Zot Limited

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Not sufficient evidence to rate
Are services responsive?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Zot Limited is operated by Zot Limited. The service provides a patient transport service (PTS). The service was registered with the Care Quality Commission (CQC) on 9 September 2018. The provider is registered for the regulated activity: transport services, triage and medical advice provided remotely.

The service transports non-emergency patients to and from community care locations, airports, hospitals and patients' home addresses. The service transports both adults and children. Zot Limited had one contract with a county council but no other contracts with providers. The service began transporting patients in February 2019 and had carried out 535 journeys between February 2019 and January 2020. The jobs the service undertakes are ad-hoc and short notice bookings all obtained via an electronic-procurement platform or requested directly from patients who are self-funding. This framework is an e-procurement system who providers apply to be an accredited provider with. Once accredited providers can bid for contracts via the portal.

The service had two vehicles equipped for patient transport.

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 21 January 2020.

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

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

We rated it as **Inadequate** overall because:

- While staff were up to date with mandatory training, this training was completed on the same seven hour day and we were not assured this provided staff with the right skills and knowledge for the role they were employed for.
- Staff did not demonstrate they had an understanding of safeguarding adults and children and were protecting vulnerable patients. The safeguarding lead was not trained to the recommended level and the safeguarding policy was not up to date and did not reflect current relevant national guidance.
- There was no evidence staff were suitably trained to use equipment such as carry chairs to keep people safe. The registered manager told us the management team had read the equipment handbook and self-trained prior to training staff. The clinical director told us they had someone in to train staff on the use of equipment but there was no evidence of this.
- The service was transporting children without a children's harness available in one of the vehicles. This placed children at risk. There was also no formal training on the use of children's harnesses for staff.
- Staff were not suitably trained to recognise a deteriorating patient and we had concerns patients were not appropriately risk assessed prior to transport. There was no exclusion criteria in place in order to ensure patients were suitable for patient transport services.
- The service had enough staff but not all staff had the right skills, training and experience to keep patients safe from avoidable harm.
- Staff did not keep detailed records of patients' care and treatment. The booking form did not always record or store information about patients the service transported.
- The service did not manage patient safety incidents well. Staff were not trained to recognise incidents and near misses. There was no incident log and no learning from incidents within the service.

Summary of findings

- The service did not provide care based on up to date national guidance. We found policies in place which staff were not aware of and did not follow.
- The provider did not have a policy or training on the rights of patients who were subject to the Mental Health Act 1983.
- The service did not collate data around response times and did not monitor the effectiveness of care and treatment.
- Staff did not support patients to make informed decisions about their care or have the knowledge to support patients who lacked capacity. The consent policy was not reflective of what the service did.
- Leaders did not have the skills and abilities to run the service. The service did not operate an effective governance process throughout the service.
- The provider did not have a written vision or strategy for the service.
- The service did not have processes and procedures in place to ensure there was an open and honest culture.
- The service did not collect data on any of their activity and therefore could not analyse it to improve the service.
- The service's data protection policy did not reflect what the service did. The registered manager told us booking forms with patient identifiable information were photographed and sent out using a social media messaging application to staff. They told us this was later deleted but there was no evidence this was audited.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements. These can be found at the end of the report.

I am placing the service into special measures.

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

Nigel Acheson
Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate	Zot Limited is a patient transport service. It is not contracted to provide patient transport services for any commissioners, NHS or private health care providers except one county council. The provider mostly made bids for the regulated activity but could also be contacted for work if required. The service had two vehicles. Between February 2019 and January 2020 the service had provided 535 patient transport journeys. We rated PTS as inadequate overall because: • The lead was not trained to the recommended levels for children and adult safeguarding training. • The safeguarding policy did not reflect current national guidance. • The provider was administering oxygen without being registered for treatment of disease, disorder and injury (TDDI). • There was no formal log for incidents which limited the service's ability to look for themes and change practice as a result. • Patients were not suitably risk assessed and we were not assured staff were trained on how to recognise a deteriorating patient. • Training on equipment did not keep patients safe and there was no children's harness available in the patient transport vehicle. • Record keeping was poor and not audited to ensure compliance. • Policies were sometimes not up to date with relevant national guidance. Staff awareness of some policies were poor and the policies did not reflect what the service were doing. • The service was not monitoring response times or patient outcomes. • There was a lack of auditing within the service. • Risks to the service had not been recorded with risk reviews or mitigating actions. However: • Vehicles were kept clean and well maintained.

Summary of findings

Contents

Inadequate

Zot Limited

Services we looked at:
Patient transport services

Summary of this inspection

Background to Zot Limited

Zot Limited is an independent ambulance service which provides patient transport services (PTS). The service opened in 2018 and is based in North West London. The service registered with CQC in September 2018 however did not start providing services until February 2019. The service transports non-emergency patients to and from community care locations, airports, hospitals and patients' home addresses primarily within London with some transfers across the whole of the United Kingdom. The service transports both adults and children. The service has two vehicles used for PTS.

Zot Limited had one fixed contract with a local authority. Between February 2019 and January 2020 the service carried out 535 journeys. Most of the jobs the service undertakes are ad-hoc and short notice bookings.

Zot Limited registered with the Care Quality Commission (CQC) on 5 September 2018. The registered manager has been in post since the service opened.

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

During the inspection we visited the service's office which was based in North West London. We inspected the service's two ambulances and spoke with the six staff members including ambulance care assistants, the registered manager, clinical director and business manager. We did not speak to any patients during the inspection.

- There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Activity between February 2019 and January 2020

- The service undertook 535 patient journeys. There was no information on whether these were children or adult journeys.

Staff:

- Six staff worked at the service. This included the registered manager, clinical director and business manager and two full time and one part time crew.

Track record on safety:

- There were no Never Events
- There were no clinical incidents and no serious injuries reported.
- There were no complaints.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC inspection manager, a CQC inspector and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspections.

How we carried out this inspection

We carried out a short notice announced inspection of the Patient Transport Services (PTS) core service using our comprehensive inspection methodology on 21 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.

Summary of this inspection

Information about Zot Limited

Patient Transport Services (PTS) were the sole service provided by Zot Limited. The service transports non-emergency patients (adult and children) to and from community care locations, airports, hospitals and patients' home addresses.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Not rated	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not rated	Inadequate	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Effective	Inadequate
Caring	Not sufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate

Information about the service

Patient transport services (PTS) was the sole service provided by Zot Limited.

The service transports non-emergency patients (adults and children) to and from community care locations, airports, hospitals and patients' home addresses.

Summary of findings

We rated it as **Inadequate** overall because:

- Staff were up to date with mandatory training. All training was completed on the same seven hour day and we were not assured this provided staff with the right skills and knowledge for the role they were employed for.
- Staff did not demonstrate an understanding of safeguarding adults and children and were not able to assure us they were protecting vulnerable patients. The safeguarding lead was not trained to the recommended level and the safeguarding policy was not up to date with current relevant national guidance.
- There was no evidence staff were suitably trained to use equipment such as carry chairs to keep people safe. The registered manager told us the management team had read the equipment handbook and self-trained prior to training staff. The clinical director told us they had someone in to train staff on the use of equipment but there was no evidence of this.
- The service was transporting children without a children's harness available in both vehicles. This placed children at risk.
- Staff were not suitably trained to recognise a deteriorating patient and we had concerns patients were not appropriately risk assessed prior to transport. There was no exclusion criteria in place in order to ensure patients were suitable for patient transport services.

Inadequate

Patient transport services

- The service had enough staff but not all staff had the right skills, training and experience to keep patients safe from avoidable harm.
- Staff did not keep detailed records of patients' care and treatment. The booking form did not always record or store information about patients they transported.
- The service did not manage patient safety incidents well. Staff were not trained to recognise incidents and near misses. There was no incident log and no learning from incidents within the service.
- The service did not provide care based on up to date national guidance. We found policies in place which staff were not aware of and did not follow.
- The provider did not have a policy or training on the rights of patient's subject to the Mental Health Act 1983.
- The service did not collate data around response times and did not monitor the effectiveness of care and treatment.
- Staff did not support patients to make informed decisions about their care or have the knowledge to support patients who lacked capacity. The consent policy was not reflective of what the service did.
- Leaders did not have the skills and abilities to run the service. The service did not operate an effective governance process throughout the service.
- The provider did not have a written vision or strategy for the service.
- The service did not have processes and procedures in place to ensure there was an open and honest culture.
- The service did not collect data on any of their activity and therefore could not analyse it to improve the service.
- The service's data protection policy did not reflect what the service did. The registered manager booking forms with patient identifiable information were photographed and sent out using a social media messaging application to staff. The registered manager told us this was later deleted but there was no evidence this was audited.

However

- Vehicles were kept clean and well maintained and prevented the spread of infection.
- Equipment we inspected on the ambulances was well maintained and servicing was up to date.
- The service was able to provide a flexible service for patients and give precise pick up times. Patients and relatives were provided with text messages with a link to a map, so they could track the vehicle live.

Inadequate

Patient transport services

Are patient transport services safe?

Inadequate

We rated it as **inadequate.**

Mandatory Training

The service provided mandatory training and all staff had completed it. However, all mandatory training modules were completed on the same day and staff could not demonstrate knowledge on some topic modules covered at mandatory training.

Mandatory training was provided by an external company and called a 'All in One-day Mandatory Training Course'. Modules covered during the day were health and safety, information governance, fire safety, equality and diversity, infection control, food hygiene, basic life support (BLS), moving and handling, safeguarding vulnerable children level one and level two, safeguarding vulnerable adults level one and level two, complaints handling and conflict management and lone working.

We were also provided with a mandatory training log which included additional mandatory training modules completed by all staff which included the mental capacity act, deprivation of liberty and consent and use of equipment.

All 12 mandatory training modules were completed on the same day and we were not assured this provided staff with a thorough knowledge and understanding of the topics. For example, staff we spoke to showed a lack of understanding around safeguarding and mental capacity and consent.

We noted that the majority of the registered manager's training took place in November 2019, following our request for pre-inspection information. There was no evidence of any training prior to this date and the service had started operating in February 2019.

Safeguarding

There were no effective safeguarding systems and processes in place for staff to follow. The safeguarding lead was not trained to the required level and the safeguarding policy was not up to date with relevant national guidelines.

We found that the safeguarding policy referenced the 2010 version of Working Together to Safeguard Children guidance which meant that the service was not using up to date relevant national guidance. The policy made no reference to the Working Together to Safeguard Children 2018 guidelines and therefore did not contain current guidance.

There was no flowchart within the policy to show how a safeguarding concern should be escalated. The policy listed several different entities to contact in the event of a safeguarding referral. There was a safeguarding referral form but it was not clear who would fill this in. The registered manager told us staff should call him to make the referrals and then call the council or police. However, we found no evidence to support that this was done. The service had made no safeguarding referrals since the service began transporting patients in February 2019.

Safeguarding adults and children level one and two training took place on the same day as 12 other mandatory training modules. We were not assured this provided staff with a thorough understanding and knowledge of safeguarding in order to protect vulnerable patients. Staff we spoke with showed a lack of knowledge around what types of things were safeguarding concerns and no evidence that staff escalated concerns appropriately.

The safeguarding lead was the registered manager and was trained to level three safeguarding adults and children. However, this level of safeguarding was not sufficient for the role. National guidance from Safeguarding Children and Young People: Roles and Responsibilities for Healthcare Staff (2019) recommends safeguarding leads need to be trained to level 4.

The booking process did not allow for specific information about safeguarding concerns or protection plans to be recorded within the form, so the crew could be made aware.

We identified two potential safeguarding concerns during inspection that had not been acted on or referrals made.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff had access to equipment and control measures to protect patients, themselves and others from infection.

Staff were provided with training in infection, prevention and control and this covered hand hygiene and how to deal with spillages.

The provider conducted monthly infection, prevention and control checks which included hand hygiene. This was a tick box list where the service checked if things were cleaned to an appropriate standard. This had been done every month between February 2019 and January 2020.

There was also a Daily Vehicle Cleaning' log completed which recorded the checks of cleanliness equipment. This included the stretcher, bed pan, wheelchair handles, vehicle patient seats, seat belts, single use items, defibrillator, glucometer, resuscitator, suction, equipment bags and suction machine.

The registered manager told us vehicles were deep cleaned every four to six weeks or as and when required. There was a deep clean checklist to be completed when vehicles were deep cleaned. There was evidence deep cleans were completed.

We inspected both of the service's vehicles and equipment and saw they were visibly clean and free from dust.

There was easy access to personal protective equipment (PPE), such as gloves. Staff told us they would use aprons where they knew they were transferring an infectious patient. There were also hand gels available for staff to clean their hands between patients.

Cleaning equipment was available on the ambulances and at the office. Staff told us that they would return to the office or go straight to the deep clean provider if a vehicle became contaminated.

The service used yellow bags for clinical waste which were disposed of safely.

Environment and equipment

Equipment servicing logs were up to date however we were not assured training on the use of equipment kept people safe.

The service had two vehicles available for patient transport. One vehicle was classed as a patient transport vehicle (PTS) and one vehicle was a high dependency vehicle (HDU).

When we asked the registered manager and clinical director about the HDU vehicle they could not explain what was meant by HDU. However, they told us this vehicle had a suction unit and defibrillator on board but could not state which patients it would be used for. Some of the equipment on the HDU vehicle should not be is use by a PTS service and would fall out of their scope of practice. There is a risk this equipment could be used as it was available and staff were not suitably trained for this equipment.

The service kept vehicle maintenance logs and we saw these were up to date. The vehicles tax, MOT and insurance was in kept in a folder within the service's office. Both vehicles were under warranty until October 2021 and therefore any repairs would be done by the manufacturer. Any repairs were documented on the vehicles' log and the vehicles would undergo a service with the manufacturer annually.

All licences were checked to ensure staff were licenced to drive the class of vehicle. Driving licence checks were checked via the Driving and Vehicle Licensing Agency (DVLA) and this was documented in the staff's human resources folder. Checks were completed at six monthly intervals and staff were told they needed to update management regarding any new driving offences.

Equipment on the ambulances was serviced twice yearly by an external company. We checked several pieces of equipment on the ambulances including a stretcher, carry chair and saw checks were all in date.

There was bariatric equipment available for patients and both vehicles had wide doors and the widest ramp to accommodate bariatric patients.

Records showed that all staff had received training in the use of equipment such as the stretcher, wheel chair and the carry chair. The certificates for this training had been signed by the registered manager. The registered manager told us the management self-taught themselves on the use of equipment by reading the equipment's manuals and they would train the staff. This could place patients at risk if staff were not using equipment properly. The management later told us they arranged for a paramedic to come in to do a teaching session on manual handling including use of the carry chair. However, there was no evidence of this in staff records and none of the staff told us this had been done by an external company. There was also no evidence this paramedic was suitably qualified to deliver this training.

The service was transporting children and young people. However, on inspection of the two vehicles we found no

children's harness available to use which put children at risk. Following the inspection the registered manager told us the service used a child harness in the high dependency vehicle. We were provided with a copy of the receipt for this and saw it had been purchased in October 2019. There was no harness on the other vehicle. The registered manager told us they would borrow this from another provider. We saw no evidence of training for the use of this harness and there were no formal arrangements in place for the borrowing of a harness.

The staff had not been trained in the use of bariatric equipment which could put patients at risk.

Assessing and responding to patient risk

Staff did not complete thorough risk assessments for each patient and did not receive training to help them identify patients at risk of deterioration. Record keeping of risk assessments was ineffective.

There was no documented exclusion criteria to state which patients the service would not take. The clinical director told us there were certain patients that the service would not take. For example, palliative care patients, tracheostomy or syringe driver without medical escort. On review of the booking forms we identified the service had taken patients who the clinical director stated would not be accepted.

Each booking was taken by one of the management team. They had no experience or training in taking bookings or completing pre-booking risk assessments. The registered manager told us they had taught themselves.

Booking details were recorded on a booking form that had been adapted from one used by a specialist trust. While this was fit for purpose for a ward or department within a hospital to request transport from their internal department it was not fit for purpose for an ambulance provider. The form was difficult to follow, did not include a section for crews to record any interventions, who they had handed over to or any issues that had occurred during the journey.

We reviewed the deteriorating patient policy and saw that whilst this policy was in date it was not up to date with the most recent national guidance. The policy stated that staff should conduct National Early Warning Scores (NEWS) assessments on patients. However, NEWS had not been updated to NEWS 2 and this was not mentioned. In addition, the service was registered as a PTS and patients requiring NEWS scoring would be outside the service's scope of practice. Therefore, the policy was not reflective of the work the service should be conducting.

We reviewed patient records and saw no evidence that NEWS was used. We asked the senior management about this policy. The clinical director told us NEWS would only be used if required. However, this is not what the policy said and we were provided with no assurance how this decision would be made. We saw no section on booking forms for NEWS assessments to be documented and there were not patient record forms. Patients requiring NEWS scoring would usually be urgent and emergency care services and not PTS.

Following the inspection we asked for a copy of the deteriorating patient policy. The registered manager told us the one we were shown on the inspection no longer existed as this was being updated. The new policy stated staff should call 999 in the event of a patient deteriorating. However, we found an example during the inspection where staff did not do this.

We found examples of patients who would be at risk of deterioration with no formal risk assessment completed prior to the journey. For example, patients with epilepsy, dementia and children arriving from airports. We were not assured that these patients were suitably risk assessed prior to transport. This placed patients at risk.

We found an example of one patient who deteriorated during a journey to a medical appointment. The receiving hospital had refused to take the patient as there was no accident and emergency service at the hospital. This patient was not escalated for additional medical support despite the potential risk. Staff did not make a call to 999 following this as per their policy. When we asked for the booking form for this patient the registered manager was unable to provide this. The registered manager told us an online booking had been made and the journey had taken place based on a booking form completed for a previous journey. This meant this patient had been transported without an up to date assessment of risk prior to the journey. The staff involved demonstrated no understanding that this patient should have been escalated. The managers also demonstrated no understanding that this was a near miss.

Staff were unprepared to deal with someone living with dementia due to a lack of training which placed these patients at risk.

We saw that the service had a policy for supporting patients who had an active do not attempt cardiopulmonary resuscitation order (DNACPR). All staff we spoke with were knowledgeable about the protocol they needed to follow.

The service did not carry out emergency transfers and therefore did not use blue lights which were installed in the ambulances. However, we found that these blue lights were not deactivated on the vehicles to prevent misuse.

The provider did not have a violence and aggression policy and we were not assured staff were protected. The provider did not undertake a thorough risk assessment before accepting a booking and therefore this left patients at risk of not receiving the care they required and staff at risk of not having the knowledge and skills to deliver the care required. Staff told us about an incident in which a patient had been verbally and physically aggressive. There was no incident reported and managers told us conflicting information about this journey. Staff had continued taking this patient on a nine hour journey despite the risk. This incident was not reported, investigated and learning identified to prevent a similar incident occurring in the future.

Staffing

The service had enough staff but not all staff had the right skills, training and experience to keep patients safe from avoidable harm.

At the time of the inspection there were three directors who managed the service. The registered manager who was also the service manager, the clinical director who was a qualified nurse and the business manager. The clinical director was the only member of the management team who had clinical experience and the service had no access to anyone else from a clinical background for advice and support.

The service employed two full time and one part-time ambulance care assistants (ACAs). All staff were on zero hours contracts and had opted out of the working time directive. The registered manager told us there was also two full time and one part-time ambulance care assistants (ACAs) going through recruitment. It was unclear when these individuals were expected to start in post.

During our inspection we noted that one of the full time ACAs had handed in their notice. It was unclear if the service would be able to continue to deliver the current service with this resignation.

All staff had an up to date disclosure barring service (DBS) certificate check in their employee file.

Not all staff had the right experience and were not provided with training to prepare them for their role. Therefore, staff may not have the right skills to keep patients safe. For example, all three directors were taking bookings and completing the pre-assessments. However, there was no evidence they had been trained to do so.

The provider had a number of policies in place to support staff to keep patients safe. However, we were not provided with evidence to show staff understood these policies and appropriate training to support them implementing them. For example, there was a lack of awareness around escalating deteriorating patients and incident reporting.

Staff said they were not always able to take their breaks and there were no audits to check whether protected break times were being taken.

Records

Staff did not keep detailed records of patients' care and treatment. The provider did not record detailed information about patients they transported.

Booking forms were paper based and completed and stored in the office for eight years. The service only kept booking forms and did not use patient record forms for staff to record care provided during the journeys.

The registered manager told us that a pre-travel assessment was completed for all patients and saw a section for this on the patient booking form. Not all booking forms had this section completed, therefore it was unclear how the decision had been made that the patient was suitable to be conveyed by the service.

Inadequate

Patient transport services

We reviewed 50 booking forms and of these, 10 booking forms were for journeys transporting children and young people. These forms lacked details of the child's condition and did not always include information about the patient and any special needs they had.

We found one booking form for a child who was collected from the airport to be taken to a specialist children's hospital. This had no patient identifiable information about the child except that they were from abroad and were with a medical escort. There was also no information about the patient's condition. This meant that there was no assurance the crew could meet the needs of the child and know what action to take should they deteriorate or if the vehicle was suitable for the transfer. Following the inspection the service informed us that the patient was transported with a doctor and a nurse. This information was included in an email when the booking was made. We were told the crew were verbally informed about this.

We also found an example of a child who needed mechanical ventilation. We saw it was recorded that the parents would deliver care for the child. However, it was unclear if the staff would know what to do if the mechanical ventilation failed and they had to support the parents.

Of the 50 booking forms we reviewed we found 15 of the forms were not signed or only had the person taking the bookings first name. We found 20 forms did not have information about the patients next of kin or contact details for this person. Therefore, in the event of an emergency we were not assured staff would know who to contact.

We found booking forms were not consistently fully completed and none had detailed information about the care needs of the patient. We also found forms generally only had a very brief medical history recorded, use of abbreviations and in some instances, no information at all.

We found an example of one booking form which stated the patient may need a nebulizer or oxygen. However, it was not clear who would decide whether this was needed and who would administer this.

We found two forms did not have the pre-travel assessment completed, this meant that it was unclear if the service could meet the patient's needs.

Staff informed us of an incident around the transport of a patient with epilepsy. When we asked the registered manager for a copy of this booking form to review the information we were provided with a booking form from a different journey for the same patient. We asked for the form relating to the challenging journey and was told they did not have this as the patient had used the service before and would not require another booking form. The only information the service had about this journey was the online booking and there was no documentation of the journey itself.

There was no information governance policy however the service did have an in date Data Protection Policy. During the inspection the registered manager told us booking forms were photographed and sent to staff over a social media messaging application so staff had the journey details. The registered manager told us these would be deleted by staff after the journey was completed. However, this was not mentioned in the service's policy and there was no audit trail to show whether photographs were deleted.

Medicines

The service did not store or administer medicines. However, they stored and administered oxygen. As the service had a registered professional and they were administering oxygen the service should have been registered for the regulated activity of Treatment of Disease, Disorder or Injury (TDDI) which the service was not registered for.

During our inspection, apart from medical gases, we did not find evidence of other medicines or medical gases being stored or administered by staff. The service was not registered to provide the regulated activity Treatment of Disease, Disorder or Injury (TDDI). Therefore, the service was delivering this treatment outside the scope of their registration. The registered nurse lacked an understanding of the impact of oxygen being administered or that the service was not registered to provide oxygen treatment.

The patient transport ambulance vehicle had two oxygen outlets with two oxygen cylinders at the front of the vehicle and an oxygen cylinder at the back of the vehicle. The high dependency ambulance had two oxygen outlets with a double oxygen cylinder at the front of the vehicle and an oxygen cylinder at the back of the vehicle. No additional cylinders were stored at the location.

Inadequate

Patient transport services

The qualified nurse and all other members of the team, even those who this training was not relevant to their role, had completed an on-line oxygen training course. Despite completing this training they demonstrated no awareness of the dangers of under or over oxygenating patients.

Staff told us some patients used their own oxygen cylinders and administered it themselves. They said when patients were transported with medical escorts they had their oxygen prescribed and administered by the nurse or doctor escorting them.

The registered manager told us that staff would administer oxygen if this was requested on booking. However, documentation of prescriptions for oxygen was not always completed. We also saw there were no records kept to say whether this was administered and if so how much was administered.

Incidents

The service did not manage patient safety incidents well. Staff were not trained to recognise incidents and near misses. The service had no incident log and there was no evidence of learning from incidents.

There was an incident reporting policy in place within the service. This was in date and stated the service would report, record and investigate all incidents. It stated the service would use this to identify learning and this would feed into service improvement.

Between February 2019 and January 2020 the service reported no incidents. We asked to see the incident reporting log and were told there was no incidents and therefore no log was kept. However, during the inspection we were made aware of incidents that should have been reported but had not been documented.

There were ineffective systems and processes for the management of incidents. During our inspection we became aware of two incidents which should have been reported as near misses. Neither had been reported and logged by the provider and safeguarding referrals had not been made. The senior leaders and staff told us two versions of what had occurred during the incidents and there was no written evidence to confirm which was the correct version. This resulted in potential harm to patients and a lack of learning for the service.

The clinical director and registered manager did not appreciate the severity of the incidents we raised with them and the potential harm to patients. We were not assured action would be taken to avoid similar incidents recurring,

Staff demonstrated a lack of understanding that these incidents should be reported and documented. This also meant staff including management were not following their own incident reporting policy.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patient (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had not applied the duty of candour as the registered manager told us there had been no incidents reported where this would be required.

There was a policy in place for duty of candour and the registered manager told us staff had received training in this. However, we found that when we spoke with staff about the principles of duty of candour, this was not well understood.

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

Inadequate

We rated it as **inadequate.**

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance. Some policies did not refer to the latest national guidance.

The service had policies and procedures in place which were all in date. Policies included data protection policy, infection prevention and control policy, lone working policy, deteriorating patient policy and safeguarding adults and children policy. However, not all of the policies were tailored to the service provision. For example, the deteriorating patient policy mentioned national early warning scores which were not being used by the service.

We also found that the safeguarding policy referenced the 2010 version of Working Together to Safeguard Children guidance which meant that the service was not using up to

date relevant national guidance. The policy made no reference to the Working Together to Safeguard Children 2018 guidelines and therefore did not contain current guidance.

We were not assured that the service kept up to date with national guidelines and disseminated these to the crew. We also saw that the service had an out of date copy of the (Joint Royal Colleges Ambulance Liaison Committee) JRCALC guidelines which could mean care was not being delivered in line with latest national guidance.

Policies could be accessed on the computers in the office. Paper copies were also kept in a folder at the office and staff could access these at any time.

The service did not have a documented eligibility criteria before a booking was made. The management could not tell us which patients they would refuse due to staff not having the skills to deliver safe, effective care to these patients. When asked what the services criteria for accepting patients was the registered manager stated non-emergency.

The service conducted very few audits. We saw audits for deep cleaning of vehicles, infection prevention and control and equipment checks. The service did not have a clinical audit policy and did not audit areas such as complaints, booking forms, incident investigations and performance indicators.

Nutrition and hydration

Staff told us they gave patients opportunities to obtain food and drink during patient journeys.

Staff told us they would carry water bottles for patients on long journeys.

Staff told us that they would ensure that they took as many rest stops as the patient needed. Prior to a long journey, they would check that a patient had their own food or snacks to take with them. They told us that they would also check during a journey if a patient needed a drink or food. Booking forms recorded if a patient required food for a journey for medical reasons.

Pain relief

The service did not provide or administer pain relief to patients.

The provider stated that they did not administer pain relief.

Response times

The service did not collect or monitor key information such as response times.

The service undertook 535 journeys in the year since they started operations. They did not monitor response times as all private bookings were made with timings agreed prior to the booking being accepted. Other bookings were made on an ad hoc, short notice basis as the jobs were obtained following the service bidding for the job via the e-procurement platform.

The service did not have formal key performance indicators as bookings were made on an ad hoc basis rather than under a contract. The service manager told us that they tried to reach a patient within 30 minutes for short journeys and 45 minutes for longer journeys. However, this data was not collected, logged or analysed to improve performance.

There was only one signed contract with a county council. The registered manager said they monitored response times for the jobs carried out. However, we were not provided with any evidence to show this was completed.

Patient outcomes

The service did not monitor the effectiveness of care and treatment.

Patient outcomes were not recorded as no patient records were completed.

Competent staff

The service provided training for staff to ensure they were competent in their roles. However, we found some staff lacked knowledge around the providers procedures and policies.

New employees had a period of supervision where they shadowed more experienced staff for a day as part of their induction.

We reviewed staff files and found evidence of staff competencies and qualifications in the form of various training certificates.

As a part of the staff induction process, staff completed training oxygen administration, first aid, moving and handling, lone working, safeguarding levels 1 and 2 and

basic life support for children and adults and mental capacity. However, staff we spoke with told us they had not received a comprehensive induction. In addition, all the training took place on the same day.

The registered manager appraised staff's work performance every six months. We viewed appraisal records which showed that all staff had up to date appraisals.

The registered manager went on some jobs with the crew as part of informal supervision to assess staff competencies. However, we found no records of this to show that this had taken place. In addition, the registered manager was no clinically trained and not trained to assess competencies.

Staff underwent a safety driving course which assessed how safe they were on the road. All three staff members were rated as low risk. Driving licence checks were conducted regularly.

Disclosure and Barring Service (DBS) checks were conducted for each staff member as part of the service's recruitment process in line with service policy. However, not all DBS certificates had been processed in line with data protection legislation. We found that the provider had retained DBS certificates and photocopies of DBS certificates which should have been returned to staff following the necessary recruitment checks.

Staff told us they were expected to use the carry chair to transport patients between floors or locations. The registered manager told us the management team self-taught themselves around the use of equipment and then showed staff what to do. For example, staff were shown how to use the carry chair by the management team. This training was not from a certified training company. The clinical director told us they had a paramedic visit who trained staff on the use of equipment but there was no evidence that this had been done.

Multidisciplinary working

The service did not work or communicate with other agencies to provide care for patients. Staff worked together as a team to benefit patients however there was little evidence of multidisciplinary working.

The service was not commissioned by any NHS provider and did not undertake sub-contracted work for other independent health ambulance services.

The registered manager told us when they transported patients for hospital appointments they would discuss a patient's requirements with the patient or relative directly and follow their instructions for care. However, there was often no information on booking forms about the patient's condition or requirements.

Staff worked well together. We saw that there was good team working with the fellow crew members. However, the service did not have a comprehensive handover policy and relied on medical escorts and the booking form which did not contain sufficient handover information.

Staff told us they had team meetings every month at the office. The service manager said that team meetings were a good opportunity to feed back any issues as a team.

We observed crew communicated well with hospital staff when carrying out patient transfers.

Health promotion

Staff did not give patients practical advice to lead healthier lives.

Due to the nature of the service provided, staff had limited opportunities to promote healthier lives.

The provider did not demonstrate an understanding of health promotion and had not discussed this with staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff's understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 was limited.

There was a policy in place around consent called 'Consent of Patient in line with Mental Capacity Act and DoLS'. We reviewed this policy and saw this was in date and reflected best practice and guidance.

Staff knowledge and understanding of the Mental Capacity Act and deprivation of liberty safeguards was limited although this was part of the mandatory training.

Staff understood the need for consent when supporting patients and we observed staff seeking a patient's consent when transferring them to a trolley.

The registered manager told us the service did not transport patients detained under the Mental Health Act 1983 or patients experiencing a mental health crisis. The

service did not use restraints. However, staff told us that they had transported patients with mental ill health which they were not informed of fully at the point of booking. This meant they may not have been able to meet the patient's specific needs.

The service did not use patient record forms; therefore, we were not able to review whether patient consent had been recorded or if this had been obtained in line with national guidance. This was not in line with the service's own policy, which stated that staff should be accurately documenting consent where appropriate on the patient consent form. We found no evidence this being done and we were not provided with copies of a patient consent form. Therefore, the service was not following its own policy.

We found evidence of patients with dementia being transported and were unable to ascertain if the patients were accompanied by an escort of family member. There was also no record the patient consented to the journey.

Are patient transport services caring?

Not sufficient evidence to rate

We did not rate caring because there was only one patient journey being carried out during the inspection and caring could not be sufficiently evidenced.

Compassionate care

Staff treated patients with care and compassion.

For the patient journey we observed we saw staff treated the patient with care and compassion. The patient's privacy and dignity was well maintained and the crew ensured the patient was supported getting on and off the vehicle.

We saw an email from a relative who praised the staff for their compassion and support during a difficult patient transport journey.

The service had previously given out feedback forms to patients at the end of each journey. However, response rates were poor, so the service had moved to online reviews on a popular online search engine. The registered manager told us online links were sent out to the patients following transport. We reviewed these reviews and saw all 106 reviews were five star reviews.

Comments on the online search engine included comments like; 'The staff were caring and professional', 'The two members of the crew were brilliant', 'excellent service, nicer staff and well communication' and 'thoroughly professional and courteous service'.

Emotional support

Staff told us they reassured patients when they were distressed.

Staff told us they would reassure patients during journeys if they felt anxious beforehand. However, we did not have the opportunity to observe this during the inspection as there was only one patient transport whilst we were there.

Understanding and involvement of patients and those close to them

Staff communicated well with the patient.

We observed one patient journey and saw staff communicated well with the patient regarding their needs.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Inadequate

We rated it as **inadequate.**

Service delivery to meet the needs of local people

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

Zot Limited transported patients from across London and undertook longer journeys across the United Kingdom which meant the service did not only serve an immediate local population. The service had two ambulances in total and only accepted work where it had capacity to carry out those patient transfers.

The service took non-emergency bookings on an ad hoc basis from private customers, clinical commissioning groups, county councils, hospitals as well as other ambulance services through an electronic portal which was

updated daily with ad hoc jobs. The service took jobs via the telephone, the portal system or email. All bookings were made on a paper booking form which was completed and kept in the office.

Referrals were risk assessed by the service and the referring provider to establish individual requirements such as the type of equipment required for the transfer. The registered manager told us they would call the patient or patient's family to check their requirements in terms of equipment and accessibility into their property. The registered manager told us they would escalate a potential booking to their clinical director if a patient had medical issues to check that the service could fulfil the job safely however such an assessment was not documented on the booking forms we reviewed. We also did not see a documented eligibility or exclusion criteria for patients. We reviewed 50 booking forms and found information regarding patients was incomplete and some had no patient information documented at all. This meant that the service could not be assured they were providing care and treatment in line with the patients individual needs.

The service had one contract with a local authority and no other contracts. They only accepted bookings they knew they had the capacity to fulfil.

The service manager was able to track vehicles to see how long a journey would take. A link to an online map could also be sent to a relative to show them the progress of the journey.

However, we found that the company's website advertised jobs such as events cover and blue light transfers which the service did not currently undertake. They were not registered to do this sort of work.

We also saw the company website advertised a high dependency vehicle (HDU). When we asked the management team about this we were told all journeys were still patient transport journeys and they could not define what an HDU patient was. However, this vehicle could be used when patients were transported with staff from hospitals.

The website also mentioned vehicles had blue lights. The service should not be providing blue lights as the drivers were not trained and assessed as competent to drive on blue lights and we found these had not been deactivated.

Meeting people's individual needs

The service did not always take account of patients' individual needs.

All vehicles had equipment to transport bariatric patients. However, staff were not trained in transporting bariatric patients.

The service transported children however, paediatric harnesses were not available for transporting children in both vehicles. Only the high dependency vehicle had a harness.

The service transported patients living with dementia however staff were not trained in dementia awareness. We also did not see any visual or communication aids to help staff communicate with patients who had learning disabilities.

The service was able to provide a flexible service for patients and accommodated short notice bookings.

The booking process was completed on paper. The service's booking form contained information such as pick up and booking addresses, care needs, appointment times and DNACPR information. The needs of the patient was discussed at the point of booking. Based on the information received, the business manager or service manager would allocate a job to a crew. However, booking form completion varied and therefore we could not be assured patient needs were met when they were not identified prior to transport.

A photograph of the booking form would be taken and sent through to a social media messaging application on a company phone which the crew held. The photograph would then be deleted after the job was completed. The service manager told us they also communicated with the crew by telephone when a job came in. We reviewed the data protection policy and there was no mention of this practice within the policy.

The service did not use a translation service for patients whose first language was not English. Staff told us they used an online translator to speak to patients who did not speak English as their first language. However, we did not see evidence that this was done during the inspection and there was no evidence the service assessed whether this was needed on booking forms.

Inadequate

Patient transport services

The provider did not maintain patient record forms therefore we were not able to evidence whether patients' individual preferences, culture or faith requirements had been met.

Access and flow

People could access the service when they needed it.

Patients could access the service provided by Zot Limited in a timely way as the service only booked jobs that they had the capacity to fulfil. The registered manager told us that patients rarely experienced delays in pick up times. However, the service did not monitor their own response times and did not monitor key performance indicators. The service manager told us there had been two occasions when a job was delayed but these were due to situations which were out of their control.

The service took bookings 24 hours a day and jobs were booked throughout the week Monday to Sunday as required by telephone or email.

Learning from complaints and concerns

The service had not received any complaints since it had started operating.

There was an up to date complaints policy which stated that the service acknowledged complaints within 48 hours and would respond within 25 days of receiving a complaint.

The registered manager handled complaints and said that any complaints would be fed back to the crew at team meetings. However, since starting operations, the service had not received any complaints.

Ambulances did not display information for patients on how to make a complaint.

The service had recently changed from asking patients to fill in a paper feedback form at the end of a journey to contacting the patient or patient's relative after a journey with a link to submit a review online. We viewed these reviews and found them to be positive. However, we were unsure how reliable this was as two of the reviews had been completed by the registered manager.

The service did not have an arrangement with another provider for an independent review of any complaints received and investigations carried out.

Are patient transport services well-led?

Inadequate

We rated it as **inadequate.**

Leadership

Leaders did not have the skills and abilities to run a service that provided high quality and sustainable care.

There were three directors in the leadership team. The registered manager had overall responsibility for the management and growth of the service. The clinical director was a trained nurse and was responsible for the clinical side of the business. This included providing advice and support around clinical work and ensuring the service was up to date with relevant national guidance. The business manager was responsible for human resources including induction of staff and complaints.

The leadership team's experience was mostly in care homes and they demonstrated limited knowledge of the NHS, ambulance service or healthcare systems. The management could not articulate the challenges the service faced in relation to quality and sustainability except to say they were a relatively new service. They demonstrated a lack of understanding about how the NHS awards contracts to independent health providers or the requirements of the contract they held with a county council.

The management team's previous experience in care homes did not demonstrate they had the skills and knowledge to run an ambulance service. The registered manager told us they engaged with other ambulance providers in order to develop the service. However, we found no evidence that this was done. For example, the service's booking form was based on one from a specialist hospital rather than an ambulance provider and was not fit for purpose. We also found the deteriorating patient policy said staff should use National Early Warning Scores (NEWS). However, there was no evidence the service completed NEWS charts and no patient record forms were used to record NEWS scoring.

The registered manager told us if he was on leave the business manager would take over. However, he was always remotely available by mobile telephone if required.

There was no process in place for annually checking Fit and Proper Person and no evidence of managerial supervision and appraisal for the directors.

Vision and strategy

The provider did not have a written vision or strategy for the service

There was no documented strategy for how the service would achieve its vision.

The service did not have any documented values. The registered manager stated the service was small and new and they were trying to be open and honest with clients. However, we did not find this underpinned the staffs work.

Culture

The service did not have processes and procedures in place to ensure there was an open and honest culture. However, staff said morale was good.

Whilst the registered manager understood his responsibility under regulation 20 for duty of candour, staff had not received duty of candour training.

Staff reported a good culture within the service and said the management team were supportive and morale was good.

Governance

The service did not have systems in place to improve service quality systematically and safeguard high standards of care by creating an environment for excellent clinical care to flourish.

The registered manager was responsible for arranging the servicing of vehicles and equipment and maintaining the paperwork pertaining to vehicle checks and servicing. The registered manager also completed staff appraisals, monitored mandatory training compliance and undertook informal supervision of crews.

The majority of the provider's work was from the electronic-procurement platform . However, the service could not explain how this differed from being commissioned by another provider to deliver work. The registered manager stated that they reviewed the jobs on the electronic-procurement platform daily and bid for jobs.

The provider stated they had no contract with any local authority but had submitted a signed contract for work with a county council. This had been signed by the business manager and when asked, the registered manager was not aware there was a signed contract.

The provider stated they had commenced monthly governance meetings in September 2019. However, these did not have a standard clinical governance agenda and the majority of the issues discussed were operational not governance topics. We reviewed the minutes which documented the conversation that took place. For example, they recorded a staff member had left because they did not enjoy sitting in the vehicle. Other topics discussed were invoices. Whilst they did discuss the cleaning audit this was to say whether it was done or not and not the actual results and any learning. There was no discussion about risks.

The clinical director told us it was their responsibility to keep policies up to date with relevant national guidance and to share this with staff. However, we found the safeguarding and deteriorating patient policy were not up to date with the most current national guidance.

The provider did not follow the service's policies and procedures and we found many examples of this during the inspection. For example, the deteriorating patient policy stated staff should be conducting national early warning scores (NEWS) risk assessments. The incident reporting policy said the service should be reporting, documenting and investigating incidents. The consent policy said the service should be documenting consent. However, we found staff had no awareness of these policies and there was no evidence to show these were adhered to.

The registered manager told us the company followed evidenced based policies and procedures. However, we were not assured they understood this thoroughly. The registered manager told us some services required ambulances with one staff member. The service had a lone working policy in place to ensure the safety and welfare of staff whilst at work.

We found the provider's website was advertising services that were outside of the services scope of practice as a

Patient Transport Service (PTS) service. For example, the service advertised a high dependency vehicle (HDU) which had equipment not suitable for PTS patients. The service was not registered for treatment of disorder and injury (TDDI) and therefore HDU transfers were outside of their scope of practice. The service was also advertising blue lights which fall under urgent and emergency care and not PTS.

Management of risks, issues and performance

The service did not use systems to manage performance effectively. They did not identify and escalate relevant risks and issues and identify actions to reduce their impact.

The provider's business manager had signed a contract with a county council, but the manager was unaware of this. The management were not clear about the information in the contract and did not demonstrate they had read and understood the contents of the contract. For example, the contract stated that the service must maintain records for each patient. The service was not aware the contract said this and were not keeping records of the patient's care for these journeys.

There were no set key performance indicators for the collection of patients and no systems and processes in place to monitor these. Therefore, areas of good practice and those for improvement were not identified.

The provider conducted infection prevention and control audits. However, there were no other audits to monitor the quality of the service provided and therefore, were unaware of where improvements could be made.

The registered manager and clinical director could not identify the top risks for the service and the only risk identified was surviving in the current market.

On further discussion with the registered manager we were told things such as business continuity, complaints, moving and handling and data protection were risks. However, these were not reflected on the risk register. On review we saw the risk register was a folder of risk assessments. These were reviewed monthly and were lists of all potential risks and not identified risks for the service. In addition, there was no actions documented to show how the service was mitigating risks and no evidence this was discussed at a senior level.

The provider had a business continuity policy to aid in planning for unforeseeable risks, such as adverse weather conditions.

Information management

The service did not collect data on any of their activity and therefore could not analyse it to improve the service.

Patient bookings were taken and booking forms were photographed and sent to staff over a social media application. The registered managed told us staff then deleted these pictures. We reviewed the data protection policy and saw no information about this process within the document. The service was not monitoring whether photographs of booking forms were deleted following use.

The journey booking forms we saw during this inspection did not always include information about the booking that would demonstrate the request for the journey had been risk assessed and that there was evidence the service could meet the patient's needs. In addition, the service was not keeping records of patient care given during transport. However, the service's contract with a county council stated the service should be keeping records of care for all journeys undertaken for them.

All directors had a current human resources file which included an application form but no evidence of their interview. Each director had a current disclosure and barring services (DBS) check certificate in their file. Initially this was for adults only but in November 2018, they had all applied for adult and children. However, we found that in two of the files, the service was keeping the original copy of the certificate which they should not be doing.

Public and staff engagement

There was limited engagement with patients.

There was no formal documented engagement with staff and patients. Patients were asked to complete reviews on a popular search engine. However, there was no patient feedback form or evidence of service user engagement to develop services.

We were provided with minutes from staff meetings. We reviewed meeting minutes from September 2019. There was no formal agenda in place and the minutes were brief paragraphs about what was discussed. The meeting touched upon operational matters such as reminding staff

to request patient views and cleaning vehicles. There was no evidence that feedback was used to develop the service and we did not see any action plans in place as a result of the meeting.

Innovation, improvement and sustainability

There was limited evidence of improving services by learning from when things went well or wrong, promoting training and innovation.

There was no evidence that the provider used audit results to make improvements to the quality of the service.

The service sent a text message to patients and/or relatives with live tracking information, so they could track the ambulance on an online map.

The service provider told us they would like to develop the live tracking further. The registered manager said they would like to develop software whereby services could see where vehicles were to aid them booking vehicles.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to safeguarding, incident recording and reporting, and the governance of the service.
- The provider must ensure all staff are trained to the appropriate level for children and adult safeguarding.
- The provider must update the safeguarding policy to reflect current national guidance.
- The provider must ensure staff are suitably trained in the use of equipment.
- The provider must ensure there is a harness available for children and young people who use the service in both vehicles. Staff should be trained on the use of this harness.
- The provider must ensure there is an eligibility criteria for the service and patients are suitability risk assessed before being accepted for patient transport.
- The provider must have effective systems and process for staff to follow in the event of a patient's health deteriorating.
- The provider must ensure care records are clear and fully completed and audited to demonstrate compliance.
- The provider must maintain written booking forms or records which includes information about patients' requirements and needs.
- The provider must not administer oxygen whilst they are not registered for this regulated activity.
- The provider must ensure policies reflect the service provided.
- The provider must ensure risks to the service are documented with risk reviews and mitigating actions.
- The provider must formally record incidents and ensure lessons learnt are shared with staff.
- The provider must ensure there is a comprehensive audit programme.

Action the provider SHOULD take to improve

- The provider should have a documented strategy, vision and values for the service. Staff should be involved in the development of these documents.
- The provider should remove information from their website that does not accurately reflect the service they are registered to provide.
- The provider should record, collate and analyse all journey data.
- The provider should take action to make the booking form is fit for the purpose for the service.
- The provider should not store original copies of Disclosure and Barring Services in staff files
- The provider should provide information on vehicles for patients on how to make a complaint.
- The provider should not advertise work that is outside of the patient transport services scope of practice. Such as high dependency and blue light vehicles.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	S31 Urgent suspension of a regulated activity