Riviera Ambulance Service Limited

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Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Riviera Ambulance Service Limited provides a patient transport service specialising in NHS and private sector mental health transfers throughout the United Kingdom.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 22 August 2017 and revisited the service on 30 August 2017.

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.

Following this inspection we used our enforcement powers to urgently suspend the registration of Riviera Ambulance Service Limited, and the Registered Manager, to protect the safety and welfare of patients. The suspension started on Wednesday 13 September and continued until Wednesday 25 October.

We re-inspected the service on 17 October 2017, following a request from the provider and receipt of an action plan identifying changes which had been made to the service. The provider was able to demonstrate a significant number of changes and improvements had been made to the service in response to the breaches identified in the suspension notice served on 13 September 2017. In light of this, we lifted the both the Registered Manager's and the provider's suspension of registration from Wednesday 25 October. A report of our findings at this re-inspection will follow in due course.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found many areas of serious concern:

- The registered manager was unfamiliar with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Incident reporting was not embedded, incidents were not adequately investigated and relevant learning was not shared with staff.
- A thorough assessment of the patient's need was not taken and recorded.
- Information provided to the service was not acted on, for example information from the referring units with regards to patient risk.
- There were no policies or procedures available for staff to follow with regards to capacity and consent.
- The registered manager was not working in accordance with the code of practice for health and adult social care and the prevention and control of infection, and related guidance 2015.
- There was no evidence infection, prevention and control risks associated with patients were collected during the initial booking stage or during the verbal handover from the unit to the crew.
- There was a lack of detail around risk management in relation to identification of risks and strategies to manage or mitigate them.
- The registered manager and the staff had not received the correct level and frequency of safeguarding training, to ensure staff were aware of their responsibilities to act upon any allegations of abuse. There was no system or process to ensure allegations of abuse were raised with the appropriate organisation to safeguard patients.
- There was no assessment of patients' capacity in line with the Mental Health Act 1983.

Summary of findings

- Neither the crew nor the registered manager received training on the Code of Practice: Mental Health Act 1983 despite the service specialising in the transport of mental health patients.
- The registered manager was not up to date with relevant nationally recognised guidance appropriate to the services they provided. For example, the management and storage of oxygen was not in line with national guidance. Neither the registered manager or the staff had an understanding of the National Institute for Health and Care Excellence guidance 'Violence and aggression: short term management in mental health, health and community settings (NG10)'.
- There were no policies and procedures available for the crew to follow when they supported patients with medicines on transfers. Crews did not record when they supported patients with taking their medicines during a journey.
- Staffing and recruitment procedures did not ensure required information was obtained to meet the legal requirements, including Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had no system of appraisal to formally monitor staff. Crew members' competence to carry out their role following their induction period or when using blue lights on the ambulance were not assessed.
- There were no governance arrangements in place to assess and monitor the service in terms of quality, safety, performance and risk.
- The recruitment procedure did not safeguard patients against unsuitable staff, and there was no process to review the fitness of the employees.
- Professional body registers were not checked to ensure appropriate staff had a current registration.
- The registered manager did not have an understanding of the duty of candour regulation and there were no policies or procedures with regards to this within the service.
- The provider was not monitoring the how long each crew member spent driving.
- The provider did not have a document to identify eligibility criteria for determining the types of patients suitable to travel with them. There was also no policy or procedure available for the management of the deteriorating patient.

However, we also found the following areas of good practice:

- Records demonstrated all vehicles were properly maintained.
- Vehicles were designed to ensure patients detained under the Mental Health Act 1983 were safely transported.
- Staff spoke about the patients they transported in a caring and insightful way.
- We received 14 comment cards from patients which provided consistently positive comments about Riviera Ambulance Service Limited.
- The provider had some flexible capacity to cope with the differing levels of demand for their service.
- The crew understood the need to keep patients calm and happy throughout their journey and where possible tried to accommodate the patient's wishes.
- Riviera Ambulance Service Limited provided a service which was flexible to meet the need of the organisations they worked for.
- The registered manager was responsive to ideas suggested by staff to improve the service.

Amanda Stanford
Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		The main service provided by Riviera Ambulance Service Limited was patient transport. The provider specialised in transporting patients with mental health conditions, some of whom were detained under the Mental Health Act 1983. During the inspection we had concerns the registered manager did not understand his role and responsibilities in relation to the Health and Social Care Act 2008 (Regulated Activities) 2014 and was only able to provide us with limited evidence to demonstrate how the requirements of the act were being met by the provider. There were no systems or processes to enable the registered manager to monitor the safety, quality or performance and no governance framework to evidence and support the delivery of good quality care.

Riviera Ambulance Service Limited

Detailed findings

Services we looked at: Patient transport services

Detailed findings

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Background to Riviera Ambulance Service Limited

Riviera Ambulance Service Limited opened in 1993. The owner for the service was also the registered manager for the service. The service is an independent ambulance service in Torquay, Devon. The service primarily serves the local communities of Devon, Cornwall and Somerset, but also serves the whole of the West Country and the United Kingdom as required. Riviera Ambulance Service Limited specialises in NHS and private sector patient transport services for patients with mental health conditions. The service provides transport 24 hours a day, seven days a week. Between April 2016 and May 2017, Riviera Ambulance Service had carried out 690 patient transport journeys.

The registered manager has been in post since 1993. The provider is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely

Riviera Ambulance Service was last inspected in March 2013 and met all the standard requirements it was inspected against. There have been no previous requirement notices or enforcement actions associated with the service.

We carried out an announced inspection of Riviera Ambulance Service on 22 August 2017 and revisited the service on 30 August 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a second CQC inspector, mental health CQC inspector and a specialist advisor with expertise in ambulances. The inspection team was overseen by Daniel Thorogood, Inspection Manager, and Mary Cridge, Head of Hospital Inspections.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

During the inspection, we visited Riviera Ambulance Service Limited's base. The service has three ambulances, with two being used regularly for patient transport journeys and one being a spare vehicle used when there was a fault with the two other vehicles, or during times where the service required more capacity to take on work. We spoke with nine members of staff, including eight crew members and the registered manager. We were unable to speak with any patients because there were no bookings during our inspection. We received 14 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed 30 journey record sheets.

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

Activity (April 2016 to May 2017)

- Between April 2016 and May 2017, 690 patient transport journeys were carried out.

At the time of our inspection, there were 15 members of staff on zero hour contracts working for the service.

Track record on safety:

- No never events
- No serious incidents
- No complaints

Summary of findings

Are services safe?

We do not currently have a legal duty to rate independent ambulance services.

We found the following issues:

- There was a lack of incident reporting at Riviera Ambulance Service Limited. Therefore, there was a lack of investigation, learning and feedback to staff following incidents to prevent reoccurrence in the future.
- There was not working in accordance with the code of practice for health and adult social care and the prevention and control of infection and related guidance 2015, and no evidence of any assessments to prevent and control the spread of infection.
- There was no process to ensure any medicines given to the patient by the crew were recorded, and no policy or procedure to support this.
- The management and storage of oxygen was not in line with national guidance.
- The safeguarding policy was out of date, staff were not up to date with training and there was no system to ensure allegations of abuse or concerns were reported to safeguard patients.
- Risk assessments lacked detail of the risks and the mitigating actions required to safely manage these.
- There was no policy or guidance for the management of the deteriorating patient.
- A safe recruitment procedure was not in place and did not meet the requirement, including Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Patient transport services (PTS)

We found the following areas of good practice:

- A system was in place to ensure the servicing and maintenance of the vehicles kept patients safe.
- Vehicles were designed to ensure the safe transportation of patients detained under the Mental Health Act 1983.

Are services effective?

We do not currently have a legal duty to rate independent ambulance services.

We found the following issues:

- The registered manager was not up to date with relevant nationally recognised guidance, for example safeguarding and the Mental Health Act 1983. They had no awareness that national guidance which had previously informed Riviera Ambulance Service Limited's policies had been updated.
- The registered manager and crew were unaware of guidance produced by the National Institute for Health and Care Excellence appropriate to their service. This included Violence and aggression: short term management in mental health, health and community settings.
- The provider had used a method of restraint which was not in line with guidance from National Institute for Health and Clinical Excellence (NICE) Violence and aggression: short term management in mental health, health and community settings, with no risk assessment to demonstrate the need to act against the guidance.
- The provider had no eligibility or exclusion criteria to help with the decision making for new referrals.
- The initial assessment of a patient's care needs and requirements taken at the booking stage was very brief and contained limited details.
- The provider did not report on any response times or patient outcomes to monitor the quality or performance of the service being provided.
- Staff did not have regular appraisals or supervision.
- There were no on going assessments to ensure staff were competent in their role or for the use of blue lights during a journey.
- Staff did not receive training on the Mental Health Act 1983.

Are services caring?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Staff spoke about the patients they transported in a caring and insightful way.
- We received 14 comment cards from patients which provided consistently positive comments about Riviera Ambulance Service Limited

Are services responsive?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- The provider had some flexible capacity to cope with differing levels of demand for their service.
- Staff understood the need to keep patients calm and happy throughout their journey, and where possible tried to accommodate the patient's wishes.
- Riviera Ambulance Service Limited provided a service which was flexible to meet the need of the organisations they worked for.

We found the following issues:

- The service was not always planned and delivered in a way which responded to the needs of mental health patients and detained patients under the Mental Health Act 1983.
- Riviera Ambulance Service Limited did not have a document to define their role and responsibility when transporting patients. This was not in line with recommendations from the Code of Practice: Mental Health Act 1983 section 17.2.

Are services well-led?

We do not currently have a legal duty to rate independent ambulance services.

We found the following issues:

- There were no systems or processes to enable the registered manager to monitor the safety, quality or performance of the service against the Health and

Patient transport services (PTS)

Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager was also unable to demonstrate how the service met the requirements of the act.

- There was no formal governance framework to evidence and support the delivery of good quality care.
- There were no processes to assess, monitor and mitigate the risks relating to the service.
- Performance measures were not reported therefore no action was not taken to improve the service.
- There was no audit programme to identify the strengths of the service and where improvements were required.
- Disclosure and barring checks (DBS) were not stored in line with the Revised Code of Practice for Disclosure and Barring Service Registered Persons 2015.

We found the following areas of good practice:

- The registered manager was responsive to ideas suggested by staff to improve the service.
- Feedback was collected from patients using the service.

Are patient transport services safe?

Incidents

- There was an ineffective system and policy for reporting and responding to incidents. The incident reporting policy outlined the process to follow when an incident was reported. This included investigating the incident, examining the outcome and feeding back to the incident reporter. However, we found this was no consistently followed.
- There was a paper-based incident reporting process to report accidents, incidents or near misses. However, incident reporting was very limited, the process was not used effectively and evidence we saw did not provide assurance that incidents were adequately investigated and learning shared. The majority of staff had never reported an incident. Staff also told us they had not received any feedback from incidents, which may have been reported by other crew members. Incident forms did not document learning or actions which had been taken to prevent the incident happening again.
- Prior to the inspection the registered manager told us that between April 2016 and May 2017 there had been no incidents reported. However, during the inspection the registered manager told us about two incidents. One related to a member of staff being bitten by a patient. This had not been reported as an incident but was documented in the staff accident book. The report stated what had happened and the actions taken after, for example the member of staff attended a local accident and emergency department. Because this was not reported as an incident it was not investigated by the registered manager. This meant there was no consideration of what had led to the incident happening or of any actions that could be taken to prevent this happening again. There was also no evidence this incident had been reported to the service who requested the transfer of the patient.
- Staff were able to provide us with examples of incidents they would report but there was no evidence to demonstrate incidents were being recorded or reported. Examples of reportable incidents were if a patient ran off, if the information on the journey form was not how the patient presented, if someone was injured, if a patient was violent or aggressive or if restraint was used.
- During conversations, staff gave us examples of when they had used restraint and when journeys were

cancelled due to the patient not presenting as documented in the booking form. However, we did not see any incident report forms documenting these events. We asked the registered manager whether the crew would complete the forms when the harness restraint was used. The registered manager told us forms would only be completed if the use of restraint had to be escalated very quickly. We observed an incident report form and an investigation following the use of hand tie restraints. The form detailed the events of the incident, however the handover and risk assessment consisted of two risks handed over to the crew, self-harm and absconding. The risk assessment did not provide any detail as to the extent of the risks, mitigating actions to reduce the risk and overall management plan to manage the risk safely. There was no documented evidence of any other information the crew received at the handover. The investigation did not identify any learning or actions with regards to undertaking and documenting a more thorough risk assessment and the overall action plan did not detail any learning or actions for Riviera Ambulance Service Limited, but rather only identified failures in other organisations' systems.

- The registered manager said the crew would provide staff at the patient's destination with the details of any injuries which had occurred during the journey; however, we did not see any evidence of this. We were told the crew completed standard injury forms with body maps (images to show where injury had occurred), however this could not be evidenced. This information was not routinely collected by the service, or provided to the hospital that organised the transfer. This meant the registered manager was unable to track incident trends and ensure appropriate measures were in place to reduce the chance of future incidents from taking place. The registered manager felt the responsibility lay with the units caring for the patient rather than Riviera Ambulance Service Limited.
- The registered manager was not able to clearly define what duty of candour was or what their responsibilities were to meet this regulation. There were no policies or procedures regarding duty of candour available to support a culture of openness and transparency. During our discussions, the registered manager was unable to demonstrate an understanding of the duty of candour even after prompts were provided. Instead, the registered manager made reference to the five domains covered by the CQC. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. 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. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong.

Clinical Quality Dashboard or equivalent

- There were no clinical dashboards or an equivalent system available to establish an overview of the safety and quality of the service. The provider did not record any data or carry out any form of monitoring for trends and themes through the use of audit or any other method. This meant there were no means to identify areas where the service was performing well and where areas of improvement were required to improve the quality and safety of the service provided.
- The registered manager explained that because the service was so small each job was reviewed daily. The registered manager told us this provided oversight of the quality and safety of the service. The registered manager told us the crew would verbally report issues directly and he trusted them to be open and honest. The registered manager did not feel there was a need to provide documentation to demonstrate quality and safety of the service.

Cleanliness, infection control and hygiene

- There was no evidence to demonstrate the provider was assessing the risk of, infection, or taking action to prevent, detect and control the spread of infections. The provider had a policy for infection prevention and control, however the policy was based on out of date legislation. The provider was using the Health and Social Care Act (Regulated Activities) Regulations 2010 on which to base its infection prevention and control practice. However, this legislation was updated in 2014 to reflect the new fundamental standards of care. The policy also outlined guidelines from the National Institute for Clinical Excellence (NICE), but this organisation had changed its name in 2012. The policy was not specific as to which guidelines the information was taken from or the date the guidelines had been

produced. The provider was not working in accordance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (2015).

- Staff did not undertake any mandatory training on infection, prevention and control practice or procedures.
- There was no evidence that patient-related infection prevention and control risks were considered and managed appropriately. Booking forms did not have a specific area to record infection control risks and questions about this were not always asked when a booking was accepted. The registered manager told us they were reliant on whoever was making the booking to tell them anything they needed to know, or for crews to get the information during the handover. We asked the registered manager how he was assured the crew had asked for the information, but he was unable to provide us with any evidence.
- Personal protective equipment such as gloves, aprons and visors were available to enable crews to protect themselves and patients from transfer of infection.
- The provider did not have cleaning schedules or checklists to ensure effective prevention and control of infection. There was no evidence to demonstrate vehicles had been cleaned. However, all three ambulances were visible clean inside and outside. The registered manager told us it was not necessary to have the crew complete checklists for vehicle cleaning as the crew knew they had to return the vehicles in the clean state they were picked up in. The registered manager told us he carried out a daily inspection of the vehicles to ensure their cleanliness. However, there was no evidence this activity took place.
- Each ambulance had a fluid spill kit on board to manage any spillage. The registered manager told us the crew would use cleaning materials at the destination unit if required following a journey. Each ambulance also carried a pack of anti-bacterial wipes to wipe down surfaces and equipment during a journey if required.
- The registered manager had access to equipment to deep clean ambulances if required following a journey which was stored in a shed at the ambulance station base. We did not see this equipment. The registered manager told us that every two months vehicles required a deep clean; however there was no set timeframe for deep cleaning the ambulances and this was at the registered manager's discretion . We did not see any evidence of deep cleaning schedules
- The procedure for the disposal of linen was not formalised and so not monitored to ensure risks were safely managed. This practice was not covered by a service level agreement. The provider had a procedure for the disposal of linen which was outlined in their infection, prevention and control policy. The registered manager explained all used linen was left at the unit where the transfer journey finished and replacement linen was collected at the same time.
- The procedure for the disposal clinical waste was not formalised and so not monitored to ensure risks were safely managed. This practice was not covered by a service level agreement. The provider disposed of clinical waste where the transfer journey ended. Colour-coded clinical waste disposal bags were carried on each of the three ambulances. Clinical waste was disposed of in the appropriate colour coded bag and disposed of the receiving unit. This procedure was in line with the provider's policy.

Environment and equipment

- The maintenance and use of equipment kept patients safe. We saw that each of the three vehicles had an in date MOT certificate and servicing records. Insurance was in place for each of the three vehicles and there were arrangements for breakdown cover and replacement of tyres.
- Equipment was serviced to ensure it was safe for use. The only piece of equipment on board the ambulances which required servicing was the automated external defibrillator. We saw evidence this had occurred and was next due in October 2018. Servicing was carried out by the medical device department at a local acute NHS trust.
- Two vehicles were equipped with blue lights and were used by staff who had been trained to use these as part of their previous role in either the ambulance or police services. Because of this the registered manager had not provided any other training or updates for the crew. Therefore, the registered manager had no assurance the crew were competent to use the blue lights on the vehicle. The registered manager told us blue lights were

not used in an emergency situation, but only to transport patients who were at higher risk of becoming violent or aggressive when there was traffic congestion to ensure the safety of the patient and others.

- There was a process to manage faulty vehicles or equipment. Staff told us that when there was a fault on a vehicle they would record this on the faulty vehicle paperwork and also verbally report the fault to the registered manager who would action the repair. Staff told us that once a fault was reported the vehicle was almost always repaired the following day. We saw records relating to vehicle defects and the actions taken to address these.
- Equipment was stored securely and safely. All equipment on the ambulances was stored in boxes on a racking system at the back of the ambulance. The location of the storage area meant patients transported on the ambulances did not have access to the equipment as it was behind them. Equipment included a first aid kit which we looked at on two of the vehicles and these were in date, an automatic external defibrillator, clean linen and blankets. Each ambulance carried blankets to ensure patient comfort during transfers.
- Vehicles used for the transport of patients who were detained under the Mental Health Act 1983 were appropriate and safe. Ambulances had electronic access to the main doors to help safe entry of patients, as well as reducing the risk of absconding. The ambulances utilised seat belts, and if needed an additional harness for patients at risk of harming themselves or others.
- The back of the ambulances were designed with three seats in a row. The patient sat in the middle seat with a crew member either side. This enabled easy access for the crew to use techniques to restrain a patient if they tried to assault the crew. The design of the seat meant the crew would be able to move around in their seat without having to remove their seatbelt.

Medicines

- The arrangements for administering and recording medicines did not keep patients safe. Although the provider did not carry their own stock of medicines, staff were required to support patients taking their own medicines. There was no medicines policy to guide staff on the arrangements for transporting and assisting patients to take medicines. There were no records maintained during the patient journey and staff were unable to document what time a patient had taken a medicine, what that medicine was, or who had assisted with this. This meant there was no way to review this after the journey if any issues or queries were to arise. Additionally, it meant staff at the receiving unit had no record of the times medicines were taken to enable them to work out when any further doses were required. The registered manager told us the crews were given sealed packs of medicine to transport with the patient and the crew would tell the staff at the receiving location whether or not the patient had taken the medicine. The expectation was that staff at the receiving location would document that medicine had been given.
- The provider only carried oxygen emergency purposes. Other than this, no other medicines were stored on the ambulances or at the ambulance base.
- The storage of oxygen on the ambulances was unsafe and not in line with guidance. This included the 'Carriage of dangerous goods and use of transportable pressure equipment regulations 2009'. The registered manager was unaware oxygen carried an expiry date. We look at two cylindered (one stored on each ambulance) and both were out of date by four and six years. On discovering the oxygen was out of date, the registered manager removed the oxygen and provided us with evidence this was going to be replaced. The cylinders were stored horizontally on a set of shelves and secured only by being placed behind a storage box. This meant that in the event of an accident the cylinders could move and injure somebody, or become damaged and at risk of exploding.
- The arrangements for the storage of a patient's medicine during transportation kept people safe. Medicines transported were received in a sealed bag and remained in a box in the front of the ambulance with the driver during the patient's journey. Crew members would pass on patients' medicines to staff at the receiving unit on their arrival.

Records

- Patient records were held securely in the office at the provider's base and during a journey. However, there was a lack of information gathered about the patient at the initial booking and throughout the ongoing journey to ensure patient safety was monitored.
- We reviewed 30 journey sheets which contained very little or no information about the patient. The provider

used a journey log sheet to document the journey details. There was very limited space on the journey form to record special notes to alert the crew to patients with pre-existing conditions or safety risks. There was no space on the form allocated to enable the crew to document if medicines were given, restraint was used, or to record other observations or information. Information which was recorded was minimal and did not provide any detail of how to manage or mitigate any risks.

- Patient records were kept secure when transporting a patient. Patient records from the unit were handed to the crew following the transfer handover. The notes were then stored in a box at the front of the ambulance with the driver. On arrival at the destination, crew would hand the patient record over to the appropriate member of staff.
- Crew members did not record the time period in which they drove on each journey. This meant there was no indication of who was driving, which had an implication for any accidents, investigations or convictions. It also meant the provider was unable to monitor driving hours and any risks crew members could be at due to being tired. The registered manager felt it was irrelevant to record who was driving at a particular time as he expected the crew to tell him if something had occurred. We were given examples from previous situations where crew members had informed the registered manager of an incident. However, this did not provide us with assurance that an individual could be identified as the driver if a concern was raised at a later date.

Safeguarding

- Systems and processes reflecting relevant safeguarding legislation were not up to date or effective to safeguard adults and children from avoidable harm and abuse.
- The provider's safeguarding policy did not set out the safeguarding responsibilities of staff and did not provide guidance on how to record and report concerns. Additionally, the safeguarding policy was out-of-date. The policy had been written in 2011 and was due an update in 2014; however, this had been done. The registered manager told us he had recently updated the policy and gave us a copy. However, we were only provided with updated contact numbers for the safeguarding team at the local county council. There were no updates to the policy itself.
- The service did not report directly to the local authority in the area they were in at the time of the transfer if they had a safeguarding concern. Information was only reported to the receiving location. The registered manager told us if they had any safeguarding concerns they would report them to the pickup or destination locations. They would not report directly to the local authority in the area they were in at the time of the transfer. Therefore there was no effective system in place to safeguard patients.
- The provider's statement of purpose stated the service provided a service for the whole population, whereas the safeguarding policy stated patients under 16 years of age were not transported. However, we saw evidence of a child aged 14 years being transported by the provider within the week before our inspection. The registered manager felt having the child's mother on board the ambulance for the journey was enough. Neither the registered manager nor the crew had completed any safeguarding children training. This meant we were not assured the child was being looked after by staff who were competent in identifying and reporting any safeguarding concerns.
- Safeguarding training for staff was included as part of their induction to the service. Crew members were trained to level two for safeguarding adults; however all the safeguarding training was out of date. The registered manager told us staff completed the training once on starting with the service. training. The registered manager told us the training provider had not told them of any further requirement for training or updates in this area.
- The registered manager was the safeguarding lead for the service; however he did not hold the correct level of training to be competent in this role. The registered manager and crew were only trained to safeguarding adult's level two, which he completed in 2011. 'Safeguarding children and young people: roles and competences for health care staff Intercollegiate document 2014', states all clinical staff working with children, young people and their parents and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person must be trained to safeguarding children level three.

Patient transport services (PTS)

Mandatory training

- Staff received limited mandatory training in safety systems, processes and practices. The registered manager told us as they were a patient transport service the only mandatory training required by the local county council was first aid training. The registered manager said to meet the needs of the patients they transferred he required the staff to have de-escalation, breakaway and restraint training, adult basic life support and choking. We sampled several of the crew members' files. We saw certificates for the de-escalation, breakaway and restraint training and adult basic first aid and choking which had been undertaken this year. In the files we examined we did not see certificates for first aid. The registered manager told us that one crew member was a qualified paramedic who worked on the bank for an NHS ambulance service. He therefore felt they did not need first aid training. However, the registered manager told us he had not seen proof of the paramedic's training. We saw no evidence the registered manager had checked the crews' registration with a professional body.
- Mandatory training did not include infection, prevention and control, information governance or manual handling. The registered manager told us manual handling training was not required as all patients who travelled with the service were mobile. However, we were concerned this did not provide adequate safety measures for staff in the event they had to move a patient who had deteriorated, for example. The registered manager felt that as the crew members were either registered paramedics, de-registered paramedics or ex police, they did not require any other training.
- Evidence of mandatory training was held in each individual crew member's personal file in the form of the training certificate. There was no other record of compliance maintained by the registered manager. The registered manager contacted all the staff once a year by email and offered two training dates where mandatory refresher training could be completed. Training was carried out face to face in conjunction with the local NHS acute trust and the local authority.
- Crew members did not undertake any driver training or assessment when they started working for the provider. There was no system to assess the safety of the crew member's driving or a process to review this on an ongoing basis. However, we received two positive comments from patients about the quality of the driving. One patient told us "the ride was steady."

Assessing and responding to patient risk

- Comprehensive risk assessments were not always carried out for patients travelling with the service. There was no evidence to demonstrate the service took action and formulated management plans around the information they were provided with, for example if a patient was known to have challenging behaviour.
- We saw one example of a completed referral form that listed 'self-harm' and 'absconding' as part of the patient's presentation; however, there was no further information detailing the extent of these risks, or guidance for the management strategies to be used to reduce these risks. The registered manager told us the crew would receive a verbal handover from the staff on the unit upon arrival. There was no space on the standard paperwork used by the crew that allowed for a detailed assessment of risk with mitigations which could be used. There was also no record made of the handover from the referring unit. We were not provided with assurance the service was aware of the full extent of patient risks.
- The crew requested a handover from the unit prior to transporting the patient, however we saw limited evidence of this recorded on the journey log forms. Staff told us they routinely obtained further risk information about the patient to ensure they remained calm throughout the journey. They said they would always ask about triggers or topics of conversation to avoid which could upset or agitate the patient, and cause their behaviour to become unpredictable. If a patient's behaviour became unpredictable, this had the potential to pose a risk to the safety of the patient and the crew during the journey. We did not see evidence of any risks being discussed recorded on the 30 journey forms we reviewed.
- The service had an escalation policy for different levels of physical restraint required. We found this included the use of disposable plastic ties. Guidance from the National Institute for Health and Care Excellence (NICE) Violence and aggression: short term management in mental health, health and community settings (NG10) states these should be used for transfer of patients between medium and high secure settings, or between

high secure settings. The registered manager told us the service did not transfer patients between these settings; however the ties had been used in one situation, a month prior to our inspection. This incident had been reported, however, the investigation lack a detailed risk assessment and did not identify any learning or actions following the incident.

- The registered manager told us the service would not transfer any patients under the effects of rapid tranquilisation medicine (medicine used to calm patients when they are agitated or aggressive and posing a risk to themselves or others).
- There was no written policy or guidance available for the crew to support with the management of a physically deteriorating patient. Staff told us in the event of this situation occurring, they would assess the situation. If they were close to a hospital they would drive directly to the hospital, or if they were not near a hospital and required immediate attention, they would call 999 for an emergency response. The registered manager did not feel a policy was necessary due to there always being a paramedic or ex-paramedic on each patient journey who had the experience of dealing with deteriorating patients and would know how to manage the situation. However, this potentially placed patients at risk if the staff member was no longer up-to-date with current best practice. We were told there had never been a case of a patient deteriorating like this.

Staffing

- A safe recruitment procedure was not in place to safeguard patients against unsuitable staff. We reviewed the recruitment files of the last two members of staff to be employed by the provider. We found they did not contain the required information to meet the legal requirements, including Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They included no evidence of identity checks or a recent photograph; there was no documented evidence of why their previous employment had ended where their duties had involved working with children or vulnerable adults; and there was no satisfactory evidence of their conduct in previous employment. The provider was in the process of arranging a Disclosure and Barring Service check (DBS) for the most recent member of crew. However, they had started work with the provider and no risk assessment was in place to make sure any risks were assessed and minimised to maintain patients' safety. The registered manager told us this crew member never worked alone and was always with other crew.
- The provider was not complaint with the Revised Code of Practice for Disclosure and Barring Service Registered Persons 2015. The provider had no policy around the secure handling of information by the Disclosure and Barring service. Copies of staff DBS certificates were held in the crew member's individual record. The registered manager told us the crew had given him their copies. The code of practice states retention of the DBS check should be no longer than six months. We found DBS checks in staff files which were years old. To comply with data protection legislation about the retention of confidential personal information, DBS must not be stored by the provider and must be given back to the staff member.
- There was no process in place to check healthcare professionals, for example paramedics, held current registration with a professional body. The provider employed one qualified nurse, however they last checked their registration with the Nursing and Midwifery Council in 2014. The provider also had paramedics working for them but there was no evidence they had checked their professional registration.
- There was no evidence to demonstrate the registered manager was regularly reviewing the fitness of the employees to make sure they were meeting the requirements of their role.
- The provider employed 15 staff. The crew members were a mixture of current and retired paramedics, police, emergency care assistants and operating department practitioners. All the crew held zero hour contracts and chose their working hours.
- Staff either telephoned or emailed information regarding their availability for the coming week to the registered manager. This information was written on a board in the office so the registered manager knew who was available when a job came in. Jobs were turned down if the registered manager was unable to source the crew required for the journey.
- Ambulances were staffed with one driver and two crew members in the back as patient escorts. Their roles alternated between driver and escort on long journeys
- Driving distances and breaks were at the discretion of the crew and the registered manager relied on their professionalism to ensure their own welfare was met.

Both the registered manager and the staff told us they only drove between 100 and 150 miles before swapping drivers. Staff also told us this was dependent upon the driving conditions and the weather, and told us of occasions where they had taken over driving duties prior to achieving this mileage. Breaks were also decided by the crew and in conjunction with the patient, dependent upon when a comfort break was required, or the patient requested to stop to have a cigarette.

Response to major incidents

- There were contingency plans for a range of issues that could affect business continuity. The business continuity policy covered telephone line faults, power failure in the office, failure in information technology, inability to use the office due to fire or flooding, vehicle breakdown or accident causing ambulances to be unavailable for a period of time and staff sickness and accidents.

Are patient transport services effective?

Evidence-based care and treatment

- There were inadequate policies and procedures available to support evidence-based care and treatment.
- The registered manager was not up to date with relevant national guidance, and was not aware that national guidance which informed the provider's policies had been updated. There was no system to ensure the policies which were available contained the most up to date relevant information. Policies which were available made reference to out of date guidelines, including the infection, prevention and control policy. Not all policies identified a review date.
- The registered manager and staff were unaware of the National Institute for Health and Care Excellence (NICE) guidance 'Violence and aggression: short term management in mental health, health and community settings (NG10)'. This contained guidance for the management of restraint, violence and aggression in mental health.
- There were no measures to assure the care provided followed evidence-based best practice guidance. Assessments did not take into account current legislation or consider relevant nationally recognised evidence based guidance. For example, we saw a report form following the use of hand ties on a patient during a journey. There was no evidence to demonstrate NICE guidance 'Violence and aggression: short term management in mental health, health and community settings' had been taken into consideration. The reason for the use of hand ties as a last resort was not documented or risk-assessed, despite the NICE guidance advising against their use.
- The provider did not have a document to define the eligibility or exclusion criteria for patients referred to the service. This meant the referring units had no access to any definitive criteria to help them determine the types of patients suitable to travel with the service. The registered manager told us the units which used them, knew them well, and knew the types of patients which were appropriate to travel with them.

Assessment and planning of care

- A limited assessment of patients' needs and care required during transportation was taken at the initial booking stage. This meant the crew may not be aware of all the patient's needs prior to the journey. Limited information was obtained about any behavioural issues, whether the patient was detained under the Mental Health Act 1983, or other issues, such as infection control, communication issues or risks of absconding. We listened to the registered manager taking an initial booking. The only question asked about the patient was if there was anything the service should be aware of behaviourally about the patient. The registered manager told us the units would tell the crew about anything they needed to know about the patient prior to the journey.
- Staff received a verbal handover from the unit prior to transporting a patient. However, the information the crew received, or the information they requested, during the handover was not recorded. This meant we were not assured staff had all the relevant information they needed about the patient. Staff told us they would always ask whether the patient had any triggers which could lead to a change in their behaviour; however, we did not see any documented evidence of this information in the 30 journey sheets we reviewed. The journey sheets had very limited space for staff to be able to record any information to enable them to effectively plan the patient's care during the journey. The

registered manager told us all the crew were experienced professionals, were used to dealing with patients with mental health conditions, and he trusted them to get the information they needed.

- The category of patients transported by the provider meant the acuity or extent of their mental health condition could change rapidly in the short period of time between the initial booking and pick up of the patient. Staff told us they completed their own risk assessment using their experience from their previous roles to determine whether they could meet the needs of the patient during the journey. If the crew felt they were unable to effectively meet the patient's needs they would ring the registered manager to report their concerns and they would not transport the patient. Staff told us the registered manager had always supported them when they had been in this situation. However, these risk assessments and discussions were not recorded.
- There were arrangements for patients who travelled long distances to ensure their nutrition and hydration needs were met. Each ambulance carried a cool box with bottles of water and a store of crisps and chocolate for patients. The departing unit would also provide a packed meal for patients travelling on long journeys. The crew would also take refreshment breaks during long journeys and the service would purchase patients a drink and something small to eat of their choice during these breaks.

Response times and patient outcomes

- There was no system to enable the provider to determine whether they were delivering an effective patient transport service. Due to this, the service was unable to benchmark itself against other independent ambulance services nationally carrying out a similar service.
- Times of bookings, pick up times, waiting times and return times were recorded on the journey log. The registered manager told us each individual job was scrutinised individually and discussed with the crew after each journey. However, data was not collected to enable the registered manager to review trends or themes with regards to response times. Therefore, the registered manager was unable to gain an overall picture of the performance of the service.
- The provider did not monitor patient outcomes. The registered manager used the patient experience questionnaires as a tool to understand the patient experience of the journey. However, this data was not collected to enable trends and themes to be reviewed.
- The provider had one spare vehicle which could be used in times of high demand. The ability to use this ambulance was dependent upon whether the registered manager was able to staff the vehicle appropriately.

Competent staff

- The provider did not carry out annual appraisals or regular supervision with staff. This meant there was no formal assessment of the ongoing competence of the staff. The registered manager told us that neither he nor the staff felt appraisals were necessary. The registered manager said the majority of the staff were retired and worked for the service to continue to be able to do what they enjoyed when they wanted to. Staff we spoke with confirmed they has spent their working careers in the ambulance services and wanted to continue to work in this capacity on a basis where work was on their terms. Staff were on zero contract hours and could choose when they wanted to work. We were told staff joined the service due to the flexibility of their contract. There was no desire amongst the staff to develop their knowledge and skills. However, supervision and appraisals are an important aspect of ensuring staff are competent and identifying any learning needs within their current role, not just for further development.
- Crew did not receive training around the Mental Health Act 1983 despite transporting patients who were detained under the act. This meant crew did not have an understanding of their role and responsibilities in relation to the requirements of the act. However, the crew were provided with yearly training in conflict resolution and breakaway. We saw evidence all crew had completed this training. Training included a practical session and provided crew with the knowledge and skills to protect themselves if a patient became violent whilst under their care.
- There was no evidence the crew were competent to administer medicines. At times the crew were asked by the referring unit to administer prescribed medicines to a patient during a long journey. The registered manager told us the medicines would only be administered by a paramedic. However, not all of the paramedics working for the provider were registered. There was no evidence

these unregistered paramedics were competent to administer medicines and no training or updates were provided by the provider to ensure the crews were trained to do this. There was also no evidence to prove it was only the paramedic and ex-paramedic staff who administered the medicines.

- There was no competency assessment for new staff, or a checklist to show what their induction included and when they had completed this and been deemed competent in the role. There was a single day induction for new crew members. We spoke with one member of the crew who had recently joined. They told us they had found the induction process very helpful and gained useful insight into the service. The process included an informal discussion with the registered manager about the service. They were given an induction pack, which included a printed version of all of the Riviera Ambulance Service Limited policies, and the registered manager also provided an orientation session to the ambulances and a demonstration of the restraint options available.

Coordination with other providers and multi-disciplinary working

- The registered manager told us Riviera Ambulance Service Limited had worked with the units which used their transport services for a long time and they knew each other well. The registered manager also told us the units were aware of the types of patients which were appropriate to travel with the service and felt Riviera Ambulance Service Limited had a good working relationship with these organisations.
- Feedback we received from organisations which used Riviera Ambulance Service Limited spoke highly of the service and the communication and co-ordination of the booking process.

Access to information

- Staff may not have always been made aware of do not attempt resuscitation orders prior to a journey, unless the referring unit provided this information. Booking forms did not have a section to record if this had been discussed or raised at the initial booking stage. We asked the registered manager how they would know whether a patient had a do not attempt resuscitation order in place. They told us the unit would tell them if this was the case, and the crew would also find out this information at the handover they received prior to carrying out a journey. However, there was nowhere for this information to be recorded.
- Satellite navigation systems were available in all three ambulances. The systems provided crews with information to establish the quickest route to their destination.
- Staff were given printed copies of Rivera Ambulance Service Limited policies on joining the service. They told us they could always go into the office to access policies if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider did not have a policy or any procedures available with regards to capacity to consent. We asked the registered manager if there was any policy or procedure held to support the crew if they had to use restraint on a patient who lacked capacity, based on the Mental Capacity Act 2005. The registered manager told us there was no policy around this but told us 'somewhere' in their paperwork there was a statement that patients who lacked capacity would always travel with an escort from the referring unit. The registered manager was unable to find this information in any documents. We were told by the registered manager, since Rivera Ambulance Service Limited started, they had never transported a patient who lacked capacity.
- There was no assessment of the patient's needs and their capacity to consent to the use of restraint in line with the Mental Capacity Act 2005. We saw evidence that restraint had been used; however there was no documented detailed record, to demonstrate any form of patient assessment to consider the use of restraint which may be required to be used.
- None of the crew had completed any recent training or updates in the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards. The registered manager was unable to tell us whether the crew had received training in these areas initially on joining the service. The registered manager told us on joining, some crew completed this training as part of their safeguarding training, however the registered manager had no evidence of which crew had and had not received this training.
- The registered manager was unable to demonstrate an awareness of The Code of Practice: Mental Health Act

1983 during our discussion, and neither the crew or the registered manager received training on the code of practice. Paragraph 6 under The Code of practice: Mental Health Act 1983 states "the code is not statutory guidance, but would be beneficial for others in carrying out their duties. This includes commissioners of health services, the police and ambulance services, and others in health and social services (including the independent and voluntary sectors) involved in commissioning or providing services to people who are, or may become, subject to compulsory measures under the Act. It is important that these persons have training on the Code and ensure that they are familiar with its requirements."

Are patient transport services caring?

Compassionate care

- During the inspection we were not able to observe any patient journeys or direct care because there were no transfers booked in.
- Crew spoke about the patients they transported in a caring and insightful way. The crew were aware of the conditions which affected the patients they transported and spoke about how it was their duty to ensure the wellbeing and safety of the patient they were transporting. Crew also told us they tried hard to "treat patients equally and like a friend to make them feel at ease and supported during their journey." Crew also told us "the person we are transporting is someone's son, daughter, mother or father and they need to be treated with respect."
- We received 14 comment cards from patients who had been transported by Riviera Ambulance Service Limited. All of the comment cards received contained consistently positive information about the provider. Patients told us crew members were "very friendly," "good listeners," "easy to talk to," and "polite and welcoming." Other patients told us 'the staff were really kind," and "the staff are all lovely and make me feel comfortable."
- We reviewed 28 patient feedback forms used by the provider since January 2017 up until the time of our inspection. They provided evidence which demonstrated the crew took the time to interact with patients who used the service in a respectful and considerate manner. For example, one patient said "the crew were lovely as always, chatty, friendly and funny. Made for an enjoyable journey". Other patients said, "great service", "excellent work" and "highly recommended".

Understanding and involvement of patients and those close to them

- We received feedback from an organisation that used Riviera Ambulance Service Limited. They told us "Riviera Ambulance Service aspired to accommodate requests, we as bed coordinators put through to them. This is done in a timely manner and in a way that is always in the best interest of the patient. Riviera Ambulance Service also maintains contact with the relevant professionals where the patient is being transferred to/ from. This is a perfect quality that is very much appreciated by all parts of the service."
- From the responses we saw on the patient feedback forms used by the provider they demonstrated how the crew communicated with patients so that they understood their role during the transfer. One patient had commented "they put my mind at rest".

Emotional support

- The crew understood the impact their care could have on a patient's emotional wellbeing. Crew told us they always discussed with the staff at the unit about any triggers or topics of conversation they should avoid when transporting the patient. This was important as they did not want to upset or cause the patient any distress during their journey and to ensure the patient remained calm. The crew told us they tried to find common ground with the patient to make them feel at ease, so they could start to build a rapport. Crew gave us numerous examples of times when they had successfully engaged with the patient.
- We received feedback from one patient about how the crew had supported them emotionally. The patient had been anxious about the journey, but told us how the crew were very reassuring and put them at ease.

Patient transport services (PTS)

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

Service planning and delivery to meet the needs of local people

- The service was not commissioned by local Clinical Commissioning Groups to provide any services. All of the patient transport work provided by was carried out privately, and directly on request by organisations, such as the NHS or independent health services. However, this was not in line with guidance from the Code of Practice: Mental Health Act 1983 section 17.2 which states, "it is for clinical commissioning groups to commission ambulance and patient transport services to meet the needs of people living in their areas. This includes services for transporting patients to and from hospital (and other places) under the Act.
- The Code of Practice: Mental Health Act 1983 section 17.2 states it is "the respective responsibilities of different agencies and service providers for transporting patients in different circumstances should be clearly established locally and communicated to the professionals who need to know. In particular, it is essential to have clear agreements in place so that people who need assistance in transporting patients under the Act can obtain it without delay." The registered manager told us there was no documentation outlining the role and responsibilities of the service which the organisations had access to. We were told the staff at the referring units knew what patients would and would not be suitable to travel with the service.
- Long distance transfers required planning to ensure the service was able to accommodate specific timings for the journey requirements. The registered manager provided us with examples of when the crew had to pick up patients from destinations several hours away from Riviera Ambulance Service's Limited base. In this instance, the crew carrying out the journey travelled up the day before and stayed overnight to ensure they met the early pick up time requested at the time of booking. The journeys were sometimes return trips, therefore the crew stayed with patients to ensure a continuity of care
- Planned work was communicated to crew when they visited the station base prior to a journey. The registered manager would provide the crew with basic details about the job such as the patients name and age, the pickup and delivery location and the current behavioural status of the patient at the time of booking. However, limited information was written on the job sheet for the crew to take with them on the journey.
- The provider had some flexible capacity to cope with the differing level of demand for their service. There was one spare ambulance which could be used in times of increased demand. The use of this ambulance was dependent upon whether the registered manager was able to find a crew to carry out the journey at short notice on the same day.

Meeting people's individual needs

- The registered manager did not request an assessment of need for the patients who were referred to the service. There was a lack of recorded information about the patient and their needs from the initial telephone booking and during the ongoing journey. The initial assessment at the booking stage was limited and only gathered basic patient information. Therefore, we were not assured the crew were fully aware of the patient's needs and requirements to ensure the safety of the patient and others during the journey. Crews also received a handover from the referring unit when picking up the patient. There was very limited evidence to demonstrate what information they asked for or received during the handover to ensure they understood the needs of the patient.
- The crew were able to adapt quickly and manage patient's individual needs if they became agitated or started to exhibit challenging behaviour. The crew provided us with verbal examples of situations where they had recognised changes in the temperament of patients they were transporting and were able to tell us how they used their communication skills to help diffuse what could have potentially turned into a serious situation. We did not see any recorded documentation of situations documented on the 30 journey sheets we reviewed.
- Crew understood the need to keep patients calm and happy throughout their journey and where possible tried to accommodate the patient's wishes. Patients who requested a break to use the toilet or to smoke were risk assessed on whether this was appropriate; however, we did not see any documented evidence of this. If the crew decided that the patient was safe then they would stop and allow the use of disabled toilets at

service stations. The registered manager said the crew would decide if it was appropriate for the patient to use the bathroom alone, and would maintain conversation or enter the bathroom should they suspect something was amiss. Smoking was facilitated around the ambulance with the crew covering possible means of absconding.

- The service tried to meet the needs of patients they transported and tried to accommodate their individual preferences. The crew gave us an example of a particular vulnerable patient who had requested specific drivers for their journeys with Riviera Ambulance Service Limited. Continuity of crew put the patient at ease. The provider had been able ensure the patients' needs were met for each journey.
- The provider tried to prevent boredom for the patients who travelled on long journeys. Each ambulance held a small selection of magazines for patients to read. One crew member also provided us with an example of when the organisation bought a patient a magazine at a service station to read on the journey.
- The seat on the ambulance used by the patient was designed to ensure the patient's comfort. The seat reclined to enable the patient to lay back to sleep during the journey if they wanted to. The ambulances also had blacked out windows to improve patient confidentiality. The manager had arranged for curtains to be installed to help protect patients' dignity at night, as the light inside the ambulance would allow people outside to see in.
- The provider had systems available to support patients whose first language was not English to ensure the crew were able to accommodate their needs. The crew would be provided with a basic language phrase book to aid communication with the patients. Some crew also had a translation application on their mobile phone which they could use if required. The crew told us it was rare for them to transfer a patient whose first language was not English, however, they told us that despite this, when this had occurred they had managed well to communicate with them.
- The service was unable to support the transportation of bariatric patients.

Access and flow

- A service was provided which was flexible to meet the need of the organisations they worked for. A service was provided seven days a week, 24 hours a day. The registered manager took on jobs outside of usual business hours to accommodate the needs of the patients using the service. However, after 7pm the registered manager would not accept any transfers to travel long distances on the same day. He did not feel this was fair to the crew and felt this could be distressing to the patient to disturb their evening routine. Long journeys outside of usual business hours needed to be booked one day in advance.
- The provider accepted transfers booked on an ad-hoc basis, at short notice, and could usually provide transport services within business hours at a time realistic for both the service and the patient.
- The provider kept people informed if there were any delays. The crew held the contact details of the collection and drop off points for each patient on the journey form. If they were delayed for any reason they told us would call ahead to the accepting unit and the registered manager to keep people informed.
- The crew were supported by the registered manager and technology to overcome disruption on the roads whist on journeys. Each ambulance had a satellite navigation system which provided details of alternative route where there were traffic delays. The registered manager would also keep up to date with the traffic news and call a member of the crew who was not driving to support them to also find alternative routes to avoid delays for patients.

Learning from complaints and concerns

- Riviera Ambulance Service Limited had a complaints policy however, unless the complaint was a classed as a 'major complaint' by the registered manager, it would not necessarily get investigated by him. This meant there was a likelihood the member of crew investigating the complaint may have had some form of involvement in the situation raised by the complainant. The policy encouraged the crew to establish ownership and responsibility and take appropriate action if the complaint was 'clearly justified, falls in their jurisdiction and can be rectified immediately.' There was an escalation procedure to escalate major complaints to the registered manager however there was no definition of what constituted a minor or a major complaint.
- Riviera Ambulance Service Limited had received no complaints between April 2016 and July 2017.
- There was no information available to inform patients about how to make a complaint.

Patient transport services (PTS)

Are patient transport services well-led?

Leadership / culture of service

- The registered manager was also the owner of the service and had worked within the ambulance service for over 30 years. A year prior to our inspection, the registered manager had stopped working operationally and was focusing on the day to day management of the service.
- The registered manager did not have an understanding of the Health and Social Care Act 2008 (Regulated Activities) 2014 and was only able to provide us with limited evidence to demonstrate how the requirements of the act were being met by the provider. We were not assured the registered manager has full oversight of the service in terms of quality, safety, risk and performance. For example, no understanding of duty of candour, no monitoring of performance, outcomes, or risks to the service and no understanding of completing in detail risk assessments for patients.
- Crew spoke positively about the registered manager and his leadership. They told us the registered manager was approachable and they felt very well supported and provided us with examples of when this had occurred. Crew also told us they felt the registered manager cared for their wellbeing and provided us with examples. All of the crew felt valued, respected and appreciated. They told us the registered manager took the time to listen to them and actually took on board what they had told him, which they felt was a "rare quality."
- Crew told us the registered manager was visible and approachable and his door was always open. The crew would always go into the office to see the registered managed before and after a job to discuss any issues which may have arisen.

Vision and strategy for this this core service

- There was no documented vision or strategy for the provider. However, the provider had a value of providing 'care while getting there' for each individual patient using the service. The registered manager told us all of the crew were trained professionals, and had the inherent qualities and characteristics of professionals who were used to dealing with complex and often vulnerable patients and on a daily basis. However, during the inspection, we found no evidence of this.
- The provider's strategy and focus was to ensure continuation of the service for a further few years prior to the registered manager taking retirement. When the time came, the registered manager told us he would have more of an idea of the future for the service. Currently, the registered manager was unsure whether the service would close completely or whether the business would be taken over.

Governance, risk management and quality measurement

- There were no systems or processes to enable the registered manager to monitor the safety, quality or performance of the service against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We were not assured the registered manager understood how the service was performing and the areas where improvements were required. The registered manager told us they never transported a patient who had not been formally assessed by a healthcare professional. The registered manager was clear that it was the responsibility of the referring and receiving unit to action with regards to anything which may have occurred during the patient journey rather than the responsibility of the service.
- There was no governance framework to evidence and support the delivery of good quality care. There was no evidence the registered manager actively recorded the views of external stakeholders with regards to the provision of the ambulance service. The registered manager did not feel it was necessary to routinely record and report everything which happened, due to the service being so small. The registered manager told us every job was discussed with the crew directly and told us he was confident crew were open and transparent, and verbally fed back information both during and following each journey.
- The provider did not maintain a risk register or any other similar document to identify risks to the service provision. There were no processes to assess, monitor and mitigate the risks relating to the service, or the health and safety and welfare of patients and others. During discussion, the registered manager did not feel there were any risks associated with the service. We raised sustainability as a potential risk. The registered manager told us "if people want to use us, they will use us, we provide a good quality and reliable service, if people don't want to use us, then don't." We also raised

the potential of violence and aggression from patients, towards the crew as a potential risk. The registered manager was able to tell us what mitigating actions had been taken in relation to this risk; however this information was not formally recorded and there was no evidence to demonstrate how the registered manager was monitoring this risk.

- There was no programme of internal audit or other system to identify the service's strengths and areas for further development. The provider did not carry out any auditing around cleanliness, infection control, outcomes or documentation. There was no managerial oversight of risk, performance, outcomes or safety; therefore, we were not assured the registered manager was fully aware of how the service was performing. The registered manager told us things were reviewed daily and following each job by both crew and him personally. Due to this, the registered manager did not feel there was any need for things to always be formally recorded and documented. The lack of formal documentation or recording did not enable identification of any trends and themes which impacted upon the quality or safety of the service.
- There was no system or process to ensure a comprehensive assurance system and service performance measures were reported on, monitored and action taken to improve performance. The organisation did not monitor performance measures such as, times of collection of patients and the monitoring of delays and aborted journeys. The registered manager used the patient experience questionnaires as a guide to how the service was performing and told us all their comments were continually positive which meant they were providing a good service.

Public and staff engagement

- Riviera Ambulance Service Limited engaged with patients in order to assess the patient's experience of the quality of the service provided. However, the evidence was not reviewed to look for trends and themes to determine if action was required to make improvements to the service. The registered manager told us each form was reviewed individually.
- The provider aimed to collect feedback from 10% of patients who had used the service during each calendar month. The comments received from patients travelling with Riviera Ambulance Service Limited were all positive, providing feedback such as, "enjoyable journey" and "loved every minute." In the year prior to our inspection, there had only been one negative comment.
- There was no documented evidence that patient views were acted upon. We saw patient's questionnaires that were either filled in with assistance from the crew or by the patients. We found one of the 28 we examined for this year had a comment about the seating. We noticed, written next to this comment was a personal remark about the patient and no evidence to suggest if any action was taken about this. The registered manager told us the comment had not been upheld and not action had been taken, as the provider had not been made aware of the patient's situation prior to the journey.
- The registered manager was responsive to issues and ideas raised by the crew. One member of crew gave us an example of how several crew members had raised the benefit of having a racking system at the back of the ambulance with baskets to store equipment to ensure the equipment was stored in an organised manner and easy to access. Within three weeks, each of the three ambulances had a racking system installed.

Innovation, improvement and sustainability

- The provider had no plans for improvement of the service and no plans to ensure sustainability of the service for the future.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure familiarity with the requirements Health and Social Care Act 2008 (Regulated Activities) 2014.
- The provider must ensure incident reporting is embedded into the culture of Riviera Ambulance Service Limited and that incidents are adequately investigated and learning shared with the crew.
- The provider must ensure a thorough assessment of the patients need is taken and recorded for patients using the service.
- The provider must take action to act on information provided to them, for example, developing action plans from information provided by referring units and patient views.
- The provider must take prompt action to ensure policies and procedures are available with regards to capacity and consent.
- The provider must take prompt action to address the lack of detail around the extent of risks, and strategies to support the management and mitigation of risks when carrying out risk assessments.
- The provider must ensure there are policies and procedures available for crew when they support patients with medicines on long journeys.
- The provider must ensure all staff have an understanding of National Institute for Health and Care Excellence (NICE), Violence and aggression: short term management in mental health, health and community settings (NG10) with regards to restraint and violence and aggression in mental health and how this guidance applies to the service. The provider must also ensure restraint is being used in line with this guidance.
- The provider must take action to ensure crew are recording care and treatment, in relation to supporting patients with taking medications, during a journey.
- The provider must ensure the safe management and storage of oxygen on the ambulances.
- The provider must take action to actively assess the infection risks associated with patients to prevent and control the spread of infection.
- The provider must ensure the crew receive the correct level and frequency of safeguarding training, to ensure crew are competent within their roles.
- The provider must ensure there is an effective system to report allegations of abuse or concerns to safeguard patients.
- The provider must ensure an assessment is completed to demonstrate the patient's ability to consent to the use of restraint in line with the Mental Capacity Act 2005.
- The provider must ensure all crew receive training on the Code of Practice: Mental Health Act 1983, to ensure understanding.
- The provider must take action to ensure there are effective systems in place to be able to assess and monitor the service in terms of quality, safety, performance and risk.
- The provider must take action to ensure the registered manager is up to date with relevant nationally recognised guidance and aware when national guidance is updated which needed to be reflected in Riviera Ambulance Service's Limited policies and procedures.
- The provider must take action to ensure there are systems or processes to carry out appraisals to formally monitor the crew's competence to carry out their role.
- The provider must ensure there is a process to demonstrate staff competence to carry out their role following their induction period or for using blue lights on the ambulance.
- The provider must ensure there is a suitable recruitment procedure to safeguard patients against unsuitable staff, and ensure there is a process to review the fitness of the employees.
- The provider must ensure there is a system in place to check registered staff have the appropriate current registration with a professional body.
- The provider must take prompt action to ensure a sound understanding of the duty of candour regulation and to ensure there are policies and procedures which the duty of candour regulation within the service.

Outstanding practice and areas for improvement

Action the hospital SHOULD take to improve

- The provider should ensure they are working in accordance with national guidance around infection, prevention and control.
- The provider should ensure there was a system to monitor the time period in which each crew member spend driving.
- The provider should ensure there is a document defining eligibility criteria for the service, to determine the types of patients suitable to travel.
- The provider should ensure the service has a policy or procedure available for staff around the management of the deteriorating patient.
- The provider should take action to ensure information about do not attempt resuscitation or treatment is sought at the initial booking stage.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers (2) (b) Has the necessary qualifications, competence, skill and experience to manage the carrying on of the regulated activity. The registered manager did not have an understanding of the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 9 (3) (a) Carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for the care and treatment of the service user: 9 (3) (f) involving relevant persons in decision relating to the way in which the regulated activity is carried out on in so far as it relates to the service users care or treatment. 9 (3) (a) The registered manager did not request an assessment of need for the patients who were referred to the service. There was no record of any handover information provided to the crew from the referring unit. Assessments did not take into account current legislation or consider relevant nationally recognised evidence based guidance. For example, The use of NICE guidance for the management of violence and aggression in mental health patient with regards to the use of hand ties.

This section is primarily information for the provider

Requirement notices

9 (3) (f) There was no recorded evidence to demonstrate the service took action and formulated management plans around the information they were provided with. For example, if a patient was known to have challenging behaviour.

There was lack of recorded evidence that patient views were acted upon. For example we found a reference from a patient regarding seating, where a personal comment had been written about the patient.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 11(1) Care and treatment of service users must only be provided with the consent of the relevant person 11(1) The provider had no policies around capacity to consent or any policies and procedures to support the crew with patients who did not have capacity to consent.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1) Care and treatment must be provided in a safe way for service users. 12 (2) (a) Assessing the risks to the health and safety of service users of receiving care and treatment 12 (2) (b) Doing all that is reasonable practical to mitigate any such risks 12 (2) (g) The proper and safe management of medicines 12 (2) (h) Assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated. 12 (2) (a) Comprehensive risk assessments were not always carried out for patients travelling with Riviera

This section is primarily information for the provider

Requirement notices

Ambulance Service Limited. There was no further information detailing the extent of these risks, or guidance for the management strategies to be used to mitigate these risks.

12 (2) (b) Systems and processes to report and learn from incidents were ineffective.

12 (2) (g) There was no policy or procedure to support the crew with their role and responsibility with regards to recording when they had supported patients to take their medicine.

The crew did not always record when supported patients to take their medicines on a long journey

The management of oxygen stored on the ambulances was unsafe and not in line with guidance produced by the Department for Transport: Carriage of dangerous goods and transportable pressure equipment regulations 2009 as amended and the Health and Safety Executive. Ambulances did not display a warning sign to identify oxygen was carried on board.

12 (2) (h) There was no documented evidence to demonstrate the provider was assessing the risk of preventing and detecting the risk and controlling the spread of infections.

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 13 (2) Systems and processes must be established and operated effectively to prevent abuse of service users. 13 (3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. 13 (4) (b) Care or treatment for service users must not be provided in a way that includes acts intended to control

This section is primarily information for the provider

Requirement notices

or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint.

13 (2) The registered manager was the safeguarding lead for the service, however did not hold the correct level of training to be competent in this role.

The provider's statement of purpose states the service provides a service for the whole population whereas the providers safeguarding policy states patients under 16 years of age are not transported. However, we saw evidence that the service, a week prior to out inspection prior to out inspection had transported a child of 14 years of age.

The provider's safeguarding policy did not provide any direction of the responsibilities of the crew towards safeguarding issues and how concerns were to be reported or recorded.

There was no evidence to demonstrate child safeguarding training had been completed by any of the crew.

There was no evidence of any up to date safeguarding training.

13 (3) The service did not report directly to the local authority in the area they were in at the time of the transfer if they had a safeguarding concern and reported only to the receiving location.

13 (4) (b) There was no assessment of the patients need and their capacity to consent to the use of restraint.

We saw evidence that restraint had been used; however there was no documented detailed record to demonstrate any form of patient assessment to consider the use of restraint which may be required to be used in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part.

17 (2) (a) Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of the service users in receiving those services)

17 (2) (b) Assess monitor and mitigate the risks relating to the health safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity

17 (2) (c) Maintain securely and accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of the decisions taken in relation to the care and treatment provided.

17 (2) (d) Maintain securely such other records as are necessary to be kept in relation to-

1. Persons employed in the carrying on of regulated activity, and
2. The management of regulated activity

17 (2) (a) There was no system to identify the service's strengths and areas for further development.

There was no evidence of any internal reviews or audits of the service.

There was no evidence of any performance dashboards or reports completed with regards to the service.

The registered manager was not up to date with relevant nationally recognised guidance and had no awareness that guidance used to develop policies and procedures had been updated for example around safeguarding and the Mental Health Act 1983.

There was no documented evidence that the provider was actively seeking the views of other stakeholders for their experience of the service they provide.

17 (2) (b) The provider did not maintain a risk register or any other similar documents to identify risks to the

This section is primarily information for the provider

Requirement notices

service provision. Therefore, were no processes to assess, monitor and mitigate the risks relating to the service, or the health and safety and welfare of patients and others.

During a discussion, the registered manager told us there were no risks associated with the service.

17 (2) (c) There was a lack of recorded information about the patient and their needs from the initial telephone booking and the ongoing journey. The staff only gathered basic patient information.

17 (2) (d)The provider was not acting in accordance with the Revised Code of Practice for Disclosure and Barring Service Registered Persons 2015 with regards to the storage of disclosure and barring checks.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. 18 (2) (a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. 18 (2) (a)The provider did not carry out annual appraisals or regular supervision with the crew. The registered manager did not have an awareness of The Code of Practice: Mental Health Act 1983, and staff did not receive training on the code of practice. There was no evidence of the registered manager checking the ongoing competence of the crew. There was no evidence of a competency assessment for new staff or a checklist to prove when they completed their induction period and they were passed as competent to undertake the role.

This section is primarily information for the provider

Requirement notices

There was no evidence the registered manager assessed the crews competence for driving the ambulance and the use of using blue lights.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **19 (2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in-** 1. Paragraph (1), persons employed for the carrying on if a regulated activity must be of good character have the qualifications, competence skills and experience and be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed or, 1. In a case to which regulation 5 applies, paragraph (3) of that regulation **19 (4) Persons employed must be registered with the relevant professional body where such registration is required by, or under, any enactment in relation to-** 1. The work the person is to perform, or 2. (b) The title that the person takes or uses. **19 (5) Where a person employed by the registered person no longer meets the criteria in paragraph 1, the registered person must-** 1. take such action as in necessary and proportional to ensure that the requirement in that paragraph is complied with, and 2. if the person is a healthcare professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question **19 (2) A safe recruitment procedure was not in place to safeguard patients against unsuitable staff.**

This section is primarily information for the provider

Requirement notices

There was no documented evidence of satisfactory conduct in previous employment in health and social care or with children or vulnerable adults.

There was no proof of identify of the crew including a recent photograph.

19 (4) There was no process in place to check on staff that had appropriate current registration with a professional body.

19 (5) There was no documented evidence that he registered manager was regularly reviewing the fitness of the employees.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour 20 (1) Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. 20 (1) The registered manager was unable to demonstrate an understanding of the service's role and responsibilities with regards to duty of candour. Also, there were no policies or procedures regarding duty of candour available to support a culture of openness and transparency. During our discussions the registered manager was unable to demonstrate an understanding of the duty of candour even after prompts were provided. The registered manager made reference to the 5 domains covered by the CQC.