Manone Medical Ltd

Manone Medical Ltd

Quality Report

Ambulance Station
Unit C
Maritime Business Park, Dock Road
Wallasey
Merseyside
CH41 1AQ
Tel: 0151 352 5387
Website:www.manomedical.com

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Ambulance Station is operated by Manone Medical Ltd. The organisation offers ambulance transport on an 'as required' basis and does not have a set contract to provide regular pre-planned transport.

Transport for NHS patients is organised when specially designated NHS staff make direct contact with the service when required. The service also receives NHS referrals from a specialist agency working on behalf of different NHS ambulance trusts. The service sends an invoice for payment after each journey.

Transfers include patients going for hospital appointments and patients detained under the Mental Health Act 1983 going to or from mental health units.

We inspected this service using our comprehensive inspection methodology. We carried out a short notice inspection on 6, 7 and 14 June 2017.

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

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

The main service provided by this organisation was patient transport.

Services we do not rate

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

We found the following issues that the service provider needs to improve:

- The service did not have effective systems and processes to assess, monitor and improve the quality and safety of the services provided. Checks on the quality of the care were incomplete because the provider did not evaluate the information gathered about the standard of care.
- Policies and procedures did not fully promote safety because they were not always in date and /or based on the most recent best practice guidance.
- Comprehensive information about the care provided was not always available because processes did not enable staff to record detailed information about the care and treatment given to patients during a journey.
- At the time of the inspection visit, the provider did not follow best practice guidance relating to safeguarding and protecting children. This was because, none of the staff had completed level three safeguarding children's training and the designated safeguarding lead had not completed level four training. Since the inspection, all staff directly employed by the provider had completed level three child protection training and the organisation's lead for safeguarding has enrolled onto a level four safeguarding course.
- The service did not have effective systems to make sure patients with mental health conditions were transported in accordance with the Mental Health Act (MHA) code of practice requirements. This was because the systems in place did not include a written proforma to support staff in recognising the correct documents that were required to authorise ambulance staff to transfer the patient. Restraint to prevent harm to the patient or others was used and records kept did not always include enough information about the incidents such as, details of how long the restraint was applied and which staff held different areas of the patient's body. However, the details recorded did show the least restrictive form of restraint was used when caring for patients.
- Records showed that although incidents were reviewed the investigations were not in-depth and, learning to share with staff, to reduce the risk of a repeat incident, was not always identified.

Summary of findings

- The service did not carry out effective infection control audits to monitor staff adherence to policies and guidelines for infection prevention and control.

We found the following areas of good practice:

- There were effective recruitment and staff support processes in place. The staffing levels and skill mix met patient's needs.
- Staff had access to a well-planned and comprehensive training and induction programme.
- Staff told us, and we saw that, the leadership of the service was open, approachable and inclusive. There was effective verbal communication between all staff and the management team.
- The fleet of ambulances was well maintained and visibly clean.
- The managers were open and engaged well with the inspection process.

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

Professor Ted Baker

Chief Inspector of Hospitals

Manone Medical Ltd

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Background to Manone Medical Ltd

Ambulance Station is operated by Manone Medical Ltd. The service opened in 2015. It is an independent ambulance service based in Wallasey, Merseyside. The service is available 24 hours a day, every day of the year.

The service predominantly provides patient transport services to people who are physically well and secure services for patients detained under the Mental Health Act (1983) (MHA).

The service provides transport across the United Kingdom mainly for adults but also a very small number of children.

The service receives individual referrals from agencies booking transport when they need it and does not have any regular contracts to provide services to NHS patients.

The service mainly transports detained patients including conveying patients to hospital when initially detained, from acute hospitals to mental health hospitals and between mental health hospitals.

The service is registered to carry out the regulated activities:-

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

Ambulance Service has had the same registered manager since initial registration in January 2015. This person is also the managing director of Manone Medical Ltd.

We inspected this service on 6, 7 and 14 June 2017. This was the first time we had inspected this service.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,two additional inspectors each with specialist knowledge of the areas to be inspected (mental health patients and ambulance services) and a CQC Mental Health Act review inspector. This inspection was overseen by the Head of Hospital Inspection (North West).

How we carried out this inspection

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the registered location Ambulance Station in Wallasey, in the Wirral. The service was managed from this location. Ambulances are also garaged and parked at this location. We also visited the

company's new offices in Hooton, near Ellesmere Port, to talk with the administrator; look at the vehicle navigation tracking system and look at the patient referral and risk assessment processes.

We spoke with seven staff, including registered paramedics, patient transport drivers, a mental health trained paramedic, and the management team. During our inspection, we reviewed 197 sets of patient records.

We had received anonymous concerns about staff training, how staff used handcuffs for detained patients, and lack of rest breaks for staff between shifts. We sought assurances from the provider at that time and inspected the service to provide further assurance. This was the service's first inspection since registration with CQC.

- We looked at one of the emergency ambulances, one patient transport ambulance and two secure transport ambulances.

We interviewed the director of operations and head of education and training who were senior members of the Ambulance Service management team.

- The service employs 40 operational staff including administration staff, ambulance care assistants (ACA), emergency medical technicians and paramedics.
- The service also employed registered paramedics on a contractual basis.
- The paramedic setting up the journey decided on the number and composition of the crew in keeping with instructions from the referring agency.

Track record on safety

- No never events were reported by the service.
- There were no serious incidents or near misses reported by the service.
- No patients had absconded from the service's care since it started trading in 2015.
- There was one complaint, which was investigated openly and with fairness.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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Patient transport services (PTS)

Summary of findings

- Some processes for reviewing and monitoring infection control were not effective.
- Policies and procedures to tell staff what to do in particular situations did not provide enough, or up to date, information.
- Staff who worked with children and their families had not completed level three safeguarding or child protection training, however; the service provided this training for staff who were directly employed by the provider in response to CQC feedback during the inspection. Managers who were responsible for dealing with safeguarding concerns had not completed level four safeguarding training.
- Staff recorded incidents in the patient's notes and it was clear that staff followed the guidance available and told managers about issues they considered as incidents. We saw evidence that managers dealt with incidents immediately, however, investigation reports lacked detail.
- The premises and ambulance vehicles were clean and well maintained but the provider did not carry out effective infection control audits.
- Effective systems to make sure care and treatment provided was in line with best practice guidance were not in place.
- The provider did not have systems to monitor the outcomes of care and treatment compared to other services and had not set internal goals to check the effectiveness of the care provided.
- The provider did not take into account the different needs of people when organising the service because policies were not in place to consider the patients' additional needs such as cultural or religious preferences or people with complex communication needs for example people who have partial sight, are hard of hearing, or deaf or people with a learning disability.
- A complaints process was in place but this was incomplete because it did not inform the complainant about the appeal process if they were dissatisfied with the services response. In the event of a complaint from an NHS patient, there were no written processes in place for working with referring agencies.
- The provider did not have ongoing oversight of the service and changes were not based on formal strategic plans.
- The provider had not developed a programme of formal quality checks to assess, monitor and improve the quality and safety of the service. Information about the volume of events such as transfers or incidents was available but this was not analysed to identify themes or areas that could be developed and improved. Checks made did not relate to previous information so possible patterns and areas for improvement could not be identified.
- The provider had not developed a comprehensive service-level risk register before the inspection. This meant the service had not been carried out a comprehensive risk analysis to identify what mitigation plans were needed. However, the provider began developing a risk register in response to feedback from the inspection.
- Formal processes were not in place for working with stakeholders.

However,

- The provider ensured staff had the skills, knowledge and experience to deliver effective care and treatment and staff worked well together.
- The service requested feedback from patients, the provider told us this included their experience.
- There was evidence that when the provider received a complaint or information from stakeholders changes to the way the service was provided were made.
- Arrangements for monitoring and supporting staff were well developed. Staff were confident in their roles, had confidence in the leadership and felt valued by the organisation. There was a positive and open culture in the service.

Patient transport services (PTS)

Are patient transport services safe?

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

Incidents

- The organisation's policies and procedures for reporting incidents provided staff with examples of what to report, supporting staff in recognising that an incident had occurred. However, the organisation's incident reporting policy did not reflect the National Patient Safety Agency (NPSA) serious incident framework. This framework is best practice guidance for how services should deal with incidents for all patients whose care is paid for through the NHS.
- There were no 'never events' reported by the service between June 2016 and May 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The provider did not have a separate Duty of Candour (DoC) policy at the time of the inspection. However, since the inspection the provider has put in a separate policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The managers stated that no DoC incidents had occurred, but they would discuss all incidents, regardless of severity, with the patient at the time or as soon as possible. Staff stated they understood that incidents must be dealt with openly. None of the information we reviewed identified a breach in duty of candour.
- The service had a clear incident reporting system, however; the investigation process lacked detail. Staff recorded incidents in the patient's notes and made a verbal report to managers. We looked at 197 patient journey records for mental health transfers in order to check whether incidents were identified and reported. These journeys had taken place between June 2016 and May 2017. Thirteen incidents were identified and we reviewed the background information for each incident. The type of incidents included use of restraints, attempted self-harm, unprepared discharge and use of the escalation policy during transfer. Evidence indicated that staff had reported incident to the managers who had taken steps to deal with the issues identified.
- Staff told us that managers discussed incidents individually or with the crew, and supervision records confirmed individual discussions about incidents and safety matters did take place.
- We noted, however; investigations lacked detail and a recognised investigation method such as, 'root cause analysis', was not used. There was no formal evidence in the information provided, including notes from the managers meeting dated April 2017, that the service checked for themes when an incident was reviewed. These findings meant changes to the service were not based on detailed information gained about the cause of an incident.
- As a part of the inspection, the provider produced a report of changes made in response to lessons learnt from incidents. This information was incomplete because the reason why changes were made and how staff were going to be updated about changes were not included. Neither was there a date to review the effectiveness of the changes.
- The provider stated they were in the process of developing a news bulletin and this would include feedback about lessons learnt and safety alert updates.
- There were no written processes in place for sharing information about incidents with outside agencies such as the referring or receiving agencies. In addition, the provider did not understand their responsibility to send the CQC notifications about certain incidents described under Regulation 18 of the Care Quality Commission (Registration) Regulations. For example, records showed that on one occasion emergency police backup was required during transfer however; the provider did not inform the CQC. Regulation stipulates that the CQC is notified about incidents that involve the police.

Cleanliness, infection control and hygiene

Patient transport services (PTS)

- The ambulance station was visibly clean and tidy with sufficient storage for cleaning equipment. Policies and processes were in place to protect people from the risk of cross infection and provide clean and hygienic equipment. Detailed checklists provided staff with enough guidance to complete infection control tasks such as deep cleaning, handwashing or dealing with spillages to the required standard.
- It was not appropriate for this service to screen patients for infections however; the initial assessment requested information about specific infections so that appropriate equipment was provided. The provider had the processes in place to protect staff and the patients from infections such as hepatitis B and C. This included screening staff and taking the appropriate action.
- Good hand hygiene was facilitated. Hand gel was provided for and used by staff. There were hand-washing basins and antiseptic hand-wash at the depot and hand washing technique posters on display for staff to follow. Hand hygiene audits, however; were not completed.
- The service ran a fleet of 10 ambulances. We looked at the cleaning schedule and records for three in total, two regular ambulances and one of the minibus style ambulances.We entered five vehicles: - two regular ambulances, one ordinary minibus style ambulance, one minibus style ambulance modified so the seats faced in from each side of the vehicle and the high security cell ambulance. All vehicles were visibly clean and fixtures and fittings were in good repair and easy to clean.
- The infection control policy and cleaning roster directed staff to clean the vehicles and equipment at daily and weekly intervals, with a deep clean completed every four weeks. The cleaning schedule was detailed and identified how frequently different pieces of equipment should be cleaned, and the cleaning products to be used. There was a good supply of cleaning liquids and equipment. Mops were colour coded and stored in keeping with the prevention of infection best practice guidance. On board, there were clinical wipes and clinical waste bags.
- Unexplained gaps in the cleaning record however meant the service could not always be certain vehicles were hygienically clean. We noted that between January 2017 and June 2017 all the cleaning schedules looked at indicated daily cleaning had not occurred 50% of the time. The provider stated vehicles were only cleaned immediately before and after use and, as they were not used daily this accounted for the gaps. However, we found several occasions when cleaning checks had not been completed despite the vehicles having been operational.
- All the vehicles viewed looked in good repair, were visibly clean and the interiors were tidy. There was no dust, stains, smears or debris in any of the vehicles entered. All vehicles checked had been deep cleaned every four weeks.
- The provider used a specialist clinical waste disposal firm. We saw that disposal bags were sealed, signed and deposited in the bin supplied by the firm. We noted that red bags for contaminated waste were not available.The bin was not full but had an unpleasant odour. We discussed this with the provider and they had the bin removed and replaced by a smaller bin. The provider also arranged to have the bins collected more frequently so that a smell did not develop.
- Staff who came on duty wore a uniform, hair was short or held above the shoulders and staff adhered to the 'bare below the elbow' guidance.

  The provider, however, did not complete infection control audit reports to check compliance with or effectiveness of the infection control policies and so could not demonstrate how well the infection control policies worked.

Environment and equipment

- The provider stated that all referrals, adult and paediatric, had to be reviewed and approved by the manager on duty. The review included a dynamic assessment about whether the correct equipment was available to meet the needs of the patient. Children and their parents had used the patient transfer service twice during the reporting period. Both were over 8 years old.
- Manone has 10 service vehicles as listed: five high dependency; one 4x4 response vehicle and five secure vehicles, designed for the transport of Mental Health patients. One of the secure vehicles housed a see-through cell unit, which could transport one patient securely where they presented with serious risks

including challenging behaviour or risk of absconding.This cell unit totally separated the patient from staff. There was no obvious ligature or self-harm points in this ambulance. There were no seatbelts in the cell unit. We discussed the design of the vehicle with the provider who stated the vehicle specification was the same as that used by the police and the limited space within the unit, rather than seat belts, provided protection in the event of an accident. A risk assessment for using this vehicle had not been formulated at the time of the inspection.

- Another specially configured ambulance had two bench seats, one either side facing into the centre. Each bench could seat three people. A Perspex screen was in place to isolate the driver from the body of the vehicle. Two other patient transport ambulances had standard seating but it was possible to separate the driver from the patient and escorts. All vehicles had mirrored privacy glass, which protected the privacy and dignity of patients.
- Appropriate systems and processes were in place to ensure equipment was accessible but stored safely.Staff held their own keys and knew the key codes to access equipment as required. Staff had to log in and out of the garage and access was monitored by a close circuit television.
- Staff had access to equipment in good repair and checked according to the manufacturer's instructions. The registration number plates indicated vehicles were between six months to seven years old and Ministry of Transport (MOT) safety test certificates were in place as required. Staff reported vehicle faults through a central online hub and repairs completed by the garage situated next door to the ambulance service depot.
- Portable ventilation equipment, which included paediatric size airways, was on each clinical ambulance.
- Training records indicated that all operational staff had completed basic life support, which included treatment of infants and children.
- Automated External Defibrillator (AED) equipment was also provided, however, paediatric pads were not available. The provider's policy indicated that staff would not use an AED unit to resuscitate a child.
- Grab bags / resuscitation / airways kits were in place and checked but the checklist did not include making sure the correct grab bag was carried for the job. We saw that all other emergency equipment grab bags were complete and included paediatric size tools such as airways and masks.
- A standard load equipment checklist was in each vehicle to make sure staff checked that the items need were available and in good order. We observed staff complete this checklist during the inspection.
- The stretcher used by service had a five-point harness for added safety and the service provided a bariatric stretcher for adult patients who needed a wider bed-base.

Medicines

- A medicines management policy outlined the roles and responsibilities of paramedics within the organisations contract with each employee.
- The service held a variety of medicines on the ambulance station which were stored securely. Medicines were carried on ambulances when required depending on the type of service provided. The service stocked oxygen for the transport of mental health patients.
- At the depot, Oxygen remained on the locked ambulances and secured to the ambulances according to best practice guidance. When not in use clinical ambulances which carried equipment and gases were locked in the secure depot. Oxygen cylinders were stored and secured according to best practice guidance.

Records

- Ambulance Station staff transferring patients between hospitals or other locations were aware that they should collect detention papers to take with the patients. This was so they could continue to transfer the person lawfully if they began to refuse part way through the journey.
- The provider instructed staff to check that papers provided were for the correct patient.

Patient transport services (PTS)

- We reviewed approximately 197 journey records for mental health patients including patients detained under the MHA. These were paper and electronic records. The information provided basic risk assessments and patient details.
- The patient records we looked at were legible and up to date. However, the records needed to include more information to provide a complete picture of the patient's experience and staff actions during transfer. For example, there was not enough space on the forms to provide details about checks and observations carried out or information about comfort breaks. Journeys took between 15 minutes and over four hours and the majority of the forms only provided a general comment about the overall journey, regardless of the length of time spent travelling.
- Paper records were stored securely in locked metal cabinets. The electronic record system was secure and accessed through a password-protected portal.
- We saw in the case of detained patients, staff received assurances from the referring agency that transfers were within the lawful framework. This was because the MHA section of the patient transfer form included a tick box to confirm authority and these were completed as appropriate. Ambulance staff were also instructed to check that the detention papers were for the patient been transported.However, ambulance staff we spoke with were not aware of what documents they actually needed to ensure that they had lawful authority to transport detained patients and hand them over at their destination.
- Whilst we did not identify any incidents of patients been transported without lawful authority, there were no standardised checks or written proformas to support staff in recognising the correct documents that were required to authorise ambulance staff to transfer the patient.
- Crew were aware of special notes relating to end of life care and described how to access and check this information was up to date and relevant for the journey.

Safeguarding

- The Manone safeguarding policy was readily accessible to staff through the intranet and provided clear information about how to access the appropriate local authority or on call manager as appropriate. The policy included a flowchart, which detailed how to refer to the appropriate local authority or on call manager.
- The safeguarding policy did not include information about 'Prevent', which deals with religious radicalisation, or information about female genital mutilation (FGM) and so did not provide staff with all the information needed to help them protect people fully.
- Staff told us that if there were concerns they made contact with the 'on call' manager who was able to solve all problems.
- The service had promoted the safety of adults as all staff had received level two adult safeguarding training. However, on the day of the inspection, staff and managers had not completed the correct training to work with children or manage safeguarding concerns. This was because they had only completed level two training when best practice guidance states level three safeguarding training is needed when providing direct care to children and level four training is needed for the person responsible for ensuring safeguarding is dealt with properly.
- Following the inspection visit and before the inspection process was completed the managers provided evidence that staff who were directly employed by the provider had completed level three child protection training. The safeguarding lead sent assurance that level four safeguarding/child protection training was arranged for completion as soon as possible. This meant that the manager had taken action as quickly as practical to make sure the service was following best practice guidance before the inspection was completed.
- The number of children transferred at the time of the inspection was in single figures and the provider stated staff had raised no safeguarding concerns. The records showed that parents had escorted their children during escort.
- We looked at how the service used restraint. We reviewed the patient transport reports for approximately 197 mental health patients. There were 10 incidents of restraint documented between August 2016 and March 2017 and none between April and May 2017.

- The restraint records showed ambulance staff using restraint to prevent harm to the patient or others. The information in the records and discussion with staff indicated that restraint, when used, was reasonable and proportionate. We did not identify any incident where restraint was used for long periods. However, records around restraint episodes were not always clear in terms of, fully detailing how staff were involved in the procedure and for how long the restraint was applied. Restraint incidents were documented on the 'physical restraint incident report form' that included pictures of authorised restraint and holding techniques. In each case, staff confirmed which holding technique was used. However, information was incomplete because staff did not record the length of time a person was held in restraint on any documents used by the service.
- The provider did not formally monitor and report on the use of restraint. Investigations into restraint were incomplete because they did not include checks for trends, time on vehicles or the accuracy of the initial risk assessment.

Mandatory training

- The training record for 12 members of staff showed they were up to date with mandatory training. Processes in place prevented staff with lapsed training from working. Topics included: level three first response in emergency care, paediatric and adult basic life support, moving and handling, equality and diversity, consent and capacity, duty of care, service user engagement, scope of practice, driving and conveyancing, how to complete vehicle and equipment checks, and infection prevention and control including the use of protective clothing.
- Paramedics who worked for the service provided evidence that paediatric and adult emergency life support was up-to-date when they applied to work for the service.
- Ambulance Station staff received three hours pay per month to complete mandatory training and had to be up to date with training before they could be allocated work.
- Policies and procedures about road safety and conduct were clear and detailed. All vehicles had speed and blue light activation trackers. Reports and certificates showed that staff driving skills were assessed and updated as required.
- We saw that additional training and competency checks were completed for staff involved in a road traffic accident (RTA). This was regardless of fault or severity. There was one RTA, in January 2017. The report indicated the Ambulance Station driver was not at fault; however, they had additional training and supervision.

Assessing and responding to patient risk

- The management of risks from patients was shared between the ambulance station staff transporting the patient and staff from the referring agency who requested the transport. For example, the approved mental health professional, staff from the mental health hospital where the patient was or staff from the care or nursing home.
- The administrator completed the initial risk assessment at the time of referral. This provided information to help decide whether the organisation could provide the service. Different forms were used for different types of patients.
- All forms included information about mobility; the reason for transfer; medical history; planned pick up and arrival time and addresses.
- The mental health journey form included a simple mental health risk assessment which requested basic information about nutritional requirements; risk of absconding; lawful status; history of violence; risk of harm to self or others and current mood and behaviours.
- Ambulance staff did not routinely request or receive a copy of the patient's completed or fuller risk management plan where this may be indicated, for instance if the patient was assessed as high-risk of, absconding, self-harm or harm to others. This meant that plans might not provide staff with the correct information about how to manage the patient as safely as possible during the journey.
- The booking form also stipulated that crew must complete another risk assessment form on collecting the patient to verify the information or record changes. We saw that these had been completed in all instances; however, we were told that these were often completed after the journey had commenced. This meant that unless something was obviously wrong at pick up, known but unplanned for risks could show up during a

journey. The booking form also instructed the crew to complete dynamic risk assessments throughout the journey, but there was only space for one comment on the risk assessment form and so periodical written record of the observations made was not possible.

- We looked at approximately 197 patient transport records for patients with mental health needs. We saw that the simple mental health risk assessments completed by staff was sufficient to result in incident free journeys in most cases (99% of cases).
- However, we saw there had been two instances where patients assessed as low risk before transfer deteriorated mentally during transfer. In one case, emergency police were called to assist with a transfer. In the other staff had to use the ligature knife because a patient tried to use the seat belt as a ligature. In each case, we saw staff took appropriate action to ensure the patient's safety. However, a more detailed management plan for how to work with the patient's prior to the journey may have prevented the incidents occurring.
- In another case, we saw that the plan of care did not mitigate the risks identified at the time of referral. For example, it was recorded that a patient was given strong sedation prior to the transport but the referring staff had not handed over the need for ongoing checks of the patients vital signs during the journey, and the Ambulance Station's triage systems did not flag that their staff needed to record whether ongoing checks were necessary.
- Staff told us they were aware that sometimes the completed risk assessments did not provide enough information to develop an effective risk management plan however, routine guidance about how to gather additional information was not in place. For example, one ambulance care assistant (ACA) said as well as observing and talking to the patient at pickup they also read the most recent daily record and tried to talk to the patient's key worker as a part of the risk assessment. Another ACA said they mainly talked to the handover staff and observe the patient at the time of the pick-up. Staff also said risk assessments were sometimes written after a journey commenced. This meant systems for planning a safe journey were not effective because staff did not always have all the information required before the journey started.
- Staff completed classroom training in dealing with disturbed and violent patients. This included holding and breakaway techniques and de-escalation techniques.
- The service did not use mechanical restraints such as handcuffs. Specialist vehicles, which kept the patient and staff separated was used when required.
- The risk assessment and patient transfer forms did not make it clear when an escort from the referring agency may be preferable or whether a male or female staff team is preferable. It was evident, however that the service accepted the guidance of the referring agency in respect of the number of escorts.
- In relation to clinical patients the organisation used the national early warning score (NEWS) observation chart to measure how well they were during transfer. The NEWS is a way for staff to assess how poorly a patient is from adding up the scores based on the result of the blood pressure, pulse and number of breaths per minute and oxygen saturation when breathing normal air. Specific steps are then taken depending on the score.
- At the time of the inspection ambulance staff did not always add up the score or use the result to decide on the correct intervention. The provider stated the NEWS guidance and training was been reviewed and would address this issue.
- We reviewed 14 urgent care patients transfer records from January 2017 and February 2017. We noted one potential concern relating to NEWS observations and so looked at all the available records for this patient and discussed the case with the provider and ambulance staff. The additional evidence provided indicated that care had been appropriate during transfer.

Staffing

- The service employed 40 operational staff including administration staff, ambulance care assistants (ACA), emergency medical technicians and paramedics.
- The service also employed registered paramedics on a contractual basis.
- The service also used a regular team of paramedics, employed by the NHS who worked for the service occasionally.

Patient transport services (PTS)

- Ambulance Station staff were rostered to be on call and deployed as and when required. There were no vacancies. The roster appeared well organised and the patients were collected from the pickup points as requested. The skill mix of staff depended on the information provided by the referring agency.

Response to major incidents

- The provider stated that the organisation was not a part of any major incident plan, however, they were able to respond at short notice to spot purchase requests for PTS transfers.
- The provider assessed that current means of communication for instance mobile phones, land lines and other telecommunication was robust enough to allow partner agencies to make contact during a major incident.
- Basic life support and Automated External Defibrillator (AED) training was completed by all new ambulance staff so they could provide the correct initial response in a medical emergency.
- A written business continuity plan was in place and staff told us they had direct access to a member of the management team for advice and support if a part of the service suddenly ceased to operate. We saw that the managers had quick access to emergency numbers such as the vehicle recovery scheme or staff who were available if needed in an emergency.

Are patient transport services effective?

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

Evidence-based care and treatment

- Policies and procedures were not always clear and did not always include the most recent guidance. For example the 'transporting detained patients policy' did notinclude all of the information in the Mental Health Act 1983 Code of Practice chapter 17 'Transport of Patients'which sets out the factors to be taken into accountwhen transporting patients under the authority of the Mental Health Act.
- The provider did not have clear policies to identify all of the different type of risk assessments and clinical observations needed depending on the individual need of the patient. For example, the 'absconding' policy provided information about using handcuffs; completing a general risk assessment; sedation and vehicle allocation. Detailed best practice guidelines about each of these topics was available but was not included as part of the policy.
- The service used the JRCALC clinical practice guidance for UK ambulance service, which outlined best practice, and evidence based guidance.

Assessment and planning of care

- The organisations administrator was the first point of contact for the service between 9 am and 5 pm Monday to Friday. The administrator completed an initial assessment at the time of referral. The service received telephone referrals from hospital or care-home bed managers or approved mental health practitioners (AMHP). The reason for the transfer was documented for example, transfer between mental health establishments, hospital appointment or hospital discharge. This initial assessment also included a summary other health needs such as diabetes, epilepsy or other diagnosed medical conditions. All referrals were assessed by a qualified paramedic and crew allocated accordingly.
- Staff received their work allocation through the staff intranet portal. The staff also had access to the information on the electronic tablet carried for all journeys. The policy was for crew to complete a further mental health or, appropriate, patient assessment when collecting the patient. This was to confirm the information provided at the referral stage, however, these did not always provide all the required information.

Nutrition and Hydration

- Nutritional needs were assessed at referral stage however; evidence did not show that ongoing assessment and monitoring with respect to food and drink were always completed.
- Staff told us it was custom and practice to ask whether patient had taken food and drink before the journey

however this information was not recorded on all patient journey reports. Staff also stated patients were often provided with a packed meal however, they did not document this.

- On the patient transfer report form a refreshment break was specified for journeys over four hours. These stops were not always evident in the reports made by staff for journeys longer than four hours.
- Water was available on the vehicles and distributed appropriately.

Response times and patient outcomes

- The provider did not have any formal systems in place to monitor clinical safety or outcomes. There were no processes in place to identify areas of care to benchmark and the provider had not set any internal goals relating to the quality of the service or outcomes for patients. There were no processes in place to look for trends and patterns in outcomes for patients.
- Data was recorded for example the number of journeys made; the episodes of control and restraint, referral to pick-up time and time patient spent on each a vehicle, but the informationwas not analysed or evaluated. There was no indication however, from speaking to staff, information in completed journey plans or the complaints log that patients had negative outcomes from using the service.

Competent staff

- Processes were in place to ensure jobs went to appropriately experienced and well-rested staff. The provider allocated staff depending on the job specification.
- The provider had completed an informal skills assessment and decided that they needed to nurture staff with a positive non-judgemental attitude towards people with mental health needs. The provider achieved this by broadening the person specification for ambulance crew applicants, this meant people with a variety of experiences applied. The organisation had also employed a dual qualified mental health nurse/ paramedic to provide expert advice about transferring patients with mental health needs.
- The induction process involved a five-day training course, which included control and restraint, mental health awareness and service user engagement. Staff had to complete 100hrs of shadow shifts before assessed as competent to work independently or with new staff.
- The electronic shift system would not allow staff with less than 100 hours shadowing to work together. The system also prevented staff with less than 11 hours rest between a shift from been rostered. Staff told we talked with during the inspection told us they had 11 hours rest between shifts and stated they felt fully competent and supported to carry out their roles.
- There was a staff performance and appraisal policy. Supervision records identified that competency and performance were discussed and support plans put in place when needed. The supervision records also included reflection on the performance and learning since any previous conversation. We saw that the organisation took disciplinary action if staff drove over the speed limit or activated the blue light without authority.
- The organisation also employed paramedics on a contractual basis; these staff had a professional obligation to maintain their skills in order to remain on the professional register. The provider's policy was to check compliance with registration in August when all paramedic registrations were renewed.

Multi-disciplinary working

- No formal processes were in place to facilitate multidisciplinary working; however, records showed that at times Ambulance Station staff worked closely with the referring agency's staff in order to complete a dynamic risk assessment for the patient before transfer.
- Staff told us they talked with the approved mental health practitioner, psychiatrist and nursing staff whenever possible to make sure they knew about the patient.
- All staff said they discussed the patient's immediate needs with the staff directly handing the patient over at the time of the transfer. The manager told us staff from the referring agency were able to travel with the patient if this met the patients need.

Patient transport services (PTS)

- Staff also told us that the protocol was for them to hand a patient over to a specific person at the end of the journey. All mental health 'patient transfer' forms reviewed included the signature of the staff who received the patient at the end of the journey.

Access to information

- All forms, policies and procedures were on the organisation's intranet site. Staff accessed the information on their personal devices or the electronic tablet provided by the organisation.
- Information including Do not attempt cardio pulmonary resuscitation (DNACPR) orders were recorded on the initial referral and patient transfer forms. Staff were clear about the documents that needed to be in place for patients with DNACPR orders and the action plans included information about what to do during transfer. The provider and staff told us that since the service started no deaths had occurred during transfer.
- The administrator had access to a satellite navigation system used to track ambulances to make sure journeys progressed as expected.The system provided real-time information about the position of vehicles, number and duration of stops.
- The administrator said stops were monitored informally and the crew contacted if unscheduled stops occurred. The satellite system also provided information about the nearest NHS emergency department or police station to each ambulance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were provided with specific Ambulance Station Mental Capacity Act (MCA) and deprivation of liberty (DoLs) guidance to follow in relation to transporting patients that was included in their pocket books. This was based on the JRCALC clinical practice guidance.
- All staff completed a half-day induction in the Mental Health Act (MHA) and the Mental Capacity Act (MCA) and deprivation of liberty (DoLs) guidance. The MHA presentation included a description of the different sections of the Act; police powers; information about the independent mental health advocacy service and what to do if things go wrong which included how to get additional support, de-escalation techniques and specific holds.
- The MHA training was provided in light of the concept of 'Patients not prisoners'. Staff we spoke with repeated this phrase to explain the way in which they treated patients during transfer. The MCA training included the principals of the MCA, how to check whether a patient understood, retained, could weigh-up and was able to communicate information received.
- At the beginning of each journey, staff recorded the lawful status of each patient. Staff also recorded whether the patient was aware of and compliant with the transfer. Staff indicated that in relation to patients who were not detained consent was implied when they cooperated with the transfer. The patient report forms did not include prompts to confirm when staff had completed a dynamic MCA assessment at the beginning of each journey. However, staff stated they would not transfer a patient who was not subject to the MHA if they did not enter the ambulance willingly.
- Ambulance staff did not routinely request details of any best interest considerations or decisions regarding transporting patients who although compliant, lacked capacity to agree to their transfer.

Are patient transport services caring?

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

- We were not able to speak to patients who used the service and so we are not able to comment on whether service provision was caring.
- The service requested feedback from patients, the provider told us this included their experience.

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

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

Service planning and delivery to meet the needs of local people

Patient transport services (PTS)

- Journeys were planned at short notice because the referring agencies and public usually contacted Ambulance Station on the day the transport was required. The organisation did not have any regular contracted work that required forward planning.

Meeting people's individual needs

- The provider did not provide specific guidance about working with particular groups such as people with dementia or learning disabilities, language or communication needs or cultural preferences.
- The service did not record the patients' preferred language. We discussed translation services with the provider who said they did not subscribe to a language interpreter service because the cost was prohibitive and they had not explored an alternative means of accessing a translation service.
- Staff did not consider requesting specialist input if they found that someone was deaf or hard of hearing and told us they would use 'sign or body language' to communicate. In relation to other languages, staff told us there were occasions when family members were used as translators during the journey. Best practice states it is not ideal to use family members to translate. This means language needs should have been a part of the risk assessment for the patient prior to the journey. Records indicated that no additional risk assessment had been in place.
- The provider told us patients' needs were assessed individually and if these could not be met, the referral would not be accepted.The initial referral phone call indicated when a referral was unsuitable, for example if a person had to remain in their wheelchair. However all enquiries and initial assessments were reviewed by the managers who made a decision about accepting the referral based on their professional judgement.

Access and flow

- Information provided by the provider showed that the company had carried out 610 patient journeys from June 2016 to May 2017. The service was available 24 hours a day, seven days a week across the year and the service had live up to the minute information about staff and vehicle availability. The majority of transfer requests were on the day required and, according to feedback from staff, completed as arranged.
- The service did not set key performance indicators or audits against recognised outcomes for patients, for example they did not check the numbers of late arrivals, delayed pick up times or cancellations. The provider collected this information but the information was not collated and evaluated.

Learning from complaints and concerns

- Processes were in place to enable people to complain and share their view about the service. A 'Raising concerns' policy was available for staff to follow when they received a complaint. There was also a printed leaflet for patients, which described the complaint process including how a concern would be investigated. Complaints and feedback was also possible through the customer feedback form on the company's website. Information did not include the appeals process for private or NHS patients if a complained was not satisfied with the outcome of an investigation.
- The service received one complaint involving the patient transport service during the reporting period June 2016 and May 2017.Records showed the complaint investigation started on the date of receipt, the investigation was thorough and the complainant kept informed throughout the process.
- All the staff we talked with including the administrator were aware of the complaint, the findings and the changes made because of the complaint.

Are patient transport services well-led?

Leadership / culture of service

- The provider had not developed a formal strategy for the service and the vision, goals and values described in the statement of purpose were generalised. There were no formal processes in place to demonstrate strategic planning or set targets for the future. This meant the provider could not provide assurance that a strategy that included all aspects of the service was used to plan future developments.
- The provider had not identified service priorities and processes for managing change within the organisation were not effective because potential risks and benefits were not formally considered prior to making the change.

Patient transport services (PTS)

- The provider (also the registered manager) and the head of education carried out the day-to-day management of Ambulance Station; both were practising paramedics and worked alongside staff. This meant the managers knew their staff and could show them the standard of work required.
- The culture within the service was positive, staff knew what was expected of them and they felt supported by the managers and described action taken by the provider to ensure they were able to complete the jobs they were allocated.
- Staff said the managers promoted and demonstrated kindness and understanding towards the patients and staff and so this attitude was the culture throughout the service.
- The organisation's administrator was the first point of contact for the service between 9am and 5pm Monday to Friday. The administrator told us they had free access to the managers and, unless they were out on an ambulance, the managers accepted informal calls from staff, patients or referring agencies.
- The managers responsibilities included all aspects of running the business for example staff supervision, developing and providing training, development of policies and procedures, checking the service was running safely and triaging referrals. The managers were also responsible for marketing the service, developing new ideas and discovering sources of additional work.

Vision and strategy for this this core service

- The provider's statement of purpose described the organisation's strategic vision as 'To protect, save and preserve life and property and relieve injury, suffering and distress primarily but not confined to the North West of England.' This information was generalised and did not describe the work the service was undertaking. These issues were discussed with the provider during and after the inspection visit and the provider agreed to develop an up to date statement of purpose.
- The provider told us that there was a business plan in place.
- Staff we spoke with were aware that the organisation wanted to specialise in providing transport services to people with mental health needs but were not aware of the wider vision in relation to the organisation's slogan.

Governance, risk management and quality measurement

- There were no detailed or formal processes for checking the standard of the service provided. The quality checks completed did not include any objectives and there were no targets to achieve. This meant areas of success or those that needed to improve were not continually reviewed or identified. The provider could articulate the reasons for changes but did not always document the reasons or rationale. No system was in place to check how well changes worked.
- We asked the provider during the inspection visit and in writing following the inspection for reports about patient outcomes between June 2016 and May 2017. The reports sent were not useful and did not show how the provider monitored the quality of the service. The information did not include an interpretation of figures in relation the quality of the service or sustainability of the organisation.
- The provider had identified there were no nationally recognised performance indicators for independent ambulance services in relation to response times or time spent traveling. The managers had not reviewed other information they had gathered about how the service was performing. For example, the provider checked how well patients' records were completed, however feedback was only given to staff about their individual performance. The level of expected compliance for the service as a whole was not established. This meant the provider did not identify and report on trends in practice for the service overall.
- The manager also held data about the types of patient journeys; the number of times control and restraint was used and other information about the patient experience. However, at the time of the inspection this data was not formally analysed this meant general areas for improvement may not be identified.
- Where goals were set the provider did not monitor against these. For example, the 'ambulance journey plan' stipulated that 'any journey where the patient is expected to be on the vehicle for more than 4 hours must have a planned welfare stop'. In the case of a patients detained under the mental health act this stop

had to be at a designated place such as a hospital or police station. However, the provider did not check how well staff followed these instructions or how well this guidance met the needs of the patients.

- At the time of the inspection, the provider told us they had completed risk assessments for the organisation. Written processes to identify, assess and manage risks associated with providing the service were not in place. In response to the inspection, the provider developed a risk record and attributed a level of risk to some of the items discussed during the inspection. However, the document did not show why a risk was high or low and no intermediate steps to mitigate risks were included. At the time of the inspection action plans with clear instructions and review dates were not available.

Public and staff engagement

- The provider did not use formal processes such as sending out staff or patient surveys to request formal feedback about the service provided.
- Processes in place for collecting feedback from patients included a patient experience webpage and feedback forms carried on the ambulances for patients. However, other stakeholders had not yet been invited to give formal feedback.
- Ambulance and office staff stated it was not always appropriate to distribute feedback forms because patients were not always well enough to answer the questions. The provider told us and staff confirmed that changes to the vehicles such as inward facing seats had come about as a result of them telling the provider about the comments made by patients during transfer.
- Staff told us and we saw information to confirm that the provider had set up a group message system and used emails to communicate changes and positive messages to staff. Staff confirmed that managers responded to their enquiries quickly. Staff said they felt up to date and informed about what was happening in the organisation.

Innovation, improvement and sustainability

- The provider recognised that the service was growing quickly. We found however, that systems in place were not resilient enough to support the development of the secure transport service. This was because the changes were uncontrolled and so, all the procedures required to promote, a safe and effective service, maintain quality and promote improvement were not in place.
- The provider advertised on the website a specialist secure ambulance service was available but did not have in place all of the safety and governance systems embedded to ensure the risk for these patients was a low as possible. Neither had the provider applied to update their statement of purpose with the CQC. This is a requirement of registration regulations.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must put processes in place to ensure they tell CQC about changes and incidents as prescribed under the Act.
- The provider must take effective steps to prevent, detect and control the risk of spreading infections.
- The provider must follow best practice guidance in relation to investigating incidents of control and restraint.
- This provider must ensure on-going risk assessments are completed during patient transfers; including, where appropriate receiving, more detailed information about the management of risks from the referring agency or worker.
- The provider must ensure that they have effective plans in place to monitor, assess and improve services when needed.
- The provider must ensure compliance with their duty of candour responsibilities by having detailed policies and procedures in place.

Action the hospital SHOULD take to improve

- The provider should make sure cleaning records are complete.
- The provider should ensure that formal incident investigating systems are in place, which meet best practice guidance.
- The provider should ensure care and treatment is provided according to the most recent best practice guidance.
- The provider should ensure that all staff delivering direct care and treatment to patients of 17 and under have received safeguarding level 3 training in line with national guidance. In addition, the designated lead must be trained to level 4.
- The provider should ensure that records relating to restraint were improved to ensure that the records indicate the length of time patients were restrained.
- The provider should ensure that systems are in place to ensure that ambulance staff assure themselves that they have proper lawful authority to convey or transfer patients under the MHA.
- The provider should include the appeals process in the information provided about making a complaint.
- The provider should ensure they can demonstrate that patients receive appropriate food and nutrition for the planned journey.
- The provider should strengthen the processes used by staff in respect of complying with MCA and DoLs best practice guidance.
- The provider should consider how to meet the needs of people with specific communication requirements such as English as a second language or people with sensory impairment.
- The provider should ensure changes meet best practice guidance before the changes are made.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include (a) (h) (a) assessing the risks to the health and safety of service users of receiving the care or treatment. This is because: • The provider did not have processes in place to make sure appropriate risk assessments were completed during patient transfers. (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; This is because: • The provider did not have systems in place to make sure infection control procedures are effective. 12 Safe care and treatment (1) (2) (a) (h)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. This was because:

This section is primarily information for the provider

Requirement notices

- Processes to ensure compliance with all aspects of the HSCA regulations were not in place, for example, duty of candour policy and guidance or processes in place to ensure compliance with CQC registration requirements.

(2) without limiting paragraph (1) such systems or processes must enable the registered person, in particular, to-

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

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

This was because:

- The provider did not have systems to monitor the outcomes of care and treatment compared to other services and had not set internal goals to check the effectiveness of the care provided.
- The provider did not have systems in place to make sure care and treatment provided was in line with best practice guidance.
- Checks were incomplete because the provider did not evaluate the information gathered about the service provided.

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

This was because:

- Comprehensive information about the care provided was not always available because forms did not enable staff to record detailed information about the care and treatment given to patients during a journey.

17 Good governance(1)(2)(a)(b)(c)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour Registered persons must act in an open and transparent way with the relevant persons in relation to care and treatment provided to service users in carrying on the regulated activity. This was because: • The provider had not developed duty of candour policies and procedures for staff to follow to ensure these responsibilities were fully understood and so complied with when required. • The provider could not demonstrate full understanding of their responsibilities in relation to this regulation. 20 Duty of Candour