Transsecure NW Ltd

Transsecure NW Ltd

Inspection report

60 Audley Range
Blackburn
BB1 1TF
Tel: 03338000999
www.transsecure.co.uk

Date of inspection visit: 1 February 2021
Date of publication: 01/04/2021

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	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Transsecure NW Ltd opened in August 2019. It is an independent ambulance service based in Blackburn. The service provides patient transport services for local, regional, and national acute NHS hospital trusts, local authorities and independent hospitals, 24 hours a day, 365 days a year.

The service provides patient transport services for adults; the service does not transport children. The service transports patients with mental health needs and those detained under the Mental Health Act 1983. Most of the work undertaken by the service is inter hospital transfers; however, the service also transports patients with mental health needs to and from home addresses when required.

We carried out a short notice announced focused inspection of the service on 1 February 2020. We inspected the providers services to check on the provider's progress towards addressing the concerns and action we took following our previous inspections in October and November 2020. Although we saw some improvements, we identified that there were still areas that posed a potential risk to patients and we took immediate action with the provider.

We did not rate the service.

We found the following areas that required improvements:

• We were not assured that there were systems or processes in place to safeguard patients from abuse and neglect. At the inspection on 27 November 2020, we noted that the adult and children's safeguarding policies did not refer to all relevant guidance. At this inspection we found that the provider had not made any changes to adult and children's safeguarding policies. Staff had not completed safeguarding training in line with the intercollegiate document as face-to-face training had not been provided, we also found there were no current arrangements in place to ensure access to a safeguarding level four trained member of staff.

• We were not assured there were robust systems and processes in place to ensure the safe management and prevention of the spread of infection. We did not see assurance and monitoring systems in place to ensure the cleaning of equipment and vehicles and there was no Infection Prevention and Control (IPC) lead in place.

• We were not assured that effective systems were in place to ensure the safety of the care and support provided to service users was regularly assessed and monitored to make sure it was being delivered safely. We saw a draft patient transfer record which included additional sections for staff to record primary risk assessments, dynamic risk assessment, briefing and de-briefing and space for patient's vital signs. However, the updated form did not include details around the maximum time that restraint should be used. We did not see clear instructions on how staff should complete this form.

• We were not assured there were systems and process in place to safely manage the risks to patients being transported while sedated. For example, the guidance was based on sedation levels used in the pre-operating environment of a hospital and was not appropriate for the service.

• We were not assured that restraint would only be used as the least restrictive option or that there were sufficient policies and procedures to support staff in the application of the Mental Capacity Act. We were not assured that restraint would be used proportionately to the risk of harm and the seriousness of that harm. We were also not assured that staff

Summary of findings

were supported in seeking consent and acting in the service users' best interest if they lacked capacity. There was no detailed instructions or guidance for staff in relation to how consent should be obtained and would be documented; how best interest decisions would be documented where patients lacked capacity; and who would be involved in making best interest decisions.

• We were not assured there were effective systems for governance and risk management to ensure patients received safe care and treatment. There was no policy and procedure to support staff in carrying out audits to improve services for patients.

• There was no registered manager in place at the time of our inspection. The provider had taken steps to advertise for a registered manager and had identified someone for this role, but this had not been formally agreed and an application had not been submitted to the CQC at the time of our inspection.

• At this inspection we found that all the requirements as set out in Schedule 3 and Schedule 4, part 2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been completed such as bankruptcy and insolvency checks for the main company director. However, we were not provided with any evidence to show fit and proper person checks had been completed for the other company director and we did not see fit and proper persons requirements for directors in the recruitment and selection policy.

• Records did not show job descriptions had been created for all key staff to outline key roles and responsibilities.

However:

• The provider had taken steps to identify an external individual who would provide level 4 safeguarding support.

• Records showed that staff had completed further training including infection prevention and control training and we saw certificates for Level 2 Mental Capacity Act and Deprivation of Liberty safeguards and Level 2 Mental Health Awareness from an external training provider. We saw transport staff had completed basic life support training.

• The provider was aware it currently was not compliant with regulations and had a lot of work to do to improve the service. We were told by the nominated individual that the service was committed to accessing relevant training for staff and writing policies, procedures and patient care documents that were relevant to the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inspected but not rated	We inspected but did not rate the service. • We were not assured that there were systems or processes in place to safeguard patients from abuse and neglect. • We were not assured there were systems and processes in place to ensure the safe management, prevention and control of the spread of infection. • We were not assured that effective systems were in place to ensure the safety of the care and support provided was regularly assessed and monitored to ensure it was being delivered safely. • We were not assured that care was provided in a way to reduce the risk of avoidable harm to patients. • We were not assured there were systems and processes in place to safely manage the risks to patients being transported while sedated. • We were not assured that restraint would only be used as the least restrictive option or that there were sufficient policies and procedures to support staff in the application of the Mental Capacity Act. • We were not assured there were effective systems for governance and risk management to ensure patients received safe care and treatment.

Summary of findings

Contents

Summary of this inspection

Background to Transsecure NW Ltd

Transsecure NW Ltd opened in August 2019. It is an independent ambulance service based in Blackburn. The service provides patient transport services for local, regional, and national acute NHS hospital trusts, local authorities and independent hospitals, 24 hours a day, 365 days a year.

The service provides patient transport services for adults; the service does not transport children. The service transports patients with mental health needs and those detained under the Mental Health Act 1983. Most of the work undertaken by the service is inter hospital transfers; however, the service also transports patients with mental health needs to and from home addresses when required.

Transsecure NW Ltd is registered to deliver the following regulated activity:

• Transport services, triage and medical advice provided remotely

At the time of the inspection, Transsecure was in the process of identifying an individual to undertake the role of registered manager and had put in place a new nominated individual who was also the company director.

This location has been inspected three times previously since it was registered in August 2019. The previous inspections were carried out in July, October, and November 2020. We took urgent enforcement action to suspend delivery of regulated activities by the provider following these inspections.

The current focused inspection was undertaken to assess if the provider had made enough improvements. Although we saw some improvements, we identified that there were still areas that posed a potential risk to patients and we took immediate action with the provider.

How we carried out this 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

We did not identify any areas of outstanding practice.

Areas for improvement

Action the provider must take to improve.

Action the provider MUST take is necessary to comply with its legal obligations.

The provider must ensure that:

Summary of this inspection

• All listed directors who have responsibility for the quality and safety of care and for meeting the fundamental standards of care are fit and proper to carry out this important role. (Regulation 19)

• There are policies, procedures and understanding to manage deteriorating patients in terms of physical or mental health conditions in the event their behaviour deteriorated and became uncontrolled. (Regulation 12(1)(2)).

• There is a clear policy to support staff in managing patients who had received sedative medication. (Regulation 12(1)(2))

• There is clear policy or procedure which supports staff in seeking consent, acting in a patients' best interests, or undertaking a mental capacity assessment. (Regulation 11)

• It reviews its restraint policy and procedures to include appropriate information, best practice, and guidance to keep patients safe, and to remove inappropriate references from policies and procedures. (Regulation 12(1)(2))

• It reviews its patient booking exclusion criteria. (Regulation 12(1)(2))

• It reviews its infection prevention control policy and procedures to ensure there is a formal process for review and audit (Regulation 12(1)(2))

• It reviews its safeguarding adults' policy and its children's and young people's safeguarding policy to support staff in recognising safeguarding concerns and to clarify when a safeguarding concern would be reported to the local authority. (Regulation 13(1)(2)(3)(4))

• It obtains and records evidence that its external healthcare professional safeguarding lead has the required skills and competence to undertake this role, and that there is a formal agreement in place to support the role. (Regulation 13)

• It develops and implements an audit programme to undertake and record any patient quality monitoring or audits in relation to key processes. (Regulation 17(1)(2))

• It reviews its patient risk assessment process to ensure it has a policy and process to support staff in the correct application and completion of the risk assessments. (Regulation 12(1)(2))

• It has a policy or process that clearly defines which elements of training are determined as mandatory and required for each role. (Regulation 17(1)(2))

• It reviews its policies and procedures to remove elements that are not reflective of the service it provides. (Regulation 17(1)(2))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Patient transport services

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

Are Patient transport services safe?

Inspected but not rated

Safeguarding

We were not assured that there were systems or processes in place to safeguard patients from abuse and neglect.

At our previous inspections it was noted that neither the Safeguarding Adults Policy nor the procedure document referred to the Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018 Intercollegiate document and the level of training required for all staff was not documented within the policy or procedure. We saw a Children's and Young People's Safeguarding Policy and procedure was in place however we saw that it did not reference the intercollegiate document for Safeguarding Children and Young People and mentioned "club" which is not appropriate for the service the provider offered. We reviewed the Safeguarding Adults Policy submitted to us with the issue date of the 10th October 2020 where we found no amendments had been made since our previous inspection.

During our previous inspections staff had not completed safeguarding training in line with the intercollegiate document as face-to-face training had not been provided. We also found there were no arrangements in place to ensure access to a safeguarding level four trained member of staff which meant there was a risk that support would not always be available when needed or dealt with appropriately. During this inspection we were told that the company was still in the process of negotiating an agreement with an external person to act as safeguarding lead (level four trained), therefore this support was not in place at the time of this inspection. We were told that face to face training had been difficult to organise due to the COVID 19 pandemic. It was therefore currently unclear who would be in place to support staff with safeguarding queries if this was required.

At the last inspection we found policies and procedures were unclear about when a safeguarding concern would be reported to the local authority and we also found that the term best interests was used throughout the transfer and booking policy without reference to an assessment of capacity. Best interest decisions are decisions that are made for and on behalf of a person who lacks capacity to make their own decisions.

At this inspection, the nominated individual was able to describe the reporting and escalation process for reporting safeguarding concerns, including to external bodies. We saw a paper-based reporting form staff would use to report safeguarding concerns but found there was no clear guidance on who to report the concern to. We saw the transfer and booking policy and the safeguarding policy had not been updated since the last inspection and there was concerns that safeguarding concerns would not always be referred to the Local Authority when required.

Inspected but not rated

Patient transport services

Infection prevention and control

We were not assured there were systems and processes in place to ensure the safe management, prevention, and control of the spread of infection.

At the previous inspection we continued to have concerns about the provider's infection prevention and control (IPC) measures as it was not clear if the provider had considered the most recent national guidance regarding the COVID-19 pandemic in relation to the business. At the last inspection, the provider had produced as evidence several COVID-19 risk assessments however, these were not reflective of the business. At this inspection we reviewed a COVID-19 risk assessment for service users and staff, we also saw an overarching business COVID-19 risk assessment which had not yet been completed.

At the last inspection, the COVID-19 risk assessment was around the likelihood or risk of getting COVID-19, there was no section to identify appropriate measures that should be put in place where service users were COVID-19 positive, and the policy and procedure was not reflective of the business. At this inspection we saw a COVID-19 management policy had been put in place dated 30th November 2020. Again, this policy did not seem reflective of the business. For example, the policy mentioned staff staying at organisations and visiting which are not procedures, we would expect of an ambulance service. The concerns found at the last inspection regarding the risk assessments had not been addressed.

During this inspection we reviewed the Infection Control Policy and Procedure dated 25th November 2020. The policy contained some aspects that seemed inappropriate for the business including a section on the management, storage, and disposal of sharps which were not used by the service.

We were told staff had completed infection prevention and control training through a local NHS service. We saw certificates of this training in staff files which we viewed during the inspection.

We saw that ambulance vehicles were clean. The nominated individual told us staff would clean and decontaminate vehicles in between patient use. However, there was no cleaning schedule record to confirm cleaning had taken place. We saw that appropriate PPE (Personal Protection Equipment) was provided in each ambulance that included face masks, gloves, face visors and aprons. However, the service had no IPC lead in place or overreaching IPC governance or audit processes.

Environment and equipment

We were not assured that effective systems were in place to ensure the safety of the care and support provided was regularly assessed and monitored to ensure it was being delivered safely.

At the last inspection we found that the service had purchased equipment to monitor patients who had been sedated, however, we found no evidence that staff had been trained to use or interpret the findings.

During our previous inspection, we were not assured that the provider had effective systems in place to regularly assess and monitor the safety of the environment or equipment. This was because we found the risks assessments in place had no indication on how the level of risk was calculated. Risk assessments did not set out the need for a formal risk

outlining action which should be regularly reviewed to ensure risks to staff and patients had not changed. At our most recent inspection we saw risk assessments had been completed for both the environments staff worked in and the ambulance however, we did not see how regularly these were reviewed and there was no completed date on these assessments.

We found there were daily inspection logs available for vehicle checks and equipment checks. The equipment checks included blood pressure monitor and pulse oximeter checks, thermometer checks and automated external defibrillator (AED) checks. There were also checks to ensure equipment and consumables such as PPE were available. We did not see a decontamination or cleaning schedule available for any of the equipment on the ambulance.

Assessing and responding to patient risk

We were not assured that care was provided in a way to reduce the risk of avoidable harm to patients.

At our last inspection we found a transfer and booking policy had been put in place which included information regarding the use of restraint. The policy did not outline the maximum time that restraint should be used or outline that patient monitoring should be undertaken. There was no section in the policy that provided guidance on the correct use of handcuffs. This was concerning because the inappropriate use of handcuffs can lead to injury and can restrict a patient's breathing. We were unsure that the use of restraint was being assessed on an individual basis. Due to this we were not assured that restraint would be used proportionately and in accordance with recommended timeframes. The safe transfer pack did not include details around the maximum time that restraint should be used. This was an issue which had been identified at the inspection on 27 November 2020. We saw no reference to the NICE (National Institute for Clinical Excellence) guidance NG10 which provides guidance concerning restraint and recommends not to routinely use manual restraint for more than 10 minutes. During this inspection we found there had been no change to policies, or risk assessment relating to the use of restraint. This meant there was still a risk of restraint being used inappropriately.

At the inspection we saw a draft patient transfer pack which included additional sections for staff to record primary risk assessments, dynamic risk assessment, briefing and de-briefing. We saw a patient observation form as part of the safe transfer pack for staff to record vital patient observations. This form did not include details of what observations to perform and record or details of the parameters that these observations should fall within. It also did not outline to staff what to do if observations were outside of the normal range.

There was no clear guidance for staff to follow should a patient try to ligature or self-harm during the journey. This was concerning because we were not assured that staff would respond effectively should a patient attempt to strangle themselves or carry out self-harm. There was still no completed ligature risk assessment as identified at previous inspections.

We again, as at previous inspections, reviewed the Patient Deterioration Procedure. We saw that the purpose of this document was to ensure staff identified and responded to seriously ill patients and those at risk of deterioration before, during and after transport in line with NICE guidance of recognising seriously ill patients. We were unsure which NICE guidance was being referenced as there is no such guidance with that title. The procedure also advised staff to escalate concerns if a patient's vitals dropped. The policy did not specify normal parameters for different patient vital signs and did not consider if a patient's vital signs increased outside of the normal parameters.

Patient transport services

We did not see guidance to support staff to carry out appropriate actions should a patient self-harm. During the inspection we saw a draft patient transfer record which included a section for staff to document details of a debrief, however the associated booking and transfer policy had not been updated to:

• provide instructions for staff on how to conduct the post-restraint debrief.

• set out who would be involved in this.

• include details around the maximum time that restraint should be used; and

• outline when patient observations should be completed, and action taken.

At the previous inspection we were not assured that the necessary observations and procedures would be undertaken after restraint was used to ensure there was early response to any deterioration and any immediate action required. During this inspection we found pulse oximeters and blood pressure monitors had been purchased to monitor patients. However, staff had not been trained to use these and there had been no risk assessment completed to ensure the equipment did not create a ligature risk. We found the blood pressure monitors had a cord and were told that if the patient was at risk of ligaturing staff would handcuff them. This was concerning because it indicated that staff were not familiar with national guidance; providers are required to consider the least restrictive options, when restraining someone.

Information from previous inspections highlighted staff had received first aid training, basic life support training (BLS) and the ambulance vehicle also had an automated external defibrillator (AED) which staff had received training for. We saw certificates of staff members who had completed basic life support and AED training. The nominated individual was unable to explain under what condition / scenario staff would be required / expected to use the defibrillator or apply basic life support skills, there was no clear information / guidance for staff on this in the existing policies. The nominated individual confirmed there had been no further updates / changes made to the booking and transfer policy in relation to 'if a healthcare professional was escorting the service user then they must have the appropriate equipment to monitor service users.'

At the last inspection we reviewed the transfer and booking policy and found it had a risk assessment section. However, this section referenced risk assessments in line with the Health and Safety at Work Act, regulation 3 of management of health and safety at work regulations and regulation 12 of the Health and Social Care Act 2008. It was not clear to staff on how they should be completing patient risk assessments as the principles and references outlined were more in line with employee health and safety risk assessments, rather than clinical risk assessments. We reviewed the Transfer and Booking Policy that had been submitted as evidence which was dated 3 December 2020. The policy contained the same information as it had previously regarding risk assessments so there had been no improvement since the last inspection.

We saw an ambulance risk assessment policy and completed formal risk assessments within this policy had been carried out at the bottom of this policy. These included generalised risks such as road transport, staff, service user and manual handling. We saw a risk assessment completed for harm and injury to a service user and noticed that the control measure for this was the service user 'is always secured,' it was not clear what the service meant by this.

We saw a risk rating system had been added to the policy; the system described risks as critical risk, high risk, moderate risk, or minor risk. However, we saw risk ratings on the risk assessment and guidance described as very low, low,

medium, high, and very high which did not match those described in the policy. We also saw a risk assessment that had described a risk as unacceptable. It was confirmed there had been no policy updates to include guidance on what and how often risk assessments should be reviewed and updated and that there had been no further improvements or changes to processes in relation to this requirement.

At this inspection we saw an exclusion criterion for patient transfers which excluded certain patients such as those with bariatric history and those who need sign language to communicate. The exclusion criteria did not include any details about physiological exclusion for example chronic co-morbidities or patients who required medications.

Medicines

We were not assured there were systems and process in place to safely manage the risks to patients being transported while sedated.

At our last inspection we found that the overarching medication policy and procedure outlined that staff were not permitted to administer medication and if support or administration of medication was required then a member of staff from the transferring hospital must accompany the patient. The nominated individual stated the only medicines handled by staff were patients own medicines and these were stored in locked cabinets inside the ambulance vehicle(s). We saw locked cabinets were present in the two ambulance vehicles we looked at. We did not see a process for recording what medications were being transported and what medicine were handed over to the receiving location.

At our previous inspection we were not assured there were systems and process to safely manage the risks to patients being transported while sedated. For example, the guidance had been based on sedation levels used in the pre-operating environment of a hospital not in the environment that would transport patients who had been detained under the Mental Health Act. It was unclear which policy staff should be following as there was no cross reference to the medication policy which was still available for staff. This did not contain any guidance for staff on transporting patients who had been sedated. We were told that the service would transport a service user who had been sedated and that this would be based on ASA grades. An ASA grade is a physical classification system used to assess patients prior to surgery and not to assess patient sedation.

We found at this inspection there had been no changes to the systems and processes to safely manage the risks to patients being transported while sedated or changes made to the transfer policy regarding sedation grades.

At the last inspection we saw in the restraint section of the booking policy that the service did not carry out any chemical restraints but may assist at the request of a healthcare profession in administering chemical restraint. There was no guidance to support staff in assisting with chemical restraint and there was no evidence of what training would be required.

The provider told us that arrangements had been put in place with an agency for registered mental health nurses to support transfers, if required, to administer medication if there was no one available from the transferring hospital. However, there was no evidence of this in any policies we reviewed.

Inspected but not rated

Patient transport services

Are Patient transport services effective?

Inspected but not rated

Consent, mental capacity

We were not assured that restraint would only be used as the least restrictive option or that there were sufficient policies and procedures to support staff in the application of the Mental Capacity Act.

At our previous inspection we found there was no clear policy or procedure which supported staff in seeking consent, acting in service users' best interests, or undertaking a mental capacity assessment. At this inspection, the nominated individual told us the process for seeking consent was outlined in the booking and transfer policy. We found this policy made some reference to seeking consent, however there was no detailed instructions or guidance for staff in relation to how consent would be documented or how best interest decisions would be documented when patients lacked capacity and who would be involved in making the best interest decisions.

At the inspection on 1 February 2021, we observed that there was a failure to update the risk assessment form to ensure the secure cell (in the back of the ambulance) was included so that staff were alerted to the fact that this form of restraint was only to be used when appropriate and as the least restrictive option.

We were told on inspection that all patients were transported in the cell of the vehicle. This included patients who were not detained under the Mental Health Act 1983. This was concerning because it meant staff were unnecessarily depriving a person of their liberty. We were told that patients who were not detained were asked if they could be transported in the cell of the vehicle. The rationale for transporting all patients in the cell of the vehicle was unclear.

In addition, transporting all patients in the cell of the vehicle was a blanket restriction. A blanket restriction is a policy or rule that restricts a person's liberty, that is applied to all patients without an individual risk assessment to justify its application. This practice is not in line with the Mental Health Act code of practice 2015.

At our previous inspection we found that full Mental Capacity Act training had not been undertaken. We also found there was a lack of understanding of when deprivation of liberty safeguards would apply. During this inspection we were shown training certificates for staff in relation to Level 2 Mental Capacity Act/DoLS and Level 2 Mental Health Awareness from an external training provider.

At our previous inspections we were not assured that restraint would only be used when needed and as the least restrictive option. The booking and transfer policy and the updated draft patient transfer record did not include any details around the maximum time that restraint should be used. There had been no changes made by the provider in relation to these points since the previous inspection.

Are Patient transport services well-led?

Inspected but not rated

Leadership of service

Inspected but not rated

Patient transport services

We were not assured the provider had robust processes to ensure that directors who had responsibility for the quality and safety of care and for meeting the fundamental standards of care were fit and proper to carry out the role.

There was no registered manager in place at the time of this inspection. The provider had taken steps to advertise for a registered manager and had identified someone for this role, but this had not been formally agreed and an application had not been submitted to CQC at the time of our inspection.

At this inspection we found that all the requirements as set out in Schedule 3 and Schedule 4, part 2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been addressed for the main director. We found the main company director's file included suitable evidence to show fit and proper person checks had been performed, including two-character references, identification checks, enhanced Disclosure and Barring checks (DBS) and HM bankruptcy and insolvency register details.

The other company director was not directly involved in the business and there was a plan in place to remove their name as a company director. We reported on 27 November 2020 that the provider had not included the requirements for FPPR (Fit and Proper Person Requirement) in the recruitment policy, meaning that there was an increased risk that such checks would not be undertaken in the future when needed. We found there had been no improvements made in relation to this during this inspection.

The recruitment and selection policy had been updated since the last inspection, to include checks for employment references and DBS checks. However, the policy did not contain all the checks as outlined in schedule 3 of 2014 Regulations. For example, it did not specify the need to have satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.

The policy also did not include details about the need to obtain satisfactory information about any physical or mental health conditions which are relevant to a person's capability to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity after reasonable adjustments are made.

The recruitment, selection and retention policy in place at the time of the inspection in October 2020 and dated October 2020 stated that driving assessments under test conditions would be required for all staff who drove vehicles; these had not been completed. In the recruitment, selection and retention policy updated in November 2020 these driving assessments, to ensure patients would be transported safety, had been omitted from the policy. Also, any reference to driving checks to be carried out had been omitted from the revised policy in November 2020. For example, driving licence checks and driving offences. At this inspection we found no improvements had been made to the guidance regarding driving assessments.

There is a risk that service users will or may be exposed to the risk of harm if staff are employed, who do not have the necessary checks to verify they possess the necessary qualifications and experience for their roles and are physically and mentally fit to perform their duties. There is a risk such matters will be overlooked if there is not a clear policy setting out these requirements.

Governance

We were not assured there were effective systems for governance and risk management to ensure patients received safe care and treatment.

Inspected but not rated

Patient transport services

Evidence was provided to us as part of the inspection that suggested the provider was aware it currently was not compliant with regulations and had a lot of work to do to improve the service. We saw written evidence that the provider had identified an external individual who could become the registered manager but had not yet submitted an application to the CQC.

At this inspection we saw policies submitted as evidence of improvement which did not always contain reference to appropriate best practice or national standards. We saw that policies and procedures we reviewed referred to a home, club, visitors, and sharps which meant we were not assured that policies and procedures had been written and adapted to be reflective of the service provided. For example, safeguarding policies and procedures outlined the need for case management groups which was not outlined in any of the governance structures presented as evidence. The safeguarding policy also referred to sports organisations which was not relevant for this provider. This was the same as previous inspections therefore no improvement had been made.

We did not see any form of documented quality monitoring such as risk registers or audit processes. We did not see quality monitoring processes or schedules for key areas such as patient records, staff recruitment, staff training and infection prevention and control. The nominated individual confirmed at the time of our inspection that there was no audit schedule in place. A meeting agenda template had been created with subheadings of topics to be discussed at formal meetings. We did not see a meeting schedule in place and did not see a completed meeting agenda. This was the same as the previous inspection therefore no improvement had been made.

As at the previous inspection we were still not assured that staff would learn from past incidents. We saw a draft incident reporting form, this included sections for recording investigations details and recommendations. This form did not include a section for recording the initial details of the incident and did not include a section to record an action plan. There was no process or policies in place to support investigation and learning from incidents.

We saw an incomplete training and development policy in place; there were parts missing such as appendix 2 where staff induction training information was supposed to be held. There was a list of training topics as part of appendix 3 however, these were not specific to the different roles within the company and did not reflect the training needs for each of the staff groups. For example, during our inspection we were told that the head of legal and compliance would not be expected to complete all the training. It also did not include the frequency or content of the training. We saw that the training and development lead had not been identified. We found there had been no improvement since the last inspection.

At the previous inspection we were told that the service would transport a service user who had been sedated and that this would be based on ASA grades. An ASA grade is a physical classification system used to assess patients prior to surgery and not to assess patient sedation. We found at this inspection there had been no changes to the transfer policy regarding these sedation grades.

We were told at this inspection that job descriptions had been developed for some of the key roles such as patient escort staff, operations manager and head of legal and compliance. Post inspection the provider sent through evidence of all the role descriptors in place however we did not see job descriptions for the nominated individual or registered manager.

This section is primarily information for the provider

Requirement notices

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance