IMT Medical Transport Ltd

IMT Medical Transport Headquarters

Quality Report

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

Ratings

Overall rating for this ambulance location	Requires improvement
Patient transport services (PTS)	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

IMT Medical Transport Headquarters is operated by IMT Medical Transport Ltd . It is an independent ambulance service which was first registered in January 2018. The service is located in Liverpool and serves several NHS hospital trusts and local authorities. The service provides a patient transport service specialising in the transfer of mental health patients, including those detained under the Mental Health Act 1983, across the country.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 2 and 3 October 2019.

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

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

We had not previously inspected this service. We rated it as **Requires improvement** overall.

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

- Staff did not always have a clear understanding of how to protect patients from abuse or how to recognise and report it.
- Risk assessments were not always comprehensive and were not updated for each patient.
- Records were not detailed and did not reflect the patient's journey or the care received accurately. Records were not always clear or available to staff and management.
- Incidents, near misses and patient safety issues were not always managed well. Staff did not always recognise and report incidents and incidents were not always documented appropriately; in line with policy and best practice guidance.
- Patient outcomes were not always measured or monitored and policies did not always follow best practice guidance or standards.
- Leaders did not always operate effective governance processes or use systems to manage performance effectively.
- Leaders did not always identify or escalate relevant risks and issues or identify actions to reduce their impact.
- Leaders and teams could not always access and find the data they needed, data was not always collected and was not always available in accessible formats to allow staff to understand performance and drive improvement.

However, we found the following areas of good practice:

- The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment. The service had suitable premises and equipment and looked after them well.
- Patients could access the service when they wanted to, and services were planned to meet the needs of the individual patients.
- Managers promoted a positive culture that supported and valued staff. Staff were clear on their roles and responsibilities.

Summary of findings

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also took enforcement action telling the service that it had to make significant improvements. This is detailed at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)	Requires improvement 	IMT Medical Services Ltd provided patient transport service specialising in the transfer of mental health patients, including those detained under the Mental Health Act 1983, across the country. We found the following issues that the service needs to improve: • Staff did not always have a clear understanding of how to protect patients from abuse or how to recognise and report it. • Risk assessments were not always comprehensive and were not updated for each patient. • Records were not detailed and did not reflect the patient's journey or the care received accurately. Records were not always clear or available to staff and management. • Incidents, near misses and patient safety issues were not always managed well. Staff did not always recognise and report incidents and incidents were not always documented appropriately; in line with policy and best practice guidance. • Patient outcomes were not always measured or monitored and policies did not always follow best practice guidance or standards. • Leaders did not always operate effective governance processes or use systems to manage performance effectively. • Leaders did not always identify or escalate relevant risks and issues or identify actions to reduce their impact. • Leaders and teams could not always access and find the data they needed, data was not always collected and was not always available in accessible formats to allow staff to understand performance and drive improvement.

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Requires improvement

IMT Medical Transport Headquarters

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to IMT Medical Transport Headquarters

IMT Medical Transport Headquarters is operated by IMT Medical Transport Ltd and registered with the Care Quality Commission in January 2018. The service is available 24 hours a day, every day of the year.

The service is an independent ambulance provider specialising in the secure transfer of mental health patients and those detained under the Mental Health Act 1983. The different types of transfers included from secure mental health units, inpatient units and acute settings; for example, accident and emergency departments to receiving mental health facilities or courts of law.

The service has had a registered manager in post since January 2018 and this individual was also the clinical lead for the service.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and the inspection team was overseen by Judith Connor, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the provider's headquarters, which is where the service was provided from. There were no other registered locations.

Although registered as a patient transport service; generally, patients transferred by the service were physically able and this meant that the majority of vehicles used by the service were not equipped in the same way that conventional ambulances would be. The service maintained one conventional ambulance, for the transportation of patients with mobility issues.

We spoke with 11 staff including; patient transport drivers, control room operatives, supervisors and management. We did not speak with any patients or relatives during the inspection. During the inspection, we reviewed 29 sets of patient records.

There were no special reviews or investigations of the service ongoing by the Care Quality Commission at any time during the 12 months before this inspection. This was the service's first inspection since registration with the Care Quality Commission.

Activity (January 2019 to September 2019)

Detailed findings

- In the reporting period January 2019 to September 2019 there were 789 patient journeys undertaken.

The service employed 41 staff in total including one registered paramedic, 16 full time staff able to undertake patient transport journeys and also had a bank of temporary staff that it could use.

Track record on safety

- There had been no never events reported by the organisation.
- There had no serious incidents reported by the organisation.
- There had been no complaints.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires improvement	Requires improvement	Not rated	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Not rated	Requires improvement	Requires improvement	Requires improvement

Patient transport services (PTS)

Safe	Requires improvement
Effective	Requires improvement
Caring	Not sufficient evidence to rate
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Patient transport services were the only regulated activity provided by IMT Medical Services Ltd and these services were provided 24 hours a day, every day of the year. The service completed 789 patient journeys between January 2019 and September 2019, which equated to an average of 87 journeys per month. The service predominantly transported adults however there had been one paediatric transfer within the 12 months prior to the inspection.

Summary of findings

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

- Staff did not always understand how to protect patients from abuse or how to recognise and report it.
- Staff did not always complete and update risk assessments for each patient and did not always remove or minimise risks.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up-to-date or easily available to all staff providing care.
- The service did not always use systems and processes to safely record and store medicines.
- The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents and near misses.
- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- The service did not always monitor the effectiveness of care and treatment. They did not always use the findings to make improvements and achieve good outcomes for patients.
- Staff did not always support patients to make informed decisions about their care and treatment.

Patient transport services (PTS)

- It was not always easy for people to give feedback and raise concerns about care received.
- It was not always clear that leaders understood the priorities and issues the service faced.
- Leaders did not always operate effective governance processes, throughout the service.
- Leaders and teams did not always use systems to manage performance effectively. They did not identify and escalate relevant risks and issues or identify actions to reduce their impact.
- The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not always integrated and secure.
- Staff did not always have a good understanding of quality improvement methods or the skills to use them.

We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- The service planned and provided care in a way that met the needs of the patients it served.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- Leaders were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and staff actively and openly engaged with patients, staff and the public.

Patient transport services (PTS)

Are patient transport services safe?

Requires improvement

We had not previously inspected this service. We rated it as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to all employed staff and made sure everyone completed it.

- At the time of the inspection we saw that mandatory training compliance was at 100% for all staff.
- Mandatory training included up to 24 modules and these were updated annually. Modules included; infection control, basic life support, safeguarding, data protection, fire safety and duty of candour.
- Training was predominantly facilitated by online learning through accredited courses. The provider had access to two qualified course instructors to provide the face to face modules including basic life support and emergency blue light driver training. We saw that there was a designated training room at the site base which contained all relevant equipment to facilitate training.
- Mandatory training was overseen by the service directors and there was a comprehensive training matrix for all staff who were employed by the service as well as retained/bank staff.

Safeguarding

Staff had training on how to recognise and report abuse; however, staff did not always understand how to apply it or how to protect patients from abuse.

- At the time of the inspection we saw that safeguarding training compliance was at 100% for all staff.
- There was a safeguarding adults policy and a safeguarding children policy; both were in date, version controlled and available to staff electronically. However, the safeguarding children policy did not reflect the latest intercollegiate guidance and there was no clear standard operating procedure for the operational centre staff to follow upon receiving a referral from an ambulance crew.
- All staff undertook safeguarding adults and children training at level three, annually. This showed good practice as the minimum training requirement for non-clinical staff who have contact with both adults and children was level two.
- One of the managing directors for the service was the designated lead for both adult and children safeguarding and was also trained to level three. However, we saw that the level three safeguarding children training course did not contain any face to face training hours, which did not meet with best practice guidance.
- Two out of five staff we spoke with during the inspection did not demonstrate a good understanding of safeguarding principles and were unclear on what the process was for making a safeguarding referral.
- The service had not reported any safeguarding incidents or concerns within the 12 months prior to the inspection.
- We saw that all staff received disclosure and barring service checks.There was a robust system in place for monitoring when disclosure and barring service checks were due and we saw that key information was recorded within an electronic spreadsheet including the disclosure and barring service number and the date the renewal was due.

Cleanliness, infection prevention and hygiene

Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- All staff undertook infection prevention and control training level one and two, on an annual basis and we saw that compliance was 100% for all staff.
- There was an infection prevention and control policy which was in date, version controlled and available to staff electronically. The policy stated there were separate procedures available for staff to follow for certain conditions. For example, infection prevention and control procedures which told staff about how to deal with an inoculation injury and a procedure for the care of infected patients. However, when we requested

both procedures during the inspection, they were not available. This meant that there was no formal procedure for staff to follow either when transporting infected patients or in the event of a needlestick injury.

- The mental health transfer request and authority booking form contained initial risk assessment information and was completed by operational centre staff when a booking was made. We saw that the initial risk assessment information did not ask if the patient was infectious. This meant that there was an increased risk that infectious patients would not always be managed appropriately. This was highlighted during the inspection and a question added to the request and authority form. However, the question added related only to if the patient had a diagnosis of Methicillin-resistant Staphylococcus aureus (MRSA) and not any other form of infectious conditions. Staff we spoke with told us that they would ask nursing staff about this when collecting patients from hospital; however, there was no documentation of this.
- All staff we spoke with during the inspection demonstrated a good understanding of infection prevention and control principles and hygiene standards. All areas we visited were clean and had appropriate hand wash basins, liquid soap, antibacterial hand gel. The service displayed posters of the World Health Organisation hand hygiene pictorial guides throughout the site base.
- Personal protective equipment (PPE) was available on vehicles for staff to use when needed. This included items such as clinical gloves and aprons.
- Staff took care of their own uniforms on a daily basis. In exceptional circumstances; for example, if there was heavy soiling of staff uniform, the fleet manager would arrange for the uniform to be laundered off site. There was a contract with an external provider for the laundering of linen such as blankets and sheets and we saw that items were stored and bagged appropriately in line with policy.
- Staff completed daily electronic cleaning checklists and deep cleans were carried out on all vehicles every six weeks. We saw that both the daily checklists and six-weekly deep cleans were monitored, spot checked and overseen by the fleet director.
- Cleaning equipment was available in the ambulance garage and we saw that this was kept appropriately. Mops were colour coded and there was clear guidance which told staff which equipment should be used to clean which area.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

- All areas observed were tidy and well maintained. Access to all areas was restricted and entry gained through intercom access for main areas and keycode or key access for all other areas.
- We saw that all areas had warning signs as required; for example, the room containing cleaning chemicals and hazardous substances.
- The service had nine vehicles which were used for mental health transfers and there were further vehicles on order. Vehicles were a mixture of ambulances, people carriers and four by four vehicles. The service had one traditional style ambulance which contained a stretcher and could accommodate a wheelchair. This vehicle could be used for patients with mobility issues. The service had one celled vehicle which had CCTV and was used only when specifically requested and deemed appropriate by ambulance staff. This vehicle had appropriate signage to advise that the CCTV was in operation. We saw that the new vehicles were more informal and the seating could be altered as and when required in order to accommodate the patient's needs. For example, seating could be faced forward or side on to the patient. This showed the service had good awareness of the vulnerability of the patients and their needs.
- All vehicles were checked for road worthiness at the start of each shift and we saw that staff completed a daily electronic checklist. These were overseen and audited by the fleet director on a weekly basis. Vehicle defects could also be recorded during these checks and we saw that there was a robust process in place to log vehicle faults.
- All vehicles had valid MOT certificates and tax and we saw that the fleet director had oversight of this on a

vehicle maintenance spreadsheet. We saw that each vehicle underwent a six weekly safety check and regular servicing. The service had a contract with a garage located on the same estate site who carried out servicing and safety checks. This garage also carried out repairs on the service vehicles as required.

- We saw that all vehicles had been equipped with satellite navigation systems which updated automatically, and all vehicles had the facility for hands free communication, which was good practice.
- All equipment that was serviceable was serviced according to a schedule and all equipment checked during the inspection was within service date. Vehicles carried basic equipment; for example, emergency first aid kits and we saw that these were checked daily and recorded electronically as part of the daily vehicle checks.
- Stores such as blankets and consumables such as vomit bowls and gloves were readily available for staff and we saw that these were overseen by the fleet director and managed appropriately.
- As the service provided was for secure mental health transfers, the service carried four sets of restraint handcuffs and we saw that these were checked on a monthly basis for integrity and metal fatigue. We saw that the vehicle location and serial number of the handcuffs were recorded each time within the audit. However, we saw on the one recorded occasion in which restraint handcuffs had been used, the serial number had not been recorded in line with policy.
- The service adhered to standards of the Department of Health Technical Memorandum 07-01 in relation to the safe standards of waste disposal; including clinical and hazardous waste. Waste bins were appropriate to the environment; for example, non-touch pedal operation. Waste was collected by an external company under a contractual agreement and was stored appropriately whilst awaiting collection.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and remove or minimise risks. It was not always clear that staff identified or acted quickly when patients were at risk of deterioration.

- We had concerns that the service did not have effective systems in place to ensure that only patients who were suitable for transportation with the service were transported; as there was no specific inclusion or exclusion criteria.
- Initial risk assessments were completed by the operational centre staff and formed part of the mental health request and authority booking form and we were told that these were completed for all patients. However, these were not always kept and during the inspection we found that 22 out of 29 request and authority forms were missing.
- The request and authority booking form asked how many staff were required to complete the transfer safely. Operational centre staff were unable to tell us how the number of staff required was calculated and there was no process within the mental health conveyance guidelines and policy for staff to calculate this.
- We saw that the request and authority booking form completed by operational centre staff did not contain the same information as the booking form within the mental health conveyance guidelines and policy. The management team told us that staff had altered the form for ease of use. However, we saw that key information was missing from the altered form such as allergy information and the confirmation of the presence of the H4 transportation form. The H4 transportation form is a statutory form which gives authority to convey a patient detained under the Mental Health Act 1983, from one location to another.
- We had concerns that other key information was missing from the request and authority booking form; for example, there was no question to ask if a do not attempt cardiopulmonary resuscitation order was in place. This was a risk because it meant that staff were potentially unaware of any special requirements a patient may have. This was highlighted to management and we saw that a question about do not attempt cardio-pulmonary resuscitation orders had been added to the initial risk assessment questions on the booking form during the inspection.
- Other key information missing from the request and booking form included that there was no specific

question around patient sedation. This was a risk because it meant that the service could potentially be transporting sedated patients and it was not clear that these patients could be safely managed by staff.

- The management team told us that the request and authority booking forms were not audited. This was a risk because the service was not able to demonstrate that operational centre staff were capturing risk assessment information accurately and the service was unable to highlight areas of concern, promote best practice or make improvements.
- We were told that the service had developed a new electronic booking system which included all the risk assessment information detailed within the policy and that this could be audited electronically. We saw the new system and whilst this was not being used during the inspection for mental health transfers, we saw that there was a planned timeframe for the implementation of the system.
- Five out of five staff told us that dynamic risk assessments were undertaken on arrival at the transferring facility to ensure that the initial risk assessment information had not changed and that the patient could be transported safely. However, staff were not aware of the dynamic risk assessment checklist form within the mental health conveyance guidelines and policy and staff told us that the risk assessment questions completed were from memory.
- All staff confirmed that the completion of the dynamic risk assessment was not recorded. This meant there was no documented evidence that staff were carrying out their own risk assessments prior to transporting the patient and could not therefore evidence that they were able to safely do so.
- However, we saw that the operational centre deployment log detailed instances were crew members had requested additional staff on arrival at the transferring facility. This meant that there was some evidence of dynamic risk assessments being carried out. The management team told us that the proposed new electronic booking system had the facility for notes and/or risk assessments completed by the ambulance staff to be uploaded onto each individual job.
- At the time of the inspection there was no deteriorating patient policy or standard operating procedure for staff to follow if a patient became acutely unwell. Staff were able to articulate what action they would take, dependent on the situation. Action involved either dialling 999 for emergency assistance or transporting the patient to the nearest accident and emergency department. The management team told us that a deteriorating patient policy was in the process of being written; following a review by an external consultant, prior to our inspection. It was unclear if staff were aware of the new deteriorating patient policy which was being written when we spoke with them during the inspection. However, we saw the policy was completed before the end of the inspection and an email composed to make staff aware of the new policy.
- We saw that all staff were emergency blue light trained and practical driving assessments were completed annually, by an external assessor. However, there was no oversight for the use of emergency blue lights and staff were unclear on the procedure for using them during a transfer. Three out of five staff we spoke with told us that they were able to self-authorise the use of emergency blue lights and sirens which did not match the policy which stated that the operational centre supervisor must give authorisation. The policy stated that this could be done retrospectively but must be recorded on the operational centre deployment log. We saw that the log had a mixture of the supervisor authorisation, no recorded authorisation and self-authorisation. The management team told us that a new system was being installed whereby the utilisation of emergency blue lights and sirens would be tracked, recorded and audited, going forwards. However, this was not in place at the time of the inspection and we did not see evidence of an agreed timeframe or planned date.
- Staff received training in basic adult and paediatric life support and how to use an automatic external defibrillator (a portable electronic device with simple audio and visual commands, which through electrical therapy allows the heart to re-establish am organised rhythm so that it can function properly). We saw that the service was equipped to carry out paediatric transfers and the management team told us that they had completed one child and adolescent mental health transfer in the 12 months prior to the inspection.

- Staff did not carry out any clinical assessments or interventions in their day to day work. Emergency first aid was administered, as and when required and this formed part of the ambulance care assistant training course.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment.

- The service had 41 members of staff in total; 16 full time staff members and a bank of self-employed staff who were called upon, on a standby basis.
- There were three managing directors, a fleet director, an operational centre manager, operational centre staff, two team leaders, an accounts officer and a human resources officer. All directors covered a senior manager rota to ensure that senior support cover was provided seven days a week, 365 days a year.
- We were told that the majority of staff working within the operational centre were also trained for mental health transfer work. This showed succession planning within the business model.
- The service had a contract for one vehicle for a regional mental health NHS provider which was covered 10 hours a day, Monday to Saturday and five hours a day on a Sunday. This contract was covered by two staff members on a rota with an additional staff member on standby.
- Ad-hoc work was covered by the remaining full-time staff and the bank of self-employed staff. This rota allowed for six staff to be on call for any transfer work which may come in.
- During the inspection we saw that there had been 11 occasions over a two-month period whereby the service had been unable to provide six staff on standby for mental health transfers. However, we did not see any evidence which suggested that the provider was unable to safely transport or had had to decline any transfer work because of this.
- We were told that the absence level for the service was low and that this was recorded by the human resources officer. However, this was not available to view during the inspection.
- During the inspection we saw that rotas indicated that staff were receiving between eight and 10 hours rest between shifts. This did not meet with minimum requirements of eleven hours consecutive rest as set out in the Working Time Regulations 1998.
- The rota was managed by the operational centre manager and the service completed rota's three months in advance for staff.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up to date or easily available to all staff providing care.

- The service had a document management policy which was in date, version controlled and available to staff electronically.
- Patient records were paper based; however, the service was implementing an electronic system to record patient journeys and transfers, going forwards.
- The paperwork completed varied based on which provider the transport was being provided for. For example, the fixed hours regional mental health NHS trust vehicle completed a basic running sheet whilst all other journeys had a request and authority booking form completed and were documented on the operational centre deployment log.
- Two types of form made up the patient record within the service; the mental health request and authority booking form and a mental health transfer log form. Completed forms or copies of completed forms were kept in locked filing cabinets within the site base.
- The request and authority form was completed by operational centre staff at the booking stage. We were told that these forms should be copied and given to the ambulance crew as the form contained risk assessment information. The original form would stay on the site base. However, we saw that in 22 out of 29 records checked, the request and authority form was missing which did not meet with policy. The management team told us they were aware of this and although there were no plans to address this at the time of the inspection, we were told that the new electronic booking system would negate this risk.

- The mental health transfer log form was completed by the ambulance crew and returned to the site base to be filed at the end of the shift. We saw that patient information contained within this form was minimal and we were told the form was predominantly for invoicing purposes.
- There was no record of the patient journey in any of the patient documents checked during the inspection. Three out of five ambulance staff told us that if anything were to happen during the journey which they thought was important, they would record the details in their own personal notebooks. This was not in line with the policy or best practice guidance. This was a risk because the service was unable to evidence what had happened on a patient journey; for example, if there was a complaint or an untoward incident.
- We saw that the operational centre deployment log used for each ad-hoc transfer included a space for comments from crews. We were told that crews would need to telephone into the operational centre to add comments to the deployment log. We saw that the majority of comments over a seven-month period related to the crew members in attendance on the transfer and we did not see any comments about the patient journey. However, the management team told us that ambulance crews would be able to add comments onto individual jobs, on the new electronic booking system.
- There was no oversight of the completion of any form of patient records and we were told that there were no audits of either any paper forms or the deployment logs. This meant that there was a risk that patient documentation was not being completed correctly and that there was an increased risk that improvements would not always be made in a timely manner, when needed.

Medicines

- The service kept oxygen at the site base. The management team told us that this had been arranged when the service had been looking to transport patients as part of their organ transplant work.
- There were no other medicines in use or being kept by the service. We saw that oxygen cylinders were stored in purpose-built racks; within a storage cupboard, in the garage area. The cupboards were locked, had appropriate signage and were checked each day by the fleet director.
- A compressed medical gases safety standard operating procedure was in place, should the service begin to use medical gases and we saw that it detailed that staff must have received training to handle and use medical gases safely. We saw that all staff had received oxygen therapy training and this was updated every two years.
- There was no standard operating procedure or policy in place which guided staff in the transportation of the patient's own medication. The mental health conveyance guidelines and policy stated that a patient's personal belongings should be stored at the rear of the vehicle and not be accessible to the patient. This meant that it was unclear where the patient's own medication was stored or if this could be administered by staff during the transfer. The policy stated that suitably qualified medical practitioners could prescribe medication and that IMT staff would not become involved in this process, it did not however, specify if IMT staff could administer medication.
- We saw that in two out of seven request and authority forms it was documented that the patient had received medication prior to transfer; however, the effect of the medication was not documented, as requested. This was a risk because it meant that staff were potentially unaware of any special requirements a patient may have and it was not clear if staff could safely manage the patient.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise or report incidents and near misses. However, managers did investigate incidents and share lessons learned with the whole team.

- There was a learning from our experiences policy in relation to incidents and we saw that this was in date, version controlled and available to staff electronically. However, the policy lacked clarity and included information on complaints, concerns and claims. We saw that the only investigation form attached as an appendix within the policy referenced 'formal

complaints' and 'complainant' throughout; it did not contain any information relating to incidents and it was therefore unclear if this form was used for the investigation of both complaints and incidents.

- The service had a Duty of Candour policy which was in line with the regulation and there was evidence that the provider understood when to apply it. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents including any incident with a patient harm level of moderate or above.
- Three out of five staff we spoke with were unclear on the types of incidents they should report and were not able to give definitive examples. Two out of five staff were unaware that an incident report form should be completed with a restraint form; whenever restraint had been used, as per policy.
- All staff we spoke with told us that they would discuss an incident with supervisory staff in the operational centre in the first instance, before completing an incident report. This meant that there was an increased risk that incidents were not being reported, were not always being recorded correctly and that there would be no documented evidence of what actions had been taken to prevent similar incidents.
- We saw that there were two incidents inputted by the management team on the provider's untoward incident register; neither of these had been reported by staff, as an incident. One incident was a concern raised to the Care Quality Commission by a former employee and the Care Quality Commission had contacted the service about it and the other was a query about an organ transplant transfer. It was therefore not clear that there was an understanding of the difference between complaints, incidents and concerns.
- We saw that the concern raised to the Care Quality Commission had resulted in the issuing of a newsletter to remind staff about best practice procedures. This was good practice and showed the service was able to respond to concerns and share learning.

Are patient transport services effective?

Requires improvement

We had not previously inspected this service. We rated it as **requires improvement.**

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

- We saw that the service had a number of policies for staff to follow in the course of their work; however, policies were not always clearly defined or available. For example, there was no Mental Health Act (1983) policy; however, we found information for staff was detailed within the provider's mental health conveyance guidelines and policy and subsequent information was provided within the capacity to consent policy.
- At the time of the inspection, not all of the policies we reviewed referenced the most up to date guidance or best practice. For example, the provider's mental health conveyance guidelines and policy stated that if a patient was sedated, a member of trust staff may be required to accompany the patient. However, the Mental Health Act 1983: Code of Practice 2015 states that sedated patients should always be accompanied by a health professional knowledgeable in the care of such patients.
- The management team and staff we spoke with were able to demonstrate to good effect the legalities and processes involved in transferring patients detained under the Mental Health Act 1983 across borders; for example, from England to Scotland. The management team told us that these transfers would not be completed without a member of trust staff accompanying the patient, which was good practice. However, we were unable to find where this was documented within any of the service policies.
- Staff received annual training in the Mental Health Act 2007 which was robust and comprehensive. We saw that staff compliance for this training was 100%. We saw that a separate module was undertaken specifically in relation to mental health transfers as part of the provider's ambulance care assistant course, which showed good practice.

Nutrition and hydration

- Staff who we spoke with informed us that they gave patients enough food and drink to meet their needs and journeys were planned in a way that met the needs of patients including stops as necessary. However, as there were no records for individual patient journeys there was no documented evidence that nutrition and hydration had been considered on occasions were the journey was of any great length.
- During the inspection we saw that all vehicles carried bottled water and snacks were available for patients, if required.

Response times and Patient Outcomes

The service did not always monitor the effectiveness of care and treatment. They did not use the findings to make improvements.

- The mental health conveyance guidelines and policy detailed four booking categories and subsequent response times; to be selected by operational centre staff, when a booking was made. However, we saw that the category and response time had not been included on the amended request and authority form. We reviewed seven completed request and authority booking forms and saw that there was no category or response time recorded on any occasion.
- We saw that there was a space for ambulance staff to record a 'target time' on the mental health transfer log form which was completed at the end of the patient journey for invoicing. However, we reviewed 29 mental health transfer log forms and saw this was not completed on any occasion.
- The operational centre kept an electronic deployment log spreadsheet for all journeys which took place. The spreadsheet detailed the time the ambulance crew left the base, the drop off time and the arrival back at base. However, as there were no recorded response or target times there was no way to provide assurances that the service was responding quickly enough to meet patient's needs or find ways in which to seek improvement.
- The management team told us that the new electronic booking system which was planned to be implemented could be utilised to gain oversight, audit, investigation and subsequently seek improvements for both response times and patient outcomes. However, this was not in place at the time of the inspection.

Competent Staff

The service did not always make sure that staff were competent for their roles. However, managers appraised staff's work performance and held supervision meetings with them to provide support and development.

- The service had a robust and comprehensive induction programme. This meant that provider had assurances that new staff received the appropriate training to give them the knowledge and skills needed to carry out their roles.
- The management team told us that they had recently begun familiarisation shifts for new starters as part of the induction process which saw new staff being teamed up with an experienced ambulance crew for a number of shifts. We saw evidence that staff were completing a minimum of three familiarisation shifts and staff told us they found this helpful in understanding what was expected of them within their roles. This was good practice and showed the service was able to respond and adapt its induction and training processes based on staff feedback.
- All staff were required to supply two references as part of pre-employment checks as per policy. The policy stated that one reference must be from a manager at a previous employer. We were told that most staff had previously worked for one of the directors at another independent ambulance service. We reviewed 10 personnel files and found that one staff file had no references, two only had one reference each and the remaining seven had a reference from the director they had previously worked for and another director at IMT Medical Transport Services which was not in line with policy.
- All staff were required to complete driving assessments at the start of their employment to ensure that they were competent to carry out their roles. Practical emergency blue light driving assessments were undertaken annually and staff were assessed by an external assessor. Theoretical emergency blue light

driving assessments were undertaken every two years. This was documented on an electronic spreadsheet and the management team had good oversight of the process.

- There was a drivers handbook and an emergency driving and blue light response policy which were both in date, version controlled and available to staff electronically. We saw that driving licence checks were completed every three months in line with policy.
- All staff were required to complete an annual appraisal and we saw that the service had moved to standardise appraisals to take place from October through to December. This meant that 100% of appraisals were due the month of the inspection. Staff we spoke with confirmed they had received their previous appraisal and had been given a pre-appraisal form for the forthcoming appraisal meeting.
- All staff we spoke with told us that the service had an "open door policy" and staff were encouraged to discuss any needs, performance issues or concerns at any time with supervisors or managers. Staff told us that they did not need to wait for an appraisal in order to do so.

Multidisciplinary working

- The service had direct meetings with the regional mental health NHS trust for which there was a permanent contract. The management team told us that a good working relationship had been developed between the trust and the service staff and this was corroborated by two emails we were shown which had been sent by trust staff. The emails commented on the professionalism of the ambulance staff; particularly in relation to the use of effective communication with the patient and a caring attitude.
- Staff told us they felt they worked well with all levels of staff from other organisations and staff could give examples of when they had worked collaboratively with other staff for the benefit of patients. For example, there was an occasion when a patient was extremely distressed but felt at ease and relaxed with a member of trust security staff. The ambulance crew worked with the security staff to transfer the patient and returned the security staff following the transfer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment and did not always follow national guidance.

- Staff received annual training in the Mental Capacity Act 2005 and consent. We saw that both training modules were robust and comprehensive. We saw that staff compliance was 100% for both modules.
- Staff told us they felt they worked well with all levels of staff from other organisations and staff could give examples of when they had worked collaboratively with other staff for the benefit of patients. For example, there was an occasion when a patient was extremely distressed but felt at ease and relaxed with a member of trust security staff. The ambulance crew worked with the security staff to transfer the patient and returned the security staff following the transfer.
- The service did not have specific policies in relation to mental capacity or best interest decisions. However, we saw that the capacity to consent policy and mental health conveyance guidelines and policy contained information, in various parts, on mental capacity and best interest decisions. We saw that there was a good amount of information relating to patients under the age of 18 years old and whilst the service was not routinely transporting children and adolescents, this was good practice.
- Information within the capacity to consent policy was not always clear. For example, the policy told staff if a patient had a decision made in their best interests, this should be documented on the patient report form or mental health form. However, the service did not use patient report forms and all five staff we spoke with were unable to tell us clearly what the mental health form was, as detailed in the policy. Three out of five staff told us that they would record the information within their personal notebooks. Two out of five staff told us they would contact the operational centre to record the information in the comments box on the deployment log.
- We had concerns that consent and capacity were not being documented appropriately. We were given a recent example of an informal patient, with capacity, refusing to be transported part way through a journey. Staff were able to demonstrate, to good effect how the ambulance crew had worked with the patient to

encourage them that the transfer to a specialist hospital would aid in their recovery and they were able to safely transport the patient. However, we were unable to corroborate that the patient had their capacity assessed, what happened during the journey and that consent was obtained to transport following the initial withdrawal. This was because there was no documented evidence of the patient journey, there were no comments logged within the comments field on the deployment log and no incident report form was completed, as per policy.

- Two out of five staff members we spoke with did not have a clear understanding of the difference between the Mental Health Act (1983) and the Mental Capacity Act (2005) or when best interest decisions would be applied. It was not always clear that all staff understood patients' rights to consent in relation to matters outside of the detained mental health transfer. Not all staff were aware of the two-stage mental capacity assessment detailed within the capacity to consent policy which was in place to assist staff and we were told that staff would contact the operational centre for advice in these instances.
- The management team gave us a list of policies which detailed a specific restraint policy, which met with best practice guidance; Positive and Proactive Care. However, we were told when we requested a copy of this that it had not yet been completed. We found information relating to restraint within both the mental health conveyance guidelines and policy and the capacity to consent policy.
- Neither policy referenced best practice guidance National Institute of Care and Excellence NG10 and subsequently there was no reference to not routinely using manual restraint for more than 10 minutes. We saw that one completed control and restraint form documented the total time the patient was restrained for as 20 minutes. The form did not ask if restraint was released every 10 minutes and we saw that the staff had recorded that the restraint had been released 'regularly'. This was a risk because it was unclear that staff were aware of best practice recommendations and the service was unable to evidence that they were following best practice guidance.
- Neither policy made reference to then use of restraint in children. This was a risk as it was unclear if staff should follow the guidance for adults when dealing with children or adolescents and the service had the capability to and had transported a child in the 12 months prior to the inspection. Following the inspection, we were told that restraint was not used when dealing with children and that all child transfers would be accompanied by a member of hospital staff; however, this was not detailed within the policies at the time of the inspection.
- Information within the policies in relation to restraint was not always clear. For example, the capacity to consent policy told staff that if restraint was used, they should complete an incident report form and record the incident on a patient report form. The mental health conveyance guidelines and policy told staff that if restraint was used they should complete a dynamic risk assessment form and an incident report form. However, we were told by staff and the management team that staff were required to complete a control and restraint form in first instance which was not detailed within either policy. We highlighted this during the inspection and were told the control and restraint form was new and would be included within both policies when they were reviewed in October.
- Staff told us that they did not use restraint often; however, as there was no oversight of restraint incidents, there was no way of corroborating this. The management team told us that there had been five or six occasions of restraint being used by staff in the last 12 months. However, only three documents relating to restraint could be located for us during the inspection.
- We had concerns that the use of restraint was not always documented correctly or investigated appropriately in line with best practice guidance. We saw that three out of three restraint incidents were not documented or completed correctly in line with policy. Two further incidents were recorded within the comments box on the deployment log; however, the documents relating to these occasions of the use of restraint were not produced during the inspection.
- The management team told us that one of the service directors reviewed all restraint forms and we saw that the two control and restraint forms produced had been signed off as seen by the director. However, it was not clear that restraint incidents were investigated in line with best practice guidance (National Institute of Care

and Excellence NG10) and there was no restrictive intervention reduction programme in line with best practice guidance; Positive and Proactive Care. This meant that there was a risk that the service was unable to highlight areas of concern, good practice, share learning or improve patient outcomes, going forwards. The management team told us that the completion of restraint documentation could be audited and reports ran easily on the new electronic booking system, once in place. However, this was not in place at the time of the inspection.

- Staff received annual training in disengagement and non-restrictive physical intervention skills, conflict resolution and in reducing the use of restraint in healthcare settings. We saw that compliance for all three modules were 100%. Staff were able to demonstrate the appropriate use of restraint and mechanical restraint (handcuffs) which showed good practice.

Are patient transport services caring?

Not sufficient evidence to rate

There was insufficient evidence to rate caring. However, we noted the following practice;

Compassionate care

- We were unable to observe patient care during the inspection and due to the nature of the service's work it was inappropriate to speak to any patients over the telephone. This meant that we were unable to fully assess how well the service had cared for patients. However, staff demonstrated a good understanding of how to treat patients with compassion and kindness, how to maintain privacy and dignity and take account of individual needs.
- Staff undertook an annual online training module in maintaining privacy and dignity in health and social care settings and we saw that staff compliance was 100%.
- All staff we spoke with were committed to delivering a high standard of care to patients. Staff were able to give specific examples of when they had maintained privacy and dignity. For example, requesting a private room to deliver handover information at the receiving facility.
- Wherever possible, the service tried to facilitate a female and male crew member so that the patient had a choice during transfer which was good practice.
- We saw that feedback from an NHS trust staff member detailed how comfortable and cared for a patient had felt with a particular ambulance crew. The patient had previously refused all transport and had never been successfully transferred without police assistance.

Emotional support

- Staff demonstrated a good understanding of providing emotional support to patients and their relatives, as required. They understood patients' personal, cultural and religious needs.
- We saw that the service had an equality and diversity policy which was in date, version controlled and available to staff electronically. All staff received equality, diversity and human rights training annually and we saw that compliance for all staff was 100%.
- Staff we spoke with were able to give specific examples of when they had emotionally supported patients during transfers and we saw that staff were committed to ensuring patients felt supported and at ease.

Understanding and involvement of patients and those close to them

- Staff demonstrated a good understanding of the importance of involving patients and their families; whenever possible, to understand the options in relation to their condition and make decisions about their care.
- Staff we spoke with were able to give specific examples of when they had recognised that the patient would feel more comfortable being transported with a relative or carer and if possible, this was accommodated.
- We saw that the request and authority booking form which was completed by operational centre staff asked specifically if the patient was aware that they were being transferred and why. We saw that in seven out of seven instances this information had been completed. Both staff and management were able to articulate the importance of ensuring the patient was aware of what was happening and why, this showed good practice.

Patient transport services (PTS)

Are patient transport services responsive to people's needs?

Requires improvement

We had not previously inspected this service. We rated it as **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 the patients it served.

- The provider offered a UK-wide service to accommodate the needs of those patients who required secure mental health transportation.
- The service had one permanent contract in which they served a regional mental health NHS trust. This accounted for 66% of the provider's secure transportation work. The remaining 34% of work was ad-hoc and originated from national NHS trusts and from private sector mental health hospitals.
- We saw evidence that the provider was having regular meetings with senior managers of the service for whom the permanent work was being undertaken for. It was apparent that the management team were keen to work with other providers to ensure clarity on what could be provided, what was expected and how to best manage patient care between the services.
- Staff estimated that approximately 80% of the patients they transferred were patients detained under the Mental Health Act 1983, the remaining 20% were informal or voluntary admissions.
- As the service had a large proportion of self-employed bank staff; working on stand-by, they were able to pull teams together at short notice for ad-hoc transfers as required.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. However, staff made reasonable adjustments to help patients access services.

- Staff received annual training in dementia awareness and we saw that compliance for the training was 100%. However, there was no documentation which specifically requested whether patients were living with complex needs such as dementia or learning disabilities. This was important as we were told that the service had transported patients living with these conditions.
- The management team informed us that the individual patient's needs were taken into account during the booking process which was carried out by operational centre staff. We saw that the request and authority form within the mental health conveyance guidelines and policy contained many individual patient information questions. For example, gender identification, the use of mobility aids, recent behaviour and if the patient had any personal items they wished to transport. However, these questions had been removed on the form currently being used by the operational centre staff.
- We were told that patients were able to take a small amount of personal belongings with them when they travelled and these would be transported securely at the rear of the vehicle.
- It was apparent that considerable thought had been given to the vehicles used to transport patients. Some vehicles were discreetly marked, had tinted windows and were deliberately coloured to look less like a standard ambulance or police vehicle. The newest vehicle had seating which could be moved in many directions dependent on whether the patient wished to interact or not. A partition was due to be fitted which was made of clear plastic rather than the punched sheet metal material which had been offered before the vehicle had arrived. The management team were keen to make the service vehicles as relaxing and comfortable as possible for patients and the new vehicle included mood lighting.
- The service retained one standard ambulance which enabled the transportation of patients with mobility issues; for example, wheelchair users or patients requiring a stretcher. This was good practice and staff were able to give a recent example of transferring a patient in her own wheelchair which had greatly aided in her comfort and dignity.
- The service was unable to transport bariatric patients. The service did not have any bariatric equipment or vehicles which could accommodate bariatric patients.

We were told by the management team that the booking would be declined at the time of request by the operational centre staff. However, as there was no inclusion or exclusion criteria and there were no questions on the amended request and authority form in relation to patient weight or medical conditions, it was unclear how this would be known.

- There was no procedure in place for transporting patients whose first language was not English. However, we saw that the capacity to consent policy gave staff information on the use of a translation application and advice on not using relatives to translate which met with best practice guidance. Staff told us that a translation application could be utilised and were able to demonstrate this on a vehicle mobile phone with ease. Neither staff nor management were able to recall any occasions were this had been used since the service began.

Access and flow

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

- We saw that the service had undertaken 789 patient journeys between January 2019 and September 2019.
- The service was available 24 hours a day, seven days a week across the year. Bookings could be made on the day of transfer or in advance.
- Bookings were taken at the operational centre which was on site in Liverpool and senior management support was available 24 hours a day for both operational centre and ambulance staff.
- All vehicles were tracked by a navigation system and the new electronic system being implemented allowed operational staff to see where a vehicle was, who the crew were and the crew qualifications. This meant that operational centre staff had oversight of vehicle availability and could allocate the correct level of staff should a new booking come in before crews had returned to site base.
- There had been no recorded occasions between January 2019 and September 2019 when a patient journey had been cancelled due to the service being unable to facilitate the transfer.
- Whilst the time the patient was accepted at the receiving facility was documented, the time the patient was collected and the target time for collection were not. It was therefore not possible to assess whether the journeys made were always at the time agreed at the booking or in a timely manner.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. However, the service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

- Staff received annual training in complaints handling and we saw that compliance for the training was 100%.
- The management team gave us a list of policies which detailed a specific complaints policy, which met with best practice guidance. However, we were told when this was requested that it had not yet been completed. We found information relating to complaints was detailed within the learning from our experiences policy.
- The learning from our experiences policy was not clear. The policy stated that formal complaints were defined as untoward events and these could also include incidents, claims and concerns.
- The policy did not contain any information for staff or supervisors on how complaints should be managed other than stating that the managing director had overall responsibility. As an appendix there was a complaint proforma to be completed on receipt of a formal complaint and this detailed response timeframes for two levels of complaint. However, the policy did not state what the abbreviations for the two types of complaint were or how each was categorised. There was no definition of what a formal complaint meant and no requirement for acknowledging the complaint on the proforma.
- The policy did not contain any reference to the Parliamentary and Health Service Ombudsman or other external bodies such as the Independent Sector Complaints Adjudication Service. These are independent bodies that can make final decisions on complaints that have been investigated by the provider and have not been resolved to the complainant's satisfaction.

Patient transport services (PTS)

- The policy did not detail how complaints would be investigated with other provider's if needed. This was important because all patient journeys were undertaken on behalf of other provider's, such as NHS hospital trusts.
- We saw that vehicles did not contain any information for patients or their relatives about how to make a complaint, if required. However, management told us that laminated signs had been printed which were due to go in all vehicles, which told patients how they could complain or compliment. In the meantime, we saw that the provider website contained clear information for patients and their relatives on how to complain and gave multiple communication options for doing so.
- Records indicated that the service had not received any complaints between January 2019 and September 2019.

Are patient transport services well-led?

Requires improvement

We had not previously inspected this service. We rated it as **requires improvement.**

Leadership

It was not always clear that leaders understood the priorities and issues the service faced. However, leaders were visible and approachable in the service for patients and staff.

- The leadership team consisted of three directors, a fleet director, a current clinical lead, a control room manager and two team leaders. The current clinical lead was a registered paramedic and was listed as the registered manager with the Care Quality Commission. However, we were told the registration for the manager was being transferred to one of the directors. It was not clear who would provide clinical or mental health support and input to the service, going forwards.
- All senior staff including one director were trained to undertake secure transfers and we saw that the director had also undertaken the ambulance care assistant course. This meant that in the event of an emergency or a staffing crisis there were a greater number of staff who could transport patients and this showed good practice.
- All staff we spoke with spoke highly of the leadership team and told us that all members of the team were approachable and friendly.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

- The management team were able to show us the growth of company over the last three years and they told us they wanted to continue to grow in a phased approach without diluting the quality of the service.
- The service had a formal strategy and we spoke with the management team who were able to articulate the vision for the service going forwards which included potentially undertaking transfers for patients awaiting organ transplants and further patient transport work which was not solely mental health related. The management team were able to demonstrate a strong commitment to only moving into other areas when the service felt they were ready and this would be based on a whole system approach including garnering staff opinion.
- The service website stated that their ethos was to focus on the needs of the patient, clients and staff along the journey. The service had four core values which were that they were caring, attentive, responsive and effective. Whilst we did not observe any patient interaction, we observed that staff demonstrated these values and it was apparent that there was a dedication to delivering high quality patient care.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Staff told us that this was a good place to work. There was a positive culture within the service and it was evident that all staff and management we spoke with were dedicated to being open and honest in all aspects of their day to day work and their roles.

- Staff told us they felt supported by all levels of staff from colleagues to supervisors and the senior management team. Staff told us they were happy to raise concerns, issues or make suggestions for the service, at any time to the management team.
- We saw that the service pre-appraisal preparation form was comprehensive and empowering for staff. For example, there was a question which asked if staff would like to suggest objectives for the coming year and there was an opportunity to discuss any issues.
- The service had a freedom to speak up and raising concerns whistleblowing policy which was in date, version controlled and available to staff electronically.
- The management team told us that the service had appointed an external Freedom to Speak Up Guardian for staff to speak to if they wished to and we were told that staff were able to do this through the service internet site. This was good practice. The Freedom to Speak up Guardian was a national recommendation which provided an advocate and point of contact for staff to raise concerns, within NHS organisations.

Governance

Leaders did not always operate effective governance processes, throughout the service. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- At the time of the inspection, some of the policies we reviewed did not contain up to date references or follow best practice guidance. This meant that the service could not be assured that they were providing the most up to date service to their patients. For example, the safeguarding children policy did not reference the latest intercollegiate guidance.
- We found that policies and procedures were not always available; for example, infection prevention and control procedures for infectious patients. Policies were not always clear and did not always reflect the service that was currently being provided. For example, the capacity to consent policy repeatedly advised staff to record information relating to consent within the patient report form. However, no patient documentation was being used by the service.
- The management team informed us that all staff read and signed to agree understanding of all available service policies and procedures as part of the induction process and we saw that this was the case. However, staff we spoke with did not always know what was in the policies and it was not always clear that the correct processes were being followed. For example, staff were not clear on the correct process for documenting restraint and the policy did not reflect the way staff were currently recording restraint incidents.
- Policies did not specify how compliance was to be monitored, meaning that there were no assurance processes in place to measure this.
- Ambulance staff we spoke with told us that they had regular team meetings which took place every five to six weeks and we saw that an attendance log was kept by the management team. This was important because any staff who had missed the meeting could be updated as and when required. Ambulance staff team meetings were not minuted, there was no set agenda or action log. The management team told us that as the service was small this was not a necessity for ambulance staff team meetings and they were able to easily recall items for discussion and resulting improvements. However, as meetings were not minuted we were not able to corroborate this. We saw evidence that all other meetings were minuted and the minutes kept within a management file.
- We saw that the service had regular management meetings which had a set agenda, were minuted and had an action log. We saw that actions were followed up at subsequent meetings and it was apparent that items discussed within management meetings resulted in updates for staff. For example, an item discussed within the July meeting resulted in a safeguarding bulletin being produced in August.
- We saw that the service had arranged for appropriate insurance policies to be in place. This included motor insurance for all vehicles and employer's liability insurance. We saw that the certificate was displayed within the site base.

Management of risks, issues and performance

Patient transport services (PTS)

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. However, they had plans to cope with unexpected events.

- The service had a formal risk register and a process in place to assess, score, mitigate and control risks. However, all risks within the register were non-clinical, some risks were not applicable to the service being provided and it was unclear how risks were scored. For example, one risk was given a potential of 'improbable' however there was no descriptor for 'improbable' and descriptors detailed in another part of the document did not match those in the scoring part. We requested the risk assessment policy which was detailed on the management list; however, we were told that this was not yet available. It was therefore unclear how risks had been calculated.
- We were not assured that all risks had been identified or that controls would be put into place to reduce the level of risk when needed. For example, the clinical lead was leaving however, the service had not considered the need to recruit or have access to another clinical lead for support and advice for staff going forwards.
- We were not assured that incidents were being recognised, reported and documented appropriately as there were only two reported incidents since the service began. This meant there was a risk that the service was unable to highlight areas of concern, seek improvement or prevent similar incidents from reoccurring.
- The service had a system in place to monitor compliance and give oversight against certain operational issues. For example, daily vehicle checks, daily cleaning schedules and six-weekly deep cleans. We saw that there was good oversight and that staff received feedback if the management team thought there were areas for improvement.
- We were not assured that other areas of the service were monitored for compliance because there were no systems in place to audit these areas. For example, the use of restraint, completion of records or undertaking of dynamic risk assessments. This meant that there was a risk that the service was unable to seek improvement, highlight areas of concern or good practice.
- The service was not recording a response times or target times when a mental health transfer booking was made and the management team told us that an 'informal' time would be agreed with the organisation. This meant that the service was unable to monitor if patients were being collected in a timely manner or provide evidence to the organisations work was being undertaken for, if required.
- The service had a business continuity plan that was version controlled and dated. It gave clear definition and guidance on what the procedure would be in the event of an emergency.

Information management

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not at the time of inspection integrated and secure.

- The service had not always kept up to date information reflective of the service being provided. For example, the deployment logs which were kept for both ad-hoc work and the permanent contract vehicle did not include the same information and were not always completed fully. This meant that it was not always easy for the service to gain oversight or audit the services being provided. However, we saw that there had been considerable investment into a new electronic booking system which we were told would negate these issues. However, this was not in use at the time of the inspection.

Public and staff engagement

Leaders and staff actively and openly engaged with patient, staff and the public.

- We saw that the management team encouraged staff to give feedback and make suggestions on a regular basis and staff told us that they were happy to do so.
- A monthly bulletin was produced which gave staff information and we saw that staff were asked to make suggestions about the bulletins to the management team. Bulletins could be clinical or operational and could relate to changes in procedures or reminders

about issues or something of concern which had been raised. For example, we saw one bulletin was advising staff about dealing with personal data following the introduction of the General Data Protection Regulation.

- We saw that staff were contacted to pass on praise by email; for example, following the contact from an NHS trust staff member regarding the professionalism of the ambulance crew. Information for staff was also put up on the staff noticeboard within the site base.
- The service website enabled the public, patients or their relatives to provide feedback and we saw that this was easily found and straightforward to use. However, due to the nature of the work, the service had not received any feedback. We saw that to the service was having laminated cards printed which would be placed inside all vehicles to inform patients and their relatives how they could give feedback, compliment or raise concerns.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving service.

- The service had sourced an external advisor to assist them with the inspection process and develop additional clinical and operational policies.
- The service had looked at improving the experience for patients during transfers and had given considerable thought to sourcing vehicles which offered comfort, flexibility and were less intimidating than standard secure transportation vehicles.
- The management team were keen to look at ways to improve the service and we were told that there was a commitment to ensure that the services delivered were as good as they could be before the team would consider working in other areas; for example, urgent and emergency work.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The service must ensure that care and treatment is provided in a safe way for service users and that the risks to the health and safety of service users is assessed and that all is done to mitigate any such risks. This was a breach of Regulation 12(2)(a).
- The service must ensure that there is a standard operating procedure for both ambulance staff and operational centre staff to follow in order to make a safeguarding referral and that staff are aware of safeguarding principles and processes. This was a breach of Regulation 13(2).
- The service must ensure that the safeguarding lead undertakes face to face training hours as part of their safeguarding training; for both adults and children, in line with best practice guidance. This was a breach of Regulation 13(2).
- The service must ensure that they have an effective system in place to make sure that only suitable patients are transferred. This was a breach of Regulation 17(2)(a).
- The service must ensure that there are systems and processes in place to support staff when managing medicines. This was a breach of Regulation 17(2)(a).
- The service must ensure that risk assessments are completed and documented in line with policy. This was a breach of Regulation 17(2)(a).
- The service must ensure that incidents of restraint are completed and documented in line with policy. This was a breach of Regulation 17(2)(a).
- The service must ensure that incidents of restraint are investigated in line with best practice guidance. This was a breach of Regulation 17(2)(b).
- The service must ensure that the system used for reporting incidents is effective and that all staff know how to use it. This was a breach of Regulation 17(2)(b).
- The service must ensure that there are monitoring systems in place so that areas for improvement can be identified. This was a breach of Regulation 17(2)(b).
- The service must ensure that all policies reference and reflect up to date legislation and national guidance. This was a breach of Regulation 17(2)(b).
- The service must ensure that an up to date, contemporaneous record is kept for all patient journeys that have taken place. This was a breach of Regulation 17(2)(c).
- The service must ensure that full recruitment processes are undertaken for all new staff, in line with policy. This was a breach of Regulation 19(1)(b).

Action the hospital SHOULD take to improve

- The service should ensure that staff are given the minimum requirement of rest between shifts as set out in the Working Time Regulations 1998.
- The service should ensure that all policies and procedures are clear for staff and reference the services currently being provided.
- The service should ensure that all standard operating procedures detailed within policies are available for staff as guidance.
- The service should ensure that there are effective processes in place to support staff with consent, best interest decisions and mental capacity.
- The service should ensure that there are effective policies and procedures in place to support staff with managing complaints.
- The service should consider ways to make sure all staff are aware of safeguarding principles and the appropriate processes for making safeguarding referrals.
- The service should consider undertaking safeguarding training with face to face hours included for the service safeguarding lead.

Outstanding practice and areas for improvement

- The service should consider detailing how compliance will be monitored within all policies.
- The service should consider ways to implement effective processes to monitor the outcomes of staff team meetings.
- The service should consider ways in which to obtain feedback from patients, their relatives and provider's for whom the service is undertaking work for.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met;** Neither safeguarding policies contained a standard operating procedure for operational centre staff to follow, in order to make a safeguarding referral. Regulation 13(2)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met;** The service had not obtained two references in line with policy in 100% of personnel files checked. Regulation 19(1)(b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met;** The service did not obtain all relevant information during the booking process to make sure that the patient could be safely transported by the service. For example, infectious status, presence of a do not attempt cardio-pulmonary resuscitation order, confirmation of the H4 transportation document, previous medical history and whether the patient had received any sedation. The service was not able to articulate how the number of staff needed to safely transfer a patient was calculated and there was no associated guidance for staff. The service did not have a deteriorating patient policy. Regulation 12(2)(a)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met;** The service did not have an effective system to make sure that only suitable patients were transported by the service. The service did not have a medicines management policy in place to provide guidance for staff in relation to the transportation or administration of patients own medication.

This section is primarily information for the provider

Enforcement actions

The service did not make sure that risk assessments were completed in line with policy.

The service did not make sure that incidents of restraint were completed and documented in line with policy.

The service did not make sure incidents of restraint were investigated appropriately.

The service did not make sure that the incident reporting system was effective or that staff were aware how to use it.

The service did not have effective systems to monitor the service provided so that improvements could be made when needed.

The service did not make sure that all policies and procedures referenced the most up to date legislation and national guidance.

The service had not kept an up to date patient record for every patient journey.

Regulation 17(2)(a)(b)(c)