Specialist Medical Transport Ltd

Specialist Medical Transport - North

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

We rated it as inadequate because:

- The service was not safe. The service did not provide mandatory training in key skills to all staff and make sure everyone completed it. Staff did not understand how to protect patients from abuse and the service did not work with other agencies to do so. Not all staff had training on how to recognise and report abuse. Staff did not complete or update risk assessments for each patient to remove or minimise risks. The information needed to plan and deliver effective care and support was not available at the right time. Staff did not keep detailed records of patients' care. Records were minimal but stored securely. Managers did not investigate incidents or use incidents as opportunities to learn and improve the service.
- The service did not consistently provide effective care. The service did not provide care based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. Staff did not protect the rights of patients subject to the Mental Health Act 1983. Staff did not support patients to make informed decisions about their care. National guidance to gain patients' consent was not followed.
- Staff treated patients using the hospital discharge service with compassion, kindness and respected their privacy and dignity. Staff did not demonstrate the same commitment to providing compassionate care to people using the secure mental health service. The service did not evidence staff provided emotional support to patients. There was no evidence that patients were supported to understand the information they were given about their care. This included during transition or transfers.
- The service did not consider patients' individual needs and preferences. The service did not use the complaints system to inform changes or improvements to the service.
- The service was not well-led. Leaders did not understand or manage the priorities and issues the service faced. Leaders did not operate effective governance processes, throughout the service and with partner organisations. Leaders did not identify and escalate relevant risks and issues. They did not have plans to cope with unexpected events. Managers did not collect reliable data or analyse it appropriately.

However:

- Staff kept equipment, vehicles and the premises visibly clean.
- The design, maintenance and use of facilities, vehicles and equipment kept people safe. Staff managed clinical waste well.
- The service had enough staff to run the service and meet contractual demand.
- The service was responsive because it monitored, and met, agreed response times.
- Staff treated patients using the hospital discharge service with compassion and kindness, respected their privacy and dignity.

This service has been rated as inadequate overall and so has been placed into special measures. One of the purposes of special measures is to ensure that providers found to be providing inadequate care significantly improve.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate 	• The service was not safe. The service did not provide mandatory training in key skills to all staff and did not make sure everyone completed these. Staff did not understand how to protect patients from abuse and the service did not work with other agencies to do so. Not all staff had training on how to recognise and report abuse. Staff did not complete or update risk assessments for each patient to remove or minimise risks. The information needed to plan and deliver effective care and support was not available at the right time. Staff did not keep detailed records of patients' care. Records were minimal but stored securely. Managers did not investigate incidents or use incidents as opportunities to learn and improve the service. • The service did not consistently provide effective care. The service did not provide care based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. Staff did not protect the rights of patients subject to the Mental Health Act 1983. Staff did not support patients to make informed decisions about their care. National guidance to gain patients' consent was not followed. • Staff treated patients using the hospital discharge service with compassion, kindness and respected their privacy and dignity. Staff did not demonstrate the same commitment to providing compassionate care to people using the secure mental health service. The service did not evidence staff provided emotional support to patients. There was no evidence that patients were supported to understand the information they are given about their care. This includes during transition or transfers. • The service had no clear system to inform patients how to raise a complaint. There was no complaint process on the services website and only hospital

Summary of findings

discharge patients received feedback forms to complete. Mental Health patients transferring on a secure vehicle were not asked about the quality of the service provided to them.

- The service was not well-led. Leaders did not understand or manage the priorities and issues the service faced. Leaders did not operate effective governance processes, throughout the service and with partner organisations. Leaders did not identify and escalate relevant risks and issues. They did not have plans to cope with unexpected events. Managers did not collect reliable data or analyse it appropriately.

Summary of findings

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Background to Specialist Medical Transport - North

Specialist Medical Transport - North is commissioned by a number of NHS trusts and Integrated care boards (ICB) to provide non-emergency patient transport for patients attending hospital or clinic appointments. Specialist Medical Transport – North also provides a secure transport service for both adults and young people over the age of 14, including those detained under the Mental Health Act 1983. Transportation is available out of hours including weekends.

Specialist Medical Transport - North is registered with the CQC to provide the following regulated activity;

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

The provider has had a registered manager in post since May 2021. The patient transport service did not have a clear inclusion and exclusion criteria. However, was accessible to transport all patients. This included patients with mental ill-health.

The provider's activity levels for January 2020 to December 2022 were:

- 6,716 total journeys
- 5,052 patient hospital discharge transfers
- 1660 secure patient transfers
- 64 transfers that were not within the scope of regulation

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

Although registered for Treatment of disease, disorder or injury, the service was not providing this regulated activity or urgent and emergency care services. The service had not provided this activity in the six months prior to inspection, although the manager told us the service had plans to do so.

As a result of its findings, CQC took urgent enforcement action to suspend the service. The decision was appealed and the Tribunal found that the level of risk was not such that the urgent action was necessary, reasonable or proportionate. The full Decision can be found here: Care Standards Tribunal > Decisions > View Decision (tribunals.gov.uk).

How we carried out this inspection

The inspection was carried out by two CQC inspectors and one specialist adviser. The inspection was overseen by Sarah Dronsfield, Deputy Director of Operations.

Our inspection took place on 10 January 2023 using our comprehensive inspection methodology. We inspected the service in response to concerns we had received from a whistleblower. The inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We looked at 19 sets of patient notes, 12 staff files and we spoke with 7 members of staff.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Summary of this inspection

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that the service has systems and processes to ensure staff assess and make plans to respond to the risks presented to service users in carrying on the regulated activities. (Regulation 12(1)(2)(a)(b): Safe care and treatment)
- The service must undertake an assessment of patients presenting risks or needs prior to commencing the journey. (Regulation 12(1)(2)(a)(b): Safe care and treatment)).
- The service must ensure care is provided with the consent of service users, or ensure staff have the training and experience required to consider and assess capacity for service users who may lack the mental capacity to consent to their care. (Regulation 11(1)(3): Need for consent).
- The service must implement systems and processes to ensure the control of physical or mechanical restraint of a patient is the least restrictive option, is necessary and is proportionate to the risk in order to prevent a risk of harm to service users or others. (Regulation 12(1)(2)(a)(b): Safe care and treatment).
- The service must ensure that staff undertake accredited blue light driver training and that evidence is maintained on file for those staff members. (Regulation 12(1)(2)(a)(b)(c): Safe care and treatment).
- The service must evidence that managers have investigated incidents thoroughly and learned lessons from these incidents or recognised potential safeguarding factors in these incidents. (Regulation 12(1)(2)(a)(b): Safe care and treatment).
- The service must ensure all staff have the training, competencies, supervision and appraisal required to provide safe care. (Regulation 12(1)(2)(a)(b)(c): Safe care and treatment).
- The service must implement effective processes to safeguard patients from the risk of improper treatment and/or abuse. (Regulation 13(1)(2)(3)(4)(b): Safeguarding service users from abuse and improper treatment).
- The service must evidence that staff have received the required training in safeguarding to recognise and respond to the risk of abuse and keep service users safe from harm or the risk of harm. (Regulation 13(1)(2)(3): Safeguarding service users from abuse and improper treatment).
- The service must ensure that all staff have a valid Disclosure and Barring Service (DBS) check prior to working with vulnerable individuals. (Regulation 13(1)(2)(3): Safeguarding service users from abuse and improper treatment).
- The service must have a clear understanding of who their safeguarding lead is and have a clear process to report safeguarding concerns to external agencies including local authorities and CQC. (Regulation 13(1)(2)(3): Safeguarding service users from abuse and improper treatment).
- The service must ensure that patients transferring on longer journeys are provided with adequate hydration. (Regulation 14(1): Meeting nutritional and hydration needs)
- The service must have effective governance and systems and processes to identify, assess, record, manage and mitigate risks in the delivery of the service. (Regulation 17(1)(2)(a)(b): Good Governance).
- The service must ensure the service has clear criteria or service specification to ensure staff assess whether they are able to meet the needs to service users prior to accepting bookings. (Regulation 17(1)(2)(a)(b) Good Governance).
- The service must maintain records of journeys to evidence patients' risks are managed and needs are met. (Regulation 17(1)(2)(a)(b)(c): Good Governance).
- The service must maintain a local risk register specific to the location. (Regulation 17(1)(2)(a)(b): Good Governance).
- The service must undertake audits thoroughly and appropriately to identify gaps or omissions and take appropriate action. (Regulation 17(1)(2)(a)(b): Good Governance).

Summary of this inspection

- The service must ensure all staff recruited by the service are fit and proper persons for their roles. (Regulation 19: Fit and proper persons employed).
- The service must ensure that there are systems in place to inform patients how to make a formal complaint. (Regulation 16(2): Receiving and acting on complaints).

Action the service SHOULD take to improve:

- The service should consider providing communication aids and access to translation services for those patients with communication difficulties or whose first language is not English.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Requires Improvement	Good	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires Improvement	Good	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Effective	Inadequate
Caring	Requires Improvement
Responsive	Good
Well-led	Inadequate

Is the service safe?

Inadequate

We rated it as inadequate.

Mandatory training

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

The provider could not evidence that all staff were up to date with their mandatory training. The registered manager told us the service's training records were not complete because some records had been lost because they were held by an external training provider. Managers had a training matrix which was incomplete and there were no training certificates or other evidence showing staff had completed training on the dates indicated on the training matrix. Managers did not maintain or have access to complete records of training delivered to staff which meant the service could not provide assurance that all staff had the training required to provide safe care.

Managers stated that they were arranging a replacement via NHS training resources. However, there was no evidence to support that managers were proactively addressing training issues to ensure staff received new or additional training to meet mandatory training requirements.

We saw that driving assessments were undertaken; these were by one of the 3 senior staff who looked at general competency and standard of driving and an assessment sheet was completed. However, no action was taken if the driver failed the assessment, the assessment was just repeated. The providers own website states that 1 week driver training should be provided for PTS services. This training is said to include getting used to larger vehicles, spatial awareness- width and length and for patient comfort, smooth gear changes and braking.

The provider told us five staff were trained to drive under 'blue lights. However, there was no evidence of accredited blue light driver training on file for any staff member. Managers told us when blue lights were required, a doctor, not employed by the organisation, approved the use of the lights. This was not in line with national guidance.

From April 2021, all services across health and social care were expected to use training in restrictive practices that was certified as complying with the Restraint Reduction Network (RRN) Standards. Prevention Management of Violence and

Aggression (PMVA) training was delivered by a senior emergency care assistance (ECA). The service could not evidence how many staff had completed this training as only one staff member had an accredited certificate in their personnel file and PMVA was not listed on the training matrix. There was a module named Conflict Management & Physical Intervention listed but there was no evidence to show that this module was an official PMVA course.

Staff did not receive mandatory training in basic life support. Training in basic life support for staff engaging in restrictive interventions is recommended by national guidance.

Training in autism and dementia (Dementia – an understanding or Dementia / dealing with challenging behaviour) were voluntary and not mandatory. The services training matrix showed 6 staff had completed this training. However, the service could not evidence that this training had been completed other than the dates on the matrix.

Safeguarding

Staff did not understand how to protect patients from abuse and the service did not work with other agencies to do so. Not all staff had training on how to recognise and report abuse.

The service had not implemented effective processes to safeguard service users from the risk of improper treatment and/or abuse. The provider had a safeguarding policy although this was not fit for purpose because it did not provide clear guidance and expectations of the process staff were expected to follow to identify and respond to safeguarding issues. Staff in the service did not demonstrate an awareness of the provider's safeguarding policy or practice. The service did not demonstrate that it adhered to intercollegiate guidance for safeguarding. A new safeguarding form had been created which managers told us had been introduced two weeks prior to our inspection. This form had been poorly implemented, and had not been shared with staff. Staff were not aware it was to be used at the time of the inspection.

None of the staff, including managers at the service location, had received training in safeguarding adults or children at level 3 or above. The training matrix and training certificate did not highlight which level of safeguarding was undertaken for adults or children. Managers we spoke with did not know who the provider's safeguarding lead was and were unsure who was undertaking the role since the last lead had left the service. Records of safeguarding training were not evidenced clearly. An incomplete training matrix held dates of completion, but we did not find certificates showing completion in personnel files. This meant there was no evidence that all staff had received the required training in safeguarding to recognise and respond to the risk of abuse, and keep service users safe from harm or the risk of harm.

The service did not have clear processes to report safeguarding concerns to external agencies including local authorities and CQC. Managers told us staff would raise safeguarding concerns with NHS staff prior to or after undertaking journeys. This was not in line with the requirements for all providers to have their own robust safeguarding policies and procedures.

Cleanliness, infection control and hygiene

They kept equipment, vehicles and the premises visibly clean.

During the inspection we saw that station and vehicles were clean and had suitable furnishings which were well-maintained.

Inadequate

Patient transport services

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed approximately 50 forms on site and found that all visual hygiene checks had been completed.

Staff followed infection control principles, including the use of personal protective equipment (PPE). Staff cleaned equipment after patient contact. However, we did not see any COVID-19 standard operating procedure or signage / staff prompts.

Staff did not undertake a risk assessment of patients to identify, assess and make plans to manage specific risks in relation to infection prevention and control for each patient prior to undertaking a journey.

Environment and equipment

The design, maintenance and use of facilities, vehicles and equipment kept people safe. Staff managed clinical waste well.

The service fleet consisted of 4 secure vehicles, 6 patient transfer vehicles of which 1 was a wheelchair accessible vehicle. Two of their secure vehicles were visibly recognisable as a secure ambulance vehicle and two had been designed to appear as vans.

Staff carried out daily safety checks of vehicles and specialist equipment. The service replenished vehicles, equipment and supplies at the base, as and when required. We saw that staff disposed of clinical waste safely.

We saw that deep cleans of all vehicles were undertaken on a monthly basis. All vehicles appeared clean and presentable. The deep clean area of the station was well maintained with appropriate resources and materials.

Although general IPC was followed, there was no evidence that the service had processes to: manage the risk of COVID-19; to ensure staff used personal protective equipment or; to indicate when this was required. The personnel files showed staff had signed for limited quantities of PPE on one occasion.

There was no evidence that the service assessed the risk of the patients' equipment, e.g. wheelchairs. There were appropriate straps / seat belts in the vehicles.

There were records of equipment maintenance and schedules (including vehicles).

We saw that oxygen cylinders were stored appropriately in locked areas. Documentation and logbooks were completed and reviewed appropriately.

The vehicle keys were stored on a board secured to the wall in the station and were continually monitored by CCTV which was displayed on a screen in the station office. However, the station vehicle door always remained open which meant the vehicle area, was always accessible from the street.

Assessing and responding to patient risk

Staff did not complete or update risk assessments for each patient to remove or minimise risks. The information needed to plan and deliver effective care and support was not available at the right time.

Inadequate

Patient transport services

Prior to our inspection we identified concerns about how the service assessed and managed risks during transfers of patients with mental health needs. Our inspection focused on reviewing the records of these journeys. Managers told us staff followed the same processes for hospital discharge patients and for patients using the secure transport service.

The service did not have systems and processes to ensure staff assessed and made plans to respond to the risks presented to service users in carrying on the regulated activities. The service did not maintain appropriate records to evidence that service users' risks and needs were assessed and met prior to and during transportation.

The service did not maintain records of secure transfers or hospital discharge journeys to evidence service users' risks were managed and needs were met.

Staff advised that the service considered bariatric secure transportation on a case by case basis. However, there were no vehicles at this location to accommodate bariatric stretchers or seats. for hospital discharge transfers. There was no evidence staff had a clear process to follow to undertake a risk assessment of patients to identify, assess and make plans to manage specific risks in relation to the transfer of bariatric patients prior to undertaking a journey.

Information provided prior to the inspection showed that there had been 1,664 mental health secure transfers between January 2022 and November 2022, of which 440 transfers required the patient to be transferred in a cell. Mechanical restraint was recorded 21 times during the same period. Managers could not provide copies of service users' risk assessments which evidenced the need to apply mechanical restraint or to use the cell area of the vehicles. There was no rationale or decision-making processes adequately recorded. Service users subject to these forms of control and restraint included children as well as adults.

We discussed the use of both soft and hard mechanical restraints with two staff members who stated that the decision to use restraint was always a multi-disciplinary discussion with those professionals detaining the patient (although accepted that they held the final decision). Staff said that they rarely used cuffs and when required, they ensured they were applied for a minimal amount of time, and always removed when in the cell (unless patient refused). Whilst staff said they took account of a patient's history they did not complete records to evidence an assessment of a patient's presenting risks prior to using restraint. The limited records that were available showed staff had used restraint at the request or on the advice of either a nurse, AMHP or the police. This was not in line with the provider's own restraint policy which stated "the person in control is the lead person for any restraint that takes place, conducting any risk assessment of the circumstances to determine whether restraint is appropriate to the situation"

We did not see evidence that staff were made aware of specific risks relating to each individual patient in advance of arriving to undertake the transfer, for example, patients' mental health risks, including risks of self-harm or violence and aggression. Staff did not undertake a risk assessment of patients' physical health or were made aware of specific needs in relation to physical health in order to undertake safe journeys.

During the inspection, we reviewed 19 secure transport booking request forms and found that none of them detailed the presentation of the service user and did not highlight any risks to the patient or their staff. There were no records of risk associated with any patient, in any records we looked at.

Managers advised that when responding to the deteriorating health of a patient, staff would dial 999 and ask for support, whilst comforting the patient to the best of their ability. Managers told us that staff were not trained paramedics and would only work within their skill grade/job description. Staff did not receive basic life support training.

The service had access to specialist mental health support, but information held by the service did not show any occasions where advice was sought during the transfer of a patient with a mental health condition.

We did not see evidence that provided assurance that staff followed best practice in anticipating, de-escalating and managing challenging behaviour.

Staffing

The service had enough staff to run the service and meet contractual demand.

The number of staff matched the planned numbers. The service comprised of 23 staff members, 2 of which were operations managers. All staff, with exception of 3, were self-employed. All staff were at a skill level of an ambulance care assistance (ACA) with the exception of 1, who was trained as an emergency care assistant (ECA).

Staff spoken to stated that the 11-hour break between shifts were complied with. Staff had opted out of the European working time directive. Staff stated that they had an obligation to be honest about the number of hours they drove as many had second or third jobs.

Rotas and shift patterns aligned to demand. Hospital discharge transfers were regular planned journeys, but mental health transfers were requested on an ad hoc basis. We saw that 2 staff members remained at the ambulance station, on stand-by, awaiting a call-out.

The service had low vacancy rates, low turnover rates and low sickness rates.

Managers did not use bank and agency staff within the service.

Records

Staff did not keep detailed records of patients' care. Records were not comprehensive but were stored securely.

Patient notes were not comprehensive. Information about people's care and transfers was not appropriately shared between staff or with carers and partner agencies.

During the inspection we saw that no patient logs were recorded during journeys. Managers said that when something went wrong it would be recorded as an incident. There were minimally recorded observations of patients, including those in restraint or transported in a cell. There was little understanding or recording of any medical need or complication that may arise from mental ill health and/or restraint.

Staff did not complete body maps and transfer observation forms comprehensively, or record details of the patient journey in line with best practice guidance. Forms reviewed during the inspection were variable in completion and lacked significant details.

When staff used any form of restraint, they recorded it on the booking form, cell usage form and handcuff form. However, they did not record decision making processes or attempts at de-escalation prior to this. We looked at 19 records where there was a use of mechanical restraint and found that none of the records detailed decision-making processes. Information was minimal, with many sections of the form left incomplete, for example, missing: signatures,

dates of restraint, whether a physical examination had taken place following the use of mechanical restraint, whether escorts had travelled with the patient, if the patient had belongings with them, the patients presentation, or the patients physical mobility. None of the booking forms were completed to state whether transfer papers had been provided either electronically or in paper format. This was not in line with the provider's own restraint policy which stated that "any use of restraint must be carefully documented in the persons care records".

Managers had audited all of the records that we reviewed, however, the audits had not effectively identified the errors or omissions we found.

Completed booking forms were stored securely in locked cabinets within the station office.

Medicines

The service did not manage medicines.

The service had appropriate facilities to manage medicines in the future. There was a medicines fridge with monitored temperatures and a lockable medicines cabinet bolted to the wall.

There were no processes in place to address situations when a long journey required the patient to have their own medicines or medication that was time critical.

The medicines fridge and cabinet where continually monitored by CCTV which was displayed on a screen in the station office.

Incidents

The service had a process for staff to report incidents. Managers could not evidence that incidents were investigated appropriately or used to identify opportunities for learning.

Staff reported 15 incidents between May 2021 and December 2022. The service had undertaken 6,716 journeys in this period which meant that 0.2% of journeys had resulted in staff reporting an incident. None of the incidents had been investigated appropriately or used to identify lessons learned or to improve the service. Patients and their families were not involved in investigations.

Incident data showed three incidents had occurred where a service user had attempted to harm themselves using a ligature. There was no evidence that managers had undertaken a comprehensive investigation, that lessons were learned or that potential safeguarding factors had been identified or considered.

Managers could provide evidence of one incident debrief which was held after an incident in the hospital discharge service. There was no evidence showing managers held debriefs after incidents involving the mental health secure transport service. Managers did not hold debriefs after the use of restraint in line with national guidance.

The service had no never events. Never events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Inadequate

Patient transport services

Managers and staff understood the duty of candour. We did not observe the application of duty of candour as none of the incidents reviewed were relevant to the Duty of Candour regulation.

Is the service effective?

Inadequate

We rated it as inadequate.

Evidence-based care and treatment

The service did not provide care based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. Staff did not protect the rights of patients subject to the Mental Health Act 1983.

Care assessments were not undertaken so people's diverse needs could not be considered when providing care. There was no monitoring of the outcomes of care.

The service's 'restraint policy' was not in line with national guidance, for example the policy did not reference the National Institute of Health and Care Excellence (NICE) guidance (NG10 2015) on the use of restraint. This guidance is applicable to this service. There was no evidence of immediate post-incident debrief after any restraint. National Institute of Health and Care Excellence (NICE) guidance (NG10 2015) 1.4.55 states that "after using a restrictive intervention, and when the risks of harm have been contained, conduct an immediate post-incident debrief, … to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses".

The rights of people subject to the Mental Health Act 1983 (MHA) were not always protected and staff did not give regard to the MHA Code of Practice. For example, prior to using mechanical restraint, staff did not evidence de-escalation techniques or monitor the patient's psychological wellbeing. There was no evidence of best interest decisions recorded on any paperwork under the Mental Capacity Act 2005 (MCA).

The service did not have clear criteria or service specification to ensure staff assessed whether they were able to meet the needs of the service users prior to accepting bookings.

The service did not have additional protocols in place in relation to the transfer and mechanical restraint of children. A booking form reviewed during the inspection related to the transfer and restraint of a child under the age of 16 years old.

Staff were not made aware of patients' mental health needs prior to arriving on scene.

Nutrition and hydration

Staff did not assess patients' food and drink requirements to meet their needs during a journey.

Journeys were not planned or carried out with consideration of patient's hydration, food and toileting needs particularly where journey times might be long. Managers told us that drinks were not provided. When asked what arrangements were in place for toileting, we were advised that the issue had not yet occurred.

The service did not evidence that adjustments were made for patients' medical, religious, cultural and other needs in relation to hydration or nutrition for long journeys.

Response times

The service monitored, and met, agreed response times.

Performance data provided by the service and reported quarterly to the Integrated Care Board (ICB) showed that for the month of November 2022 the service met 100% of response times within 60 minutes. This was a consistent picture across the year with minimal percentage drops occurring due to factors outside of the service's control.

Competent staff

The service did not make sure staff were competent for their roles. Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development.

Not all staff had the right qualifications, skills, knowledge and experience to do their job. The learning needs of staff were not fully understood. Staff told us they felt they had the right training to undertake their roles, but the service could not evidence all staff had the training required to provide safe care.

Managers had completed appraisals for two staff at the time of inspection. The service could not evidence staff had received ongoing group or individual supervision or support. This was not in line with the provider's own supervision policy which states that all staff would receive annual supervision.

Managers gave all new staff a minimal induction before they started work. However, personnel files did not hold induction information. Staff described their induction as an "informal walk through of the organisation".

Multidisciplinary working

There was limited participation in multidisciplinary working.

The service did not maintain appropriate records of bookings and journeys to evidence multidisciplinary working with other professionals. Managers told us mental health professionals using the service maintained their own records.

Staff did not hold regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw that contracts meetings were held quarterly with the Integrated Care Board (ICB), but on review of the minutes, quality of care or service improvement was not discussed.

Staff regularly worked with other agencies, such as mental health professionals, hospital discharge staff and the police, although there was limited information available in records to evidence a commitment to multidisciplinary working.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Inadequate

Patient transport services

Staff did not support patients to make informed decisions about their care and treatment. National guidance and legislation to gain patients' consent was not followed.

The service had not ensured care was provided with the consent of service users, or ensured staff had the training and experience required to consider and assess capacity for service users who may lack the mental capacity to consent to their care or transfer.

Managers told us that consent was not considered in the provision of services because the service conveyed service users who were detained under the Mental Health Act 1983. Staff did not recognise or understand their responsibilities under the Mental Capacity Act 2005. There was no process, or evidence that staff followed a process to obtain and record consent from service users who were not detained under the Mental Health Act 1983.

There was no documented evidence to show that attempts were made to find less restrictive options before using restraint or mechanical restraint, when transferring mentally unwell children or adults. However, staff spoken with stated that they were aware of least restrictive principles.

Staff we spoke with had a good understanding of the Mental Health Act 1983 with a clear understanding of section papers for adults. However, they showed limited knowledge of consent, capacity and Mental Capacity Act, believing that when a patient was detained under section it meant the patient no longer needed to consent to any aspect of their treatment and care.

Managers did not monitor how well the service followed the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

We rated it as requires improvement.

Compassionate care

Staff treated patients using the hospital discharge service with compassion, kindness and respected their privacy and dignity. Staff did not demonstrate the same commitment to providing compassionate care to people using the secure mental health service.

We were unable to contact patients who used the secure mental health transfer service to gather feedback about the care they had received, as the service did not maintain sufficient records.

Staff did not always understand or respect the individual needs of each patient. Managers did not always show understanding or a non-judgemental attitude when caring for or discussing patients with mental health needs. One manager asked why we "would contact mental health patients and if we believed what they said when they were mentally ill". This was witnessed by 3 people.

However, we saw 20 compliments received from a variety of social workers and approved mental health professionals (AMHPs) which thanked staff for their compassion and kindness and for taking time to interact with patients. One AMHP said staff provided "a high level of care and compassion". Another AMHP said, staff "went out their way to treat him [patient] with dignity and respect to safely transfer in the least restrictive manner".

Anonymous feedback cards completed by hospital discharge patients said, "very helpful crew and caring towards patients and staff". Another said, "girls were very friendly and attentive".

We did not see any evidence to support that staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

The service did not evidence staff provided emotional support to patients.

There was no evidence that staff understood the emotional and social impact that a person's care or condition had on their wellbeing and on those close to them. We did not see any records of staff supporting patients who became distressed in an open environment or how they helped them maintain their privacy and dignity.

We observed a booking form which showed that a patient had transferred between two ambulance vehicles in a service station car park. Due to the lack of written records relating to risk management, the patient's conveyance plan or journey log, we were not assured that the patients' privacy and dignity were maintained.

However, feedback from one AMHP stated that staff "were so lovely with the elderly gentleman who was extremely distressed, their professionalism was second to none".

Understanding and involvement of patients and those close to them

There was no evidence that patients were supported to understand the information they are given about their care. This includes during transition or transfers.

Staff did not have access to communication aids, to enable them to communicate with patients, families and carers who required an alternative means of communication.

We reviewed patient feedback cards from hospital discharge patients and saw positive feedback from patients, relatives and health professionals. AMHP feedback stated that staff were "professional and understanding towards [mental health] patients". There was no evidence of feedback being obtained, or a proactive approach to regularly sourcing feedback from mental health patients who used the secure transfer service.

There was no evidence that staff supported patients to make informed decisions about their care as there was no supporting documentation to evidence best practice.

Inadequate

Patient transport services

Is the service responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people

Services were delivered in a way or at a time that was convenient for people. Facilities and premises were appropriate for the services being delivered.

The service worked with other providers of healthcare, for example, hospitals/clinics to which patients were conveyed, and other health and social services which patients were conveyed to following assessment under the Mental Health Act (1983).

Facilities and premises were appropriate for the services that are delivered.

The services that were provided reflected the needs of the population served and they were flexible.

The service had identified a shortage of emergency care in the local community and planned to provide urgent and emergency care services in the future.

Staff could access emergency mental health support during transfers, if required.

Meeting people's individual needs

The service was not fully inclusive and did not take account of patients' individual needs and preferences.

We found that facilities and vehicles were appropriate for the services being delivered. Staff advised that the service considered bariatric secure transportation on a case by case basis. However, there were no vehicles at this location to accommodate bariatric stretchers or seats. for hospital discharge transfers. There was no evidence staff had a clear process to follow to undertake a risk assessment of patients to identify, assess and make plans to manage specific risks in relation to the transfer of bariatric patients prior to undertaking a journey

There was no process for meeting the information and communication needs of patients with a disability or sensory loss.

The service did not have information leaflets available in languages spoken by the some of the patients in the local community.

We were not made aware of any interpreter, translation services or communication aids to help patients become partners in their care.

There was no evidence that cultural and religious preferences were considered.

Inadequate

Patient transport services

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Services were provided on an ad hoc basis and were contracted to respond within the hour when requested. Managers monitored waiting times and made sure patients could access services when needed.

The service operated 24 hours a day, 7 days per week and leaders told us this meant they never had to cancel a patient or secure transport journey. The service responded quickly to requests for hospital discharge and secure patient transport.

Leaders monitored response times through monthly performance data that highlighted how many patients were transported and the response rates.

Requests for conveyancing were made to the main office and booked using a secure transport booking form. The request was verbally handed over to ambulance staff who added the request to their log sheet on the vehicle.

Learning from complaints and concerns

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

Patients using the service hospital discharge transport were invited to express their views about their care and support on feedback cards. However, there was no method of feedback for secure transfer patients.

The service had no clear system to inform patients how to raise a complaint. There was no signage in vehicles or complaint process on the services website.

The service had received 3 complaints since May 2021. Managers investigated complaints but did not maintain appropriate records of their investigations. None of the complaints had been upheld or had learning identified for the service to support improvement. There was no evidence to show the outcomes of the complaints had been shared with staff to support improvement.

Is the service well-led?

Inadequate

We rated it as inadequate.

Leadership

Leaders did not demonstrate skills and abilities to run the service. They did not understand or manage the priorities and issues the service faced.

Managers did not demonstrate the necessary experience, knowledge, capacity, capability to lead effectively.

Inadequate

Patient transport services

Managers could not identify and did not understand the risks and issues associated with the service.

There were no examples of managers making a demonstrable impact on the quality or sustainability of services.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action, developed with all relevant stakeholders.

Managers of the service could not articulate the service vision and guiding values. The provider had a strategy although service managers could not articulate how this was relevant to the local service.

There was no effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy. The strategy was aligned to local plans in the wider health and social care economy, and the service had planned to extend the service to provide Treatment of disease, disorder or injury in the future.

The strategy had not been translated into meaningful and measurable plans at all levels of the service. There was no evidence that staff understood how their role contributed to achieving the strategy.

Culture

Staff felt respected, supported and valued. Equality and diversity were not consistently promoted.

Staff we spoke with during the inspection stated that they were happy in their work, that they had good working relationships and that the team felt like a large family. However, it was acknowledged that several staff members including managers, were related.

There were no mechanisms for providing all staff, at every level, with the development they needed, including high-quality appraisal and career development conversations.

The service could not evidence that the service's culture was centred on the needs and experience of people who use services.

The provider had a whistleblowing policy and a Freedom to Speak up Guardian was based at the provider's headquarters.

Governance

Leaders did not operate effective governance processes throughout the service and with partner organisations. Staff at all levels were unclear about their roles and accountabilities.

We reviewed 12 staff files. Four of the staff files did not have evidence showing references had been obtained for the staff prior to commencing their employment. Three staff files did not include evidence showing staff had been interviewed. Six of the staff files had no evidence of training records. Most staff files we reviewed did not include an application form, CV, or other details of staff members' full employment history. The service had not ensured all staff recruited by the service were fit and proper persons for their roles.

We saw a member of staff working prior to receiving DBS clearance. Mangers told us that the staff member was under the continuous supervision of a colleague. However, registration under the Health and Social Care Act 2008 Disclosure and Barring Service (DBS) checks (formerly criminal record (CRB) and barring checks) guidance states that new members of staff who are going to work in regulated activity with adults can only begin work before their DBS certificate has arrived, after review of the 'Adult First' system. This should only happen if the safety of people using the service would be put at risk if the person wasn't started in their role. We did not find this to be the case. Adult First is a service that allows an individual to be checked against the adults' barring list while waiting for the full DBS check to be completed. Managers could not evidence that they had undertaken a risk assessment of the decision to allow the staff member to work prior to receiving the appropriate DBS clearance.

Managers told us that the training records had been lost following the termination of contracts with an external training company. The service had not maintained records of the training staff had received, therefore the service could not evidence staff had the training required to provide safe care. Managers could not provide plans to ensure all staff would receive the required training within an appropriate timescale or evidence that there were effective systems to manage this risk during the time taken to retrain staff.

Managers had not recognised the requirements to provide and record appraisals and supervision for staff. Only two of the 23 staff employed by the service had received an appraisal at the time of the inspection.

The service did not have effective systems and processes including audits to ensure compliance with infection prevention and control (IPC) procedures. Managers did not undertake hand hygiene audits, instead these were done by staff observing each other's practice and indicating compliance.

The provider did not audit records appropriately to identify gaps or omissions and take appropriate action. We reviewed 19 records of journeys undertaken by the provider. Records were not consistently or fully completed. Managers told us that these records had been checked in line with the service's processes.

The provider's policies were not always specific and relevant to the service being provided. Some policies contained out of date or irrelevant information, including information for staff working in NHS ambulance services.

We found that the safeguarding adults' policy included a detailed description and definition of safeguarding principles but did not clearly describe what action staff must undertake if a concern was identified as needing escalation.

Audits were not effective or standardised and did not identify errors or omissions in documentation. We were advised that all audits were completed by the manager. However, we saw no proforma or standard procedure followed. Audits were more of a subjective review of the level of form completion rather than the content, decision making standard or review of best practice.

We reviewed audit data for hand hygiene, cell, handcuff and blue light usage and found that audits were not thorough or detailed, containing only minimal information. There was no proforma to highlight what was checked, that checks were consistent, what the findings were and what actions were taken to improve or maintain findings. Audits consisted of 3 to 4 words. Quality management was not integrated to support decision making. The lack of comprehensive audit highlighted the lack of knowledge in relation to their purpose.

Inadequate

Patient transport services

We reviewed 15 records of patients whose journey had involved the use of a secure cell. None of the records included a risk assessment of the patient to indicate that the cell was the least restrictive, safest and most proportionate way to transport the patient. All records had been audited by managers and were deemed to be compliant with the service's standards. Many forms were illegible and most contained limited information. These findings were not in line with the provider's own governance policy: Clinical Policy Indicator/Ambulance Quality Indicator policy.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not identify and escalate relevant risks and issues. They did not have plans to cope with unexpected events.

There was little understanding or management of risks and issues, and there were significant failures in performance management and audit systems and processes.

The service did not have effective governance and systems and processes to identify, assess, record, manage and mitigate risks in the delivery of the service.

Governance systems did not operate effectively to identify the risks found by the inspection team. Managers did not demonstrate insight into the risks and could not produce evidence that there were effective action plans to address the identified risks.

Managers had not acted to address known risks in mandatory training records.

The service did not have a local risk register. There was a provider level risk register however managers told us there were no local risks specific to the location which required adding to the register.

The service did not provide examples of business continuity plans for unexpected events.

Information Management

The service did not collect reliable data or analyse it appropriately. Staff did not have access to data they needed to understand performance, make decisions or improvements.

There was minimal information available to monitor performance, or quality or patient experience.

There was inadequate access to, and challenge of, performance by leaders and staff. There was no evidence to show that staff performance was managed and monitored in line with best practice.

There were significant failings in systems and processes for the management or sharing of information. We did not see evidence of adequate information sharing between the service and other services. There was no documented risk assessment, handover, journey log or detailed recorded decision-making process in relation to restraint or consent under the Mental Capacity Act or Mental Health Act 1983.

The service made notifications to external regulators when required.

Engagement

Inadequate

Patient transport services

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

There was limited engagement with people who used services or the public. Staff were unaware of what patients using the mental health secure transfer service thought of their care. Feedback forms were shared with some patients during hospital discharge transfers. Staff helped patients complete these forms, where required.

It was unclear how managers collated feedback from mental health service user groups to improve services. Managers told us that they only requested feedback at the time of the transfer of the service user and only asked the service users that were well. There was not a clear process for service users to share their experience following their transfer.

There was minimal formal engagement with staff and external partners. Managers advised that meetings were not well attended and had ceased as a result. This correlated with COVID-19 and the service began using a secure social media app to communicate information to all staff. This enable the sharing of information without close contact.

There were no staff survey mechanism in place. However, staff could provide feedback via a QR code located on the provider monthly newsletter.

Managers stated that they were visible and approachable to staff as they spoke with them daily and continued to undertake shifts alongside staff members.

Managers held quarterly meetings with stakeholders to provide an update on their overall performance. The minutes showed that discussion was primarily linked to funding, contracts and response times.

Learning, continuous improvement and innovation

Staff did not have a good understanding of quality improvement methods. There was no drive for innovation or improvement.

There was no innovation or service development, no knowledge or appreciation of improvement methodologies, and improvement was not a priority among staff and leaders.

There was no evidence of learning and reflective practice. The impact of service changes on the quality and sustainability of care was not understood.