R & K Healthcare 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 known to CQC and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

R & K Healthcare Limited provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced inspection on 20 February 2018.

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.

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 the following issues that the service provider needs to improve:

- There were no incidents recorded during the reporting period but we were verbally told of at least two incidents that should have been formally documented.
- The provider could not evidence that all members of staff had up to date mandatory training in first aid at work.
- There were no business continuity or major incident plans in place.
- Some of the policies and guidance were not specific to the roles, responsibilities and type of service provided, and were created less than a month before our inspection.
- There were unclear audit arrangements and there was no auditing of patient transport services.
- There was no evidence of how audit outcomes and details were to be reviewed or how audit formed a part of the governance structure.
- Recruitment checks were minimal, including criminal checks on staff prior to their commencing employment with the provider. Staff references or checks regarding the validity and endorsements of driving licences were incomplete or inconsistent. Following our inspection the provider sent us a revised recruitment policy and procedure.
- Staff had received no appraisals and there was no evidence of a structured induction. Following the inspection, the provider sent us an example staff induction checklist and advised us that staff appraisals had commenced.
- The service did not monitor its performance, including number of patient transport journey or time on scene.
- There was a lack of systems and processes to assess, monitor and improve the quality and safety of services. There was no formalised system of governance.

The provider also acted quickly to resolve the following issues:

- Following our inspection, we issued the provider with a letter of intent to impose conditions to the registration regarding the improper use of blue lights when completing patient transport journeys. We received confirmation from the registered manager that no staff would use blue lights in the future, and he sent us a policy setting out the rationale and consequences for this.

Summary of findings

- During our inspection, we saw that none of the staff had received any safeguarding training. Following the inspection, the registered manager contacted us to advise that safeguarding training had been booked for all members of staff and we saw training certificates that indicated this had occurred

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

- We saw positive feedback received by the provider from service users.
- The registered manager recognised the service shortcomings and was passionate and dedicated to make these right.

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

Amanda Stanford (Deputy Chief Inspector), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)	Not sufficient evidence to rate	The only service was patient transport services. The service did not hold any formal contracts and worked on an ad hoc basis for a local trust when their contracted provider could not cover all of the shifts needed.

R & K Healthcare Limited

Detailed findings

Services we looked at
Patient transport services (PTS).

Detailed findings

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Background to R & K Healthcare Limited

R & K Healthcare Limited opened in 2014. It is an independent ambulance service carrying out patient transport services in East Surrey and some parts of London. The service transfers patients to and from hospital appointments, returns patients to their homes after a stay in hospital, or on to care homes, nursing homes & hospices.

The service covers the whole of the UK. The service did not have any formal contracts in place, and instead worked on an ad hoc basis for a local NHS trust and had recently commenced other informal work with a provider in London.

The service has had a registered manager in post since 29 September 2014 who is the only employee of the service and there are eight staff members employed on a bank of staff. The service has seven vehicles but only three were in use at the time of our inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a second CQC inspector and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Patient transport services (PTS)

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

Information about the service

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.
- Treatment of disease, disorder and injury.

During the inspection, we visited the service headquarters in Horley, Surrey. We spoke with Richard Hartley who was the registered manager and reviewed all of the staff records.

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

The service did not have any formal contracts; however it did provide regular work to a local NHS trust when their own sub-contractors could not fulfil all the transfers and had recently started regular informal work with a provider in London.

Activity (January 2017 to December 2017)

- In the reporting period January 2017 to December 2017 there were approximately 1028 patient transport journeys undertaken by the service.

The registered manager was the only employee of the company, and there was a bank of eight drivers that it could use.

Track record on safety:

- No never events
- No incidents reported
- No serious injuries
- Two complaints

Patient transport services (PTS)

Summary of findings

- There were no incidents recorded during the reporting period but we were verbally told of at least two incidents that should have been formally documented.
- The provider could not evidence that all members of staff had up to date mandatory training in first aid at work.
- There were no business continuity or major incident plans in place.
- Some of the policies and guidance were not specific to the roles, responsibilities and type of service provided, and were created less than a month before our inspection.
- There were unclear audit arrangements and there was no auditing of patient transport services.
- There was no evidence of how audit outcomes and details were to be reviewed or how audit formed a part of the governance structure.
- Recruitment checks were minimal, including criminal checks on staff prior to their commencing employment with the provider. Staff references or checks regarding the validity and endorsements of driving licences were incomplete or inconsistent.
- Staff had received no appraisals and there was no evidence of a structured induction.
- The service did not monitor its performance, including number of patient transport journey or time on scene.
- There was a lack of systems and processes to assess, monitor and improve the quality and safety of services. There was no formalised system of governance.

The provider also acted quickly to resolve the following issues:

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  We received confirmation from the registered manager that no staff would use blue lights in the future, and he sent us a policy setting out the rationale and consequences for this.
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However, we also found the following areas of good practice:

- We saw positive feedback received by the provider from service users.
- The registered manager recognised the service shortcomings and was passionate and dedicated to make these right.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- There was little or no use of systems to record and report safety concerns, incidents and near misses.
- There was an adverse incident and serious untoward incident policy. However, this was dated 16 January 2018, indicating it had been written one month before the inspection took place. The policy defined what an adverse incident and a serious untoward incident was, however, some of the examples given such as: 'delay in diagnosis, wrong diagnosis' were not relevant to the service as they did not provide clinical care. The policy set out that incidents must be reported within 24 hours. The policy also included job roles such as 'senior clinicians' which were not employed by the company. There was also no definition of a 'near miss'.
- There were no reported incidents for the service in the last 12 months. However, when speaking to the registered manager (RM), examples were given of incidents that had not been reported. This demonstrated a poor culture of incident recognition and reporting within the service. For example, when two members of staff accompanied a patient to their home following their transfer, they realised the patient's oxygen cylinder had not been switched on by the hospital. The staff members switched this on for the patient. However, this was not reported as an incident or reported back to the local hospital. The RM informed us that the incident was shared with staff so that they now check oxygen is set up and working when collecting patients. There was no documented record that this had been shared with staff. We spoke to the RM about why this was not reported, and he recognised that this should have been reported.
- As no incidents had been reported or formally documented, there was no evidence of learning from any incidents.
- We spoke to the RM regarding duty of candour and they were unaware of this duty. 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 meant that the RM might not recognise when the regulation should be applied.

Mandatory training

- The provider could not evidence that all members of staff had up to date mandatory training.
- As part of a routine request for data prior to the inspection, the provider told us that all staff were trained in defibrillation, manual handling, infection control and first aid at work and that there were plans for dementia training. The RM informed us that staff were also given equipment training prior to starting their role, however this was verbal training by the RM and was not recorded or documented.
- We reviewed six staff record files, and found that four members of staff were in date for manual handling training, with two having no certificates demonstrating this training had been completed. Three records showed that staff were out of date for first aid at work training, one had no certificate present, and two were in date for this training. Defibrillation training certificates were present and in date in one folder, two had no certificates for this and three had expired certificates with expiry dates in 2017. We also saw that one member of staff had a certificate of training for oxygen therapy and suction that was in date.
- We spoke to the RM regarding the out of date training, and were advised that staff had completed the updates but did not have certificates for these. We were shown an invoice for four training sessions for basic life support and automated external defibrillation (AED) training in January 2018, but it was not clear who this related to and whether relevant staff had completed this training.

Safeguarding

- No members of staff had received safeguarding training, which was not in line with national guidance or the provider's own policy. Following our inspection, we saw that staff had attended safeguarding adults and children level two safeguarding training.
- There was a child and adult protection policy and procedure, however this was dated 16 January 2018, indicating this had been written a month before our inspection. The policy stated that "All Company

professional transport staff will have received some training in relation to child and vulnerable adult abuse as a part of their basic training." We asked the RM what level of training staff had received, and we were told that no staff had received any form of safeguarding training within the last 12 months. This meant that staff did not have the necessary training to be able to recognise and escalate adults or children at risk of abuse.

- The intercollegiate guidance document "Safeguarding Children and Young People: roles and competencies for health care staff" (2014) states, "All non-clinical and clinical staff who have contact with children, young people and/or parents/carers" require safeguarding children level two training. It is also best practice for a nominated individual within the provider to act as a safeguarding lead, and would require level three safeguarding training.
- The policy was combined and there were no references to national and local guidance, or legal duties and responsibilities. The policy also referred to a training manager who was not part of the service. Following our inspection, we saw that the policy had been updated to reflect national guidance.
- The procedure for reporting a safeguarding concern was to inform 'a sub-contracting ambulance' trust control room and to follow their policy. However, as the service was not currently sub-contracted by an NHS ambulance trust, this procedure was incorrect. We asked the RM what staff were advised to do in the event of identifying a vulnerable person, they told us that staff were expected to report this to the NHS trust. However, as no concerns had been reported, and there were no staff available to speak to other then the RM, it was not possible to corroborate this.
- There was a disclosure and barring service (DBS) policy. This stated that staff must bring in original DBS certificate to be copied and kept on file by the provider, prior to commencing employment. However, we checked six staff folders, and found that only two had DBS certificates present. We spoke to the RM regarding this and they told us the application numbers for the DBS certificates, but these had not yet been returned. This meant whilst the DBS applications were in process the RM did not have assurances that staff were suitable to undertake their role.

Cleanliness, infection control and hygiene

- There was a principles of infection prevention and control policy. However, this was dated January 2018, indicating this was written the month before our inspection. The policy described the principles of infection control and methods of transmission, however did not define what the expectations were for cleaning regimes or what to do in the event of a spillage or contamination. T
- In some of the staff folders we reviewed, there were signed 'crew role job descriptions', which specified that the 'stretcher, wheelchair, handrails and chairs' were to be wiped down with anti-bacterial spray after every patient', however when we spoke to the RM they were not confident that this occurred, and there was no audit process in place to provide assurance that this was occurring. The RM was confident however, that they were cleaned effectively at the beginning of each shift and if there was bodily fluid or a patient travelling on the vehicle who had an infection. The vehicle we reviewed pre-shift, appeared visibly clean, but it would not have been possible for the RM to have assurances that all vehicles were clean.
- We inspected one ambulance vehicle that was on site, this appeared visibly clean and tidy. We saw that there were clinical decontamination wipes for general cleaning and a spill kit and cleaning fluid for spilled bodily fluids. The vehicle also had hand cleansing gel on board for staff to use.
- We reviewed cleaning records for two of the vehicles in service and saw that these had been completed and documented for the last 12 months. This indicated that regular cleaning was occurring of the vehicles, but there was no written guidance or policy to support this.
- There was a sharps disposal bin on board the ambulance we reviewed for any service users who used needles for chronic diseases such as diabetes. When these were full or went beyond their expiry date, the RM told us that they disposed of them at the local hospital.

Environment and equipment

- Two vehicles were kept at the registered office of the provider. The third vehicle was kept at the local NHS trust hospital site where staff worked from on a daily basis and had permission to leave the vehicle on site there.
- The provider had seven ambulances but only three were in use. All vehicles had valid MOTs in place and we saw servicing records indicating that all vehicles had been serviced within the last 12 months.
- We reviewed one of the vehicles that was on site. We observed that the inside of the vehicle including the cab area was visibly clean and tidy. The condition of the outside of the vehicle appeared good with no visible damage or dents.
- The automatic external defibrillator (AED) on board was serviced within the last 12 months, and had an electrical safety testing sticker present.
- We checked single-use sterile equipment such as defibrillator pads and found one set of out of date pads. We also found a bio-hazard spill kit that was out of date. We informed the registered manager who informed us they would replace the items.
- The provider used a web based application (app) to monitor that daily vehicle checks were performed by staff. Vehicle checks included, checking tyres, headlights, side lights, all seatbelts, horn, mirrors, stock levels and vehicle cleanliness. Staff also checked tyre pressures monthly at a local garage, however these tyre checks were not recorded.
- The RM showed staff how to complete vehicle checks correctly, for example checking tread depth on tyres and that they were free from cuts and any bulges. The app had a checklist which staff completed whilst carrying out the checks. When vehicle checks were not completed using the app, for example if the app was down, then staff were supposed to complete a paper form. However, when we asked to see these, the files for 2017-18 and 2018-19 could not be found. The RM was unable to tell us how many times the app had been down so we were unable to assess whether there should have been any paper records available.
- The RM told us that it should take at least five to six minutes to complete the vehicle checks thoroughly. We checked eight vehicle check durations recorded on the app, and saw that six out of eight of the checks took less than five minutes, with one of the checks lasting 59 seconds. This indicated that drivers were not consistently carrying out thorough checks on the vehicles.
- The app also had a 'defect notification'. When a staff member identified a fault on a vehicle, they inputted this onto the app form and this notified the registered manager. Staff also rang the RM to inform them of any defects. For example, a head light was defective on a vehicle and they called the RM who sent them to the local garage to replace it. However, there was not a defect notification form for this defect on the system, indicating that staff were not following the process for reporting vehicle defects.

Medicines

- The service did not keep any medicines on site. If patients needed to transport medicines with them on their journey, they remained the responsibility of the patient throughout the journey.
- Some patients required personal oxygen during their transfer. As with other medicines, this remained the responsibility of the patient whilst on the journey.

Records

- There was a security of patient data policy dated January 2018. This referenced the Data Protection Act 1998 and contained guidance and advice for crews such as not leaving documentation on display in the vehicle and not putting loose documents in the door pockets in case wind blew them away. We did not see any vehicles during a transfer so we were unable to review if this happened in practice.
- We reviewed the web based app that recorded all patient journeys. This recorded the name of the crew member on the journey, the registration of the vehicle and the mileage reading at the start of each journey. This could also demonstrate when a member of staff had a defect on their vehicle. We saw an example where this had occurred and a defect with a tyre had been reported via the defect notification, but there was also an example where a defect had occurred but this had not been reported via the notification route on the app

and had instead been called through to the registered manager. This indicated that although defects were always promptly reported, there needed to be greater clarity around the proper route for reporting this.

- We saw on the app that upon collection of the service user, staff completed a check list form. This included whether the patient had a do not attempt resuscitation (DNAR) form in place, whether the staff were in possession of it, whether the service user had a known infection, and if any controlled drugs (CDs) were travelling with them. Staff could also photograph and list what these CDs were. Each of these checks were dated and time stamped so that if required, a check that they had been completed could be made. These checks were made again at patient handover at the end of the journey.

Assessing and responding to patient risk

- Part of the service mandatory training was first aid at work. This course was aimed at providing staff with a knowledge of what to do if a patient were to faint, become unresponsive or unconscious, alongside some basic first aid training. However, we did not see evidence that all staff had received this training within the recommended time period.
- There were policies in place to direct staff when looking after patients that may deteriorate such as the cardiac arrest policy and the DNAR policy.
- The cardiac arrest policy was dated January 2018 and stated that a minimum level of training in first aid at work, CPR and use of AED must be completed by staff. However, we did not see evidence that all staff had received this training within the recommended time period. The policy stated that in the event of a service user not breathing, to call an emergency ambulance and begin resuscitation procedures. The policy referred to both adults and children, however the flow chart in the appendix of the policy was only relevant for adults. There was also a section for early advanced life support and post resuscitation care, however as no staff had received this level of training, the appropriateness of this inclusion was questionable.
- There was a DNAR policy dated 16 January 2018. This stated that DNAR forms need to be specifically shown to the ambulance crew before the patient is on board the ambulance and we saw a checklist on the app that confirmed this was occurring. This meant that staff would be aware if the patient stopped breathing on route that they were not for resuscitation.
- We asked the RM if they had any incidents of patients deteriorating whilst on route. We were told that there had been one incident where a patient deteriorated close to the hospital, and therefore the staff turned round and took the patient straight to A&E. However, the procedure and policy did not specify what to do when a deterioration occurred close to an emergency hospital, or how close they would need to be in order to drive to the department or whether to pull over and dial for an emergency ambulance.
- The RM told us of an occasion where a service user had asked for some food shopping on their journey. The RM took them to a supermarket and completed their shopping on their behalf. Whilst this was done at the patient's request, the patient was left unaccompanied in the vehicle and if the patient deteriorated unexpectedly, they would have been unable to alert anyone.
- We asked the RM about dealing with disturbed or violent patients and were not assured that staff were able to assess or manage the level of risk. The RM gave examples such as a patient being transported with a knife, and a patient with mental health issues who was threatening a member of the hospital team.
- We were given an example where an informal risk assessment was completed when a patient with a history of aggression was transported with a female driver and a male staff member accompanying in the back as they did not feel it would be safe for the female to be alone with the patient. Staff did not have any conflict resolution training and there was no policy with guidance on what to do in a conflict situation.
- The RM told us that three of the vehicles had blue lights fitted to them. Blue lights on vehicles are generally reserved for vehicles completing emergency work, and as a PTS provider, it was not appropriate for R&K to use blue lights. In addition, staff had not received blue light driver training. Driving on blue lights can involve driving above the recommended speed limit and driving on the

wrong side of the road, meaning it is a high-risk activity for drivers, passengers, other road users and pedestrians. Therefore, training for this is essential to ensure safety.

The RM told us that the service had used blue lights approximately four times in the last 12 months. On one occasion, the police had informed the ambulance to use blue lights to get through traffic, and on another occasion, a service user with psychiatric issues became distressed. The RM told us that he felt these were legitimate uses of blue lights, but there was one occasion where blue lights were used for a non-urgent reason. A staff member used blue lights when a transfer was running late in order to get a patient to their appointment on time. The RM advised us that this was unacceptable and that they had given a verbal warning to the staff member.

Following the inspection, the RM informed us that they would not use blue lights under any circumstances, and submitted a policy

The RM told us about an occasion where staff had recognised, on returning a patient home, that their partner was unwell. Staff called for an ambulance for the partner, and then returned the service user back to the hospital as there was no one at home to care for them.

Staffing

- The registered manager was the only employee of the company. Another eight members of staff were available on the service 'bank'. The structure of the organisation was very flat with the registered manager leading the organisation and the drivers reporting through to the manager.
- The RM told us that he had recently appointed a new member of bank staff to work as a HR manager to support with the HR processes. The RM was also planning to make two of the bank drivers 'team leader' so that they could be developed in managing the other drivers and take some of the responsibility from the RM.
- The shift pattern was a four days on and four days off. Shifts were 11 and a half hours long, and staff could choose to complete overtime if they wished.

Anticipated resource and capacity risks

- There was no inclement weather policy, however, the RM showed us that the vehicles had winter tyres that were switched to during the colder months to ensure the vehicles could be used in colder or icy conditions. This was the responsibility of the RM to identify and action.
- We asked the registered manager what would happen in the event of a staff member calling in sick. We were told that quite often the RM has to cover the shifts if other bank staff were absent.

Response to major incidents

- There was no business continuity plan in place for the service. Business continuity plans are used in services to ensure that in the event of a disruption (eg power failure, inclement weather etc) there is a process for staff to follow to ensure business continuity. The absence of a policy meant that, should there be an interruption to business continuity, there was no assurance that staff would know the procedures or processes for the business to continue.
- The service had vehicle breakdown cover in place. The RM told us about a breakdown that had occurred the week prior to the inspection and the process for calling the breakdown company. However, there was no policy or procedure in place for this, and in the event of a breakdown this would not be reported anywhere, so the provider would not have an overview of breakdowns or issues over the course of a year.

Are patient transport services effective?

Evidence-based care and treatment

- The policies we reviewed were written in January 2018, which was after the inspection had been announced, and one month before our inspection took place. The registered manager (RM) advised us this was because the original copies of policies were no longer relevant and required updating. However, we were unable to see any of the previous policies at the time of our inspection. The usual process for updating of policies is to update the version number of the policies to ensure a complete audit trail and track changes made to policies, for example in light of updated guidance or processes.

- Some of the policies we reviewed, referred to staff roles that were not relevant to the service. For example in the safeguarding policy, there was reference to a training manager, who was not currently part of the staff structure, or the planned changes to the structure that the RM told us about. The policy also stated that compliance would be monitored through clinical audit. No audits had been carried out and any audits that could be carried out by the service would not be clinical, as none of the staff had clinical qualifications or training. Also in the incident policy, there was reference to recording incidents of wrong or delayed diagnosis, which would not be relevant or appropriate for a patient transport service to determine.
- The service did not always follow their own policies. For example, the safeguarding policy stated that all staff would have a basic level of safeguarding training, and we saw that no staff had received any safeguarding training.
- There was no process or procedure for staff confirming and documenting that they had read and understood the provider policies and procedures. The RM showed us that hard copies of policies were stored at the main office, however not all staff reported into the office before commencing their journeys (such as staff who started from the hospital site), and so it was not possible to gain assurance that all staff had sight of these.

Assessment and planning of care

- The RM told us that they provided snack boxes and water for service users on their journeys. However, as we were unable to attend any journeys during the inspection this meant that we were unable to view this in practice.

Response times and patient outcomes

- As the service did not have any formal contracts, they were not held accountable to any key performance indicators.
- The service did not monitor key outcome data such as number of journeys, response times or patient time on vehicle. The RM estimated the amount of journeys that had been carried out in the last 12 months, but did not have a documented way for recording or monitoring this. The web-based app recorded details of all journeys, but the RM was not clear on if or how this data could be used to give a verified number of journeys carried out.

Competent staff

- There were gaps in the management and support arrangements for staff, such as recruitment processes, appraisals, supervision and professional development.
- No staff members had appraisals within the last 12 months which meant there had been no review of staff performance or assessment of training requirements. The registered manager explained that they realised appraisals should be occurring regularly and a new member of staff with a HR role had been appointed to help with the implementation of this in the future.
- The registered manager told us that as part of the induction to the company, new drivers would be accompanied by the registered manager. However, this was not documented anywhere as part of a formal policy or procedure. The registered manager told us that he planned to do this in the future.
- There was a DBS policy and procedure dated January 2018. This stated that all staff members must have a DBS check, although a previous DBS check less than 3 months old from a previous employer would be accepted for recruitment purposes, they would still complete one under the provider's name. However, in the nine staff files we reviewed, only two had DBS copies or applications in. The RM told us the DBS checks had all been applied for and he gave us application reference numbers, however we were not able to see assurance that all of the DBS checks had been received and checked prior to commencing employment with the provider.
- The DBS policy also referred to a 'full range of checks' in addition to the DBS on commencing employment such as requesting references from previous employers. However in the nine folders we reviewed, one had a personal reference, one was a previous reference applied for from a previous company and therefore not recent, and the remaining seven folders had no reference information. The RM told us that references had been applied for but not always received and that he was assured of the staff as they had been recommended informally or were known to them.

- The RM told us that out of the nine members of staff (including the RM) that only six drive the ambulances. We checked nine staff folders, and saw that only five of these had photocopies of driving licenses, and one of these was an old-style driving licence that was no longer valid for use although we were told this particular member of staff did not drive any of the vehicles. The RM told us that he had seen all driving licences but had not copied all of them. There was also no documentation about whether each staff member who drove had any points or fines on their licence. The RM told us that they would only accept drivers with six points or less on their drivers licence, but without the proper checks, this could not be assured.
- Following the inspection, the RM sent us a driving licence check policy. This set out the need and rationale for why staff members' driving licence information needed to be checked, what the maximum endorsement on a driving license was, and an appendix with a consent form from the DVLA (D796) that staff would be required to sign to allow the registered manager to view their licence information online.

Coordination with other providers

- The provider worked under an informal arrangement with a local NHS hospital and reported they had regular informal catch ups with the contact at that NHS hospital.

Access to information

- As part of the pickup and handover process, staff had to check and record whether any special notes such as do not attempt resuscitation orders (DNARs) were in place, so there was end to end assurance at pick up and handover that these documents had been transferred. However there was no policy or protocol for this process.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not have specific training inthe Mental Capacity Act and deprivation of liberty safeguards.
- We spoke to the registered manager regarding whether patients who were sectioned would be transferred on their vehicles. They told us that only if a registered mental health professional accompanied them.

Are patient transport services caring?

Compassionate care

- We were unable to directly observe any patient care as there were no journeys we could attend on the day. However, we saw a folder containing letters of appreciation from over 30 service users since January 2017.

Understanding and involvement of patients and those close to them

- The eligibility for the transport service was controlled and decided upon by the NHS trust.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The service did not hold any formal contracts. They held informal regular work with a local NHS trust, where the service would pick up patients who could not be catered for through the formal contracted PTS service. The hospital informed the service whether a one or two-man crew was needed for the patient transfer.
- Most of the transport journeys were ad-hoc due to the 'stand by' nature of the service. However, the registered manager explained that some planned journeys that the contracted provider could not cater for were written on a job sheet within the NHS trust office, and if R&K could take on these journeys, they would.
- The service could not give us accurate data about their activity in the last 12 months, but estimated they completed approximately four journeys every weekday, with one at the weekend. This would amount to 708 journeys per year over the last 12 months. In addition to this, since December 2017, additional work was taken on, with approximately eight additional journeys per day, amounting to an additional 320 journeys from December 2017 to January 2018. This amounted to approximately 1028 journeys in total over the last 12 months.
- Vehicles were tracked and monitored via a web-based application that the registered manager could access

from the site office. This could monitor where the vehicle was, and what speed it had travelled at throughout the journey. However, as the RM spent a limited amount of time in the site office, there was no way of regularly checking or auditing this.

- The RM advised us that on long journeys they would use the vehicle with the bariatric stretcher for additional comfort and space whilst travelling.
- If patients required the toilet whilst travelling, staff would try to stop at public toilets on route. Staff also carried urine bottles for males. It was unclear what facilities they had for female service users if they needed to go to the toilet mid journey.
- We were told about a staff member who bought a patient their favourite newspaper each day they transported them, and we were told how the ambulances carry some cushions and other items to make patients more comfortable on their journey.

Meeting people's individual needs

- The RM gave examples of how they managed a patient who did not speak English as a first language. They were able to communicate with the patient via a relative, however this is not considered best practice. Another example given was using a web based application to translate to English.
- The service had access to bariatric stretchers. A bariatric patient is one whose body mass index (BMI) is over 40. This meant that bariatric patients could travel safely and comfortably on transfers.
- The service did not possess any picture books for patients who may have learning difficulties, and the RM described they do their best by talking calmly and clearly to these patients.

Access and flow

- The service did not monitor response or turnaround times. If one of the drivers was running late on a journey, the RM told us that the second person in the vehicle would ring ahead to inform the service user. However, as there was no way of documenting and monitoring response and service times, this could not be corroborated.

Learning from complaints and concerns

- There were two formal complaints to the service. We saw a folder where the correspondence for these were kept. We saw evidence of thorough and timely investigation into both of these complaints.
- One of the complaints concerned an allegation that staff had not returned a service user's DNAR certificate when they transported the patient home. An investigation was undertaken, and the RM as a result, added a DNAR tick box to the app used when picking up and handing over patients.

Are patient transport services well-led?

Leadership of service

- The registered manager (RM) did not have the necessary experience, knowledge or capacity to lead effectively. They had a wide remit, managing all other members of staff, company policies and processes and covering drivers when they called in sick. Because of this, the RM said they had been unable to spend as much time overseeing the service as they would like and recognised this as an issue. They told us that they hoped the appointment of a HR manager and team leaders would allow them the time to focus on the running of the service.
- As we were unable to speak to any other drivers during our inspection, we were unable to get feedback from other staff members.

Vision and strategy for this this core service

- There were no documented vision or values of the service.The RM spoke about the values of the company being to treat patients as if they were family As we only spoke to the RM, we were unable to ascertain if other members of staff were aware of and understood these values.
- There was no written strategy for the service. The RM told us that in the future he would like five vehicles on the road, but emphasised the main priority was the patients and ensuring the service was working within regulations prior to any expansion. They also told us about the planned change to structure and roles, with the appointment of a HR manager and expanding two of the driver roles to team leader positions.

Patient transport services (PTS)

Governance, risk management and quality measurement

- The governance arrangements and their purpose were unclear. There was no process in place to review key items such as the strategy, values, objectives, plans or the governance framework
- There was no effective system for identifying, capturing and managing issues and risks. Following the inspection, the provider sent us an example of their risk register, and a incident log for staff to record incidents on. A revised risk management policy had also been initiated.
- Policies did not always reference national guidance and some policies were not being followed in practice. Policies such as the Health and safety policy referred to identifying health and safety hazards, which was not done, and the adverse incident policy referred to a clinical risk management strategy, which did not exist.
- The system and technology for monitoring vehicles and their whereabouts was effective but the lack of auditing and actual monitoring of this meant that governance and performance overview was limited.

Culture within the service

- As we only spoke to the registered manager, it was not possible to accurately assess the culture of the organisation. We passed CQC contact details at the time of the inspection should other staff members like to give us feedback about the service but we did not receive any response to this.

Public and staff engagement

- There was no public website or public information regarding the service.
- No team meetings had taken place in the last 12 months. The RM advised that they had previously tried to set these up but it was difficult to get all members of staff in the same place at the same time. They were hopeful that the change to structure in the future may make this an easier task to achieve.

Innovation, improvement and sustainability

- The RM had recognised that they needed support in the management of both staff and the service and was changing the structure of the organisation to include team leaders and an HR lead, allowing the RM to oversee the service and governance of the organisation better.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The provider must ensure that all staff have received an appropriate level of safeguarding training for both adults and children. A nominated individual must be appointed as the safeguarding lead for the service and trained to an appropriate level. There must be a safeguarding policy and local protocol in place that accurately reflects current national guidance.

The provider must ensure that all staff are suitably qualified for the role. Checks at recruitment should be robust and include satisfactory references and satisfactory disclosure and barring service (DBS) certification in place prior to commencing work for the service.

Staff must receive appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform.

The provider must address a number of concerns identified during the inspection in relation to incident recording and reporting, assessment and monitoring of risk and the governance of the service. This must include implementation and embedding of an incident reporting system, the commencement and ongoing monitoring of a service risk register and monitoring of the service activity and performance.

Action the hospital SHOULD take to improve

The provider should ensure that cleaning regimes are specified in policies and procedures, and regular auditing of this should be completed to ensure this is being completed.

The provider should ensure that business continuity plans are put in place and regularly reviewed.

The provider should ensure that formal translation services are used for patients who do not speak English as a first language.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding** **Safeguarding service users from abuse and improper treatment;** 13 (1) & (2) 13.— 1. **Service users must be protected from abuse and improper treatment in accordance with this regulation.** 2. **Systems and processes must be established and operated effectively to prevent abuse of service users.** **There was no nominated individual as the designated safeguarding lead.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance** **Good Governance;** 17 (1), (2), a & b: 17.— 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

This section is primarily information for the provider

Requirement notices

2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—
   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 service users in receiving those services);
   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;

The service had not reported any incidents, but described an example to us during the inspection. There was an incident policy but this had been created in January 2018 and there was no assurance that any staff had read or understood this. There was no way of monitoring activity or performance.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing Regulation 18: Staffing; 18 (1) & (2) a: 18.- 1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. 2. Persons employed by the service provider in the provision of a regulated activity must— 1. A. 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,

This section is primarily information for the provider

Requirement notices

No members of staff had received an appraisal and we only saw partial assurances that staff had received mandatory training. Driving licenses had not been checked for points/disqualification. No references were seen in the staff folders we reviewed. Not all staff had evidence of DBS checks in their staff files.