Rapid Response Secure Ambulance Limited

Quality Report

Badger House
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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?	
Are services responsive?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Rapid Response Secure Ambulance is operated by Rapid Response Personnel Limited. Rapid Response Secure Ambulance provide a patient transport service for mental health patients.

We inspected this service using our comprehensive inspection methodology. We carried out the short-notice announced inspection on 25 February 2020.

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

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

The main service provided by this service was patient transport services.

We rated this service as **Inadequate** overall.

- The recruitment processes for agency staff were not enough. The service did not have clear expectations of required mandatory training for agency staff and did not complete thorough checks to make sure the agency staff were up to date with mandatory training. We were not assured agency staff were appropriately trained to provide a safe service to children of all ages. The service did not take account of the specialist needs of patients with dementia when selecting agency staff. There was no documented induction for agency staff.
- There was no clear protocol for the use of mechanical restraint. We could not be assured the service only used mechanical restraint in a safe, proportionate and monitored way as part of a wider person-centred support plan. There were no clear protocols regarding use of restraint reduction plans and audits, no processes for ensuring appropriate staff training, no processes to monitor risk of harm to patients during use of mechanical restraints and no processes for effective record keeping around use of mechanical restraints.
- The service did not have systems to control infection risk well. Staff did not follow best practice to protect patients, themselves and others from infection. The vehicle was visibly dirty.
- The service did not ensure there were processes to make sure staff completed safety checks of the vehicle prior to each journey. The service did not ensure first aid equipment was checked or that loose items were secured in the vehicle. Equipment to manage clinical waste was not always available to agency staff.
- The service did not consistently document risk assessments. Records did not contain risk management plans for patient journeys. We were not assured staff removed or minimised risks. There was no formal document to define the eligibility or exclusion criteria for patients referred to the service.
- We were not assured the service provided care and treatment based on national guidance and evidence-based practice. Policies were not fit for purpose and contained information irrelevant to the scope of the service.
- We were not assured the individual needs of patients with dementia, autism or a learning disability were being recognised by the service. We were not assured that information about patient's specific needs gained during the bookings process was always communicated to agency staff prior to commencing the journey. There was no system or equipment available to meet the needs of patients with hearing impairment or speech difficulties. There was no written information available in the vehicle for patients. It was not easy for people to give feedback and raise concerns about care received. Complaints procedures were not accessible to patients.
- There was no governance structure to ensure there was oversight of quality, safety and performance. The service did not use systems to manage performance effectively. The manager was not clear about accountability for the

Summary of findings

service. The manager was unable to give assurance the information systems were secure. The manager did not have all the skills and abilities to run the service well. There was no documented vision or strategy for the service. Leaders and staff did not actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services.

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

Dr Nigel Acheson
Deputy Chief Inspector of Hospitals (London and South region), 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 	Rapid Response Secure Ambulance provide a patient transport service for mental health patients.

Summary of findings

Contents

Inadequate

Rapid Response Secure Ambulance Limited

Services we looked at
Patient transport services

Summary of this inspection

Background to Rapid Response Secure Ambulance Limited

Rapid Response Secure Ambulance is operated by Rapid Response Personnel Limited. The service opened in April 2018. It is an independent ambulance service based in Weston-Super-Mare, Somerset. The service primarily carries out journeys on behalf of private healthcare providers, within a three to four-hour radius of the office base.

The service has had a manager in post since April 2018. The registered manager was also the owner and manager of the company. Prior to opening the business, the manager had eight years of experience working as a mental health nurse. At the time of our inspection, the registered manager continued to work in this capacity. This person is referred to as 'the manager' in this report.

The service offers patient transport for patients with a severe and enduring mental illness. The service is offered to both adults and children. According to the patient records available at the time of our inspection, the service had completed 12 journeys since it opened, 11 of which were within the 12 months preceding our inspection, and one of which was for a patient below the age of 18 (the patient was 16 at the time of the journey). Of the journeys completed, one patient was subject to a community treatment order, two patients were under section two of the Mental Health Act, seven patients were under section three of the Mental Health Act and two patients were informal patients not under a section of the Mental Health Act.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two other CQC inspectors. One of these inspectors was a mental health inspector for the CQC. The inspection team was overseen by Amanda Williams, Interim Head of Hospital Inspection.

Information about Rapid Response Secure Ambulance Limited

The service is registered to provide the following regulated activities:

- Transport Services, triage and medical advice provided remotely
- Treatment of diseases, disorder or injury.

During the inspection, we visited the service headquarters based at Suite 5, Badger House, Oldmixon Crescent, Weston-Super-Mare. We spoke with the manager and three members of agency staff who regularly attended jobs for the service. We were unable to speak with patients or relatives. During our inspection, we reviewed 12 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC.

Activity (March 2019 to February 2020)

In the period March 2019 to February 2020 there were 11 patient transport journeys undertaken.

There were no staff employed by the service. The manager used agency staff to meet the staffing requirements of the service. The service did not hold any controlled drugs.

Track record on safety

- No never events
- No clinical incidents

Summary of this inspection

- No complaints

Inadequate

Patient transport services

Safe	Inadequate
Effective	Inadequate
Caring	
Responsive	Inadequate
Well-led	Inadequate

Information about the service

The only service provided by this ambulance service was patient transport services.

Are patient transport services safe?

Inadequate

We rated this service as **inadequate** for safe.

Mandatory training

The service did not provide mandatory training in key skills to all staff and did not make sure everyone completed it.

Agency staff did not receive effective training in all safety systems processes and practices. The service did not complete thorough checks to make sure the agency staff were up to date with mandatory training.

The manager's expectations of mandatory training were not clear and did not cover the scope of the service being provided. The manager stated he required agency staff to complete five areas of mandatory training: prevention and management of violence and aggression (PMVA), safeguarding training for adults and children to level three, patient moving and handling, fire safety awareness and infection prevention and control. These requirements were not specified in a policy. Mandatory training requirements did not include essential areas of knowledge and skills, for example, Mental Capacity Act 2005 (MCA), Mental Health Act 1983 (MHA), dementia, information governance, and first aid training.

The systems to monitor mandatory training compliance were not reliable. The manager did not make appropriate checks of training certificates to ensure agency staff complied with mandatory training expectations. The agency informed the manager of the training status of employees by sending an employee profile. However, the manager did not check the training certificates of the agency staff and was not aware of important details in relation to the scope of mandatory training provided. For example, the manager was not aware whether the Prevention and Management of Violence and Aggression training included teaching related to the needs of children and older adults. Following our inspection, we asked the manager to obtain evidence of the training completed by agency staff. The manager submitted the certificates of three of four agency staff used by the service plus the manager's own training certificates. We checked all of these and saw that mandatory training compliance was 100% for all five courses except safeguarding adults and children level one and two, which was 75%.

Agency staff did not receive a formal driving skills assessment when starting work for the service. The manager told us he accompanied new staff to check their skills when they first joined the team. There were no records of this process.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

There were arrangements to safeguard adults and children from abuse and neglect which reflected relevant legislation and local requirements. There was a process for reporting

safeguarding concerns to the local authority. Staff told us they would telephone the manager and then complete an incident form. The manager told us if something was serious, it would be reported to the police immediately.

Staff understood their responsibilities. There was a safeguarding policy. Staff were able to describe hypothetical situations where they would report a safeguarding concern. However, there was no system to demonstrate staff had read the safeguarding policy. There had been no safeguarding concerns raised by the service in the 12 months prior to our inspection.

Safeguarding training did not meet best practice guidelines. Agency staff received safeguarding training to level two for safeguarding adults and children. The service did not have a named safeguarding lead, as recommended in the intercollegiate guidelines for safeguarding children.

The manager had some assurance safe recruitment practices were used by the staffing agency. The manager received information from the agency regarding the recruitment checks completed for each agency staff member who joined the team. The documentation from the agency included confirmation of an up to date disclosure and barring service (DBS) check and confirmation the member of agency staff had no gaps in their employment history. However, of the three agency profiles reviewed, none stated whether the DBS check was enhanced to cover working with vulnerable adults and children.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff did not follow best practice to use equipment and control measures to protect patients, themselves and others from infection. Staff did not always keep the vehicle visibly clean.

Guidance for agency staff around infection prevention and control was not clear. There was no protocol or checklist for staff to refer to in the vehicle for guidance. There was no infection control lead for the service. The infection prevention and control policy was not specific to the service and it did not clearly identify the responsibilities of staff before, during and after journeys. The manager did not complete audits to check compliance with the infection prevention and control policy.

The vehicle we inspected was not cleaned and ready for use. The vehicle had not been cleaned since the previous journey four days before our inspection. There were dirty tissues and used cutlery in the passenger area and the carpet was visibly dirty. The manager told us he would normally complete the cleaning before the next journey. The manager did not complete any records of this process.

The procedures for maintaining the cleanliness of the vehicle were not in line with best practice. For example, on board the ambulance, agency staff and the manager used household cleaning materials to clean fabric seats and carpeted floors. The manager was unable to provide evidence the vehicle was regularly deep cleaned. The manager told us this occurred on a monthly basis at a local garage. There were no records of this process. The manager told us the vehicle was also deep cleaned at the garage if the seats or floor became contaminated. There were no records of this process.

We were not assured agency staff were always made aware of specific infection and hygiene risks associated with individual patients. The manager told us the expectation was that the provider would alert the ambulance service to any infection risks associated with the patient. However, the booking form did not include a prompt around infection control to remind people to include this information.

Personal protective equipment was provided on the vehicle. Gloves and aprons were available for staff. Hand cleaning facilities were readily available at the office base. Hand gel was available on the vehicle for staff to use during a journey.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people safe. Staff were not trained to use restraint equipment located in the vehicle. Staff did not always manage clinical waste well.

The service used one vehicle. This was an unmarked van with tinted windows to provide privacy to passengers. The vehicle was not adapted for patient use. The vehicle did not have a security screen to separate the passenger area

from the driver's compartment. The vehicle did not have capacity to accommodate a secure cell within the passenger area. There were seatbelts available for all passengers on board.

The vehicle was not checked prior to each journey to confirm it was safe for use. The service had a 30-item vehicle checklist document, which included checks of the steering, cab interior, wipers and tyres. The manager told us this process was completed by the person driving the vehicle. Only one vehicle check had been carried out since the service first opened.

There were no records of essential equipment checks being completed prior to every journey. There was no checklist or protocol for agency staff to follow to complete this task. The manager told us they undertook the checks, but these were not recorded.

Disposable items were not always within their expiry date. For example, a small first aid box was held on the ambulance, but the saline had expired in June 2019. We found some items of equipment were not well maintained. For example, the fire extinguisher was dented in several places and had expired in September 2018.

Inside the vehicle, agency staff could access equipment they were not trained or authorised to use. There were handcuffs in the glove compartment of the vehicle. There were no systems to check this equipment was safe to use.

The vehicle insurance, servicing and maintenance was up to date. The vehicle dashboard alerted the driver when a service was due. At the time of our inspection, the vehicle had a valid insurance, tax and Ministry of Transport (MOT) test certificate. The vehicle was serviced in March 2019 and had a routine check in July 2019. This was completed as part of an ongoing service package. We saw evidence that vehicle faults were repaired at the garage. The manager had valid breakdown insurance for the vehicle. During our inspection, the vehicle was stored in the car park outside the office. The vehicle keys were carried by the manager on his person. The car park was not locked.

The vehicle had an up to date satellite navigation system. This updated automatically via the internet. The manager could keep track of the vehicle when they were not present for the journey through a tracking application on their mobile telephone.

The vehicle carried only basic equipment. The vehicle did not carry any emergency equipment or any equipment for moving and handling apart from a portable step. At the time of our inspection, the service did not have any specialist equipment for children. For example, there were no car seats or booster seats in the vehicle. According to the manager and the patient records available at the time of inspection, the service had not transported any children who would require this equipment.

The manager did not have a system to secure loose items within the vehicle, for example the fire extinguisher was not secured. The manager stored equipment in storage boxes in the open hatchback compartment of the vehicle. These boxes were not secured to the vehicle so there was a small risk they could move in transit if the vehicle was to break harshly.

The manager told us there was a system for disposal of contaminated waste such as bodily fluids. There was an arrangement for a private company to collect this when required, which the manager could arrange on the same day. However, there were no records of this process and there were no clinical waste bags on the vehicle for the agency staff to access. There were no storage arrangements for the waste in the interim period.

Assessing and responding to patient risk

Staff did not complete and update risk assessments for each patient or remove or minimise risks. It was unclear if staff identified and quickly acted upon patients at risk of deterioration.

The safe conveyance policy stated that a detailed risk assessment and management plan must be completed for each patient. However, up to date information about individual patient risk was not usually documented. The manager asked referrers to complete an online referral form. This form requested referrers to notify the service of any risks related to the proposed patient journey. This included, for example, risk of absconding, aggression, self-harm, and suicide. The form asked referrers to give details of any triggers for these risks or behaviours. However, we checked the records of patient journeys and saw this form had been completed on one occasion out of 11 during the 12 months preceding our inspection. The other 10 referrals were received via email directly and only contained the patients' names, pick up and drop off points.

The manager told us referrers were sometimes reluctant to complete the form and, on these occasions, they obtained the relevant information via email correspondence. The manager told us that for all referrals, they telephoned the referrer to discuss the referral in more detail and to determine the risks and associated management plan. We checked the emails and the records of all the 12 journeys completed since the service opened (11 of which were in the 12 months preceding our inspection). Out of 12 patient records reviewed, only three contained mention of risk and only one contained a risk management plan, provided by the referrer. Of the three records that mentioned risk, none contained adequate levels of detail. For example, one patient had a risk of self-harm, but it was not detailed how high this level of risk was and what method of self-harm was used.

We spoke with three of the five agency staff used by the service. They told us they were given a copy of the booking form, which included a tick against certain risks if these were highlighted on the referral form. They told us the manager discussed pertinent risks in detail with them prior to setting off on the journey and they agreed a management plan. This information was not documented.

There was no assurance that agency staff would know how to monitor for risks and respond appropriately if they used handcuffs to restrain a patient during a journey. The procedure to check a patient for signs of harm when they are in handcuffs was not included in the restraint policy and procedure or the safe conveyance policy.

The escalation process for deteriorating or seriously ill patients was unclear. The team on the vehicle were not equipped to recognise when a patient's physical health was deteriorating or to provide emergency assistance. The medical emergency policy and procedure stated care workers would provide a higher level of observation for patients at risk of deterioration and respond to any non-emergency changes in condition by contacting the patients GP in a timely manner. The policy and procedure stated the registered manager was responsible for ensuring all staff had access to monitoring equipment. However, this equipment was not available. There was no equipment for taking patient observations.

The medical emergency policy and procedure contained extensive information that was not relevant to the service. There was no evidence to show agency staff had read this policy or that the policy was being followed.

The manager told us the service would not accept referrals for patients who were at risk of deterioration. If a patient became physically unwell during a journey, the agency staff told us they would telephone the manager to alert them to the risk and, if necessary, they would call 999 or drive the patient to an emergency department.

The team took account of the risks associated with being a driver or a passenger for long periods in the vehicle. If a journey was more than 2.5 hours the driver scheduled a stop. For high risk patients, agency staff told us they would plan to schedule a rest break at a police station where police could assist them to escort patients to use facilities. However, we saw no evidence that this was pre-arranged with the police in advance of journeys.

Staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave agency staff a limited, verbal induction.

There were no staff directly employed by the service. The manager contracted agency staff to support the service when they transported patients. The manager told us they tried to use the same five members of agency staff where possible for continuity. One of these staff had recently stopped working for the agency. In the event of the manager not being able to source agency staff, the journey would not go ahead.

We were not assured agency staff were appropriately trained or experienced to provide a safe service to children of all ages. There was no assurance agency staff working for the service had any experience in working with children or had completed training to understand the Gillick competence. Gillick competence is a term used to decide whether a child (under 16 years of age) can consent to his or her own medical treatment, without the need for parental permission or knowledge. The service had only transported one patient under the age of 18 since being in operation.

Agency staff were supported when the manager was not available. For most journeys, the manager was the driver of

the vehicle and was therefore present during the journey to support staff. When the manager was not present, agency staff told us they could contact the manager via their mobile telephone at any time.

Records

Staff did not keep detailed records of patients' care and treatment. Records were not always clear, up-to-date, or easily available to all staff providing care. There were no systems for recording restraint.

Records did not always contain a clear management plan for patients who presented with high risks, such as risk of self-harm, absconding, and suicide. Written records of patients' risks and management plans were not available for agency staff to refer to in the vehicle during the journey.

Records were not stored in line with best practice guidance. There was no record keeping policy and the retention policy for records was unclear. The process for the retention of patient records was not clear. The manager told us he kept patient journey records for two years. This applied to all patients regardless of their age. The records management policy required records to be kept for six years. The manager was not able to provide an explanation and rationale as to why they operated a different retention schedule to that recommended for NHS providers and different to their own company policy. Paper records were stored securely in a locked cabinet. Some patient information was stored in the manager's email inbox on a password protected computer.

Medicines

The service did not prescribe or stock medicines or medical gases.

The arrangements for the storage of a patient's medicine during transportation kept people safe. There was an up to date policy for managing patients own medicines. Medicines transported were received in a sealed bag and remained in the locked glove box in the front of the vehicle during the patient's journey. The vehicle included a cool box which could be used to keep medicine cool if the weather was warm. Agency staff passed on patients' medicines to staff at the receiving unit on their arrival.

There was a system for qualified agency staff to administer previously prescribed medicines during the journey. The medicines management policy included reference to this process. The manager told us medicine would be administered and then recorded on the journey form. However, there was no identified section for this information to be documented. We were unable to see evidence of how this system worked because there had been no requirement to administer medicines during the 12 months preceding our inspection.

Incidents

The service had a system to manage patient safety incidents. Staff knew how to recognise incidents and near misses and how to report them appropriately. There had been no incidents reported during the 12 months preceding our inspection.

There was a system for reporting incidents. There was a paper incident form which could also be completed electronically, and the manager was responsible for investigating incidents. Staff were aware of this system and could give examples of hypothetical situations that would be reported as incidents. There had been no incidents reported in the year prior to our inspection.

The manager showed a basic understanding of their responsibilities under the duty of candour with regards to keeping the patient and families informed in writing and the need to apologise. The manager was not aware of the more specific requirements of this legislation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

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

Inadequate

We rated this service as **inadequate** for effective.

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. There was no evidence to show that staff protected the rights of patients' subject to the Mental Health Act 1983.

Policies were not reflective of the scope of practice of the service and were very long documents which contained irrelevant information. The manager told us he downloaded policies from an online company and adapted these to meet the specific needs of the service. However, we noted policies included information which was not applicable to the service. For example, the infection control policy referred to the use of the sepsis management tool which was not required for use by this service, and the medicine policy referred to the storage of medical gases which were not used. The manager had written two policies: the safe conveyance policy and the safe transportation policy. The manager was unable to tell us which guidance he had checked to ensure these policies were in line with recommended best practice.

We were not assured the service provided care in line with legislation and best practice guidance. There was no clear protocol for the use of mechanical restraint, which meant we could not be assured the service only used restraint in a safe, proportionate and monitored way as part of a wider person-centred support plan.

The provider told us before the inspection they did not use mechanical restraints (handcuffs). The manager confirmed this during our inspection. However, there was evidence to suggest mechanical restraint could be used. The online booking form included a section asking if the referrer required the use of mechanical restraints (handcuffs) and the reason why handcuffs were being requested. We found a set of handcuffs stored in the glovebox of the vehicle.

During our inspection, the policy relating to the use of restraints was not available for us to view. Following our inspection, the manager provided us with a copy of the 'safe conveyance policy' and an updated 'Restraint Policy and Procedure'. The safe conveyance policy contained brief reference to the use of mechanical restraints. This included a requirement they will only be prescribed by the client requesting transport and only be used on an individually named patient basis in line with guidance given by the client. Only trained staff were permitted to use mechanical restraints and authorisation from the registered manager was always required prior to using restraints. The 'Restraint policy and Procedure' contained reference to various processes to minimise the potential risk relating to the use of restraint. For example, there was a flowchart to guide decision making. However, during our inspection we did not see evidence that either of these policies were known to staff and there was no evidence these processes were used by the manager or by agency staff.

All the agency staff we spoke with told us they had never used the handcuffs but knew they could use them in an emergency. One agency staff member told us the manager had shown them how to use the handcuffs as part of their induction and they might use the handcuffs if a patient became aggressive or tried to abscond. Another agency staff member told us they felt reassured to know the handcuffs were there for them to use if they needed to.

There were no easy to access protocols to guide agency staff when out and about in the vehicle. For example, the manager and agency staff we spoke with were aware of the requirements of documentation in relation to transport of patients detained under the Mental Health Act 1983.However there was no checklist for staff to follow to ensure the paperwork was in order prior to starting the journey.

There was no formal document to define the eligibility or exclusion criteria for patients referred to the service. The manager told us he reviewed referrals on an individual basis to determine whether the service was able to safely transport the patient. We did not see evidence of this process. However, the manager was able to describe criteria he used to make these decisions, which were based on being able to provide the right care for the patient.

Nutrition and hydration

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

The manager planned journeys to account for a patient's hydration, feeding and toileting needs, particularly when journey times were long. No bottled water was held on the vehicle. Agency staff purchased bottled water when required in preparation for a journey. If food was required, agency staff asked the discharging service to provide a packed lunch for the patient.

Response times

The service did not monitor agreed response times so they could facilitate good outcomes for patients.

The responsiveness of the service was not monitored against any internal or contracted standards. The manager

told us marketing emails for the service stated the aim was to provide a service for patients within four hours. However, no data was recorded as to the time referrals came in, therefore no evidence could be provided to see if this performance target was being met.

There was no formal process to monitor patient outcomes to identify where the service was performing well and to identify areas which required improvement. The manager did not collate journey information to provide oversight of the number of transport journeys carried out by the service. To identify this figure, the manager counted the number of paper journey forms which had been completed.

Competent staff

The service did not make sure staff were competent for their roles.

The manager did not complete all necessary checks to make sure agency staff were competent to meet the needs of patients transported by the service. The agency sent the manager a profile of the agency member of staff who was coming to work for the service. However, these profiles did not provide information about previous employment experience.

There was no documented evidence the manager took account of the needs of children when selecting agency staff for journeys. The manager told us if they received a referral for a child, they would request an agency nurse with experience of working with children with mental health conditions. However, we did not see evidence of this process and the manager did not have any records of the type of work experience of agency staff.

The manager did not take account of the specialist needs of patients with dementia when selecting agency staff. The manager told us experience of working with dementia would be “a bonus” rather than a requirement.

Agency staff had access to mechanical restraints and were not trained to use these safely. There was no evidence that team members were competent to use mechanical restraints in line with the Mental Health Act Code of Practice, Mental Capacity Act 2005, Human Rights Act 1998 and common law.

There was no evidence agency staff completed an induction. The manager told us he printed off important policies for staff to read. Staff told us the manager verbally introduced them to their responsibilities and the expectations of the service. This included showing them around the vehicle and explaining how to use the paperwork. However, the manager did not document the induction process and staff did not sign to say they had read relevant policies.

Multidisciplinary working

There was limited evidence of multidisciplinary working.

Agency staff told us they spoke to staff on the ward where they collected the patient to confirm details and to glean any further information regarding the management of the patient. Agency staff told us they gave a verbal handover to the receiving hospital regarding the patient journey. None of these conversations were documented.

The manager told us none of the patients had had an advanced care plan or a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) order. None of the patients were under a Section 136 of the Mental Health Act. For this reason, we were not able to assess how the service worked with other disciplines to meet the needs of such patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The manager supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, staff did not always follow national guidance to gain patients’ consent.

The manager understood the relevant consent and decision-making requirements of the Mental Capacity Act 2005. The manager was able to discuss the need to respect a patient’s decision if they had capacity to make their own choices and provided examples.

We were not assured children would be considered in relation to the decision-making requirements of the Gillick competence when being transported by the service. The Gillick competence refers to criteria for establishing whether a child under 16 has the capacity to provide consent to treatment. The premise of this is that children under 16 can consent if they have enough understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. The manager did not have a clear

understanding of the principles and their responsibilities around Gillick competence. However, no children under 16 had been transported by the service since it became operational.

There was no specific policy for obtaining and recording patients' consent to receiving care from the service. The 'Consent Authorisation Policy and Procedure' referred only to the collection and processing of patients' data.

The manager told us if a patient was deemed as having capacity, the service respected their decision to consent or not to consent to the journey. If a patient who was deemed to have capacity was not consenting to the journey, the service did not transport the patient. The manager told us if a patient had fluctuating capacity, staff kept checking the patient was content to continue with the journey.

Are patient transport services caring?

We were unable to inspect and rate caring as we were unable to observe the care of patients during the inspection. We were unable to speak with patients or their relatives and there was no patient feedback on which we could base our rating.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Inadequate

We rated the service as **inadequate** for responsive.

Service delivery to meet the needs of local people

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

The service offered to local people was limited to the bookings secured by the business. The service was not part of the framework of providers able to bid for NHS and social services contracts. In this sense, the business was not able to work with the wider system and local organisations to plan care.

Wherever possible, the service was flexible to meet the needs of patients. However, the vehicle specification limited the ability for the service to accept referrals for patients requiring additional security. The driver's compartment could not be separated by a screen, and there was no facility for providing a secure compartment within the passenger area for additional security.

The capacity of the service to cope with differing level and nature of demand was dependent upon the agency to supply staff with suitable training and expertise. Capacity was also limited by having only one vehicle. The service had not yet experienced the need to cope with an increase in demand for services.

Meeting people's individual needs

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

We were not assured agency staff had access to the right information to meet the individual needs of patients. The manager gained information about patients who had specific needs during the booking process. However, we were not assured this information was always communicated to agency staff prior to commencing the journey. The manager verbally briefed the team on the individual patient and associated risks prior to the journey taking place. This process was not documented, and we saw no evidence the team had any record of patients' individual needs to refer to during the journey.

We were not assured the individual needs of patients with dementia, autism or a learning disability were being recognised by the service. We saw from the email correspondence and booking forms that patients with these conditions had been transported by the service. Agency staff we spoke with did not recollect these patients and the manager told us there had been no patients with dementia during the 12 months preceding our inspection.

We were not assured the agency staff working for the service always had the required skills to meet the individual needs of the patients being transported by the service. The manager did not require agency staff to have dementia training when transporting a patient with dementia.

We were not assured agency staff working for the service had the required skills or guidance to meet the needs of patients who were showing aggressive or disruptive behaviour. The manager was not aware of the specific

content of the training received by agency staff around prevention and management of violence and aggression. The policy for the safe use of restraint was not clear or embedded.

The service did not have a system for engaging an interpreter if a patient's first language was not English. In this situation, the manager said he would ensure the hospital found an interpreter to accompany the patient for the journey. The service had not transported anyone who had required this service in the 12 months prior to our inspection.

There was no system or equipment available to meet the needs of patients with hearing impairment or speech difficulties. There was no written information available in the vehicle for patients.

Access and flow

There was no evidence to show people could access the service when they needed it, in line with national standards, or to show they received the right care in a timely way.

Transport requests were dealt with by the manager. Clients requesting to use the service completed a booking form which the manager reviewed. The manager then telephoned the client to gather further information required to identify whether the patient was suitable to be transported by the service. There was no documented exclusion or inclusion criteria for the service.

It was unclear whether patients accessed care and treatment in a timely way. There was no data to show if patients were collected on time. The manager aimed to provide a service that could respond within four hours of receipt of referral if required. However, the manager did not collect data to monitor compliance with this standard. During the 12 months preceding our inspection, only one referral had requested transport the same day. The service had not cancelled any journeys.

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received.

There was an up to date complaints policy. This policy stated the service should provide information to patients about how to raise complaints. Information about making complaints was not available for patients on board the vehicle or on the company website. Feedback forms were not available in the vehicle or on the website. No written information was given to the patient about their journey or what they could expect from staff during their journey.

There had been no complaints made to the service in the 12 months prior to our inspection. As there had been no complaints, we were unable to review the complaints process used by the service.

Are patient transport services well-led?

Inadequate

We rated the service as **inadequate** for well-led.

Leadership

The manager did not have the integrity, skills and abilities to run the service. However, they understood and managed some of the priorities and issues the service faced. They were visible and approachable in the service for patients and agency staff.

The manager did not always demonstrate good character during our inspection. We were not assured that the manager provided complete and honest information about the service provided. The responses to questions in our provider information request were not all true. For example, the provider information request stated that restraints were not used in the service. We saw mechanical restraints stored inside the vehicle. We were not assured that the registered manager answered our questions truthfully. For example, the manager told us the vehicle checklists were completed for every journey. However, when asked to supply evidence of this, he admitted the checklists were not completed. The website was controlled by the manager and it contained erroneous information. For example, the website contained pictures of vehicles not owned by the provider and described services that were not offered at the time of our inspection.

The manager had limited skills and no prior experience in running a patient transport business. The manager did not demonstrate an understanding of healthcare governance and showed limited awareness of their accountability in law for the service they provided, At the time of our inspection, the manager had no plan to develop these skills and there was no documented leadership strategy.

The manager showed some understanding of challenges to sustainability of the service. The manager discussed the challenge of maintaining a work-life balance and the challenge around procuring subcontracts from other companies. However, the manager showed limited understanding of the potential challenges to the quality of the service.

The manager demonstrated some understanding of the needs of the patients transported by the service. For example, he demonstrated empathy and understanding when describing how he would manage challenging behaviour. The manager was visible and attended many of the journeys completed by the service. The manager provided support for the agency staff during the patient journeys he attended and, on the telephone, when they needed advice.

Vision and strategy

The service had an undocumented vision for what it wanted to achieve but no strategy to turn it into action.

There was no documented vision or strategy for the service.

The manager explained to us his vision for the service. The vision was to grow and develop the services and to eventually take on permanent staff. The manager also hoped to invest in a larger ambulance, which included a secure cell to enable the service to be able to take on patients with additional needs.

Culture

Agency staff felt respected, supported and valued. Agency staff told us they could raise concerns without fear.

The manager described the culture of the service to be reliable, safe and well-led. They told us they aimed to lead the team and ensure agency staff were supported. The manager told us the safety of the agency staff was very important and this was considered as part of the risk assessment to accept or reject a referral. However, we did not see evidence of this process.

Without a permanent team of staff., there were limited opportunities for the manager to influence the culture of the service. However, agency staff told us the culture was supportive. They were confident to speak to the manager about any concerns. Agency staff told us they worked well together as a team.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.

There were no systems and processes to assess, monitor and improve the quality and safety of the service provided. We were not assured the manager understood how the service was performing and the areas where improvements were required. The manager told us the factors that would indicate the service was safe and of good quality would include promptness and professionalism of the staff. However, the manager did not use any system to monitor these indicators. No data around response times was collected or analysed. No documented feedback was gathered from patients, staff or external organisations.

The service did not collect reliable data to inform service delivery or make improvements. There was no programme of audit. For example, the manager did not audit cleanliness, infection control, patient outcomes or documentation.

There were no governance systems to provide oversight of the potential use of mechanical restraints stored in the vehicle. There were no clear protocols to provide assurance that use of any restraint was in accordance with the principles outlined in the Department of Health publication: Positive and Proactive Care: reducing the need for restrictive interventions 2014. There were no clear protocols regarding use of restraint reduction plans and audits, processes for ensuring appropriate staff training, or processes for effective record keeping around restraint.

The governance framework did not provide assurance that Mental Health Act procedures were followed. There were no processes to record, monitor or audit Mental Health Act procedures. There was no written guidance for staff to follow in relation to Mental Health Act procedures.

Management of risk, issues and performance

The service did not use systems to manage performance effectively and did not have plans to cope with unexpected events. The service identified relevant risks and actions to reduce their impact but did not record these.

There was no evidence of management of risks. There was no risk register or any other similar document to identify risks to the service provision. There was no process to formally document risks and risk management plans associated with the service.

The manager was able to verbalise some risks associated with the service. These included ensuring the vehicle remained roadworthy, the need to have a contingency plan to replace the vehicle, staffing risks when a skill mix was not available to support a journey and attacks on staff. However, there was no identification or documented evidence as to how these risks were assessed, mitigated and managed by the service.

There were no audit systems or processes. There was no information used to monitor or to manage performance.

There was a business continuity policy to manage any unforeseen risks to the service. However, this policy contained irrelevant information and the 'critical function priority list' and 'hazard analysis table' was not completed.

Information management

The service did not collect reliable data. The information systems were not secure.

The manager did not collect data to inform their understanding of the service. No data was used to make service improvements. The manager told us they reviewed individual journey times after each journey, but there was no documented evidence of how this information was monitored and reviewed.

There was inadequate assurance that electronic systems maintained the confidentiality of patient information. The manager was unable to give adequate assurance of robust arrangements (including internal and external validation) to ensure the integrity and confidentiality of identifiable data. Referrers used an online webform to submit sensitive confidential information about patients as part of the pre-booking process. This included information such as: patient's name, date of birth, type of mental health section, and known risks (for example risk of suicide or sexually inappropriate behaviour). The manager was unable to explain how this information was protected when it was processed by the website.

Confidential information was also stored in emails on the managers computer. This email account was password protected. However, the manager was unable to provide any further assurance around the governance of this information.

The manager was aware of their requirement to submit notifications to CQC and other external bodies when required.

Public and staff engagement

Leaders and staff did not actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. They did not collaborate with partner organisations to help improve services for patients.

The service did not engage with the providers it carried out work for to collect feedback about the service being provided. The manager and agency staff were unaware of what people who use the service thought of their care and treatment.

The method used for engaging with patients was ineffective. There was a patient feedback form. This form asked patients about their experience of using the service. Patients were asked to comment on punctuality, staff attitude, cleanliness of the vehicle and whether they would recommend the service to others. However, no patients had completed the form during the 12 months preceding our inspection. The manager said the forms were kept on the vehicle for patients to access. During our inspection we did not see any of these forms on the vehicle.

There were opportunities for agency staff to provide feedback. The manager held a debrief session with agency staff following each journey. Agency staff could use this time to discuss any concerns or give suggestions. The manager gave an example of a member of staff suggesting the service needed to invest in other types of vehicles to improve the scope of the business. However, we saw no documented evidence of any feedback which had been provided.

Innovation, improvement and sustainability

Inadequate

Patient transport services

The service was not committed to continually learning and improving services. Staff did not have a good understanding of quality improvement methods or have the skills to use them. Leaders did not encourage innovation.

At the time of our inspection, the manager was focussed on building the business. The impact of future changes to the scope of the service were not well understood. There was no evidence the manager had anticipated any risk to the quality and sustainability of the service.

There was no process to review key items such as the strategy, values, objectives, plans or the governance framework. There was no evidence of learning and reflective practice. However, the manager told us he was keen to improve the service as a result of this inspection. The manager identified work was required to establish a governance system, obtain feedback, implement a programme of audit and improve due diligence around training and competency of agency staff who worked for the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure mandatory training covers the scope of the service being provided and appropriate checks are carried out to ensure compliance with mandatory training.
- Ensure safeguarding training meets best practice guidelines.
- Ensure staff receive training around the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Ensure systems and processes to prevent and control infection are in line with best practice.
- Ensure policies and procedures are meaningful and relevant to the scope of the service being offered.
- Ensure the vehicle is checked prior to each journey to confirm it is safe for use.
- Ensure staff are competent to carry out their role with the range of patient groups who use the service.
- Ensure the agency staff induction process is documented.
- Ensure procedures and safeguards are introduced around the use of any restraint in line with best practice guidance. These must include processes to provide assurance of staff training and competencies in use of restraint.
- Ensure there are processes to provide assurance that all staff protect the rights of patients' subject to the Mental Health Act 1983.
- Ensure there are systems and processes to assess, monitor and improve the quality and safety of the service provided.
- Ensure there is a governance structure which enables full oversight of quality, safety and performance of the service.
- Ensure there is a process to formally document risks and risk management plans associated with the service.
- Ensure patient risks are individually assessed and plans to manage patient risk are documented and communicated to agency staff.
- Ensure there is adequate assurance that electronic systems maintain the confidentiality of patient information.
- Ensure there is a process to gather feedback from agency staff, patients and organisations which use the service.

Action the provider SHOULD take to improve

- Develop a process to check the driving skills of staff driving the vehicle.
- Include a prompt around infection control risks on the booking form.
- Secure loose items within the vehicle.
- Make sure clinical waste bags are available for use on the vehicle.
- Include a medicines management section on the journey log form.
- Develop an understanding of the requirements of the duty of candour.
- Provide staff with access to important information around policies and procedures on the vehicle.
- Develop a formalised document outlining inclusion and exclusion criteria to support service delivery.
- Implement a process to demonstrate the experience and suitability of staff working with children.
- Record risks and associated management plan for each patient journey and make this available to the agency staff on the vehicle.
- Develop a process for engaging an interpreting service for patients in case this is required.
- Provide information for patients explaining how they can make a complaint. Make this information available in the vehicle and on the website.

Outstanding practice and areas for improvement

- Formally document the vision and values of the service and produce a strategy for how the vision will be achieved.
- Retain and destroy patient records in accordance with legislation and national guidance.
- Improve the manager's knowledge and understanding of governance and risk management in healthcare.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were no systems or processes to assess, monitor and improve the quality and safety of the service provided. No data around response times was collected or analysed. No documented feedback was gathered from patients, staff or external organisations. There was no programme of audit. There were no clear protocols to provide assurance that use of any restraint was in accordance with the principles outlined in the Department of Health publication: Positive and Proactive Care: reducing the need for restrictive interventions 2014. There were no clear protocols regarding use of restraint reduction plans and audits, processes for ensuring appropriate staff training, or processes for effective record keeping around restraint. There was no process to formally document risks and risk management plans associated with the service. There was not adequate assurance that electronic systems maintained the confidentiality of patient information.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The manager's expectations of mandatory training were not clear and did not cover the scope of the service being provided. Mandatory training requirements did not include essential areas of knowledge and skills.

This section is primarily information for the provider

Enforcement actions

Appropriate checks of training certificates were not carried out to ensure agency staff compliance with mandatory training.