Mobile Medical Cover Ltd

Mobile Medical Cover

Inspection report

Unit 10, New Clee Ind Est.
Spencer Street
Grimsby
DN31 3AA
Tel: 01472739998

Date of inspection visit: 10 August 2021
Date of publication: 10/11/2021

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 responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We rated this service as inadequate because:

The service did not control infection risk well.

Staff did not thoroughly assess or record risks to patients.

Staff required to transport patients from events were not recruited in accordance with Schedule 3 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not manage or store medicines, including medical gases, safely.

We did not see evidence the service had processes in place to share lessons learned from safety incidents.

Fire and health and safety risks had not been addressed at the service's premises.

Managers did not adequately monitor the effectiveness of the service.

Not all staff had access to information such as company policies and procedures.

Leaders did not always run services well using a reliable information system.

Staff did not understand the service's vision and values, or how to apply them in their work.

Staff were not always clear about their roles and accountabilities.

The service did not engage well with the community to plan, manage and improve services.

However:

The service had enough staff to care for patients.

Patient transport staff had training in key skills and understood how to protect patients from abuse.

Staff appeared caring and worked together to provide effective care.

Key services were available seven days a week.

The service had several mechanisms in place for people to give feedback.

Although we saw some areas of improvement following our inspection in October 2020, we were concerned there were still areas which had not been adequately addressed in relation to safe care and treatment, the environment, and the service's governance processes. As a result, we wrote to the provider to issue a warning notice relating to these issues. Representations were submitted following this which were independently reviewed and were not upheld.

Summary of findings

The warning notice was served to the provider on 19 August 2021 under Section 29 of the Health and Social Care Act 2008, in respect of the regulated activities: transport services, triage and medical advice provided remotely; and treatment of disease, disorder or injury. It related to: Regulation 12, (2), Safe care and treatment; Regulation 15, (1), Premises and equipment; and Regulation 17, (1), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We specified the date by which the provider was required to become compliant with these regulations.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate 	We rated this service as inadequate because: The service did not control infection risk well. Staff did not thoroughly assess or record risks to patients. The service did not manage or store medical gases safely. We did not see evidence the service learned lessons from safety incidents. Fire and health and safety risks had not been addressed at the service's premises. Managers did not adequately monitor the effectiveness of the service. Not all staff had access to information such as company policies and procedures. Leaders did not always run services well using a reliable information system. Staff did not understand the service's vision and values, or how to apply them in their work. Staff were not always clear about their roles and accountabilities. The service did not engage well with the community to plan, manage and improve services. However: The service had enough staff to care for patients; they had training in key skills and understood how to protect patients from abuse. Staff appeared caring and worked together to provide effective care. Key services were available seven days a week. The service had several mechanisms in place for people to give feedback.
Emergency and urgent care	Inadequate 	We rated this service as inadequate because: The service did not control infection risk well. Staff did not thoroughly assess or record risks to patients. Staff required to transport patients from events were not recruited in accordance with Schedule 3 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not manage or store medicines, including medical gases, safely.

Summary of findings

We did not see evidence the service learned lessons from safety incidents.
Fire and health and safety risks had not been addressed at the service's premises.
Managers did not adequately monitor the effectiveness of the service and did not make sure all staff were competent.
Not all staff had access to information such as company policies and procedures.
Leaders did not always run services well using a reliable information system.
Staff were not always clear about their roles and accountabilities.
However:
The service had enough staff to care for patients.
The service had several mechanisms in place for people to give feedback.
Emergency and urgent care was a small proportion of service activity. The main service was patient transport. Where arrangements were the same, we have reported findings in the patient transport service report.

Summary of findings

Contents

Summary of this inspection

Background to Mobile Medical Cover

Mobile Medical Cover Ltd registered with CQC in 2016 and is an independent ambulance provider based in Grimsby, North East Lincolnshire. It provides a patient transport service (PTS) for a local NHS hospital, and emergency and urgent care cover at events; this includes the transportation of patients to hospital, which is an activity regulated by CQC. The service also provides medical cover on film sets and for the Ministry of Defence, but this does not fall within the CQC scope of regulation.

The service has previously received two focused inspections which were not rated. The first was in February 2017 and looked at the Safe and Well-led key questions. The provider received 'should do' recommendations in relation to recruitment processes, including verification of supporting employment references and disclosure and barring checks (DBS) checks, and timescales for the return of documents. The second was a risk-based inspection again looking at elements of Safe and Well-led. This took place in October 2020 and the provider subsequently received 32 Requirement Notices with associated 'must do' and further 'should do' actions. An action plan was produced, and the service has been working with an independent governance advisor to support with the completion of actions, which have been discussed regularly during CQC engagement meetings.

The provider currently has no contract in place for patient transport services (PTS), but provides crews and ambulances as required to local healthcare providers to facilitate patient transfers and discharges; these are usually booked on a week by week basis. The provider has, until recently, provided vehicles and clinicians to undertake transfers of patients between the local NHS trust's coronary care facilities; however, this service is no longer required due to changes within the hospitals.

The service has had a registered manager in post since 2016.

It is registered to provide the following regulated activities:

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

The main service provided was patient transport. Where our findings on emergency and urgent care, for example management arrangements, are the same, we do not repeat the information but cross-refer to the patient transport service report.

How we carried out this inspection

Mobile Medical Cover Ltd is registered to carry out the following regulated activities:

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

The inspection was unannounced and was conducted on 10 August 2021 at the provider's operating base: Unit 10 New Clee Industrial Estate, Spencer St, Grimsby, DN31 3AA.

During the visit, the inspection team:

Summary of this inspection

- looked at the quality of the environment; this included offices, staffrooms, storage areas, the garages, and ambulance vehicles
- spoke with the registered manager, operations' manager and PTS manager
- spoke with five other members of staff including the safeguarding lead and PTS staff
- reviewed 14 patient care and treatment records
- reviewed seven staff records, which included those for the registered manager and medical director
- looked at a range of policies, procedures and other documents relating to the running of the service.

The on-site team who inspected the service comprised of four CQC acute inspectors and a specialist advisor with expertise in ambulance services. They were supported off-site by a CQC acute inspector and a CQC inspection manager. The inspection was overseen by Sarah Dronsfield, Head of Hospital Inspection.

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.

Outstanding practice

None

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 any outstanding mandatory training, such as courses delivered on a face to face basis, is completed as soon as possible. (Regulation 12)
- The service must ensure staff receive training and updates in relation to mental capacity, duty of candour, and mental health awareness, and that this is recorded. (Regulation 12)
- The service must ensure staff responsible for transporting patients from events are recruited in line with Schedule 3 requirements, staff files are maintained, and skills and competence necessary for their roles are assessed and recorded. (Regulation 12)
- The service must ensure all vehicles are cleaned and maintained in line with national guidance and company policy, and that this is clearly recorded. (Regulation 12)
- The service must ensure premises and equipment are cleaned and maintained in line with national guidance and company policy, and that this is clearly recorded. (Regulation 12)
- The service must ensure staff are aware of who to contact for infection prevention and control advice. (Regulation 12)
- The service must ensure sharps' disposal containers are labelled and signed in line with national guidance and company policy. (Regulation 12)
- The service must implement a system to record details of staff members' employment with other organisations, monitor their working hours and ensure they are able to take adequate rest breaks. (Regulation 12)
- The service must ensure patient risk assessments are completed, recorded and audited. (Regulation 12)
- The service must ensure all patient documentation is audited, and audits are recorded. Clinical record forms completed in addition to running sheets must have their reference numbers clearly linked and these must also be audited and recorded. (Regulation 12)

Summary of this inspection

- The service must ensure there is space on the daily PTS running sheets to record any additional patient information, such as infection risk and any mitigating actions, and that staff complete this when necessary. (Regulation 12)
- The service must ensure information relating to staff grade and, when required, patient consent, mental capacity and do not attempt cardiopulmonary resuscitation (DNACPR) status is documented on patient clinical records. (Regulation 12)
- The service must ensure there is a policy in place to provide staff with guidance around the safe transportation of a patient's own medicines. (Regulation 12)
- The service must ensure medicines' log sheets are thoroughly and accurately completed, and that robust audits are completed and recorded in line with company policy. (Regulation 12)
- The service must ensure all medicine errors, including miscounts and missing stock, are escalated and incident reported, as specified in company policy. (Regulation 12)
- The service must ensure there is a process in place to share learning from incidents with all staff. (Regulation 12)
- The service must ensure there is a robust system to record all staff have read and understood company policies, and to monitor compliance with these policies. This includes staff responsible for transporting patients from events. (Regulation 12)
- The service must ensure a patient's pain score is assessed and recorded and re-evaluated following intervention. (Regulation 12)
- The service must ensure there are effective communication and translation aids available. (Regulation 12)
- The service must record patient handovers between the provider and hospital staff. (Regulation12)
- The service must record the details of staff who are at each event and who are able to do emergency transfers. (Regulation12)
- The service must ensure there is a safe and effective system for the storage, administration and reconciliation of medicines, including medical gases. (Regulation 15)
- The service must ensure all medical gases are stored safely and pose no fire or health and safety risks. Storage information and guidance must be clearly documented in the medicines' management policy. (Regulation 15)
- The service must ensure there are fire safety risk assessments in place for the premises, which include the storage of medical gases. (Regulation 15)
- The service must ensure all managers can clearly articulate their roles and responsibilities within the organisation, and the duties delegated to them within company policies. (Regulation 17)
- The service must ensure managers are aware of risks to the service as recorded on the risk register. (Regulation 17)
- The service should ensure the vision and strategy are clear and shared with all staff and managers. (Regulation 17)
- The service must ensure managers understand and comply with the regulatory requirements around submitting notifications to CQC. (Regulation 17)
- The service must ensure all company policies are service specific, contain all relevant information, are version controlled, and have a clearly documented review date. (Regulation 17)
- The service must ensure there are clearly defined assurance processes, including audits, and that all staff are aware of the required frequency and recording of these. (Regulation 17)
- The service must ensure all infection prevention and control audits are completed and recorded regularly, in line with guidance, which must be specified within the corresponding policy. (Regulation 17)
- The service must ensure all checks and agreements are in place before entering into any sub-contracting arrangements with other services, particularly in relation to the transportation of patients from events. (Regulation 17)
- The service must ensure all managers are able to access electronic files and systems relevant to their role, and that files are up to date and contain all information specified within the relevant policies. (Regulation 17)
- The service must improve staff and stakeholder engagement and feedback. (Regulation 17)

Action the service SHOULD take to improve:

Summary of this inspection

- The service should ensure there is adequate support for newly appointed staff, including those responsible for transporting patients from events, and consider introducing a preceptorship programme.
- The service should ensure the quick response scanning system works and is utilised effectively, and that managers can access the system and take action.
- The service should ensure relevant equipment is labelled with maintenance and service dates.
- The service should ensure patient documentation is version controlled and updated when needed.
- The service should ensure there is evidence recorded on patient records to confirm a patient handover has taken place with the receiving service.
- The service should ensure compliance with specified policies is monitored and reported on as stated in those polices, namely the deteriorating patient and clinical governance policies.
- The service should ensure staff are aware of how incidents will be investigated and followed up.
- The service should have access to an interpreter's service.
- The service should ensure all staff had access to the providers closed social media group

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Requires Improvement	Not inspected	Requires Improvement	Inadequate	Inadequate
Emergency and urgent care	Inadequate	Inadequate	Not inspected	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not inspected	Requires Improvement	Inadequate	Inadequate

Inadequate

Patient transport services

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

Are Patient transport services safe?

Inadequate

Our rating of safe was inadequate.

Mandatory training

The service provided mandatory training to all staff and made sure everyone completed it.

The service had a system in place to ensure patient transport service (PTS) staff received training when they started working with the service, which included infection prevention and control, manual handling, equality, diversity and human rights, health and safety, conflict resolution, fire safety, safeguarding adults and children at a level commensurate with their role, information governance, basic life support, and preventing radicalisation. The service had a mandatory training policy in place which was version controlled and within the specified review date.

We did not see documented evidence of staff receiving training regarding the Mental Capacity Act 2005 or obtaining and recording patient consent.

We did not see evidence of specific staff training relating to duty of candour

Ongoing training compliance was monitored through a central database which listed each mandatory training module, the date the training was undertaken, and the date renewal was due. If training had not been completed by the renewal date, managers told us staff would not be rostered for any shifts until they were compliant. The clinical quality, compliance and audit manager led on training on a voluntary basis in addition to their operational work.

Training was delivered using a combination of face to face sessions and online learning through the Skills for Health system, which staff could access on work computers or at home. Not all staff had completed manual handling updates; this was due to COVID-19 restrictions impacting on face to face training delivery.

We reviewed management meeting minutes for the service and saw training compliance was a standing agenda item discussed each month. Staff told us they found the training useful and easy to access. Managers acknowledged some staff had received elements of required training with their main employer and, in these cases, accepted evidence of this. We reviewed staff records and saw evidence was present.

We saw evidence the training needs of staff were assessed at the time of employment, and ongoing development was discussed as part of the appraisal process. Managers told us they were receptive to staff requesting any further training they wished to complete.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had a safeguarding lead with level three training, who had previous experience of working with vulnerable adults and children in the police and social services. The safeguarding lead provided training to staff and was available for support and guidance, with assistance from the operations' manager who was the safeguarding deputy, also trained to level three. The service was supported by an independent external advisor who was due to complete level five training.

The service had a policy for safeguarding adults and children, although children were not transported, which complied with national legislation. The policy was version controlled but did not have a specific review date documented, although information relating to review was contained within the policy and we saw a recent update had taken place. The policy contained key contact details and informed staff how to report any concerns. Staff could access the policy through a private social media site or in a folder at the office base. The safeguarding lead was kept informed of updates through liaison with the local authority, and there was a member of staff responsible for updating the policy.

PTS staff received level two safeguarding training in line with intercollegiate safeguarding guidelines; this was updated annually. Records showed all eligible staff had completed this training.

Staff could explain what constituted abuse and gave examples of when they would need to report this. They understood their responsibilities in line with the safeguarding policies and procedures, including working in partnership with other agencies such as the police. They knew who to contact for advice or support, could explain the referral process, and knew how to access information and guidance from the provider. The referral process included the use of a quick response (QR) code, which automatically generated a form for completion and alerted managers. We reviewed three recent safeguarding referrals made by staff and all had been documented and completed correctly.

All new employees were required to complete enhanced disclosure and barring service (DBS) and reference checks before they could work operationally. The service also required DBS checks to be updated every three years for staff in post. This was referenced in the service's DBS and vetting policy which also detailed actions to be taken for staff members with a positive disclosure on their DBS check. The policy was produced in April 2019 and did not have a specified review date. Information within the policy stated it would be reviewed every two years; at the time of our inspection the policy was out of date. All patient facing staff records we checked contained completed DBS information.

The provider informed us the service's medical director did not require a DBS check due to being non-patient facing. This is a direct contradiction of the company's DBS and vetting policy. A DBS application was made following our inspection.

Cleanliness, infection control and hygiene

Inadequate

Patient transport services

The service did not control infection risk well. We were not assured staff used equipment and control measures to protect patients, themselves and others from infection, or that they kept equipment, vehicles and premises visibly clean.

During inspection we found the provider had failed to effectively complete the actions required in relation to cleanliness, infection control and hygiene from the last inspection. We did not see enough evidence that the provider was assured there were enough infection prevention and control measures to mitigate the risks of infection and protect patients from a potential risk of harm.

The station premises, including the garage, storage areas and toilets, appeared visibly dirty. Tools, vehicle parts, and other non-sterile equipment were stored together in a disorganised manner. The service's cleaning guidance document stated general areas, including offices, corridors, crew rooms, garages, toilets and storerooms, should be cleaned a minimum of once each day. Due to visible dirt around the station premises, we did not see evidence the provider could be assured regular, effective cleaning processes took place.

We inspected two ambulance vehicles which staff informed us were ready for use. Both were visibly dirty. We saw evidence of a rusty component on a stretcher which would affect the ability to adequately clean it and reduce the risk of infection.

We reviewed vehicle cleaning records and saw not all vehicles were cleaned daily, despite the service's cleaning guidance document giving instructions for the cleaning of surfaces and floors within the vehicles and stating these should be cleaned a minimum of once each day. Deep cleaning of the vehicles had not been undertaken or recorded in line with company policy. Boards within the vehicles used to record deep clean dates had not been completed.

During the inspection we saw that the infection prevention and control policy did not identified who staff could contact for advice and support regarding infection control matters.

We did not find evidence of a systematic programme of clinical and internal audit. We reviewed governance meeting minutes which stated infection prevention and control audits were being completed, including spot checks on all vehicles, and there were no areas of non-compliance to report. However, we did not see evidence the provider was assured of the cleanliness of vehicles during our inspection. During our inspection, the register manager was unable to access electronic files through the QR code system used by staff. This system contained information including vehicle cleaning logs and deep cleaning records, therefore we were not assured there was adequate oversight of these processes.

We reviewed station infection prevention and control audits and saw a station audit had not been undertaken since 21 June 2021. There was no set frequency documented for these audits and the information provided indicated previous audits had taken place sporadically.

The registered manager told us hand hygiene audits were carried out by the clinical quality, compliance and audit manager using an ultraviolet light machine. However, the hand hygiene audit spreadsheet we reviewed during inspection indicated these audits had not been recorded at the registered location since March 2021.

We reviewed patient records and found only COVID-19 status was included on the daily running sheets as a specific infection and hygiene risk; there was no additional space to record further information other infection and hygiene risks associated with the patient.

Patient transport services

During the COVID-19 pandemic, the service was able to access adequate levels of personal protective equipment and tests for staff; all staff had received two COVID-19 vaccinations. Staff were able to explain where to find COVID-19 guidance and we saw this was displayed on notice boards on the base station; they told us it was also shared through a closed social media group and by email. Staff followed national guidance for the transportation of COVID-19 positive patients and told us they would return to base to deep clean their vehicle following this.

Linen such as blankets, sheets and pillowcases were laundered after single use at the relevant hospital. Staff were responsible for the laundering and care of their own uniforms in line with the service's uniform policy.

All clinical waste was separated into different coloured bags and managers told us this was disposed of at the local hospital each day.

Environment and equipment

The design, build, systems used, maintenance and use of facilities, premises, vehicles and equipment did not keep people safe.

The service did not have an effective system for the safe storage of equipment at the service base. We found medical gas cylinders stored alongside a propane gas bottle in a storage cage despite the cage having clear signage, stating 'medical gases', 'oxygen and Entonox', 'compressed gas' and 'oxidising agent'. This had not been identified as an explosion risk.

Several out of date fire extinguishers were also stored in the same area and it was unclear why these had not been removed from the premises.

The registered manager told us there were no fire safety risk assessments in place for the registered provider operating location because this was the responsibility of the local authority. We found a fire safety concern in the building which posed a risk to staff which was the unsafe storage of medical gases.

We saw equipment and various boxes placed on top of, and in front of, the medical gas storage cage. We had to request the removal of these items to gain access to check the contents. The premises were cluttered with equipment and stores placed around the building and lying on the floor. This was a potentially hazardous working environment and posed a potential risk to staff.

Later, during the inspection, we saw the equipment from the vehicles had been stored off the floor.

Staff told us vehicle daily checks and any corresponding issues found would be reported using the QR scanning system. During our inspection, the registered manager was unable to access this; therefore, we were not assured there was adequate oversight of these processes. The service used a wheelchair for patient transport, but staff were unable to tell us if the floor clamps had been safety tested.

None of the equipment carried on the ambulance vehicles had stickers visible with the recorded maintenance or service dates; managers told us they should have been present. However, there was a process in place for the labelling of faulty equipment and any items needing repair were placed in a box in the office with a red tag attached.

The provider used an external company to service equipment; this was completed annually. We reviewed servicing records and saw each had a certificate of calibration including the date, customer details, item reference, equipment used and the calibration results. We completed a dip sample of the records and saw items recorded had been serviced.

Staff confirmed they utilised the QR code system to report vehicle checks and faults and mobile telephones were available on each vehicle to facilitate this; staff could also report vehicle issues directly to the fleet manager, if available, for advice or to arrange repair. All vehicle defects and repairs were tracked using a spreadsheet. We confirmed all six vehicles owned by the company had a current ministry of transport (MOT) test certificate.

The premises were secure and were supported by a closed-circuit television system and entry locks. Administrative and staff files and other documents were stored securely in the office on the first floor.

Assessing and responding to patient risk

Staff did not routinely record risk assessments for each patient and did not always remove or minimise risks. Staff identified and acted upon patients at risk of deterioration, but we were not assured this was always documented.

The service had a policy in place for the management of deteriorating patients, of which staff confirmed they were aware. The policy was version controlled but did not have a specified review date, although within the policy itself it was stated review would take place every three years. It was within this date at the time of our inspection. It was also stated that the clinical quality, compliance and audit manager was responsible for monitoring compliance with this policy and submitted reports to the operations director and managing director. We asked to see copies of these reports, but they were not provided.

There was a tick-box space on the daily PTS job sheet in which staff could record if a patient's condition had deteriorated. Managers told us if a patient did deteriorate, staff would complete a further patient record, which would include documentation of clinical observations. We reviewed seven PTS job sheets which showed patient deterioration had been recorded but saw no reference to additional paperwork.

We, therefore, did not see evidence the service documented the details of deteriorating patients.

We did, however, review further forms, named patient incident report forms, which had been completed by PTS staff following failed discharges, when patients were returned to hospital; these were completed in a satisfactory manner.

During the inspection we saw evidence of a patient eligibility policy which version was controlled and within the specified review date. The policy stated absolute exclusion criteria included patients with acute behavioural disturbance and secure mental health transfers. There was no evidence of other policies in relation to patients with mental health needs. Managers told us staff received mental health awareness training, but we did not see evidence of training records or reference to this in relevant policies.

Managers told us they discussed patient risk assessments at the time of booking, before confirming they would provide transport, but they did not record this information. During inspection we found this was not completed due to the lack of risk assessment documentation. The criteria for accepting a booking were that the patient required a non-emergency transfer and did not need medical intervention.

Staff described how they would respond to any patient feeling unwell. Patient Transport Vehicles carried oxygen for emergency use and monitoring equipment; staff utilised these as part of their first aid skills and would call for emergency support from an NHS ambulance crew if they believed that a patient required further intervention. All staff we spoke with and whose records we reviewed were trained in basic life support.

Inadequate

Patient transport services

During the inspection we saw evidence staff could contact the duty manager for advice and the service operated an on-call system to enable this to continue out of hours. Staff told us who they could contact and when. The medical director for the service, who was an emergency medicine consultant, and a paramedic who also worked for the service, were both available by telephone for advice. The medical director informed staff of clinical changes using social media and the staff notice board.

Staffing

The service had enough patient transport service staff with the right qualifications, skills, training and experience to provide the right care. Managers gave their staff including those who were self-employed a full induction, but there were some gaps in documentation.

The service employed the managing director and PTS manager on a full-time basis, and a part-time accountant. All other staff were all either self-employed, or 'bank', or worked on a voluntary basis. This included 34 PTS staff. Those who worked on a voluntary basis, who were mostly management staff, told us they were paid for any events' cover they provided, but all other work was on a good will basis to help build up the company.

During the inspection we saw evidence the service ensured all patient transport staff received an induction on commencement of employment, as detailed in the recruitment and induction policy. This policy was version controlled and within the specified review date. Induction included information about company policies and procedures, infection prevention and control, manual handling, equipment use, vehicle familiarisation and documentation. Staff would then spend time observing alongside a crew. Managers were unable to tell us if any information regarding this was recorded and there were no set criteria to be signed off. There was no formal preceptorship programme in place.

The PTS manager reviewed staffing levels and skill mix and told us the service had enough staff with the right qualifications, skills, training and experience to keep people safe and provide the right care. The PTS rota was planned at least three weeks in advance. Staff rostering information could be securely accessed using an electronic application, from a mobile telephone or computer. Managers stated there was a low staff turnover in the service.

During the inspection we reviewed five PTS staff files selected at random and all showed the staff had an enhanced DBS certificate, proof of identity, a driving licence assessment, employment history, details of relevant qualifications, an application form and details of references. The service held a combination of paper and electronic staff files. Paper files were locked away in a drawer in the managers' office; others were on a database, which not all managers could access. Basic details such as contact telephone numbers were stored on an electronic application. Managers told us they were in the process of moving to a fully electronic file database.

The staff files did not contain any type of health questionnaire. We asked managers whether health conditions were discussed with staff at the recruitment phase; they told us staff were given the opportunity at interview to mention any individual requirements. Following interview, staff then had to pass a 'carry chair' assessment to check if they were physically able to move patients up and down stairs. They also needed to pass a driving assessment before being employed.

During the inspection we did not see any evidence of a system of recording staff working hours to ensure they were not working excessively or contravening working times' directives. Managers told us they relied on staff to tell them this information, but we did not see evidence this was recorded or monitored.

Records

Inadequate

Patient transport services

Staff kept records of patients' care and treatment. Records were up to date, stored securely and easily available to all staff providing care.

During inspection we saw evidence of details of multiple journeys recorded on a daily job sheet, which included information such as patient identification numbers, collection and drop off times and locations, COVID-19 status, DNACPR information, and whether the patient's condition had deteriorated during the journey. We were told if this should happen, a separate patient clinical record form would be completed with additional information and observations. There was no space on the job sheet to record this or to add further comments or information, and no evidence effective completion was monitored by managers. However, all documentation we reviewed displayed the company's name and had DNACPR information recorded.

The recording of patient information had improved since the last inspection with exception of deteriorating patients' information.

Managers told us the job sheets were not audited, but patient clinical record forms (if used) were audited. We did not see evidence of any audits despite requesting this information. Managers told us any issues with patient record completion would be addressed directly with staff members, and learning would be shared, but we did not see evidence of this during our inspection.

The service stored patient records securely in a locked cupboard in the office. Electronic information was stored securely on a shared drive which could be accessed by service managers; however, at the time of our inspection, the registered manager was unable to demonstrate how he would gain access to this system. In the event of needing staff information urgently, there an electronic application was utilised, which held basic details such as staff contact telephone numbers.

Medicines

The service did not effectively use systems and processes to safely prescribe, administer, record and store medicines.

During inspection we reviewed the providers medicine policy. It was service specific. There were references to the management of controlled drugs which were not stored or used by the service at the time of this inspection. Although the policy stated this may be introduced in the future. The policy was version controlled and within the specified review date.

During inspection we did not see evidence of a policy for the management of patients own medicines during transport.

We reviewed the action plan following the last inspection which stated a section on carriage of patient medicines would be included in the medicines' management policy. This was recorded as being completed in May 2021.When we reviewed the medicines' management policy the section on carriage of patient medicines had not been added.

Incidents

We were not assured the service managed patient safety incidents well. Managers and staff told us incidents were investigated but were unable to share examples of lessons learned.

Inadequate

Patient transport services

The service had an incident reporting policy which was within the specified review date but not version controlled. It was not always clear or service specific, for example it made references to 'heads of department' and the 'control room', neither of which were relevant. The policy listed types of incidents but did not identify these as being potential examples and the list was not exhaustive, which may have been misleading to staff. The policy referenced serious incidents and never events, neither of which were applicable to independent health providers.

The policy did not describe how incidents would be dealt with or followed up. Managers and staff were unable to give us examples of how learning from incidents would be shared.

The duty of candour is a regulatory duty relating 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. At this inspection, we found there was a duty of candour policy in place which was clear in terms of definition and responsibility. The policy was version controlled and within the specified review date. Information about duty of candour was displayed on the staff notice board.

Are Patient transport services effective?

Requires Improvement

Our rating of effective was requires improvement.

Evidence-based care and treatment

The service provided patient transport considering national guidance and evidence-based practice, but we were not assured managers always checked to make sure staff followed guidance. The service did not transport children or patients detained under the Mental Health Act 1983.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a long journey.

The service made sure a patient's food and drink requirements were met during longer journeys; however, managers and staff told us this was a rare occurrence as most transfers and discharges were within the local area. We saw all vehicles inspected were stocked with bottles of water.

Response times

The service monitored, and met, internally agreed response times so that they could facilitate good outcomes for patients. They were not required to monitor any external response times.

The service had systems to monitor response times even though they did not have contracts with their commissioning providers. Managers told us they consistently met their response times and that the key performance indicator (KPI) for PTS transfers was two hours. Staff recorded the time they left base, the time they arrived at the destination to pick up the patient, the time they left to transport the patient to their destination and the time of arrival at the destination. The provider voluntarily shared this information with the NHS hospital which used their patient transport service.

Patient transport services

Staff contacted the hospital or service managers in the event of any delays which might make them late in picking up patients for their journey, such as heavy traffic or road closures, and the PTS manager had oversight of this.

The service had not received any concerns from the NHS hospital which used their patient transport service about response times in the 12 months prior to our inspection.

Competent staff

The service made sure patient transport staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

All staff files we reviewed showed induction had been completed and those we spoke with told us they were satisfied it had provided them with knowledge and skills to effectively carry out their roles.

The service completed driver and vehicle licensing agency checks for eligible staff before the commencement of employment; we reviewed the service's recruitment records and saw this had been completed. All staff were required to undertake a driving assessment, which consisted of a 15-point checklist and free text box to record additional information. Any concerns identified were addressed immediately and further support provided when necessary. This assessment was documented and recorded in the staff file; all files we reviewed contained this information.

At this inspection we saw evidence all staff had received an annual appraisal, including the management team and registered manager. Records we reviewed showed all appraisals had been completed at the time of our inspection and staff we spoke with confirmed they had received an appraisal within the last year. The appraisal form had 15 sections for managers to complete. All appraisals seen had objectives set, considered staff competencies and highlighted areas for development.

During inspection we saw evidence the provider had a disciplinary policy which included addressing behaviour and performance issues that was consistent with the company vision and values, regardless of seniority. We saw the policy was version controlled and within the specified review date.

Multidisciplinary working

All those responsible for delivering patient transport worked together as a team to benefit patients. They worked effectively with other agencies.

The provider coordinated all transport journeys with NHS hospital which used their patient transport service. For hospital discharges and transfers, staff described how they worked with the hospitals on every shift, for example, by contacting the ward, discharge lounge, or transport support desk. Staff and managers told us they had positive relationships with hospital staff. This enabled effective handovers when they transported patients to and from hospitals. Managers explained they had informal discussions with liaison managers from each commissioning provider.

Staff reported handovers between themselves and hospital staff were effective; however, these were not documented.

Staff telephoned care providers if there was a delay with the transfer of a patient or an issue that needed to be resolved. They also discussed patient acuity, medicines and potential risks with care providers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Inadequate

Patient transport services

Staff supported patients to make informed decisions.

Staff described how they would support patients and would seek verbal consent before transporting them.

We saw evidence staff checked all patient information, including if there was a DNACPR decision in place; there was space for this to be recorded on the PTS daily log sheets and this had been completed on all those we reviewed.

Are Patient transport services responsive?

Requires Improvement

Our rating of responsive was requires improvement.

Service delivery to meet the needs of local people

The service provided patient transport in a way that met the needs of local people and the communities served.

The service undertook 3423 patient transport journeys from July 2020 to July 2021. The PTS manager ensured there were enough vehicles and crew numbers to meet the requirements of the work they had been requested to carry out, and therefore the needs of local people. The service undertook patient transport services including transfers between hospitals and other healthcare facilities, and discharges from hospital to home. The service was often able to respond to short-notice bookings if they had staff available.

Ambulance vehicles were not equipped with tracking devices. Managers told us most transport journeys were short, local transfers and they were confident the hours crews had driven were not excessive and they took breaks. Staff told us they usually managed to take breaks, but some shifts were very busy. However, there was no formal system to assure staff were nor working excessively or without scheduled breaks.

Meeting people's individual needs

The service was not always inclusive; we did not see documented evidence the service made reasonable adjustments to help patients access services.

Managers discussed patients' eligibility for transport at the time of booking. However, when journeys were allocated directly to staff at the hospital this was not documented.

Managers discussed patients' eligibility for transport at the time of booking wherever possible, however many journeys were allocated directly to staff at the hospital. Staff received information prior to transport to enable them to meet a patient's individual needs, however this was not all recorded on the daily job sheet paperwork and there was no space to add additional comments.

Staff had access to communication aids such as picture books and electronic applications with translation tools to help them communicate with patients whose first language was not English. However, managers told us staff would also utilise family members to translate. This is not considered to be good practice because the provider could not be assured the correct information had been passed or received.

There was seating in the ambulances to allow an additional person to travel with the patient if required to follow social distancing guidance.

Ambulances could be accessed by either steps or a tailgate, to enable those with decreased mobility safe access. Staff told us they would provide a wheelchair if required, which could be secured to the vehicle floor using clamps.

Access and flow

People could access the service when they needed it, in line with national standards, and received patient transport in a timely way.

Staff carried daily job sheets on which they could record journey information including the destinations and pick up and drop off times. This was monitored by managers to ensure patients received timely transport. Journeys were mostly allocated on arrival at the hospital, either by the discharging area the NHS hospital using the patient transport service. If a patient collection or discharge journey was running late, the crew would contact the destination with an update and keep the patient informed if present. Crews communicated any potential delays or issues with patients, carers and hospital staff by telephone.

Managers confirmed patients transported were usually clinically stable.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

The service had a system for handling, managing and monitoring complaints and concerns. Each ambulance had feedback forms available for patients to complete; contact details were available on the service's website and patients could also scan QR codes using a mobile telephone to access feedback forms. All methods gave details of how to contact the office and how to complain. Staff knew how to advise a patient if they wished to complain.

The service's complaints' policy was version controlled and within the specified review date. It outlined the process for dealing with internal and external complaints, including how they were screened, classified and investigated. The policy referred to staff welfare and support during the complaints' process.

Managers told us they received very few complaints about the service. We discussed a recent complaint with the registered manager and were satisfied it had been dealt with. Learning had been shared with staff through the service's private social media page. Complaints' information and outcomes would be shared with the NHS hospital used their patient transport service.

Inadequate

Patient transport services

Are Patient transport services well-led?

Inadequate

Our rating of well-led was inadequate.

Leadership

Leaders did not have all the required skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They were, however, visible and approachable for staff.

The leadership team at Mobile Medical Cover Ltd consisted of a managing director (also the registered manager) who had been in post since 2016, an operations' manager, who performed this role on a voluntary basis and coordinated events' activity, and a patient transport manager, who was responsible for all PTS work. They ensured delivery on agreed bookings and management of the team. The service was supported by a medical director who was responsible for implementing and maintaining clinical standards, including medicines' management.

Managers could not always clearly articulate their roles and responsibilities within the organisation and did not appear aware of some of the duties delegated to them in company policies.

Senior managers did not have a comprehensive understanding of the risks to the service, policies and governance issues, although these were discussed and reviewed at monthly governance meetings.

All staff spoke highly of the leadership and culture at the service. Staff felt comfortable to raise any concerns and felt supported when they did so. They told us managers were always visible at the base and by telephone when needed.

Vision and strategy

The service had a vision and set of values, but staff and managers were unable to clearly articulate them. The strategy was not robust, and we did not see evidence it was developed with all relevant stakeholders.

During the inspection we saw the providers vision and values were displayed on the staff notice board and the registered manager told us they were available to view on the private social media page; however, staff were unable to describe them and managers could not clearly articulate the details.

We reviewed the service's quality strategy. We did not see evidence of it being developed with staff or wider engagement. The service had a three-year plan in place, which we saw was discussed at monthly management meetings. However, we were not assured this process was robust; we saw items had been documented as completed, such as embedding of governance, assurance and policies, which were clearly ongoing at the time of our inspection.

Culture

Staff felt supported and respected. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff described an open culture where they could speak freely and raise concerns with managers. They told us they had been supported throughout the COVID-19 pandemic. Managers told us they were in the process of appointing a freedom to speak up guardian and hoped this would be completed by October 2021.

The management team were visible and approachable, discussed any concerns raised by staff, and provided support when required. Staff told us they felt issues would be taken seriously and followed up. Managers stated there was a low staff turnover in the service.

The service had a whistleblowing policy in place which was version controlled and within the specified review date. The policy gave a definition of whistleblowing and described how any internal or external concerns received would be managed.

Managers provided staff with information about expected work standards. They told us they encouraged a supportive and inclusive culture and spoke highly of their caring and committed staff members. However, there had been a very poor response to the staff survey and the registered manager told us staff were reluctant to give negative feedback as they thought it may impact on their work. The service did not hold regular staff meetings other than the monthly meeting for managers. We were told the service was looking at ways in which to encourage feedback from staff.

Governance

Leaders did not operate effective governance processes. Managers were not always clear about their roles and accountabilities. However, they met regularly to discuss issues and service performance.

During this inspection we did not see evidence of effective systems and processes being in place to comply with regulatory requirements. We saw several new governance processes had been implemented, but we saw no evidence the provider could have been assured these had all been embedded within the service. The systems and process included audits, such as infection prevention and control and medicines' management.

Managers could not always clearly articulate their roles and responsibilities within the organisation. The registered manager was not aware of how to comply with the CQC notifications' process. The registered manager was unaware of their responsibilities in relation to fire safety.

They were not all aware of, and therefore did not carry out, some of the duties delegated to them in the service's policies, including the safeguarding and medicines' management policies.

We were told an exercise had been completed to identify who was responsible for specific areas of practice but were not assured this was adequate to ensure a safe, effective and responsive delivery of the service.

During inspection we reviewed the providers deteriorating patient policy. It stated at section 2.3.1, The Clinical Quality, Compliance & Audit Manager is responsible for ensuring that compliance with this policy is monitored and provide reports as directed to the Operations Director and Managing Director. We did not see any evidence of any reports to demonstrate compliance with this policy.

Inadequate

Patient transport services

At section 5.2 the policy stated, A comprehensive Patient Clinical Record, appropriate to clinical grade, must be produced for any Non-Emergency Patient Transport Service user who deteriorates or suffers an injury/illness whilst in the company's care. We reviewed seven PTS job sheets which showed patient deterioration had been recorded but saw no reference to additional paperwork. There was, therefore, no evidence of staff compliance with the providers deteriorating patient policy.

The service's clinical governance policy stated audits should take place but did not specify the frequency or which audits should be undertaken.

We reviewed the action plan from the last inspection which stated there was a systematic audit programme, however we did not see evidence of this being embedded at this inspection or following a review of additional information shared by the provider.

Governance meeting minutes stated infection prevention and control audits were being completed, including vehicle and station checks, and there were no areas of non-compliance to report. However, we were not assured by the cleanliness of vehicles or premises during the inspection, or by the infection prevention and control audits we reviewed.

The provider's action plan from the last inspection indicated hand hygiene audits for staff was a completed action; however, the hand hygiene audit spreadsheet we reviewed showed audits had not been carried out regularly.

During the inspection we did not see evidence all the providers policies were service specific. Managers told us this was still a work in progress. Some policies were generic and contained information which did not apply to the service. Others did not contain pertinent information, had passed the specified review date, or did not have review dates recorded. We did not see evidence the provider had prioritised the review of the existing polices to ensure those which impacted upon the potential risk to patients and staff were reviewed and amended first.

The service did not always work in line with company policies, for example in relation to medicines' management and DBS checks for non-patient facing staff.

The service's clinical governance policy was version controlled but did not have a specified review date, although within the policy itself it was stated review would take place annually. It was within this date at the time of our inspection. It was also stated that the clinical quality, compliance & audit manager was responsible for monitoring compliance with this policy and submitted reports to the operations' director and managing director. We asked to see copies of these reports, but they were not provided. Not all information in this policy was related to clinical governance.

We said the provider should have a separate duty of candour policy, which we saw had been implemented; however, we also said the provider must have a policy in relation to staff declaring all external working arrangements and hours, which should be recorded, but did not find evidence of a policy or recorded working hours at this inspection. Managers told us they relied on staff to be open and honest about their working arrangements.

We discussed policies with managers who acknowledged there was still work to do on them but stated they had read the policies and were happy with their content; their assurance being gained from employing an external governance advisor to assist and support them. We did not see evidence the provider could be assured the actions required from the last inspection had been completed, fully understood or embedded within the service.

Inadequate

Patient transport services

During the inspection managers told us that, although regular vehicles were provided to local hospitals and independent providers, no commissioning agreements or service level agreements were in place; all work being completed on an 'as required' basis.

Managers had regular governance meetings which covered policies, incidents, risks, audits, and the CQC action plan. They told us information and updates were shared with staff in various ways. The service utilised a private social media group for information exchange; policies and procedures could also be viewed here. However, not all staff had access to social media. Managers told us they planned to review this and produce hard copies of policies.

We saw evidence the service had implemented systems to ensure staff had completed their required mandatory training and had up-to-date DBS checks.

Managing risks, issues and performance

Managers used systems to manage performance, identified and escalated relevant risks, and identified actions to reduce their impact. However, we were not assured all processes were embedded in the service.

During this inspection we reviewed the providers risk register and confirmed they were recording and managing risks, issues and had mitigating actions in place. In addition, potential risks when planning services had been considered and were record However, patient health and safety risk assessments were not documented.

The service used an electronic spreadsheet to help managers identify, classify and manage risk. We reviewed the current risk register which contained strategic, organisational and business risks. Each risk had a named lead, details of actions, completion timeline and a risk score. The management team discussed and reviewed these at monthly meetings to identify themes and trends and enable them to manage or minimise the identified risks.

During inspection we discussed current risks with managers and not all risks mentioned in those discussions aligned with those recorded. Staff would escalate any risks they identified directly to a manager, either by phone or in person. They said a manager was always available to contact when required.

We also said the provider must have a systematic programme of audit and systems to identify where action should be taken. At this inspection, we saw the service carried out a range of audits such as vehicle cleanliness, hand hygiene, and medicines; however, we found that audits were not always performed regularly and audit information, particularly in relation to medicines, was inaccurate or not correctly recorded. Because of this, we were not assured the service used audit information to effectively plan services, improve performance or identify risk.

During inspection, we saw managers monitored response times for PTS. This gave the provider assurance of a timely service, with patients picked up within internally agreed timeframes.

During inspection we found a business continuity plan had been implemented and provided guidance on actions to be taken in the events of: adverse weather; pandemic illness; loss of, or denial of access to, premises; flooding; disruption of IT systems; industrial action; and theft or loss of vehicles and equipment. Designated roles and associated actions were specified within the plan. The document was version controlled but did not have a specified review date.

Managing information

Inadequate

Patient transport services

The service collected data, but staff could not always find the data they needed. The information systems were secure; however, systems and processes were not always robust.

The service understood performance and had taken steps to monitor internal performance information such as PTS response times and failed discharges. Managers had oversight of the service, but this was not always robust. We saw there had been performance measures, such as monitoring training compliance, which had been implemented following our last inspection.

Managers maintained documentation such as staff files, patient report forms and mandatory training compliance. Although this had improved since our last inspection, there were still areas which were not complete or accurate.

We discussed the regulatory requirement for submission of certain notifications to CQC and managers were not clear of this process. The registered manager was unable to access electronic files important to their role during our inspection, which included being unable to access the QR code system used by staff, and electronic staff files. When access was gained to the staff files, the medical director's file could not be found, and the registered manager's file was incomplete.

Records showed information governance training formed part of the mandatory training programme and all staff had received this. Staff showed us how they accessed information, including electronically and using QR codes; these could be used to complete documentation relating to late shift finish times, safeguarding referrals, vehicle cleaning, incident reporting, defect reporting and vehicle daily inspections. Mobile telephones were available on all ambulance vehicles.

There were notice boards utilised at the service's base to display relevant information for staff; these were updated regularly and included clinical notices, COVID-19 updates, management structure charts, guidance relating to accessing policies, the on call rota for managers, and duty of candour information.

Engagement

Managers told us the service engaged with patients and local healthcare providers to plan and manage services, but we did not see evidence of this. They did not have formal collaboration with partner organisations to help improve services for patients, and staff engagement was not always effective.

During inspection we the provider was still dealing with the issue of improving the number of staff who responded to staff surveys. Although managers told us they were addressing this we did not see evidence of improvement. Anonymous surveys were being considered. We also said the provider should actively engage with, and seek feedback from, those who commission the service; however, we saw feedback from commissioning providers was not received. The registered manager told us it had previously been requested but rarely provided.

The service encouraged patient feedback using paper forms accessible on the ambulances, through the company's website, and by utilising a QR code which staff were able to provide. We requested examples of recent patient feedback as the registered manager told us positive comments had been received. The registered manager was unable to provide us with the information.

Staff received feedback from managers through appraisals and when needed during their work. The service regularly communicated with staff and encouraged feedback from them. They used private messaging groups and mobile phone applications to keep in touch with their colleagues.

Inadequate

Patient transport services

Managers told us they were always available, and staff could approach them at any time. There was an on-call system for staff to use if they had concerns out of hours, or issues requiring urgent escalation. There was a notice board which displayed relevant information for staff.

Inadequate

Emergency and urgent care

Safe	Inadequate
Effective	Inadequate
Responsive	Requires Improvement
Well-led	Inadequate

Are Emergency and urgent care safe?

Inadequate

Our rating of safe was inadequate.

Mandatory training

The service did not provide mandatory training in key skills to events' staff.

Events' staff did not receive training when they began working with the service. The operations' manager told us staff were asked to provide evidence of training and qualifications prior to them starting work but were unable to show us evidence of this as the information was not recorded.

Safeguarding

We were unable to discuss safeguarding processes and procedures with events' staff and were not assured of their training or levels of understanding.

The service had a policy for safeguarding adults and children which complied with national legislation. However, managers told us events' staff did not have access to company policies.

Events' staff did not receive safeguarding training delivered by the provider. The operations' manager told us events staff were asked to provide evidence of their level of safeguarding training. This information was not recorded by the provider, so we were unable to corroborate this.

We were told DBS checks were also completed for events staff, but again were unable to corroborate this as this information was not recorded by the provider. The service's DBS and vetting policy stated all managers and patient-facing staff must hold satisfactory enhanced DBS clearance. Managers told us they were assured events' staff had the relevant training and experience as they were employed by NHS providers, however, we did not see any evidence to support that assurance.

Cleanliness, infection control and hygiene

Please see patient transport service report.

Inadequate

Emergency and urgent care

Environment and equipment

We saw sharps' disposal containers in use which were not correctly labelled and there were overflowing domestic waste bins at the premises. These practices were not in line with health technical memorandum (HTM) 07-01: safe management of health care waste, or with the company's waste management policy. We also found out of date consumable items during a spot check of one of the ambulance vehicles.

Sharps' disposal bins which were in use at the station and on vehicles had not been signed and dated. This was not in line with national guidance or the service's waste management policy.

Assessing and responding to patient risk

An overall risk assessment was completed prior to an event, in line with national guidance. Patient risk was assessed on an individual basis when required.

The operations' manager told us a risk assessment was completed for each event in accordance with National Ambulance Resilience Unit (NARU) guidance, to ensure the service at events was safe and effective, with staff who had the required level of training and qualifications in place for the role. We were told by managers individual patient risk assessments would be carried out by clinicians but were unable to discuss this with staff.

The service had a policy in place for the management of deteriorating patients; however, managers told us events' staff were unable to access these policies. Although managers told us they would not transfer children or patients with mental health concerns, we were not assured this was the case at events, and the service did not have evidence of staff competence regarding the treatment of these patient groups.

During inspection we saw evidence of a formal on-call system. Staff could contact the duty manager for advice and the service operated an on-call system to enable this to continue out of hours. The medical director for the service, who was an emergency medicine consultant, and a paramedic who also worked for the service, were also available by telephone for clinical advice. The medical director kept staff informed of clinical changes through the providers closed social media and updates on the staff notice board.

Staffing

Managers told us the service had enough events' staff with the right qualifications and experience; however, we were not assured there was a system in place to verify skills and training to enable staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers reviewed and adjusted staffing levels and skill mix, but staff did not receive a full induction.

Managers told us the service employed over 300 events' staff on a self-employed basis. During inspection, we found there was no system in place to maintain records for staff working at events and no employer references were requested. The provider could not be assured these staff were recruited in accordance with Schedule 3 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requirements.

We asked for further information regarding records for events' staff. Managers told us they would check a staff member's qualifications and professional registration prior to an event; as most were employed by NHS providers, they would be deemed competent to work. This information was not recorded anywhere by the service. The provider could not be assured events' staff who required to treat, or transport patients had the training and competence to perform the roles expected of them, particularly in relation to the management and administration of medicines.

The operations' manager told us a medical risk assessment was completed prior to an event, in accordance with NARU guidance, to ensure the correct number of staff with up to date qualifications dependent upon role were provided. All events staff were self-employed, and shifts were made available through an electronic application through the providers closed social media page.

Records

Staff kept records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care, but did not always contain the relevant information.

During inspection we saw evidence the following was recorded on patient records; do not attempt cardiopulmonary resuscitation (DNACPR) orders; ensuring the company's name was displayed on records' documentation; and ensuring patient handover information was recorded and shared, with the receiving provider signing to confirm this.

We reviewed running sheets which gave a summary of patient transfers from events during each shift; they were all completed with the transfer type (emergency or normal road speed), location, destination, call time and arrival at destination time. It was also recorded if a further clinical record form had been completed along with the corresponding reference number. The running sheets were completed to a consistent standard; however, grades of staff were not always recorded.

We reviewed five patient clinical record forms completed for patients transported to hospital from events. There was nowhere to specifically record patient consent, mental capacity or DNACPR status; there was a free text box to enable the recording of any additional information, but we did not see any of the information mentioned recorded on the forms we reviewed.

Managers told us clinical record forms used for patients at events were audited informally and they would discuss any learning with the staff. The director provided feedback to staff on both the content of the PRF and the care they provided to patients. We did not see evidence of these audits being documented. The clinical record forms were not version controlled.

The company's name was visible on all patient documentation we reviewed.

Medicines

The service did not effectively use systems and processes to safely prescribe, administer, record and store medicines.

During inspection we reviewed the providers medicines policy it was not service specific. The policy was version controlled and within the specified review date.

Inadequate

Emergency and urgent care

The provider did not request evidence of training or competence from events' staff relating to medicines administration, nor did they assure themselves any medicines procured and carried by paramedics were obtained, stored or administered correctly, therefore the provider could not be assured of the safe use of medicines during the transportation of patients from events to hospital.

We reviewed medicines' log sheets and found multiple gaps and errors in medicine stock reconciliation counts. The medicines name sections on log sheets were not always completed, meaning staff were unable to clearly identify the medicines to which these sheets referred. We saw audits recorded which had not identified or documented errors, therefore no correcting actions had been taken. Audits had not been completed in line with company policy. Also, the medicines' management policy stated all medicines errors should be logged as incidents; no such incidents had been identified or logged.

The service did not have a safe storage system for medical gases; managers told us this was included in the service's medicines' management policy but, following a review of the policy, we found it was not referenced. Medical and non-medical gas cylinders were not segregated, nor were they stored safety. For example, adequate appropriate racking or cylinder trolleys were not available. This had not been identified as a health and safety risk by the provider. However, we saw empty and full cylinders were segregated.

During inspection we did not see evidence of an effective medical gases stock control system. We spoke with staff about this and asked how they would swap and record empty and full cylinders; the responses varied therefore we were not assured there was a robust system in place. The procedure for storing and acquiring gas cylinders was not outlined in the medicines' management policy.

Medicines were stored securely at the premises. The service's medicines' management policy contained guidance about which medicines different staff grades could administer dependent on their role and scope of practice.

The service's medicines management policy described which medicines different staff grades could administer dependent on their role and scope of practice. However, we were told during our inspection events' staff were unable to access company policies.

Medicines were stored securely at the premises; however, we found the medicines' logbook was stored outside the medicine's locked cupboard. We raised this with staff, and it was moved inside. We were told only the necessary staff had access to the medicines store.

Incidents

Please see patient transport service report.

Are Emergency and urgent care effective?

Inadequate

Our rating of effective was inadequate.

Evidence-based care and treatment

Inadequate

Emergency and urgent care

The service considered national guidelines such as those recommended by the National Institute for Health and Care Excellence (NICE); these were referred to in the provider's policies and procedures. Managers made changes to electronic policies using a shared electronic database and obtained updates through liaison with a local NHS ambulance trust.

Staff could access policies and procedures through a closed social media group and any changes to policy were also communicated there, however we did not see evidence the provider could be assured managers made sure staff had read these. Not all staff had access to the closed social media group; managers told us hard copies of the policies were in the process of being produced to be kept in the office. Updates were also shared on the staff noticeboard.

Pain relief

We were not assured staff assessed and monitored patients regularly to see if they were in pain or gave pain relief in a timely way. We did not see evidence of suitable assessment tools to support those unable to communicate.

Managers told us pain would be assessed and recorded in a timely manner and any analgesia would be administered by a clinician as required. We were unable to discuss this with staff; however, we reviewed five patient clinical record forms and saw pain relief was not always assessed prior to the administration of pain relief, and not always reassessed to determine its effect.

Nutrition and hydration

Please see patient transport service report.

Response times

The service did not monitor response times for events

All times relating to patient care and transport were recorded on patient clinical record forms; however, the service was not required to monitor response times in relation to treating patients at events or transporting patients from events to hospital.

Competent staff

We were not assured the service made sure staff were competent for their roles. Managers did not hold supervision meetings with events' staff to provide support and development.

Managers told us they would ask to see training records for events' staff and would check their professional registration. If this information was inaccurate or out of date, staff would not be offered shifts by the service. However, this information was not recorded and retained by the provider, we therefore could not corroborate this.

Events' staff did not receive a formal induction, training or familiarisation with equipment or vehicles; we were told this would be done on site during commencement of their shift. We did not see evidence an events staff member's skills or level of competence in relation to their role within the service had been assessed or documented.

Inadequate

Emergency and urgent care

Managers told us DBS records would be checked; however, as staff records were not maintained for events staff, we did not see evidence of this. Events' staff did not receive an appraisal when working for the service.

The service often utilised staff from other independent ambulance providers to provide events' cover and managers said they carried out due diligence checks prior to this, however we did not see evidence of this.

Multidisciplinary working

Please see patient transport service report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

We were not assured staff supported patients to make informed decisions about their care and treatment or followed national guidance to gain patients' consent. experiencing mental ill health.

We did not see evidence managers checked all events' staff had received training about the Mental Capacity Act 2005; we were unable to speak with staff to confirm this.

We reviewed the service's patient clinical record forms, which staff completed when they transported patients from events to hospital, and saw there was nowhere to specifically record patient consent, mental capacity or DNACPR status; there was a free text box to enable the recording of any additional information, but we did not see any of this recorded on the forms we reviewed.

Are Emergency and urgent care responsive?

Requires Improvement

Our rating of responsive was requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations.

The service undertook 13 emergency and urgent care patient transport to hospital from events from July 2020 to July 2021. The operations' manager ensured there were enough staff to meet the requirements of the work they had been requested to carry out, in line with national events' planning guidance.

Ambulance vehicles were not equipped with tracking devices. Managers told us they monitored the hours crews had driven to ensure they took breaks. Staff we spoke with felt satisfied they often managed to take breaks and managers encouraged them to do so. However, there was no formal system to assure staff were nor working excessively or without scheduled breaks.

Meeting people's individual needs

Inadequate

Emergency and urgent care

Please see patient transport service report.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Managers told us staffing was planned and provided in line with NARU guidance and they ensured each event they covered had enough staff with the right qualifications; this included having clinicians available to transport patients to hospital when necessary. However, due to the lack of record keeping in relation to events staff the provider could not be assured of this.

Learning from complaints and concerns

Please see patient transport service report.

Are Emergency and urgent care well-led?

Inadequate

Our rating of well-led was inadequate.

Leadership

Please see patient transport service report.

Vision and strategy

Please see patient transport service report.

Culture

Please see patient transport service report.

Governance

Please see patient transport service report.

In addition to the information provided in the PTS report, we discussed sub-contracting arrangements with service managers. They told us they often utilised vehicles and staff from other independent ambulance providers and performed due diligence checks prior to this. We were not assured this was the case and saw no evidence of this being recorded. No service level agreements in place during our inspection.

Managing risks, issues and performance

Inadequate

Emergency and urgent care

Please see patient transport service report.

Managing information

Please see patient transport service report.

Engagement

Please see patient transport service report.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The service must ensure there is a safe and effective system for the storage, administration and reconciliation of medicines, including medical gases. (Regulation 15) • The service must ensure all medical gases are stored safely and pose no fire or health and safety risks. Storage information and guidance must be clearly documented in the medicines' management policy. (Regulation 15) • The service must ensure there are fire safety risk assessments in place for the premises, which include the storage of medical gases. (Regulation 15)

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 • The service must ensure all managers can clearly articulate their roles and responsibilities within the organisation, and the duties delegated to them within company policies. (Regulation 17) • The service must ensure managers are aware of risks to the service as recorded on the risk register. (Regulation 17) • The service should ensure the vision and strategy are clear and shared with all staff and managers. (Regulation 17) • The service must ensure managers understand and comply with the regulatory requirements around submitting notifications to CQC. (Regulation 17)

This section is primarily information for the provider

Enforcement actions

- The service must ensure all company policies are service specific, contain all relevant information, are version controlled, and have a clearly documented review date. (Regulation 17)
- The service must ensure there are clearly defined assurance processes, including audits, and that all staff are aware of the required frequency and recording of these. (Regulation 17)
- The service must ensure all infection prevention and control audits are completed and recorded regularly, in line with guidance, which must be specified within the corresponding policy. (Regulation 17)
- The service must ensure all checks and agreements are in place before entering into any sub-contracting arrangements with other services, particularly in relation to the transportation of patients from events. (Regulation 17)
- The service must ensure all managers are able to access electronic files and systems relevant to their role, and that files are up to date and contain all information specified within the relevant policies. (Regulation 17)
- The service must improve staff and stakeholder engagement and feedback. (Regulation 17)

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 • The service must ensure any outstanding mandatory training, such as courses delivered on a face to face basis, is completed as soon as possible. (Regulation 12) • The service must ensure staff receive training and updates in relation to mental capacity, duty of candour, and mental health awareness, and that this is recorded. (Regulation 12) • The service must ensure staff responsible for transporting patients from events are recruited in line with Schedule 3 requirements, staff files are maintained, and skills and competence necessary for their roles are assessed and recorded. (Regulation 12)

This section is primarily information for the provider

Enforcement actions

- The service must ensure all vehicles are cleaned and maintained in line with national guidance and company policy, and that this is clearly recorded. (Regulation 12)
- The service must ensure premises and equipment are cleaned and maintained in line with national guidance and company policy, and that this is clearly recorded. (Regulation 12)
- The service must ensure staff are aware of who to contact for infection prevention and control advice. (Regulation 12)
- The service must ensure sharps' disposal containers are labelled and signed in line with national guidance and company policy. (Regulation 12)
- The service must implement a system to record details of staff members' employment with other organisations, monitor their working hours and ensure they are able to take adequate rest breaks. (Regulation 12)
- The service must ensure patient risk assessments are completed, recorded and audited. (Regulation 12)
- The service must ensure all patient documentation is audited, and audits are recorded. Clinical record forms completed in addition to running sheets must have their reference numbers clearly linked and these must also be audited and recorded. (Regulation 12)
- The service must ensure there is space on the daily PTS running sheets to record any additional patient information, such as infection risk and any mitigating actions, and that staff complete this when necessary. (Regulation 12)
- The service must ensure information relating to staff grade and, when required, patient consent, mental capacity and do not attempt cardiopulmonary resuscitation (DNACPR) status is documented on patient clinical records. (Regulation 12)
- The service must ensure there is a policy in place to provide staff with guidance around the safe transportation of a patient's own medicines. (Regulation 12)
- The service must ensure medicines' log sheets are thoroughly and accurately completed, and that robust audits are completed and recorded in line with company policy. (Regulation 12)

This section is primarily information for the provider

Enforcement actions

- The service must ensure all medicine errors, including miscounts and missing stock, are escalated and incident reported, as specified in company policy. (Regulation 12)
- The service must ensure there is a process in place to share learning from incidents with all staff. (Regulation 12)
- The service must ensure there is a robust system to record all staff have read and understood company policies, and to monitor compliance with these policies. This includes staff responsible for transporting patients from events. (Regulation 12)
- The service must ensure a patient's pain score is assessed and recorded and re-evaluated following intervention. (Regulation 12)
- The service must ensure there are effective communication and translation aids available. (Regulation 12)
- The service must record patient handovers between the provider and hospital staff. (Regulation12)
- The service must record the details of staff who are at each event and who are able to do emergency transfers. (Regulation12)