MediPatrol Ltd

MediPatrol Ltd

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	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

We inspected safe and well led domains for MediPatrol Ltd. but did not rate them at this inspection. We are taking regulatory action in response to the concerns we have described and this is ongoing at the time of publication.

- There were no reliable systems to ensure staff were trained adequately for their roles to keep patients safe. There was no assurance that staff had training in key skills, understood how to protect patients from abuse or manage safety well. The service did not always control infection risks well. Staff assessed risks to patients, but the provider was not able to assure us that staff were adequately trained to be able to safely monitor patient conditions. There were no records kept by the service of patient monitoring or their conditions. Medicines were not securely and safely stored nor were expiry dates checked and acted upon. There was no embedded system for staff to identify, report, receive feedback or share learning about incidents and concerns. Safety was not a sufficient priority. Managers did not ensure actions from patient safety alerts were known, implemented and monitored.

- Leaders of the service showed a limited understanding of the safety and business priorities and how to manage them well. There had been major disagreements between directors, which caused a disconnected and dysfunctional leadership team. There were no reliable and consistent systems which provided oversight of safety and quality of care delivered. Systems that were in place had been stopped and not all staff and leaders had access to them. This had led to disruption for the maintenance of electronic records. Leaders were not clear about their legal limitations of providing care and what regulated activities they should be registered with the Care Quality Commission (CQC) to provide. Leaders tried to support staff but found it challenging and opportunities for staff development were limited. Staff were allocated roles but not always provided with opportunities to access specific training to support these roles. Leaders and staff wanted to provide a safe service and wanted to put the patient at the centre of their service planning. However, they were not clear on how they would achieve this. There was no consistent, embedded system for gathering and reviewing feedback, incident reports or risks. This had the impact of limiting opportunities for learning and improvement. There were processes for gathering patient views but there was no documentation of how these were discussed or actioned. Staff support systems were inconsistent and guidance for staff depended upon who they contacted within the senior leadership team.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inspected but not rated	This was a focused inspection and had not previously been inspected or rated.This was the first inspection of this service since it was first registered to provide the regulated activity in April 2020. It is an independent ambulance service based in Cinderford, Gloucestershire. The service primarily serves the communities of Gloucestershire when they need to be transported between the two acute hospital sites in the county. It also provides a service at independent events nationally.

Summary of findings

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Summary of this inspection

Background to MediPatrol Ltd

We did not rate the services of MediPatrol Ltd. In order to rate a service, we need to inspect at least three domains. We inspected the two domains of Safe and Well Led at this inspection.

MediPatrol Ltd is operated by MediPatrol Ltd. The service opened in April 2020. It is an independent ambulance service based in Cinderford, Gloucestershire. The service primarily serves the communities of Gloucestershire when they need to be transported between the two acute hospital sites in the county. It also provides a service at independent events nationally. The CQC do not have powers to regulate independent events and this element will not be included in our inspection activity.

The regulated activity performed by the service is for Transport services, triage and medical advice provided remotely.

The service has had a registered manager in post since 17 April 2020 but who had recently resigned from their role. At the time of the inspection, the service had no registered manager.

This was the first inspection of this service since it was first registered to provide the regulated activity in April 2020.

We received information which gave us concern about the safety and quality of the service provided. Our subsequent contact with the provider and requests for information did not provide assurance they were providing a safe service. We therefore, suspended the registration of the service for a period of 28 days from the 30 October 2020 and carried out an unannounced inspection at our earliest opportunity, on 11 November 2020. The service had 24 hours' notice of our visit to ensure staff would be available to give us access to the site.

How we carried out this inspection

The team that inspected the service comprised of a CQC inspection manager, two other CQC inspectors and a specialist advisor with expertise in ambulance services.

During the inspection we visited MediPatrol base at Cinderford. We spoke with 13 staff including the executive leadership team, paramedics and other ambulance care staff.

We reviewed documents and records kept by the service.

You can find 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

The service Must:
Use systems to ensure all staff have attended and are up to date with mandatory training and key skills for their roles, including life support.

(*Regulation 12 Safe care and treatment).*

Summary of this inspection

Develop and use systems to ensure the safe prescribing, administration, recording and storage of medicines. Take actions to ensure medicines are stored securely, at the correct temperature and cannot be used if they are beyond their expiry date. Ensure medicines are accessed by staff who have the correct level of training. Ensure there is a process of audit for all medicines including oxygen.

Provide methods for staff to accurately record patient care provided and maintain records security including assessing and responding to individual patient risks.

(*Regulation 12 safe Care and treatment*.)

Ensure staff have attended training modules for adults and children's safeguarding at the recommended level and that the lead for safeguarding has achieved level 4 safeguarding training.

(Regulation 13 Safeguarding.)

Ensure the design maintenance and use of facilities, premises vehicles and equipment keep people safe Including storage of substances that are hazardous to health.

(Regulation 15 Premises and equipment.)

Ensure leaders operate effective governance processes throughout the service to provide assurance the service is safe. Ensure staff are clear about their roles and accountabilities and have regular opportunities to meet, discuss and learn from performance of the service.

Ensure leaders use systems to identify, escalate, review and manage risks to reduce their impact. Create reliable systems for the thorough investigations when incidents occur or things go wrong. Educate staff regarding what and how to report and that action plans to prevent a recurrence are created, monitored and reviewed.

(regulation 17 Good Governance)

Ensure safe recruitment processes are followed to ensure all staff and directors are assessed for their suitability for their roles. This should include fit and proper persons requirements.

(regulation 19 fit and proper persons)

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

The Service Should:

Use a system to demonstrate the relevant number of appropriately trained staff are planned according to the needs of the service.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inspected but not rated

Patient transport services

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Patient transport services safe?

Inspected but not rated

We inspected but did not rate safe at this inspection.

The service provided only limited mandatory training in key skills and did not make sure all staff completed it. Managers were not able to provide assurance that staff were up to date with training and did not have an awareness of when further training or update training was required. The service had a training policy but this did not identify the training needs of each staff group. We looked at three staff records, none of which identified what mandatory training had been completed. On two records there were stickers on the front of the files stating no training had been completed. The service could not provide evidence of the number of staff who had completed mandatory training for all subjects and staff groups, although provided evidence that of the 34 crew, 23 had not completed the e-learning.

The members of staff we spoke with told us they had received their mandatory training at other organisations they worked for, and this had been accepted by MediPatrol when they started work for them. They had not been requested to provide evidence of this training.

There was no evidence of staff having received training on how to support people with mental health conditions, learning disabilities, autism or dementia.

The service also could not provide evidence of which members of staff had ambulance blue light training.

Staff understood how to protect patients from abuse but the service could not provide evidence staff had the right training. Staff we spoke with understood the different forms of abuse and could recognise the potential signs of abuse. They explained how they would report safeguarding concerns and where to seek additional advice when necessary. Staff were confident in recognising a safeguarding concern and the action they would take to ensure the patient's safety and told us the service had provided a safeguarding telephone number to call if needed. However, the service could not provide evidence staff had attended the appropriate level of safeguarding training.

The service's nominated safeguarding lead did not have level 4 training in safeguarding children and there was no other person in the service with this level of training. Roles and competencies for child safeguarding training are outlined in 'Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document Third edition: March 2014, which states that in the case of independent ambulance providers, there should be a minimum of one level 4, a named professional. Although the senior managers told us they did not transport children, its safeguarding policy stated staff should be able to recognise when abuse may be happening and fulfil their responsibilities in relation to safeguarding children.

The service also provided us with a spreadsheet of staff employed by the service, which included 34 ambulance crew. This showed that eight staff did not have a current Disclosure and Barring Service (DBS) number recorded, despite being

recorded as 'active' crew. The medical director, who had resigned in October 2020, had also not had a DBS check carried out by MediPatrol Ltd. The CQC expects providers to undertake safety checks at the appropriate level for staff and volunteers who are eligible for them. Providers should risk assess different roles and look at their responsibilities and activities to determine if staff are eligible for a DBS check and to what level.

We reviewed three safeguarding referrals made by the service. The information recorded on the 'learning from safeguarding' forms did identify specific actions required or learning outcomes for staff. It did not identify timescales and who had responsibility for actions.

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. The service kept some equipment, vehicles and premises visibly clean. At the time of the inspection the service told us they were using four ambulances to provide patient transport services. We looked at all four ambulances. Overall, the ambulances were clean on the outside but the inside required greater attention to detail, for example a used face mask and rotten apple was found inside one vehicle. We saw daily logs completed by staff when they returned vehicles at the end of each shift. The service had employed a person to clean the vehicles at the end of each shift and staff spoke positively about this. However, it was not clear whether actions had been taken to rectify cleaning faults identified by the crew. There was no oversight of when vehicles were cleaned or when it was next due.

We were advised by managers that each vehicle was deep cleaned every six weeks, but they could not provide us with evidence this had occurred or provide a timetable to show when the vehicles were next due to be deep cleaned.

Staff told us they were provided with uniforms and personal protective equipment (PPE) to help prevent and protect people from a healthcare-associated infection. They told us they were provided with masks, gloves, aprons and hand gel. Staff had easy access to PPE and we saw vehicles were stocked with hand sanitiser, gloves, hard surface wipes, and labelled pump bottles of bacterial cleaner. Staff could describe how and when they would use this equipment and understood the importance of handwashing over the sole use of anti-bacterial gel. We saw that ample stocks of cleaning materials were safely stored at the ambulance base. However, we noted the service's PPE policy had not been updated with guidance relating to Covid-19, and there was no Covid-19 policy to outline the extra preventative steps staff should take. For example, the policy stated PPE was not required when taking patient observations including blood pressure, pulse and temperature. We saw no guidance to staff on how to safely use PPE.

Clinical waste was securely managed. Waste was managed to ensure it was appropriately segregated, stored and disposed. An approved waste management company collected clinical waste regularly.

The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people safe. Control of substances hazardous to health (COSHH) equipment was not safely secured when it was stored within the building. Some substances were left outside of a storage cage and we saw the cage was not locked. Hazardous substances should be stored in appropriate spill-proof containers and not allowed to come into contact with each other if there is a risk of a dangerous chemical reaction occurring between them. The service could not provide us with evidence of oversight of maintenance equipment and schedules.

We looked at the four ambulances on site. On one we found the side step was not working to help patients get into and out of the vehicle. On another we noted the roof was leaking and had damaged some packaging of medical supplies held on the vehicle. On another vehicle we found the footwell was covered in grass and dirt and had not been cleaned since its last use.

Patient transport services

Vehicle check sheets were not consistently completed. The policy of the service expected them to be completed daily and signed by both vehicle crew members. We reviewed the vehicle daily check sheets for July 2020. We saw 'start of shift checks' were completed; 'during shift checks' were not completed; and on 'end of shift checks' restock and cleaning record not completed on the majority of occasions. Staff had identified issues such as: 'stretcher faulty lock', 'ramp not working', 'winch control holder snapped – reported to management'. We found staff had documented one of the vehicles had a faulty air suspension but no action had been taken to remedy the fault over a six-day period.

'Start of shift checks' included checking the tyres of each vehicle, which was confirmed by staff we spoke with. However, we found during the inspection that one of the ambulances had two illegal front tyres, as the tread was below the legal standard. We informed the provider at the time of our inspection and leaders booked the vehicle in for replacement tyres to be fitted.

We saw all vehicles used for patient transport services had current MOTs, were taxed and regularly serviced, and were properly insured at the time of the inspection.

We saw keys to vehicles were securely stored. They were kept in a locked metal cabinet. The key to the cabinet was stored in a combination lock key safe secured to an external wall.

Risks to people who used services were assessed, but their safety was not always responded to as required. Managers could not provide assurance to us that all staff working on the ambulances were trained in basic first aid and basic life support. This training is designed to give staff initial skills to notice if a patient was deteriorating and how to respond including calling for emergency support.

Staff did not always follow the escalation procedure when a patient's condition deteriorated. We spoke to the director of operations who was the only clinical leader within MediPatrol. In the event of a patient's condition deteriorating during a patient journey the director of operations confirmed staff knew they should pull over and call 999. However, they gave an example of a patient who developed chest pains and was taken on blue lights to hospital alerting the hospital on route.

Managers told us staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times. However, they were not able to provide any evidence of work schedules to show how actual staffing levels matched with planned levels. All ambulance staff were on zero-hour contracts.

Staff did not keep detailed records of patients' care and treatment. The service could not provide any records for us to view. We did find details of patient journeys, including patient names, written on the back of vehicle check forms. The service had a patient documentation policy which stated its 'legal and moral duty to ensure that appropriate patient record forms are completed for all patient it assesses and treats'. This also outlined an annual clinical, audit programme to measure documentation standards and quality of care. The service was unable to produce results of records audits.

The service did not use systems and processes to safely prescribe, administer, record and store medicines. The service did not store medicines safely. Some medicines were stored in a fridge outside the safe storage temperature (between two and eight degrees). In the preceding 10 days the temperature of the fridge was between 0.1 and 0.6 degrees and had been checked every day by one of the directors. The fridge was not locked. The service's management

of medicines policy stated the fridge should be locked and if the temperature of the fridge was outside of the safe storage temperature advice should have been sought straight away and advice sought regarding the continuing suitability of the stock. At the time of the inspection the directors we spoke with were not aware the fridge temperature was outside of the safe limits.

We found some medicines stored in a locked cupboard (but the key was kept in the lock) which were out of date. Out of date medicines were kept and used for training purposes but the active ingredient was not removed therefore there is a risk that a medicines error could occur by taking an out of date medicine believing it to be in date. Medicine labels were not seen in the medicines cupboard, medicines bags or ambulances. Medicines labels are required to ensure the right medicine does to the right patient at the right dose as required in the Medicines Healthcare Regulatory Authority (MHRA) guidance.

There were small medicines bags labelled as 'Tech drugs bag', prepared for crews to take out on patient journeys. Ambulance technician and those trained to a higher level, such as in First Response in Emergency Care 3 (FREC 3), took these bags for patient journeys. The bags we reviewed were sealed with the earliest expiry date being visible from the outside of the bag. Two of the bags were opened and we reviewed the contents. There was a wide range of medicines and all medicines were in date. However, the director of operations could not justify why the 'Tech drugs bag' held such a wide range of medicines. They were not able to confirm that staff employed as ambulance technicians would have received adequate information, training, instruction or supervision in the correct use of all of the medicines held in the 'Tech drugs bag'.

The room in which the medicines were stored was not properly secured because there was a space where the wall did not meet the ceiling which could have given unauthorised persons access to the medicines.

We found oxygen cylinders from two different suppliers which had no clear audit trail. This was not in line with regulations for safe medicines management. MediPatrol only had a contract for one supplier of oxygen. Should a safety notification be issued from the other supplier, MediPatrol staff would not be made aware as the contract for these cylinders is not with MediPatrol. The oxygen cylinders were stored with varying cylinder contents, for example empty and full were stored together. This increased the risk of staff mistakenly selecting an empty cylinder rather than a full cylinder which would provide sub-optimal patient care. Many cylinders were not stored securely and would constitute a missile and an explosion risk in the event of a collision. Staff we spoke with were not aware of the correct opening and closing process of cylinders based on the manufacture's instruction in respect of pressure risks and subsequent fire risks.

The service had a management of medicines policy which had last been reviewed in May 2020 and been approved by the medical director employed at that time. The policy stated that an audit of stock medicines held by the service will be carried out 'often'. However, the service could not provide evidence that audits had taken place.

We spoke to the medical director as part of the inspection. They had been in post for approximately one year before resigning from the post in October 2020. During their time in post they had not visited the premises where the medicines were stored or carried out any medicines audits in the preceding 12 months. They had not been asked for, or given any medical advice during that time.

The service did not manage patient safety incidents well. There was no embedded system for staff to recognise what incidents to report and we were not assured that all incidents were being reported or acted upon. There was little

evidence of learning from events or action taken to improve safety. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient and of poor quality. There was poorly documented evidence of identified actions and of shared learning. We were told this was done using a telephone messaging app service.

We reviewed the evidence logs and saw a number of incidents were closed without being fully investigated. We saw directors sometimes disagreed over outcomes and actions. We noted one concern had been closed but the investigation was still ongoing. Some actions were to remind staff about following MediPatrol procedures. However, the service could not provide assurance that all staff had reread and understood procedures.

We noted that ambulance staff reported daily on check sheets to the service. The check sheets were to note any concerns they had about vehicles and equipment needed. Missing equipment was noted as including no clinical waste bags or masks on vehicles, missing sharps bin, damaged door hinges. None of these issues had been recorded as incidents so they could be reviewed by managers and executive leads. Staff we spoke with did not recognise what to report as incidents.

Safety was not a sufficient priority. Managers did not ensure actions from patient safety alerts were implemented and monitored. There was limited measurement and monitoring of safety performance. The service did not receive or comply with patient safety alerts. No staff members we spoke with were aware of the recent safety alert in relation to adiabatic pressure and the explosion of an oxygen cylinder and there was no attempt to seek out safety alerts.

Are Patient transport services well-led?

Inspected but not rated

We inspected but did not rate well led at this inspection.

Leaders did not demonstrate they had the skills and abilities to run the service. The executive leadership team could not demonstrate they had appropriate management experience and skills. Where leadership skills were not evident, they had not used support from external specialist providers such as human resources. A person had been appointed to support the leadership team who had experience related to human resources but to a limited level. Following this appointment changes had been made to the leadership structure but not all directors had accepted the new structure. There was very limited clinical input to support the leadership team. The executive team had no clinical experience. The medical director and the CQC registered manager had recently resigned from their roles and there were no replacements recruited at the time of our inspection. One of the directors who had clinical experience, advised on policies and protocols and provided specific clinical all staff. However, there was no contingency if they were not available for any reason.

Leaders did not show an understanding of the priorities and issues the service faced or how to manage them. Executive leads articulated a limited understanding of what the priorities of the service were in order to be assured they were providing a safe service. There was no system to provide oversight of the service, identify and monitor risks, investigate complaints and identify and share learning. Major risks to the service were not documented on the risk register and could not be articulated by executive leads when we asked them.

Inspected but not rated

Patient transport services

Leaders of the service did not have full understanding of their responsibilities as to the CQC regulations or compliance. The CQC registered manager had recently resigned due to feeling overwhelmed by recent events in the service. There were no plans to remedy this situation.

Some leaders were visible for staff. Some of the executive team also worked shifts on the patient transport alongside other colleagues and met with teams each morning before they left for the hospital location.

Leaders tried to support their staff to develop their skills. However, we were not provided with any evidence that all staff who were assessing competencies were adequately qualified and experienced to do so. Leaders supported staff to attend training for their roles such as First Response Emergency Care (FREC) skills at different levels. We saw evidence that staff had undertaken training in FREC skills and a few months later, signing that other staff were competent in the same skills. We saw no evidence that staff assessing skills had undertaken additional education or assessing courses. Staff were allocated roles but not provided with additional training to support their roles. Staff investigated incidents but had not received support or training dedicated to this activity. Investigation reports we reviewed were of poor quality.

The service had a vision that it wanted to provide safe care for patients. However, they did not have a strategy to turn it into action. There were allegations of hostile takeovers from directors and offers to buy the other out but no agreed actions for progressing the business. One director had control of electronic systems and blocked director colleagues from accessing these. Reasons given for blocking access were that invoices had not been paid. The impact was that staff and directors could not access electronic records or email systems and had to set up new systems.

The vision was not focused on sustainability of services or aligned to local plans within the wider health economy and there was no defined strategy. Leaders and staff did not articulate an understanding of how to apply a strategy or monitor its progress. There was a lack of long term financial planning to ensure the provider could sustain the service. The service had one main contract, which had recently been suspended and there was no contingency plan to create further cash flow or income. Covid 19 had provided an opportunity for the service to expand from events work to provide transport for patients in receipt of NHS care. The service had responded to this need but there was no clear plan on how the service would progress. Financial challenges threatened the sustainability of the service. Bank accounts and other assets had been frozen and the directors we spoke with could not access these funds to pay creditors or receive payment for services already undertaken. Reasons given were that one director had control of the account and had blocked access. Some substantive staff had not been paid for a number of weeks. Directors told us they intended to use their own funds but recognised this was a short term solution and had not been actioned at the time. Lack of payment had resulted in staff resigning their positions or finding employment elsewhere.

Staff we spoke with did not all feel respected, supported or valued by all leads and managers. We heard of suggestions for improvements staff had made but these had not been accepted or acted upon by their managers at the time. Some staff told us how they had been supported and witnessed other staff being supported by managers and leads of the service. They also told us how they were being told different stories on a daily basis about leadership disagreements and were not certain planned work or training would go ahead. There was a culture of taking sides and staff aligning themselves to their director of choice. Directors and staff told us of disrespectful exchanges between directors. Directors felt their director colleagues did not have the best interests of the service at the heart of their actions. They all told us safe patient care was their priority. However, they could not agree on how best to do this. Directors were in legal exchanges with each other.

Inspected but not rated

Patient transport services

There were no opportunities for career development. This was a small service with very few substantive staff. The majority of staff were self-employed and paid for each session of work they completed. These staff were offering to support other ambulance services because there was not enough work being offered with MediPatrol. The personnel files we reviewed held no appraisal paperwork and staff told us they had not received an appraisal. Development was centred on the FREC training staff could attend, which was delivered by an external trainer at the provider's premises. Further development opportunities were not identified in personnel files.

The service did not evidence it promoted equality and diversity in daily work. The leadership team could not agree on who should be leading the service and the consequence was not all people were treated with equal respect. We saw complaints and allegations from senior staff about how their information had been handled and that their individual choices had not been respected. Staff who had protected characteristics under the equality act 2010 expressed how they had felt discriminated against by how their complaints had been handled.

The service did not have an open culture where staff could raise concerns without fear. There was no system to support staff with raising concerns and feeling they would be supported. Directors told us of bullying between the leadership team and of whistleblowing procedures not being properly followed. Some directors made allegations of being pushed out of the company and others of being obstructed from undertaking their role. Some staff told us of occasions they had given improvement ideas to the leadership team and actions had been taken. However, this had been three years previously.

Patients and their families could raise concerns using feedback forms in the vehicles or through the NHS trust who commissioned the transport service. The policy stated patient feedback forms should be in each vehicle but we saw no feedback forms from patients having been presented or discussed at board meetings. One complaint was mentioned at the September board meeting but no details could be discussed at that time. This was also not followed up at the October board meeting.

Leaders did not operate effective governance processes, throughout the service or with partner organisations. There were no reliable systems of oversight to monitor if staff were following policies to keep people safe. Policies were in place but staff had recognised they were not fit for purpose and were being rewritten. We found examples where this had impacted upon safety. A daily check sheet was completed by staff to note any defects with the vehicles. However, there was no system to confirm staff were completing the checks accurately or that it was consistently acted upon. This was apparent when we found a vehicle, which was in service, and had two tyres with tread below the legal limit. We found records where DBS checks had not been completed before staff transported patients. The medicines fridge was monitored daily but no actions had been documented when it was found to be outside of safe temperature limits. Medicines which were out of date were still available for staff to use. There was no evidence that the executive team were aware of these issues.

Meetings were held monthly with the local NHS trust to monitor the service. The feedback had been mainly positive concerning the timeliness and responsiveness of the service. However, there was no monitoring of the level of care provided for these patients and whether this was within agreed contractual limits.

Monitoring of staff working hours within the service was undertaken by the operations director. However, staff chose the shifts they wanted to fill and there was no formal process of monitoring that staff declare their working hours with other providers. This could have led to staff working excessive hours and adversely impact on care they provided.

Leads of the service had relied upon individuals to perform tasks such as setting up data collection systems, communication systems and clinical activities. However, there was no evidence that the activities were reported to the

board of directors. Access to electronic systems was not shared with all of the directors and leadership team and had resulted in individuals preventing the current executive team access data, emails and bank accounts. Some directors had felt kept in the dark and uninformed. There was no evidence training data had been discussed or scrutinised at executive level. The data we saw did not provide detail of modules attended. Staff told us this overview sheet was being redesigned to provide better information. However, the directors we spoke with had their access blocked from this system at the time of our visit. They were working on ways to gain access but this had been unsuccessful at the time. There was no other form of oversight of systems including training, induction and appraisal compliance.

Staff were not all clear about their roles and accountabilities and the provider was providing regulated activities which they were not registered to deliver. Leaders did not understand their responsibilities under providing regulated activities legislation. Staff were providing care to patients which met the regulated activity of treatment of disease disorder of injury but they were not registered with the CQC to provide this activity. Directors had accepted patient transport contracts which may require them to monitor a patient's condition. A number of staff told us that patient monitoring had been undertaken by staff during journeys between hospital sites and were not aware this was not part of the agreed contract between providers.

Opportunities to meet, discuss and learn from the performance of the service were limited and **there was no reliable system to provide the executive board with clear oversight of risks to the service or patients**. The service held a risk register but this had not documented the main risks for the service. A new system of board meetings had been instigated to provide oversight and two meetings had been held. The minutes from these meetings had no standing agenda items. There was no documentation of oversight discussions, what the risks were, how the service was performing and what they needed to improve upon. There was no clear system for risks to be escalated for senior review. We saw some risks had been assessed but not entered on to the risk register. The risk register we reviewed contained risks which were undated, were not allocated an owner. One was allocated to the HR department, which the service does not have. COVID 19 had been assessed as a risk but was not included on the risk register. No mitigating actions were documented. There was no formal audit structure. There was no programme of audits to measure quality of the service. Audits took place on an adhoc basis and were generally not documented to identify areas for improvement.

There were no systems of assurance for the executive board that staff were providing patient care in a safe way. Senior staff could not provide us with a copy of the contract for the service they had agreed to provide for the local NHS trust and were not clear about the details of the contract. The local NHS trust provided us with this information. Staff told us that during a routine patient transfer, senior staff advised the use blue lights but to stay within legal driving regulations. This was due to a patient's deteriorating condition during the journey. Patient observations had been requested to be completed and the staff member driving the vehicle was untrained in blue light driving. The advice provided did not follow the terms of their contract, which stated they should have stopped and called the emergency services. This had been investigated by one director but no sharing or learning from the incident had been documented as having taken place.

The service did not collect reliable data or analyse it. Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Audit data was not collated in a meaningful way to provide information on performance. There were no identified audit outcomes to provide improvements opportunities and no evidence audits were discussed at executive level. Before the inspection we saw some data on training compliance but it did not identify the level of staff compliance and actions they needed to take. At the time of our inspection this information, as well as other electronic data bases, was no longer accessible by the service leads we spoke with. They told us this was due to another director having blocked their access. Training details were available in the individual personnel files and showed not all staff were up to date with required training.

Inspected but not rated

Patient transport services

The information systems were not integrated or secure to the service. Systems had been set up to be dedicated to the service but these were controlled by one person. This meant that during a dispute, one person could take control of the system and deny access to others in the service. There was no fail safe because the same person was able to deny access to back up systems also. Data or notifications were submitted to the CQC when requested.

Leaders and staff tried to engage with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. Leaders engaged with staff using dedicated social media applications. This electronic platform was used to share information and developments within the service. Some staff lived in areas of the country hundreds of miles away and could not always meet in person. A director met with vehicle crews each day before shifts started. There was also liaison using radios during a shift which managers used to identify if there were any issues. There was no documented evidence that staff views were actively sought. Patient feedback forms were placed in vehicles but we did not see any completed forms. Directors met with the commissioner of their service each month to identify if there were any areas for improvement.

There was little demonstration of how learning was encouraged to improve services. Managers had little understanding of quality improvement methods. Staff were able to put ideas into place but there was no demonstration of innovation and participation in research. The lack of audit processes governance procedures and responses to complaints and incidents led to limited opportunities to share learning. Investigation reports were poorly written with limited learning identified. Some staff told us of having tried to make improvements but being hampered in progress or not listened to. Other staff told us they had made changes but there was no use of a standardised improvement tool to support a project. Changes were made to forms or data collection systems but there was no monitoring of progress, checking of quality and accuracy or supportive training attended. Improvements were acted upon by an individual rather than as a team and there was no forma executive review process.

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 There were no embedded systems to ensure staff were up to date with Mandatory training and key skills for their roles, including basic life support. There were no systems which ensured the safe prescribing, administration, recording and storage of medicines. Medicines were not stored securely because there was a gap between the wall and ceiling big enough for a person to crawl through and the medicines fridge was not locked. The fridge had been found to be outside of its recommended temperature range and no actions had been documented that medicines kept in the fridge had been disposed of or replaced. Medicines beyond their recommended use by date were available for staff to use because they had not been disposed of. Service leads were not able to confirm that staff employed as ambulance technicians and who used 'tech drugs bags' would have received adequate information, training, instruction or supervision in the correct use of all of the medicines held in the 'Tech drugs bag'. There was no audit process documented that assured all medicines were used and stored safely including oxygen cylinders. There were no methods for staff to accurately record patient care which had been provided by staff including assessing and responding to individual patient risks.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Enforcement actions

Safe recruitment processes were not always followed. Staff and Directors were not all documented as having been fully assessed for their roles. There was no assurance in personnel files that executive leads had appropriate management skills for their allocated roles and no evidence of plans for additional training. Some Directors had been working for the service before a DBS check had been completed. In other personnel records there was minimal employment history, unsigned and undated application forms and references not followed up with previous employers.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were no effective governance processes to provide assurance the service was being provided safely. Staff were not all clear about their roles and accountabilities. Staff were not clear about the limits of the regulated activities they were registered to provide and often provided care outside of the regulated activities. There were no regular opportunities for staff to meet, discuss and learn from performance of the service. There were no systems used for staff to consistently identify, escalate, review and manage risks to reduce their impact. There was no oversight of the service to assess, monitor and improve the quality and safety of the service provided. Audits were ad hoc, not collated and not regularly reviewed at executive board meetings.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The design, maintenance and use of facilities, premises, vehicles and equipment did not keep people safe.

This section is primarily information for the provider

Enforcement actions

Control of substances hazardous to health (COSHH) equipment was not safely secured when it was stored within the building. Some substances were left outside of a storage cage and we saw the cage was not locked.

Vehicles being used by the service had defects which needed attention. This included: steps for patient use to access the vehicle, a leaking roof which had resulted in damage to medical supplies in the vehicle, tyre tread of one vehicle were below the legal limit; cleaning had not been thoroughly carried out on all vehicles;

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service's nominated safeguarding lead did not have level 4 training in safeguarding children and there was no other person in the service with this level of training. Roles and competencies for child safeguarding training are outlined in 'Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document Third edition: March 2014, which states that in the case of independent ambulance providers, there should be a minimum of one level 4, a named professional. Senior managers told us they did not transport children. However, its safeguarding policy stated staff should be able to recognise when abuse may be happening and fulfil their responsibilities in relation to safeguarding children. There was no record that all staff had attended level 2 safeguarding children training, which would have supported staff with skills in recognising abuse in children. Not all staff had up to date Disclosure and Barring Service checks documented which would have searched for potential risks presented by newly recruited staff and updated risks presented by existing staff.