that the manager was visible and approachable and was always available for advice at the end of the phone. They explained how the manager had checked in with regularly during the COVID-19 pandemic to ensure they had appropriate support. The manager described how he met with staff at the beginning of each shift to ensure the plans for managing the work that day were clear.

Vision and strategy

The service did not have a clear vision for what it wanted to achieve nor a robust strategy to turn it into action. There was a statement of purpose for the organisation, but this had not been developed in partnership with staff or referring providers. The statement of purpose was not focused on sustainability of services or aligned to any local plans within the wider health economy. Leaders and staff did not understand how to apply the statement of purpose to monitor progress.

The manager told us that there was not a vision and strategy document for the organisation. Following our inspection, they sent us a brief statement of purpose one-page document which identified aims and objectives for the service. The manager was unable to communicate these plans with us when asked about a vision for the service.

It was unclear how the service aims had been identified. There was no evidence of involvement of staff or referring providers in the development of this purpose of statement document. Staff we spoke with were unaware of any vision or strategy for the service.

There was a strategy section within the statement of purpose document which listed some aspirations for the future of the service. However, there was no detail to describe how these aspirations could be achieved and no information on how achievement against these aspirations would be measured.

We were not assured that the service had a clear and credible vision and strategy with robust plans to deliver high quality sustainable care to people who use the service.

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. However, there was no evidence that the service promoted equality and diversity in their daily work.

Staff we spoke with told us they felt supported by the service manager. They described being happy in their work and feeling able to raise any concerns with the manager. One staff member gave an example of how they had received positive feedback from the manager following a staff observation session.

Inadequate

Patient transport services

The statement of purpose document described a service culture of providing a customer focused transport service with patient safety at the forefront of operations. As we were unable to observe any patient care due to the COVID-19 restrictions, we were unable to witness this culture firsthand.

There was no specific evidence that the service promoted equality and diversity in its daily work. Only the registered manager and one other member of staff had completed training in Equality and Diversity.

Staff did not receive regular supervision sessions in order to identify any areas for learning and development within their role. One member of staff had received an annual appraisal, but the other staff had not been in the service long enough to receive an appraisal. This meant that following their induction into the role, most staff had not had any conversations with the manager about their learning and future development needs.

Governance

Leaders did not operate effective governance processes, throughout the service nor with partner organisations. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service. However, staff were clear about their roles and accountabilities

The service did not have effective structures, processes and systems to support the delivery of good quality sustainable services. There were no service level agreements with referring providers. The service did not have a formal arrangement, such as a contract, with referring providers. This meant the expectations of both referrers and the ambulance service were not clear and there was no system for monitoring satisfaction with the service provided.

The service did not have a clinical governance policy or governance framework which described good governance and the appropriate elements required to achieve this. There was no document to set out systems or processes to achieve robust governance within the service. This resulted in the manager not having a structure for monitoring the safety and quality of the service.

We saw that there were ad hoc systems in place for monitoring cleaning processes, safe management of oxygen cylinders, completion and recording of appropriate pre-employment staff checks, management of all chemicals used subject to the control of substances hazardous to health regulations, and reliable systems for the management of clinical waste. There were no systematic audits completed within the service. Data collected around journey times, staff performance and patient feedback was not collated and reviewed in order to evidence that services were of high quality. The manager kept a log of staff compliance with training, but the version originally provided to us did not evidence that all staff were compliant. When we raised this with the manager, they provided us with an updated version of the log. There did not appear to be a robust system for the manager to maintain training records up to date. We were not assured that the manager had full oversight of any issues or concerns within the service.

The responsibility for investigating incidents was devolved to referring providers. The service did not take ownership of incidents occurring whilst patients were in their care. Instead, they were forwarded to other providers for them to investigate. This meant there was poor oversight of safety issues within the service and a missed opportunity to learn from incidents.

Policies for the service were devised by the registered manager and an administrator and did not have any input from experts. We saw that this resulted in some policies not referring to up to date guidance or best practice. There was a policy folder which contained copies of policies that were overdue for review. However, the manager showed us that there were more up to date versions of policies held electronically. Staff could access these on the ambulance mobile phones.

Although staff meetings were held, there was no set agenda which incorporated good governance. For example, there was no robust system for sharing learning from incidents and complaints with staff.

Managing risks, issues and performance

The registered manager did not used systems to manage performance effectively. There was no evidence that staff contributed to decision making to ensure the quality of care was not compromised. There was not a robust arrangement for identifying, recording and managing risks. However, the manager had identified some relevant service risks and some actions to reduce their impact. The service had a plan to cope with unexpected events.

There was no system for monitoring of service performance. The manager did not have a systematic programme of audit. They told us the only audit they completed was the staff observation audit. There were no audits of vehicle cleanliness, staff hand hygiene, patient journey times, or any delays. There were no key performance indicators agreed with referring providers as there was no formal contractual agreement. This meant there was no process for review of the service's performance or referring providers satisfaction with the service. We had previously raised concerns about the lack of a formal agreement between the referring providers and SNP Medical during our transitional monitoring activity in January 2021. Following this, a transport meeting had been set up six weekly by the local NHS trust. This was a meeting with all transport providers for the trust to identify and issues or concerns, however, this did not identify or discuss performance expectations of the individual transport providers. There was no such meeting set up with the other referring provider.

Staff told us all decisions about the service were made by the manager. There was no forum for staff to put forward ideas for service development or to contribute to decisions about service delivery.

The manager kept a folder of risk assessments for potential risks such as needle stick injuries, changing oxygen cannisters, manual handling and assault. We saw these risks were rated and response measures were identified, however, there was no responsible person named for carrying out the required measures. The risk assessments were all overdue their review dates since June 2020. In addition, to these risk assessments we asked the manager for a service risk register. They provided a brief document identifying ten risks which were rated based on likelihood and impact, six as moderate and four as severe. The manager was named as the responsible risk owner for all the risks and there was a brief outline of mitigating actions. This meant that the manager had oversight of all identified risks across the service. However, the risk actions lacked detail such as how and when they would be carried out and how their impact would be measured. There was no review date for any of the risks identified and there was no process in place for regular review of the risk ratings.

We saw that there was a business continuity plan for the service which identified critical functions required to continue service delivery and resources required for their recovery in the event of a system failure.

Managing information

Inadequate

Patient transport services

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.

The service did not collect data in order to help the manager and staff understand the performance of the service. There were no key performance indicators set by the service or referring providers. Basic data relating to the time referrals were received and journey pick up and drop off times was collected. The database where this was kept also identified if there had been any delays in the process. However, there was no evidence that this data was reviewed, monitored or shared in order to measure the service for assurance and improvement purposes.

The provider kept patient records which were completed by staff on paper and then uploaded to an electronic system by the service manager. Only the manager had access to the electronic system which was accessed through a password protected process. This meant that patient information was kept secure.

Engagement

Leaders did not actively engage with local organisations to plan and manage services. They did not collaborate with staff or partner organisations to help improve services for patients. There was limited engagement with patients about their experience of using the service.

The service did not actively seek feedback about its performance from the providers who referred work to them. There was no discussion between the service and referring providers about capacity and demand, activity levels and wait times or satisfaction of service users with the care they received. This meant there was no engagement with local stakeholders in order to appropriately plan and manage the service delivery.

Staff were not consulted on any aspects of how the service was delivered. The manager did not actively engage with staff to seek their views or ideas for improvement. There was no staff survey to enable staff to feedback their experience of working in the service.

The manager explained that patient feedback forms were available to all service users. We saw these were kept on each vehicle, however, because we were unable to observe any patient care, we were not sure how easily available the feedback forms were to patients. Staff told us that patients had to request a feedback form and they were not routinely offered to patients. The manager told us feedback was also received from patients by email. We saw that the number of feedback forms received from the service was very low. From May 2020 to April 2021, the manager told us only one feedback form had been received by the service alongside an email expressing satisfaction with the care received. We were not assured that patients views, and experiences were actively sought in order to shape and improve the service.

Learning, continuous improvement and innovation

The service was not committed to continually learning and improving services. There was no understanding of quality improvement methods and no evidence that leaders encouraged innovation.

There was no quality improvement agenda in the service. The manager did not actively monitor service performance and did not strive to make improvements.

Staff were not encouraged or supported to develop themselves or the service.

Inadequate

Patient transport services

There was no opportunity for staff to review service systems and processes and make suggestions for improvement and innovation.

There were no service objectives that could be used to evaluate and improve service delivery and performance.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Staff checks were not consistently performed on recruitment for all staff. The recruitment process did not promote patient safety. Not all staff files complied with schedule three recruitment requirements. Not all DBS certificates were relevant to the staff member's current job role. There were not copies of driving licences or identification photographs for all staff. Not all staff records had the right to work in the UK declaration signed by both the staff member and the registered manager. There were no references on file for some staff members. There were not completed medical questionnaires in all staff files to indicate they were fit to work in their role. There was not evidence that driving licence checks had been completed for all staff.

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 The provider failed to ensure the quality of the care and service provided was regularly monitored, assessed and steps taken to improve the quality and safety of the services provided in the carrying on of regulated activity. There were not adequate systems and processes in place to ensure the provider was able to deliver high quality sustainable care to patients. There were no records of quality assurance audits and checks and performance information was not routinely collected or reviewed. There was a lack of governance oversight across the service. The provider failed to ensure all staff had completed required training. Incidents were not investigated by the service and responsibility was devolved to referring providers; there was no process for learning from incidents. Policies did not always refer to current legislation and guidance and there was no expert involvement in developing policies. The service did not have a measurable strategy against which to monitor the sustainability of the delivery of high-quality care. There were no formal contractual agreements in place with referring services meaning expectations of service delivery were not clear. Performance was not monitored and reviewed in order to identify any required areas of improvement and to ensure patient satisfaction.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Enforcement actions

The provider failed to maintain standards of cleanliness and hygiene in the vehicles used to provide patient transport. Reliable systems were not in place to prevent and protect people from infection.

The patient transport vehicles we inspected during our site visit were found to be dirty. The equipment on the vehicles we inspected was not clean. Equipment was not properly maintained. We saw that there was damage to one of the stretcher coverings which had not been repaired. Deep cleaning processes were not effective. The cleaning processes used were not adequately monitored. There was not a robust system for the management of clinical and hazardous waste.