Mr Sam Alan Bull

Secure Care Uk

Quality Report

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Date of inspection visit: 05 February 2018
Date of publication: 23/04/2018

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

Secure Care UK (SCUK) is operated by Mr Sam Alan Bull. The service provides a patient transport service for adults with mental health disorders, as well as the transport and supervision of people in section 136 suites whilst awaiting mental health assessment.

We carried out an announced inspection on 5 February 2018 to follow up on our previous concerns about the service. This report looks specifically at those concerns and so does not cover all of the areas of our comprehensive inspection methodology.

We completed an announced inspection of SCUK on 17 October 2017, along with an unannounced inspection on 25 October 2017. We found the following issues:

- The provider did not adequately investigate incidents and there was no evidence of shared learning.
- Staff at this ambulance station did not always complete the cleaning and vehicle safety checklists.
- The external door to the ambulance station was open on arrival at the unannounced inspection.
- The provider did not have equipment for children and young people.
- Oxygen cylinders were stored incorrectly.
- Managers lacked awareness of an understanding of safeguarding children and adults at risk.
- There was ineffective storage of patient records.
- Some of the policies and guidance were not specific to the roles, responsibilities and type of service provided.
- There were no policies or guidance for the transport of children, monitoring at 136 suites and bed watches.
- Staff were unaware of how to contact the translation service.
- Staff were unaware of the organisation's visions and strategy for the service.
- Governance arrangements were not of a good enough standard to identify and minimise risks. There was a lack of oversight and self-assurance of compliance with the fundamental standards.

Because of the above, CQC issued the provider with a warning notice in November 2017 because the provider was not compliant with Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider that they must be compliant with this regulation by 7 December 2017.The provider was also issued with two requirement notices.

We carried out this inspection to review what actions had been taken by the provider to respond to CQC's concerns about the governance of the service. This included reviewing the progress made in accordance with the action plan, which the provider submitted to CQC following the previous inspection.

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 that the provider had made some improvement on the concerns listed above.
- The ambulance station was secure with restricted access through the internal doors.
- The provider had obtained equipment for children and young people.
- Oxygen cylinders were stored correctly.

Summary of findings

- The safeguarding lead had the correct level of safeguarding training and fully understood the provider's duty to report safeguarding concerns.
- Leadership within the organisation had changed but it was too soon to establish the effectiveness of these changes.

However:

- At the time of inspection, there had been little progress to address our previous concerns about incident management.
- The organisation had not met its requirement to apply the duty of candour for incidents.
- There was still poor staff compliance to the completion of vehicle cleaning and safety checklists.
- At the time of inspection, the provider had not implemented changes to improve patient assessment and record keeping.
- The provider had not reviewed and updated policies to reflect changes made to practice.
- Staff remained unaware of how to contact the translation service.
- There was still poor compliance to first aid training.
- Management acknowledged information provided to CQC at the previous inspection was incorrect.
- At the time of inspection, there had been little progress to address our previous concerns about recruitment checks.

We sent the provider a letter highlighting our concerns following this inspection. We requested and received an action plan, which addressed each area for improvement. The action plan is discussed in more detail throughout the report.

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 four requirement notice(s) that affected the patient transport service. Details are at the end of the report.

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

Secure Care Uk

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Background to Secure Care Uk

Secure Care UK (SCUK) is operated by Mr Sam Alan Bull. The service opened in 2013. It is an independent ambulance provider in Hastings, East Sussex.

The types of transport provided include: transfers from secure mental health services to prisons or courts; transfers from mental health inpatient units to general acute settings for medical care; transport from patients' home addresses to a mental health inpatient setting and transfers for patients using community mental health services and learning disability services. The service also provided bed watches on mental health wards and monitored patients at section 136 suites. A section 136 suite is a dedicated unit for the reception and assessment of patients with mental health disorders.

SCUK provides patient transport services to a number of NHS trusts and private providers across England, Scotland and Wales. The service completed 3,233 patient journeys between September 2016 and August 2017.

SCUK only transport adults aged 18 or over, and stopped transporting children and young people in November 2017 following concerns identified at our previous inspection in October 2017. The provider subsequently suspended all services for children and young people. The provider has no plans to reintroduce the transport of children and young people until it had achieved full regulatory compliance.

The service has had a registered manager in post since 2013; this individual also became the Managing Director of the provider in 2014. During this inspection, we were told the training manager would be applying for the position of registered manager.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC inspector and a CQC mental health inspector. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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.

The service is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely

We carried out an announced inspection on 5 February 2018 and visited the base in Hastings. We spoke with five members of staff including managers and call centre staff. We did not have the opportunity speak with any patients during the course of our inspection. We reviewed 16 sets of staff records, nine incident report forms and 10 booking forms.

Summary of findings

We found the provider had made some improvement since the previous inspection:

- The ambulance station was secure with restricted access through the internal doors.
- The provider had obtained equipment for children and young people.
- Oxygen cylinders were stored correctly.
- The safeguarding lead had the correct level of safeguarding training and fully understood the provider's duty to report safeguarding concerns.
- Leadership within the organisation had changed but it was too soon to establish the effectiveness of these changes.

However:

- At the time of inspection, there had been little progress to address our previous concerns about incident management.
- The organisation had not met its requirement to apply the duty of candour for incidents.
- There was still poor staff compliance to the completion of vehicle cleaning and safety checklists.
- At the time of inspection, the provider had not implemented changes to improve patient assessment and record keeping.
- The provider had not reviewed and updated policies to reflect changes made to practice.
- Staff remained unaware of how to contact the translation service.
- There was still poor compliance to first aid training.
- Management acknowledged information provided to CQC at the previous inspection was incorrect.

Patient transport services (PTS)

- At the time of inspection, there had been little progress to address our previous concerns about recruitment checks.

Are patient transport services safe?

Incidents

At the previous inspection, we raised concerns about the management of incidents including organisational oversight, investigation, documentation and shared learning. At this inspection, we saw there was some improvement.

We reported in our previous inspection in October 2017, that the incident forms did not contain any risk grading, which was not in line with the organisation's, 'Incident management & serious incidents requiring investigation (SIRI)' policy.

During this inspection, we saw the provider had introduced a new incident reporting form, which included degree of harm. Staff had indicated the degree of harm in all nine incident report forms we reviewed. Six forms indicated no harm, one form indicated low harm and two forms indicated moderate harm. However, the degree of harm did not reflect the risk grading described in the organisation's policy.

The new incident reporting form, unlike the previous version, did not capture specific information about restraint such as type of restraint, duration of restraint and the member of staff who applied the restraint. Following the inspection, we saw an action plan, which showed the service had developed a post journey patient record, which included this information. This was not in use at the time of the inspection.

Incident report forms were not fully completed. In the nine incident report forms reviewed, five did not contain the job number, four did not contain the type of patient conveyed and four did not contain the patient's date of birth. This suggested managers did not review the incident report forms prior to submission.

The new clinical governance lead told us, he wanted staff to have training on how to complete the incident forms correctly including the level of detail required and writing style. There were no scheduled dates for this training at the time of the inspection.

At the previous inspection, we found the majority of staff did not complete the reflective section of the incident form. During this inspection, staff had only completed the reflective log in one out of nine incident report forms. In

this reflection, there was no staff name, date or documented debrief with their line manager. This meant staff did not evaluate their own practice in order to improve.

At the previous inspection, we reported each member of staff completed an incident report form when patient restraint took place. We recognised this as best practice, however during this inspection only one in nine incidents had an account from each staff member.

Staff did not comply with the incident reporting policy. The organisation's policy, stated staff should complete a body map when patient restraint takes place. Only one in nine incident report forms we reviewed had an attached body map. We escalated this to the clinical governance lead, who reported attaching the body map to the corresponding incident report form was a new process. He provided a pile of body maps but we were unable to find any for the remaining eight incident report forms we reviewed. This also meant management did not review incident report forms prior to submission.

Following the inspection, we saw an action plan, which showed the service had developed a post journey patient record. It captured full details of the patient journey including incidents and debriefs in one document. This was not in use at the time of the inspection.

The provider reported one serious incident since the previous inspection in October 2017. The incident involved patient use of a weapon during a patient journey. The provider carried out a root cause analysis (RCA), which identified a system wide failure. A RCA is a method of problem solving used for identifying the causes of faults or problems. Recommendations from the RCA included introduction of a duty manager, a minimum of three staff per patient journey and the allocation of staff by managers rather than call handlers. Staff we spoke to were aware of this incident and the changes to practice which had been implemented.

Following the inspection, we saw an action plan, which showed the provider uploaded completed RCAs on the staff intranet page and planned for managers to discuss learning at one to one supervisions. The provider was rolling out one to one supervisions for all staff, which aimed to improve staff awareness of learning from incidents.

The incident log did not capture all incidents or incident details. Since December 2017, the new clinical governance lead had adjusted the electronic spreadsheet of incidents to include the person responsible for actions, date and status of actions. Only six out of nine incident reports were on the log and none of these identified lessons learned. This showed the provider was not able to identify themes in order to learn, protect patients and develop the service. Following the inspection, the provider reported the incident log was redundant and all managers across the organisation would take ownership and record incidents locally.

The provider failed to identify incidents, which required further investigation. We identified two incidents whereby an investigation should have taken place, one involved a patient assaulting a driver during transit and one where mechanical restraint had caused patient harm.

The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. Within the RCA, the investigator indicated duty of candour was met, however there is no evidence of this and no contact with the family or their family was sought. Therefore, the provider had not applied the duty of candour for the serious incident.

Following the inspection, we saw an action plan, which showed the provider had developed a serious incident requiring investigation (SIRI) policy, which the clinical governance committee would approve. The policy outlined minimum reporting timeframes and a procedure flow chart.

Mandatory training

During the previous inspection, we were unable to report on the contents of the basic life support training. At this inspection, the training manager confirmed this training included basic life support for adults and children.

In October 2017, we reported 61% of staff in the South had completed face-to-face basic life support training. In February 2018, 41% of staff in the South had completed face-to-face basic life support training. The drop in compliance rates between October 2017 and February 2018 were due to the number of new starters waiting to complete the training. We escalated our concerns to the training manager who predicted there would be 100%

compliance by the end of February 2018. The training manager had undertaken an instructor's course for first aid training with the aim to bring first aid training in house and improve training compliance.

An update from the provider, showed at 7 March 2018, 60% of staff in the South had completed face-to-face basic life support training. This demonstrated a 19% improvement in staff compliance since this inspection, however this rate was below the provider's predicted compliance rate.

The training manager confirmed staff received training on how to use defibrillators as part of the basic life support training for adults and children.

During the previous inspection, we were unable to report on the contents of the prevention and management of violence and aggression (PMVA) training. At this inspection, we saw evidence to show staff received training which covered techniques and legislation related to restraint of adults, children and young people.

The provider had implemented a new electronic training platform, which we reviewed at inspection. The training manager allocated different mandatory courses to different staff groups. If mandatory training was due to expire, the training manager emailed the senior team managers who spoke to the member of staff during their one to one supervision.

The governance lead who was an approved mental health professional would carry out the Mental Capacity Act and Mental Health Act mandatory training to all control room and frontline staff in the future.

Safeguarding

At the previous inspection, we raised concerns about the safeguarding training levels completed by the safeguarding lead, staff recruitment checks, obtaining safeguarding information at the point of referral and management of safeguarding concerns.

At this inspection, we found improvements in compliance to safeguarding training. The provider had a new safeguarding lead in post that had extensive clinical knowledge in safeguarding. There were still outstanding recruitment checks; however, none of these staff were in physical contact with patients.

Since the last inspection, the provider appointed the new clinical governance lead as the safeguarding lead. He had completed safeguarding children level three training. We saw training confirmation for safeguarding children level four scheduled in May 2018. This is in line with Safeguarding Children and Young People: Roles and Competences for Health Care Staff Intercollegiate Document (2014).

The safeguarding lead understood their duty to report safeguarding concerns and was an approved mental health professional.

The training manager reported 94.4% of all staff had completed safeguarding adults at risk training. This was better than the provider's target of 80%. The training manager explained the compliance level was not 100% because of staff on long-term sickness.

The training manager reported 50% of all staff had completed safeguarding children level two training. This was worse than the provider's target of 80%. At the inspection, the training manager predicted compliance rates would reach 100% by 16 February 2018. We received the safeguarding children level two training rates as of 13 February 2018, which showed 90.1% compliance. This demonstrated the provider had met its target.

Staff told us the new electronic booking form for patient journeys highlighted if patients were under 18 years of age when they entered the patients date of birth. If the provider recommenced the conveyance of children and young people, the booking form would prompt staff to ask the referrer additional questions such as had they sought assistance from Child and Adolescent Mental Health Services (CAMHS), if the child is a looked after child and whether the Multi-Agency Safeguarding Hub (MASH) had been notified. This would ensure call handlers obtained essential information at the point of referral.

At the last inspection, we found not all staff had a completed Disclosure and Barring Service (DBS) checks. These checks were set up to prevent unsuitable people from working with children and adults at risk. The human resources audit in December 2017 showed seven staff were awaiting a completed DBS check. We escalated our concerns to the provider who reported there were no drivers or escorts without a current DBS check in line with their current DBS policy. However, since inspection the provider had decided to carry out DBS checks for all call centre and office staff, which was due for completion by 2 March 2018.

Patient transport services (PTS)

An update from the provider, showed at 7 March 2018, seven members of call centre and office staff still required DBS checks. The provider explained three staff needed to update the address on their official documents and this caused a five week delay.

The clinical governance lead reported he planned to schedule specific staff training on female genital mutilation (this is a procedure where the female genitals are deliberately cut, injured or changed for no medical reason) and the PREVENT duty (this aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves). There were no scheduled dates for this training at the time of the inspection.

The provider had implemented a general safeguarding training flowchart, we saw it was clear and outlined the different levels of staff training. This was in line with the 'intercollegiate document' (2014).

Cleanliness, infection control and hygiene

At the previous inspection, we found incomplete cleaning and vehicle safety checklists. At this inspection, we reviewed 15 checklists completed in January and February 2018. We found 67% were fully completed with a vehicle safety and cleaning check recorded. This showed there were still inconsistencies in staff completing the necessary checks to ensure vehicles were clean and ready for use.

At the last inspection, we reported the fleet manager did not record the weekly vehicle spot checks. At this inspection, we saw six recorded spot checks carried out between December 2017 and January 2018. Where there was non-compliance to the standards such as low oil levels and no translation telephone number displayed, the fleet manager recorded the actions taken to correct the concern. This meant the provider could monitor the compliance of staff to ensure vehicles are safe to use.

The training manager planned to upload to the new training platform, a step-by-step video for staff on how to complete the vehicle checks.

Staff completed an e-learning infection, prevention and control module. At the previous inspection, we requested but did not receive the training rates. At this inspection, we saw 50% of staff had completed the infection, prevention and control e-learning module. This was significantly worse than the provider's target of 80%.

Environment and equipment

At the previous inspection, we raised concerns regarding the security of the station, the lack of equipment for children and young people and it was unclear if staff received training on defibrillators. At this inspection, we saw the ambulance station was secure, there was equipment for children and young people and staff were trained to use defibrillators as detailed below.

During the previous inspection, the entrance to the station and the subsequent internal doors were open on arrival, which posed a security risk. The entrance to the station was open on arrival at this inspection; however, the access to the subsequent internal doors was by security keypad.

The service had a fleet of 12 vehicles including unmarked cars, ambulances and celled ambulances.

The organisation had a clear policy for the use of containment facilities. The 'vehicle and transfer policy and procedure' stated escorting staff should use a 'cage' or containment facility if the patient risk assessment indicated this is required. However, staff told us they never used the containment facilities, as these were too small.

At the previous inspection, we saw vehicles with a partition between the driver and the passengers; however, an incident we reviewed suggested this is not in place in all vehicles. This meant not all vehicles were appropriate to use for the conveyance of patients detained under the Mental Health Act.

The provider had ordered and received equipment for children and young people in preparation to recommence this service in the future. We saw booster seats for children aged zero to two years, seat belt soft pads, disposable thermometers, oximeters (machines used to monitor a patients oxygen levels) and paediatric airway equipment.

During the inspection, the provider was unable to locate the paediatric blood pressure cuffs and defibrillator pads it told us it had purchased. After the inspection, the provider reported it had located the defibrillator pads, which were single use for adults and children.

Staff were provided with monitoring equipment, such as blood pressure machines and disposable thermometers. However, during this inspection, management told us staff were not trained in how to use the equipment. We escalated our concerns to the provider who told us it would carry out a risk assessment.

Patient transport services (PTS)

Following the inspection, we saw a completed risk assessment used to determine if the use of monitoring equipment in a moving vehicle posed a risk to patients and staff. The provider had decided to remove all monitoring equipment from the vehicles. This ensured staff did not carry out duties above their scope of practice and reduced the risk of patients using the equipment to cause harm.

Medicines

The provider did not have any stock medicines on site, nor did the ambulance crews administer any medications.

The updated 'Medicines management policy version two' (February 2018) stated, "All medicines must be stored in a locked compartment specifically for the storage of medicines" and for patient own controlled drugs, it stated; "They should not be stored in the ambulance's CD compartment". This policy identified different standard operating procedures for medicines and patient own controlled drugs. However, staff employed were not clinically trained and therefore would not be expected to distinguish which medicines are controlled drugs. This meant staff might have difficulty in understanding the policy.

Staff reported they received patient's medicines in a sealed green bag from the ward staff. However, they could not state what action they would take when transporting a patient with controlled drugs. This identified a continued lack of understanding by staff, which the provider had failed to resolve since the previous inspection.

The updated medicines management policy stated, "All transported medication is to be recorded". The policy failed to identify where staff should record transported medication. We requested to see evidence to show staff recorded medicines. However, we did not receive this information.

Following the inspection, we saw an action plan, which showed the provider planned to place laminated cards on every glove compartment to remind staff to store all medicines in the locked compartment during transit. It stated the updated policy reflected this; however, the updated policy we reviewed still contained conflicting information.

Following the inspection, we saw the action plan also showed the provider had developed a post journey patient record. It included a section where staff could record if the patient travelled with medicines and if staff handed these to the ward staff. However, the post journey patient record it was not in use at the time of this inspection.

The storage of oxygen complied with the British Compressed Gases Association Code of practice 44: The Storage of Gas Cylinders, 2016. Since the previous inspection, the provider had moved the oxygen cylinders to a locked storage room with signage on the door to identify the presence of compressed gas.

Records

Since the previous inspection, the provider had implemented a new electronic booking form for patient journeys. Staff told us they thought this form was more in depth and the use of drop down boxes made the process easier.

However, the provider had not updated its 'Referral operation & clinical risk assessment/management policy' to reflect the new booking form. This meant staff had no guidance on how to complete the booking form and what process to follow if they had concerns with the patient's suitability for secure transport.

Staff had no identified place to document details of restraint. This was not in line with the organisation's mechanical restraint policy, which stated, "The use of restraint should be clearly documented on the relevant forms."

Management told us if crew carried out restraint, they encouraged the receiving hospital staff to complete observations on the patient. In the different records we reviewed, we did not see any documentation of handover between the crew and hospital staff. This meant the provider could not gain assurance crew were handing over vital information such as the use of restraint or pat down searches. Likewise, the crew had no identified place to document vital information received by the hospital staff on collection of a patient such as do not attempt cardiopulmonary resuscitation (DNACPR) documentation.

Following the inspection, we saw an action plan, which showed the provider had developed a post journey patient record. It captured full details of the patient journey including the use of restraint, body maps and visual

observations of patients following restraint. It was not in use at the time of the inspection. However, this level of patient monitoring would be in line with National Institute for Health and Care Excellence guideline (NG10).

Assessing and responding to patient risk
At the previous inspection, we reported the service did not have a policy to outline the procedures to follow for restraining children and young people. The provider had updated its mechanical restraint policy to include guidance on the restraint of children. It outlined the appropriate use of mechanical restraint and indicated a member of staff of the same sex as the patient should carry out restraint. This was in line with the National Institute for Health and Care Excellence guideline (NG 10).

The provider was still unable to gain assurance staff followed the restraint policy and procedures. We saw staff had completed a body map in only one of nine episodes of restraint. However, the implementation of the new post journey patient record would enable better documentation of restraint.

At the previous inspection, we reported the resuscitation policy did not reflect the service provided. At this inspection, we reviewed the updated resuscitation policy (dated February 2018) which did better reflect the service provided, however it failed to outline the standard operating procedure staff should follow if a patient collapsed in cardiac or respiratory arrest.

Staffing
Since the previous inspection, the provider had introduced a minimum staffing level of three members of staff for every patient journey. The senior management team allocated staff to each patient journey instead of the call handlers.

Anticipated resource and capacity risks
We did not gather evidence for this as part of the inspection.

Response to major incidents
We did not gather evidence for this as part of the inspection.

Are patient transport services effective?

We did not inspect this area of the service, as this was a focused follow up inspection and no serious concerns were identified at the previous inspection.

Are patient transport services caring?

We did not inspect this area of the service, as this was a focused follow up inspection and no serious concerns were identified at the previous inspection.

Are patient transport services responsive to people's needs?

We did not inspect this area of the service, as this was a focused follow up inspection and no serious concerns were identified at the previous inspection.

Are patient transport services well-led?

Leadership of service
Since our last inspection, the provider had appointed a new clinical governance lead and a compliance manager.

At the last inspection, the provider did not have staff meetings. At this inspection, we saw the provider had developed a 'Team Meeting Policy' (dated November 2017). It outlined the purpose, procedure and staff responsibilities.

The registered manager told us the provider had scheduled staff meetings for the year ahead and diarised the dates in staff calendars. We saw the annual meeting schedule, which included links for the minutes of previous meetings. This enabled the senior management team to have better oversight of outcomes and actions for completion.

Vision and strategy for this this core service
We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement
Since the previous inspection, the provider had developed; 'Clinical Governance Committee Terms of Reference'. The document outlined objectives of the group and clear responsibilities for each member.

Since the previous inspection in October 2017, one clinical governance committee meeting had taken place. A member of staff told us the provider cancelled December

2017 meeting and rescheduled January 2018 meeting to February 2018. This meant the provider might not have had complete oversight of the quality, performance and risks associated with the service over the previous months.

At the previous inspection, we reported on supervision and appraisal rates. At this inspection, management informed us they were now aware these rates were incorrect. This suggested the provider did not have effective arrangements in place to ensure that the information used to monitor and manage quality and performance is accurate. The provider told us all staff would complete one to one supervision by 16 February 2018.

An update from the provider showed, at 7 March 2018, 17 members of staff had outstanding one to one supervisions. The human resources manager had escalated this to the chief executive officer and the operations manager.

Since the previous inspection, the provider changed its Disclosure and Barring Service (DBS) policy so only clinical staff required an enhanced DBS check prior to employment. We asked the provider to show evidence of the rationale behind this decision. However, there was no risk assessment or documentation of this discussion.

We reviewed the human resources audit carried out in December 2017 and compared the findings to the information contained in 16 staff files. We found inconsistencies throughout the audit, for example the audit showed one member of staff had two references, however the staff file only showed one. Another example showed one member of staff was missing immunisation information on the audit; however, we found a completed form within the staff file. This showed the actions taken by the provider to mitigate risks were not effective.

There was no evidence of actions taken in response to the concerns highlighted by the human resources audit or timeframes to obtain missing information for each staff member. This meant the provider did not have oversight on what actions were taken and if these were effective.

We saw 26 joined the organisation since our previous inspection. We found the following which demonstrated the provider was not compliant with its recruitment policy:

- 19% had completed two reference checks, 27% had one reference and 54% had no reference checks.
- 88% had a completed DBS check, 8% had applied for one and 4% had 'N/A' recorded
- 23% had a contract in place and 77% had no contract

We escalated our concerns to the provider who provided an action plan, which showed all staff would receive a contract by the end of February 2018. An update from the provider showed, at 7 March 2018, 20 members of staff had no contract in place. This showed the provider had not met its internal deadline.

The provider had applied for the outstanding DBS checks for all grades of staff and these were due for completion by 2 March 2018. An update from the provider showed, at 7 March 2018, seven members of staff had no DBS check. The provider explained some of these staff needed to update the address on their official documents and this caused a five week delay.

The registered manager told us the human resources department have commenced a risk assessment in relation to references and whether staff now employed in the service for a substantial period still required these.

In order to improve employment checks, all staff would receive a contract on their first day of employment and the human resources department will carry out all DBS checks before employment commences.

The provider had changed standard operating procedures; however, these were not updated in the policies. For example, the level of harm used within the incident report form did not reflect the risk grading referred to in the policy. We escalated our concerns to the provider who reported the service would implement a policy spreadsheet, which would include links to every policy. Each time the service changed a policy, the spreadsheet would update automatically.

The provider told us all policies were on the staff intranet; however, staff we spoke to were not aware of this. We raised our concerns with the provider who reported all managers would be notified of policy changes and discussed at team meetings and during supervision.

Since the previous inspection, CQC received three statutory notifications of incidents involving the police. This showed the provider understood its duty to submit statutory notifications to the Commission.

At the previous inspection in October 2017, staff were unable to retrieve the completed journey report forms showing the driving times for each member of staff.

Patient transport services (PTS)

At this inspection, the provider used a digital driver tracker system, which identified individual drivers, driving time and average speed. We reviewed the electronic journey reports for two vehicles in the South for the two weeks prior to this inspection. The organisational policy stated drivers should take a 15 minutes break after driving for two hours. We found seven out of 12 staff did not take a break within 15 minutes of the maximum driving time of two hours. This showed staff did not consistently take breaks, which might lead to tiredness when driving.

Culture within the service
We did not gather evidence for this as part of the inspection.

Public and staff engagement
We did not gather evidence for this as part of the inspection.

Innovation, improvement and sustainability
We did not gather evidence for this as part of the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider MUST take prompt action to ensure recruitment procedures are completed for all staff carrying out the regulated activity.
- The provider MUST update and review policies when changes to practice occur.
- The provider MUST ensure patients are monitored during and post restraint in line with national guidance.
- The provider MUST ensure all staff have undertaken mandatory training.
- The provider MUST ensure staff take sufficient rest breaks from driving.
- The provider MUST ensure it applies the duty of candour when applicable.
- The provider MUST ensure staff know how to access translation services.

Action the hospital SHOULD take to improve

- The provider SHOULD ensure all staff receive one to one supervision and appraisals as part of their performance management.
- The provider SHOULD continue to monitor its progress against its improvement action plan.
- The provider SHOULD ensure staff complete vehicle cleaning and safety checklists consistently.
- The provider SHOULD ensure incident report forms are fully completed by staff.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Recruitment procedures must be established and operated effectively to ensure that persons employed are fit to carry out the duties required of them.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Governance arrangements must provide senior managers with oversight and assurance of the quality and safety of the service.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **All reasonable steps must be taken to ensure the health and safety of people using the service and that risks which may rise during care and treatment are managed effectively.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

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