Tascor Services Limited

Keynsham Vehicle Base

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 know to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

Keynsham Vehicle Base is run by Tascor services Ltd and is located on a trading estate in Keynsham in the south west of England. It is part of Capita Plc. The service provides non-emergency ambulance transport for people with mental health conditions, most of whom are detained under the Mental Health Act 1983. The service also provides transport for non detained patients, for example patients living with dementia who attend day centre groups.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 7 and 8 August 2017, and returned unannounced on 22 August 2017.

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

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

Services we do not rate

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

We found the following areas of good practice:

- The service performed well on safety. Staff we spoke with understood their responsibilities to raise concerns, to record safety incidents, and to report them.
- Vehicle cleanliness and hygiene was maintained with daily cleaning.
- Patients' records were kept secure during patient transport.
- Systems, processes and practices were in place, which were essential to keep people safe such as incident reporting and training and these were communicated to staff.
- Staff received annual training in first aid, control and restraint and the prevention and management of violence and aggression and received regular driving assessments.
- Risks to people who used services were assessed, and their safety was monitored and maintained. Potential risks to the service were anticipated and planned for in advance.
- There were enough staff to deliver the service they were running.
- There were plans in place for a range of issues that could affect business continuity.
- Assessments were carried out to inform what care and support was needed during transport and staff followed evidence-based practice in relation to control and restraint and detention of patients under the Mental Health Act 1983.
- Staff and other services worked well together to deliver effective care and treatment. Other providers were very complimentary about how the provider worked with them, which sometimes reduced the need for patient restraint.
- The provider monitored response times and quality measures which were reported to the commissioner of the service every six to eight weeks.
- Staff had annual performance appraisals.
- Patients and those close to them were treated with kindness, respect and compassion while they received care and support.
- Staff ensured patients' dignity was maintained in public places and during transportation.
- Staff communicated with patients so that they were involved in and understood their care.
- Staff understood the impact that a person's care, treatment or condition would have on wellbeing and on those close to them, both emotionally and socially.
- Staff did what they could to help patients who used services maximise their independence.

Summary of findings

- Patients accessed care and treatment in a timely way. Services ran on time, and people were kept informed about any delays. The service was over performing on out of area journeys with a planned pick up occurring within 24 hours. The provider had never fallen below the performance indicator of 95% of all patients being picked up within two and three hours for urban and rural journeys respectively.
- Transport services were planned, delivered and coordinated to take account of people with complex needs, including those detained under the Mental Health Act 1983 and people living with dementia.
- The provider operated 24 hours a day and seven days a week.
- Complaints were used to improve the service.
- Leadership and culture at all levels, encouraged openness and transparency. The registered manager was visible and approachable for staff. Staff told us they felt respected and valued, and were very proud of the work they did.
- The board had oversight of the quality standards through monthly board reports from the registered manager.

However, we also found the following issues that the service provider needs to improve:

- There was a limited understanding of the formal definition and the legal implications of the Duty of Candour.
- Most complaints were managed through other organisations or trusts the provider worked with. Tascor was unable to provide information about the total number and type of complaints that may have been made about them to other providers. This meant the service may have been missing opportunities to improve the service.
- Patients we spoke with did not know how to make a direct complaint about the transport service.
- Some patient identifiable information was not kept securely at base location.
- Not all staff understood all their responsibilities to adhere to safeguarding policies and procedures but reported safeguarding issues.
- There was no comprehensive, regular safeguarding or Mental Capacity Act 2005 training.
- Not all policies were up to date or had been regularly reviewed.
- There was no vision for the service.
- The governance framework did not always ensure that responsibilities were clear. At Tascor board level it was not clear who was responsible for CQC updates, Duty of Candour, training or equality and diversity, safeguarding or for the Mental Health Act 1983 and Mental Capacity Act 2005.
- There was no local risk register and the board risk register did not reflect issues we identified during inspection.
- There was no up to date statement of purpose
- There was no patient feedback or engagement and the staff survey was not representative.

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

Name of signatory

Deputy Chief Inspector of Hospitals (area of responsibility), on behalf of the Chief Inspector of Hospitals

Professor Edward Baker

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		The service provides non-emergency ambulance transport for people with mental health conditions, most of whom are detained under the Mental Health Act 1983. The service also provides transport for other patients for example those living with dementia who attend day centre groups. We regulate independent ambulance services but we do not currently have a legal duty to rate them. We found areas where the service performed well during our inspection. For example on safety and where risk was assessed. Staff understood their responsibilities to raise concerns, to record safety incidents, and to report them and patients' records were kept secure during patient transport. Staff also understood their responsibilities to protect patients from avoidable harm. Equipment and vehicles were appropriate, clean, regularly checked and serviced and maintained. Staff received annual training in first aid, control and restraint and the prevention and management of violence and aggression and received regular driving assessments. Patients and those close to them were treated with kindness, respect and compassion while they received care and support. The leadership and culture at all levels, encouraged openness and transparency. Staff told us they felt respected and valued, and were very proud of the work they did. However we also found areas where improvement was needed There was a limited understanding of the formal definition and the legal implications of the Duty of Candour and most complaints were managed through other organisations or trusts the provider worked with. This meant the service may have been missing opportunities to improve the service. Patients we spoke with did not know how to make a direct complaint about the transport service. Not all policies were up to date or had been regularly reviewed and the governance arrangements did not always ensure that

Summary of findings

responsibilities were clear. There was no local risk register and the board risk register did not reflect issues we identified during inspection. There was no patient feedback or engagement.

Keynsham Vehicle Base

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

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Background to Keynsham Vehicle Base

Two teams of specialist staff are employed by the provider. One group, provides transport for patients who are detained under the Mental Health Act 1983. The other group, provide transport for voluntary patients who have rights to treatment but are not detained and attending treatment at hospitals. The second group of staff provided a non-emergency patient transport service for people with dementia to attend day centres.

Keynsham Vehicle Base is registered to provide the regulated activity of transport services, triage and medical advice provided remotely.

Tascor has been providing a service to a local mental health trust since 2007 and serves the communities of Avon and Wiltshire, along with north Somerset and south Gloucestershire. They also occasionally carry out transport to repatriate patients from or to elsewhere within the United Kingdom and Europe.

The service has had the same registered manager in post since 14 October 2011. We last inspected this service in March 2013 when we found that the service was meeting all standards of quality and safety it was inspected against. There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months prior to this inspection.

We carried out an announced inspection on 7 and 8 August 2017 and returned unannounced 22 August 2017

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two other CQC inspectors one of whom had a specialist mental health background

The inspection team was overseen by an inspection manager. Helen Rawlings.

How we carried out this inspection

During the inspection of Keynsham Vehicle Base, we observed several patients receive support from staff on ambulance vehicles and spoke in person with one patient and one relative. While staff worked we listened to and observed staff dealing with transport requests and interacting with other professionals. We reviewed 12 patients' records, including patient profiles, risk assessments and transport requests. We also spoke with 14 staff, including patient transport drivers and patient escorts, coordinators and service managers.

The managers included two secure transport managers, the deputy contracts manager and the registered

Detailed findings

manager who was also the operations manager for the service. In addition to operational managers we also spoke with the board members; the operations director, the business director and the safety, health, environment and quality assurance manager.

We inspected three of the 12 vehicles based at the station. We reviewed booking systems, the control room and the management of information and storage of confidential patient information.

As part of the inspection we spoke with the commissioner of the service and saw evidence from other stakeholders the provider worked with, including approved mental health professionals.

We carried out an announced inspection on 7 and 8 August 2017 and returned unannounced 22 August 2017

Facts and data about Keynsham Vehicle Base

The service has had the same registered manager in post since 14 October 2011. We last inspected this service in March 2013 when we found that the service was meeting all standards of quality and safety it was inspected against. There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months prior to this inspection.

September 2016 to March 2017 the service provider carried out:

- 2231 patient journeys
- An average of 2750 patient journeys per year
- An average of 249 journeys per month which equalled seven to eight journeys per day.

At the time of our inspection there were 54 staff employed comprising full-time, part-time and zero hours contracts.

The track record for patient safety in the period September 2016 to August 2017:

- There were no never events
- No clinical incidents
- No serious injuries

The service had received three complaints in the period September 2016 to August 2017 two of which had been investigated with one complaint being investigated at time of inspection.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- The provider had a good track record on safety. Staff we spoke with understood their responsibilities to raise concerns, to record safety incidents, and to report them initially verbally to the team leader or registered manager. Staff would then complete a paper based reporting system so that the registered manager could review the causes and outcomes of incidents. Staff completed additional statements if the registered manager required more information. The information was shared with others as necessary.
- There had been no serious incidents and no never events reported in the period September 2016 to August 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Examples of incidents which could be reported included a lack of documentation to enable lawful detention and transport, use of restraint, or staff and patients sustaining an injury during a restraint.
- In the period September 2016 to August 2017 there were two occurrences reported which involved patients receiving bruising to their wrist due to standard practises involved in control and restraint. Both incidents had been investigated and learning shared by registered manager and team leaders.
- Lessons were learned when things went wrong, and action was taken as a result. Staff told us there was sometimes a problem with patient transfers where warrant and other detention paperwork was either missing or incomplete or the availability of a patient's bed had not been confirmed. This resulted in delayed or abandoned transfers and a poor experience for patients. These events were reported as incidents internally and to the commissioner of the service. Staff now ensured they checked the warrant and any other detention paperwork for completeness and accuracy and did not just rely on the health professional sanctioning the detention of a patient. The registered manager had also implemented a process where the team leader rang the receiving unit to check the bed was available and confirmed, before the ambulance transfer began. This minimised the chance for errors in the transfer process.
- We saw evidence which showed how the organisation shared learning from incidents and occurrences. This was done through newsletters and information displayed on the station walls. Information was also shared at team meetings and team leader handovers.
- Staff showed a good understanding of what constituted an incident. However, during the inspection, we noted an approved mental health practitioner (AMHP) had brought medication for a patient which had the wrong name on it. Staff had raised this with the practitioner at the time. Staff were unsure whether to report this to the registered manager or not as the AMHP had already dealt with the situation, ringing ahead to the receiving ward to explain the error. We shared this event with the registered manager who promptly investigated what had occurred and shared the information with the appropriate people.

Duty of Candour

- The operations director, and the registered manager, who was also the operations manager explained the process that occurred when something had gone wrong. We were told few apologies were issued from the service directly and the process of Duty of Candour was carried out by others. The commissioner explained that two apologies had been issued from their patient advocacy and liaison service on behalf of the provider from incidents that had been investigated. The service did not have copies of these apologies and were not aware of the time scales used to issue responses.
- There was a limited understanding of the formal definition and the legal implications of the Duty of Candour. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person'.

Cleanliness, infection control and hygiene

- Vehicle cleanliness and hygiene was maintained with daily internal and external cleaning and daily checks of cleanliness were carried out by staff using the vehicle. We saw vehicle checklists were signed when this had

been completed. Staff explained how they cleaned the vehicles using a spray and vacuum system which removed excess moisture from the upholstery of the vehicle. This process was undertaken after an incident involving urine, faeces or vomit. The spray and vacuum equipment was cleaned periodically by a private contractor.

- When vehicles were contaminated they were returned to base and taken out of use until thorough internal and external cleaning had taken place.
- Staff told us if blood had contaminated the vehicles, they would use paper roll to contain any body fluids and then the vehicle would be sent to a specialist cleaning company. Staff could not recall an instance where this had happened. The registered manager supplied evidence of the contract with the external provider of vehicle and laundry cleaning. Staff we spoke with knew not to attempt the cleaning themselves and they were aware of the potential safety risks.
- We did not see any cleaning wipes or cleaning solutions on any of the four vehicles we inspected so staff were unable to wipe hard surfaces down if needed. However vehicles were cleaned on return to base.
- One vehicle had crystals in sealed pouches to absorb blood. We also saw bottles of water for patients stored in the same box. We raised this with the registered manager as the crystals were marked as hazardous under Control of Substances Hazardous to Heath Regulations 2002. The registered manager immediately separated the water from the decontamination crystals.
- Personal protective equipment was provided, which included gloves and disposable overall suits, which were present on vehicles we inspected. All staff we saw carried alcohol-based disinfectant gel for hand cleaning. Staff told us the gel did not replace hand washing with soap and water and they would use it in addition. Staff we saw had clean uniforms and washed their hands at the station where there were several sinks. Staff were aware to follow infection prevention and control procedures of the units they attended such as bare below the elbow when required. However Tascor's infection prevention and control policy did not provide guidance.
- Staff told us they always undertook assessments which included hygiene and infection risks when they arrived at collection locations. This was due to not all information being available at time of referral. For example one patient was identified through the risk assessment as behaving in a way which could put staff at risk of infection. This information was not passed on at the time of booking. Staff risk assessed the situation and put actions in place to reduce this risk while transporting the patient.
- There were appropriate arrangements for managing waste, including clinical waste. For example, vomit bowls were disposed of in clinical waste bags and stored in a locked clinical waste bin at the base. The provider had a contract with a waste disposal company to empty bins on a frequent basis. We checked the bins and found they were locked and stored in an easily accessible location. Staff knew to place soiled laundry in appropriate bags when they returned to the station. There was a contract in place for a commercial laundry to manage soiled laundry. Staff told us they would speak with the registered manager if they had any concerns about cleaning or needed advice or support regarding infection control matters.

Environment and equipment

- There were systems, processes and practices in place, which were essential to keep people safe and these were communicated to staff. At the start of each shift, the driver or delegated member of the team checked their allocated vehicle. Checks included cleanliness, oil and other fluid levels, any vehicle vaults, mileage, and first aid kit checks. We reviewed 60 daily check sheets, which were completed, signed and dated. Some sheets identified issues such as cleanliness of the vehicle after the shift, which were then addressed.
- First aid supplies were replenished by staff as part of the daily vehicle checks, along with urine receptacles and incontinence pads. A box containing first aid supplies was stored in the staff rest room, so it could be accessed by staff on all shifts. We checked four first aid boxes on vehicles, and found one which had not been checked since August 2016. The operations manager who was also the registered manager told us all first aid boxes had been checked in July, but the vehicle had most likely been out on a job at the time. The first aid box was immediately checked once this was raised.
- There was a defibrillator on the vehicle used for stretcher transport. We saw that it was checked regularly.
- There were 11 vehicles used for the transport of patients who were detained under the Mental Health Act 1983. The seated passenger vehicles had a seat removed from

the front row of the passenger cabin. This allowed staff easier access to the rear seats in the event of an emergency or incident during transport. One vehicle was adapted to transport patients on stretchers but were not adapted for bariatric use. Staff were aware that some patients who needed to use trolleys due to their weight and size and would check the vehicles specification to ensure correct weight was not exceeded.

- All vehicles were provided by a leasing company who had made the modifications prior to delivery of the vehicles. Vehicles were compliant with the Ministry of Transport or MOT roadworthiness testing and vehicle servicing scheduling. Maintenance and servicing, including routine safety checks were carried out by authorised vehicle repairers as part of each vehicle's leasing agreement. Breakdown recovery and replacement vehicles were available through the leasing arrangement in place. We saw full records of maintenance carried out and safety checks were available electronically within 30 minutes of request.
- The provider had installed vehicle tracking on every vehicle. This enabled the provider to ensure the nearest vehicle was used for patient journeys and that staff knew where vehicles were at any time. Another feature was that it monitored patient comfort and safety through aspects of driver style such as acceleration, cornering and braking.
- Some vehicles were fitted with steps to ensure easy access for patients. We saw that in one vehicle some steps were loose in the passenger compartment. We pointed this out to the operations manager who immediately ensured that all were secured with straps in the boot of the vehicle. This information was then shared with crews the same day.
- Patients, including those who required to be transported in a wheelchair or on stretchers were able to be safely secured whilst they were being transported. We saw patients travel safely when we accompanied staff on patient transfers. There were child seats available for use if necessary, for example when patients or relatives wanted young family members to travel with them.
- Keys to vehicles were signed in and out of a secure locked cupboard in the vehicle base, and allocated to a named team and team leader at the start and end of each shift.
- Appropriate fire extinguishers were located at the vehicle base and on vehicles and were checked regularly.

Medicines

- There were arrangements for the storage of medicines during transportation. The staff of the service did not administer any medication. Staff told us, medicines were received in a sealed bag, and were kept with the driver or in the boot of the vehicle.
- The service did not carry any medicines for emergency purposes. Some patients had oxygen prescribed for them routinely by other professionals and a vehicle was available to transport the patient and oxygen cylinder safely. Vehicles carried compressed gas safety information and vehicles had visible warning on them that compressed gas was carried.
- There were facilities to transport temperature sensitive medicines on long journeys. These would be carried in cool boxes if needed and requested by staff requesting the transport.

Records

- Records were comprehensive and complete and consisted of, Mental Health Act 1983 (MHA) detention paperwork, paper records needing to transfer with a patient, the Tascor referral and initial risk assessment paperwork and electronic records were kept securely. Ambulance crews were made aware of 'special notes' to alert them to patients with pre-existing conditions or safety risks through the booking sheet for each transfer. When the transport request was received, the coordinator completed an internal provider risk assessment, which was printed out for staff on the transfer request information. The risk assessment did not include specifically asking for records such as those relating to 'do not attempt cardio pulmonary resuscitation' or DNACPR. The provider was aware of DNACPR documentation, and told us staff requesting transport would inform them of when a DNACPR were in place.
- Patient records were kept secure on the ambulances. The crews carrying out work under the Mental Health Act 1983 ensured they received all relevant paperwork for the patient who was travelling. This was kept in a sealed wallet and passed to the receiving health professional on arrival at the unit or hospital. This process was used for secure document storage and

transfer. On arrival at the receiving establishment, the team leader would hand over the sealed document wallet to the receiving person in charge who will check that the seal is intact and sign for receipt of the wallet. This ensured crews managed patient's notes during transfers in a confidential way.

- Some paper based patient-identifiable information was kept at the base to inform risk assessments. The base was occasionally left unoccupied but securely locked. The arrangements for storage of these paper records at the base did not comply with the Data Protection Act 1998. The service provider did not have an information governance policy that described what patient identifiable data could be kept and for how long. We raised this with the registered manager who immediately secured the information and issued an instruction to staff on how to access the information when needed. We also requested a review of length of time that paper records were kept against the provider's policy for the creation, storage, security and destruction of medical records as some records were from 2014. We did not receive this.
- There were arrangements for disposal of confidential records which were no longer required. This was undertaken by an external contractor.

Safeguarding

- Systems and processes were in place to ensure people were safe and safeguarded from abuse. The service had a safeguarding policy which set out the process and responsibilities of its staff for adults and children. The operational lead for safeguarding was the registered manager and team leaders ensured concerns were shared with them. The registered manager knew that they could contact the local authority or the commissioner of the service to discuss safeguarding if needed.
- However not all staff understood their responsibilities to adhere to the safeguarding policies and procedures. Refresher safeguarding training had not been monitored after level one safeguarding adults training in induction. The registered manager took prompt action to address our concerns about the lack of regular appropriate safeguarding training. They reviewed the level and availability to staff of the online safeguarding adults training and ensured all staff were booked to complete it. They also commissioned new face to face level two training for staff who have some degree of contact with children and young people and/or parents or carers. The training was compliant with safeguarding children and young people: roles and competences for health care staff intercollegiate document Third edition: March 2014.
- Five staff we spoke with were not familiar with the term safeguarding, and could not explain what their responsibilities under the policy were. However, we saw evidence that identification and reporting of safeguarding did occur and that other staff were able to identify indicators of potential abuse. Staff told us they passed any information of immediate concern to the nurse in charge of either the ward they were transferring the patient to, or to the group leader in the day centre. For example, one ambulance crew had transported a patient and they had identified potential self or care provider neglect. The crew shared their concerns with the team leader who escalated this to the person in charge of the therapy group the patient was attending.
- Staff demonstrated an awareness of how to identify and deal with what they described as 'concerning situations' at the locations they attended. They told us they always passed these concerns on to healthcare professionals. On another occasion, a driver was due to pick up a patient who had been physically abusive toward their partner. The driver identified the signs of physical abuse in the home and escalated this to the healthcare professional in charge of the patient care, who subsequently raised an urgent safeguarding referral.
- Staff told us they did not always receive feedback from providers or commissioners about concerns they had raised, and were unsure what happened with some of the information they passed on.

Mandatory training

- All staff had received mandatory induction training. The provider delivered mandatory core skills training during a five day induction course, which all staff had completed. This included:
- Standard operating instructions and company policies and procedures, for example, infection control, data protection, fire procedures and health and safety.
- First aid was reviewed annually for all staff.
- Prevention and management of violence and aggression which included communication skills, control and restraint techniques and use of hard and soft handcuffs. This was renewed annually for all staff.

- Use of equipment training including tail lift vehicles, wheelchair securing and stowage and carry chair use. This was reviewed annually for all staff.
- Training in the Mental Health Act 1983.
- Safeguarding adults and children awareness.
- Driving assessment training.
- Following induction all staff were required to undertake annual training in specific areas for example first aid. All staff had completed all training except safeguarding. The provider had their own approved trainers who delivered mandatory training in First Aid and manual handling, this ensured flexibility in the delivery of this training. They used an external provider for the prevention and management of violence and aggression training, which included techniques of control and restraint including use of hard and soft handcuffs.
- Paper and electronic records were kept of staff induction training, subsequent refresher training and first aid and other certificate expiry dates. The information was monitored by the registered manager, in their role as operations manager to support each member of staff to attend or complete the statutory annual refresher training. However, staff we spoke with could not confirm when they had had annual refresher training for the Mental Capacity Act 2005 for Mental Health Act 1983 or for safeguarding. In response to our concerns about staff awareness of safeguarding the operations manager immediately booked all relevant staff on to safeguarding refresher training. We saw evidence that training was booked to take place with all staff booked onto a course within the next four weeks.
- All staff received a mandatory driving assessment upon commencement of employment. A practical driving assessment was carried out on the vehicles used for transporting patients. This was done by a qualified driving assessor. Staff were re-assessed if there was a self-declared health issue or concern raised about the standard of driving.

Assessing and responding to patient risk

- Risks to patients were assessed, and patient safety was monitored and maintained. Additional risk assessments were carried out by the provider for patients to supplement those supplied to them by the person requesting transport. This was because staff had previously identified that the information provided for the assessments was sometimes out of date or incorrect. Staff routinely contacted wards and units to get a more accurate understanding of the needs of the patient at the time of transfer. The lack of information available had been shared with the contract commissioner to enable a review to take place.
- Staff were able to identify and respond appropriately to deteriorating health and wellbeing, medical emergencies or challenging behaviour. Staff had access to telephone advice and dialled 999 for emergency services in the event that a patient needed emergency care. Staff told us that patients were categorised according to their needs and if at any time the staff member felt their needs had changed, they would inform the registered manager and seek advice. This informed how the plan to support the patient could be improved, which sometimes involved using additional staff or seeking advice from the person requesting the transport.
- There were policies and procedures in place to manage disturbed behaviour during transport, and staff knew how to respond to a patient whose behaviours changed during the journey. For example, staff told us they responded to the individual requirements of the patient for example by sitting away from them and giving them space, or sitting with them and talking to them if that was required. If patients became aggressive or violent, staff knew that, as a last resort, they could undo their seatbelts to assist in restraining the patient to keeping them and other staff safe, in line with the Road Traffic Act (1993).

Staffing

- Staffing levels were reviewed and adjusted on a regular basis to ensure that they were appropriate for the anticipated pattern of demand. There were sufficient staff employed and staff rotas were planned a year in advance. During the inspection there were 54 staff employed comprising full and part time and zero hours contracts. All staff were required to undergo an enhanced check disclosure and barring service (DBS) check prior to employment. Thereafter, DBS status was monitored annually.
- When needed, the service could call on a bank of staff who were part time to fill posts when staff were absent. There were also staff available to cover work at short notice, these staff were contacted on an on-call basis.

Staffing levels were planned to ensure full account was taken of planned absence of staff with the number of people on leave at one time being restricted to ensure adequate cover.

- The service employed three managers: an operations manager who was also the registered manager, a deputy contracts manager and a secure transport manager. The management team provided the service with a duty manager 24 hours a day, seven days a week which was rotated. This provided essential support to staff and the manager was onsite or available 8.30am. to 5.30pm. When not on site the manager or on call manager could be contacted at any time via telephone. It also ensured that the local mental health trust had a point of contact at any time. The secure transport manager had recently been promoted and had been provided with support from the previous secure transport manager who was available as a bank member of staff. This individual also provided managers' cover when needed.
- Staff worked the following hours; two days 7am to 7pm, one late 10am to 10pm and a night shift 7pm to 7am. Handovers of information occurred between the vehicle base coordinator and the team leaders. Staff used a paper based diary system with relevant information recorded in it to ensure information was available for handovers.
- The registered manager arranged staffing where possible so there was a balance of gender for patients. This was also informed by any current risk assessment from an approved mental health professional that suggested all male or all female teams to fit the patients' requirements.
- The staff turnover rate was 7.4% for a total group of 54 staff. From July 2016 to April 2017 four staff had left employment. Those that did leave often went on to the bank. Two members of the bank had left following an initial trial period. The bank was used to ensure that new staff were suitable and that they wanted to continue and at some point be offered further work.
- Staff sickness absence from January 2017 to August 2017 was less than 1% for staff carrying out work with patients detained under the mental health act 1983. For staff carrying out other work it was less than 2.14%.

Response to major incidents

- All staff had access to a duty manager 24 hours a day, seven days a week for the service. There were contingency plans in place for a range of issues that could affect business continuity, such as terrorist attacks, loss of electronic systems or lack of vehicles or other disruption to the service. If electronic systems were affected there was a paper based back up for up to five days. In the event of loss of vehicles there were arrangements in place with the provider's vehicle leasing company to supply appropriate vehicles.
- Desk top exercises had been carried out by senior managers to assess business continuity at six month intervals. This involved reviewing the process which would take place if there was an impact on the service. However some operational staff had not been involved in these exercises and so had not practiced them.
- There was no requirement for the provider to be part of any major incident response by the commissioner of the service.

Are patient transport services effective?

Evidence-based care and treatment

- The provider had policies that staff followed in the course of their work. These included management of complaints, management of health and safety, management of infection control, management of risk, safeguarding, incident investigation and management, and dress code and uniform policy.
- Policies we reviewed were not all in date and some were not clearly defined as Tascor policies repeating a previous company name in their title and references. We found some policies that were not relevant to the service provided, for example a policy relating to escort and detention or custody suite work, police, private finance initiatives and secure services use of force policy.
- Staff who worked remotely had access to guidelines and protocols in an operating procedures folder kept in every vehicle. The folder contained details of policies, including booking procedures, escort tasks, performance monitoring and health and safety. It also contained the business continuity plan and risk assessment tools. We looked at four of these files, with the exception of the business continuity plan, not all policies had a review date, those that did were not in

date. We told the registered manager about this and within six days of the inspection we received up to date copies of a range of key policies with review dates identified.

- Staff we spoke with regarding detention of patients under the Mental Health Act 1983 were aware of evidence-based practice in relation to control and restraint. For example, staff told us they should be aware of preventing or minimising periods during which a patient would be in a face-down (prone) position. This was because of the dangers of suffocation of a restrained patient being kept or left in the prone position with their hands held behind their back in wrist restraints. Staff told us any form of restraint they used, such as manual restraint or mechanical restraint using handcuffs, was to be used at the minimum amount necessary, for the shortest possible time, and as a last resort.
- Staff followed best practice advice and worked in teams with an identified lead during restraint of patients. We saw incident reports that clearly described staff working in this way. This practice was in line with the Department of Health guidance, Positive and Safe (2013) and National Institute for Health and Care Excellence guideline Violence and aggression: short-term management in mental health, health and community settings Published: 28 May 2015 Guideline 25. However policy did not include references to service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services clinical guideline [National Institute for Health and Care Excellence CG136] December 2011 reviewed in 2016.

Assessment and planning of care

- Assessments were carried out to inform the care and support for patients required during transport. Prior to accepting a transport booking, the base coordinators clarified the details of a patient's mental and physical health with the person booking transport. This included whether or not the patient was detained under the Mental Health Act 1983, any other issues, such as manual handling, violence and risk of absconding. When staff collected the patients, they asked staff at handover what the patient's preferences and interests were. They then assessed which member of the team would be most appropriate for the patient. When collecting patients who were detained, ambulance crews would liaise with referring staff and the patient to decide whether to use or discontinue use of mechanical restraints such as hard or soft hand cuffs.
- Staff maintained a paper log which recorded patients' previous transport risks. These included triggers for change in behaviour, presence of potential hazards or preferred methods of support. The file was maintained as these details were not always included in the referral as some staff who requested transport did not have a detailed knowledge of patient's home circumstances. The provider had raised concerns about the quality of information contained in referrals with the commissioner of the service but concerns continued.
- The provider had installed vehicle tracking on every vehicle. This enabled the provider to ensure the nearest vehicle was used for patient journeys. Plans for transport took into account patient behaviour and preference. For example, there would be consideration in relation to where the patient was placed in the vehicle and the proximity of the staff member
- When transferring all patients, the ambulance crews attempted to meet people's nutrition and hydration needs. Bottled water was provided and during some longer journeys patients were provided with snack boxes by hospital staff. On an extended journey, the crew asked the nursing staff in advance if the patient had been fed or if there were any special dietary requirements should the need to supply food arises.

Response times and patient outcomes

- The provider monitored response times and quality measures and reported to the commissioner of the service informally every week. The provider met in person with the commissioner every six to eight weeks so that oversight of the quality of service occurred. Performance was also discussed at provider board meetings.
- The service was performing well on it's out of area journeys with all patients picked up within the 24 hour target. On some occasions patients could not be picked up at the times requested. This was due to the volume of out of area requests. The service had discussed this with commissioners and there was a plan to improve response to specific times for pick up.
- The service was also meeting its target of 95% for two and three hour pick-ups for both urban and rural journeys with over 95% of patients being picked up

respectively. Monthly reports did not provide information on how late vehicles were responding to specific time requests which were within the performance target for urban and rural patients.

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Competent staff

- Staff had the skills and knowledge to deliver effective care and support. Annual specialist training in the prevention and management of violence and aggression and how to safely use control and restraint was in place. The training included mental health awareness and communicating in a way to support distressed people in a confusing situation.
- During the recruitment process applicants' qualifications and experience were assessed through a competency-based interview process, which included questions on how potential staff had managed situations involving aggression. Applicants were also required to provide professional and character references from someone who had known them for 10 years, in addition to a professional reference.
- Control and restraint training included some references to MHA 1983 and MCA 2005 and the Human Rights Act 1998. Most driver and escort staff did not have easy access to online training due to limited number of computers available and most of the refresher training that was completed was paper based, administered by the registered manager.
- Staff told us they had annual appraisals with their team leader who they worked with regularly, during which any learning needs were identified. They told us appraisals were useful and gave them an opportunity to discuss many aspects of their jobs, including training, incidents and any barriers preventing them doing their job. Team leaders told us appraisals were also used as a forum to discuss any performance issues and re-training, for example, if concerns had been raised around driving competencies. There were some opportunities to develop into other roles, such as team leaders, and staff said if they expressed an interest in this, they went to see the registered manager to discuss it. Appraisals were on target to be completed. At 26 July 2017 numbers of appraisals completed were
  - Driver Escorts who mainly worked with patients who were detained under the mental health act 1983 62% (17 staff)
  - Driver Escorts who mainly worked with patient who were not detained 70.0% (9 staff)
  - Vehicle Base Coordinators 100.0% (2 staff)
- Team meetings often included reinforcement of practice knowledge for example general issues around control and restraint.
- The service monitored staff performance through a driver escort evaluation report. This was completed with a member of staff chosen at random every month. Prior to the evaluation the registered manager ensured that the staff member was unaware of the evaluation was to take place. Items evaluated included: documentation, vehicle documentation and checks, health and safety, server user knowledge, monitoring of driving standards, communication with outside agencies, initial contact with service users, transportation, handover to receiving unit, final vehicle check, final documentation, de-brief, actions. We saw that the provider had carried out one driver evaluation per month in the year to July 2017.

Coordination with other providers and multi-disciplinary working

- Staff and other services worked well together to deliver effective care and treatment through the provision of timely and appropriate transport. Care was delivered in a coordinated way when other services were involved. The coordinators recorded key information when they received the transport request. Staff liaised with both the transferring and receiving hospital or units to understand how the patient was at that time. Staff also confirmed if beds were available by calling the appropriate bed manager for the area the patient was being transferred to.
- Members of staff from other providers who were caring for the patient being transferred were able to travel with the patient if they felt it improved the experience for the patient.
- Drivers who transported patients who were not detained under the mental health act 1983 worked and coordinated with other providers of healthcare, such as the therapy day groups. Staff told us changes to groups such as breaks for holidays were communicated to them by the coordinators from the requester of the transport so drivers did not go to pick up patients unnecessarily.
- We saw several positive reports from a range of staff from different providers about how the provider worked with staff that had requested transport. They

commented positively about crews' professionalism, team work, patience and excellent people and communication skills, which often reduced the need for patient restraint. Other comments related to patient safety and welfare and knowledge of MHA and conveyance law. We saw an example of excellent coordination with the commissioner and hospital staff when a hospital had needed to close wards and patients needed transferring urgently.

Access to information

- Risk assessments were available to teams before they set out on the transfer. The information was given to the staff by the coordinator in a timely and accessible way. The risk assessments were added to by the provider to ensure that the information was accurate and up to date. Ambulance staff requested all the information they needed to deliver effective care and support for patients being transported by them, with additional verbal risk assessments by telephone on the way to the transfer.
- Staff ensured they had all detention paperwork before leaving a hospital or unit and scrutinised it to ensure there were no errors or omissions which may prevent the receiving hospital unit accepting the patient.
- Staff ensured they were made aware of any special requirements patients had, for example for a patient living with dementia.
- The service used accurate and up-to-date satellite navigation and vehicle tracking systems which ensured staff knew where the nearest or most appropriate vehicle and crew was.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent to care and treatment was sought in line with legislation and guidance. Patients who had decision making capacity were enabled to make decision about transport as voluntary patients. The use of restraint of people who lacked mental capacity to make decisions was monitored for its necessity and proportionality and action was taken to minimise its use in accordance with MCA 2005 and MHA1983.
- Staff explained they had received training in both restraint and aggression management, which included consent issues, and always tried to calm situations verbally before resorting to any form of restraint. Staff told us mechanical restraint was always a last option and was very rarely used. When used it was reported to the commissioner of the service for evaluation although the number of times additional restraint was used was not available at the time of the inspection.
- Training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was not refreshed annually and not comprehensive.

Are patient transport services caring?

Compassionate care

- Patients and those close to them were treated with kindness, dignity, respect and compassion while they received care and support.
- During our observations staff were very respectful and caring to relatives and carers travelling with the patient. Staff took the time to interact with patients and those close to them in a respectful and considerate manner.
- Staff showed an encouraging, sensitive and supportive attitude towards patients and those close to them. We saw staff adapt and change their tone and language for patients with cognitive difficulties who were attending group therapy sessions. Staff told us they were also aware they had to further adapt the way they interacted with patients as their illness progressed.
- Staff ensured patients' dignity was maintained in public places and during transportation. We saw this when we observed care. This was also demonstrated in feedback from professionals involved in patients' care and treatment who spoke highly of patients' treatment by ambulance staff. Staff described how they had been called to transfer a patient who was refusing to dress, they wrapped blankets around the patient to keep them warm. This also ensured the patients dignity was maintained throughout the transfer.
- Staff told us they always ensured patients were dressed appropriately for the trip, taking into account the weather and where they were going. They made suggestions to patients to bring coats and would check that their property was secure when they left and when they returned

Understanding and involvement of patients and those close to them

- We saw that patients and those close to them were involved in their care. Staff communicated with people

in a way so that they understood their care, treatment and condition. Staff told us they altered their communication style or language for each patient. This was based on work with patients with varying stages of dementia or patients who were acutely unwell and were detained under the Mental Health Act 1983. We saw staff providing clear instructions to a patient to assist them in boarding the ambulance safely, but allowing them to do so in their own time.

- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care. Day centres and therapy groups sometimes requested that relatives or carers accompany the patients on their first trip to the group. Staff told us they knew about these trips in advance; however, they told us if a relative or carer expressed a wish to accompany the patient when they were picked up, staff accommodated this.
- Staff told us they knew about and responded to the particular needs of the patients. Information was available from the provider's booking office system and, when transporting patients who were detained, through their additional risk assessments. Staff told us this worked well after they had met and begun establishing a relationship with the patient.

Emotional support

- Patients and those close to them received the support they needed to cope emotionally with their care and support. Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. They told us they frequently transported patients who had very few or sometimes no other visitors, besides social workers. Staff understood the importance of encouraging these patients to dress and go to their therapy group, and frequently assisted them with outer clothing and footwear in order to get them to attend.
- Staff told us that, due to the nature of the illnesses the patient had, they tried to spend time building a relationship with the patient's family or carer, as well as the patient. Staff understood how important it was for the patient and their family to have a change to their day to day routine. We were told about a patient who enjoyed being out in the vehicle. The driver adjusted their route to drop off all other patients before that patient to allow them more time in the vehicle.

Supporting people to manage their own health

- Staff told us they did what they could to help patients maximise their independence. Staff did not put seatbelts on patients until it was clear they could not manage to do so themselves. We also observed staff allowing patients time walking to vehicles so they could do so as independently as possible. Patients were provided with clear verbal instructions to help them board the vehicles safely and encourage them to achieve this.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet the needs of people using the service. The location of the vehicle base and vehicles had been assessed by the provider to offer good access to the local people who used the services
- Tascor provided relevant information regularly to the commissioner of the service regarding the types of journeys undertaken to enable the effective monitoring of this activity and to improve forecasting and operational planning.
- The provider worked closely with the commissioner to provide performance and incident feedback and to suggest improvements in between the contract meetings. For example, suggestions had been made by the provider to improve pick up time performance for detained patients. These suggestions were under consideration by the commissioner.

Meeting people's individual needs

- Transport services were planned, delivered and coordinated to take account of people with complex needs. For example Information about patients' mobility and other needs such as those for people living with dementia was obtained by coordinators when they took referrals or request for transport. Staff told us, where possible, the same drivers would pick up patients as they understood the importance of routine for some patients.

Patient transport services (PTS)

- We saw that nearly all patients were collected in vehicles which were unmarked and not identifiable as ambulances. The service had two vehicles with tail lifts for wheelchairs and one vehicle was equipped to carry a stretcher.
- Services engaged with people who were in vulnerable circumstances and took action to remove barriers when people found it hard to access or use services. For example, one patient was collected weekly by the same driver, who also collected their assistance dog and transported both to a weekly therapy group.
- Staff also told us if a patient's first language was not English, they would be alerted by the bookings team, and would speak to the day centre coordinator about arranging translators; however, staff we spoke with said they had not needed to access the service.
- Staff escorting detained patients told us when they collected patients from places of safety or home assessments; they ensured that personal items were taken with them which gave the patient comfort. These items were secured in the boot of the vehicle. For example, staff enabled a patient to bring a piece of equipment from home which provided reassurance and helped the patient remain calm for the transfer.
- In the event that patients were not at home when the ambulance crew arrived, the crews remained at the property until they established where the patient was. For example, one patient was due for collection, but was not at home. The driver had then informed the day centre and reported it as an incident to the registered manager.

Access and flow

- Patients accessed care and treatment in a timely way. Staff told us they understood the importance of timeliness for the patients they transported. Staff told us they had access to day centre or therapy group coordinators' contact number to let them know if there was an issue with delays.
- Types of transport requested varied day to day and were a mix of detained patient and other transport.
- Staff who acted as escorts for detained patients told us they were frequently required to attend a patient's home where a mental health act assessment was to be carried out. The police and an approved mental health practitioner were required, and the transporting crew often had to wait for one or both to attend. We saw one ambulance crew wait in excess of one hour for a professional to attend a patient's home address. These delays were notified to the trust.
- Services ran on time, and people were kept informed about any delays through the booking office and day centre coordinator. For therapy and support groups with a set start and end time, drivers often stayed at the centre so that they were available to take the patients home at the end of the groups.
- The provider operated 7am to 7pm and was available 24 hours a day and seven days a week.

Learning from complaints and concerns

- The provider told us complaints were either dealt with immediately by staff or formally through organisations that received patients. When we spoke with the commissioner of the service they confirmed that complaints were managed through receiving organisations or through the trust's patient advocacy and liaison service. This may have led to some complaints not being known about by the provider and missed opportunities to improve. Complaints known about were discussed regularly between the commissioner of the service and the registered manager.
- The service kept a central log of known complaints which were discussed in team meetings. The service was aware that they had received three complaints in the period September 2016 to August 2017 two of which had been investigated one complaint being investigated at time of inspection. We reviewed a selection of the monthly patient reports for February, March and April 2017 which were reviewed by the board. There were no direct complaints made to Tascor in this period.
- People's concerns and complaints were listened and responded to by the provider. They were used to improve the quality of care when issues had been raised with the commissioners of the service or the unit or hospital they or their relatives attended. For example the service had recently received a complaint raising questions about methods of restraint from a safeguarding lead at another provider. The service explained how they were dealing with the complaint which included investigating the methods used with the commissioner of the service.
- Staff told us they did not have any information about the complaints process to give to patients, although we

observed that some vehicles had complaints information on them in the form of a leaflet. Some staff told us patients' concerns were directed to other providers and to the contract holding organisation. Staff said they did not always get direct feedback from the unit, hospital or person that had made a complaint as sometime complaints were made through other provider's complaints department.

- Patients we spoke with did not know how to make a direct complaint about the transport service. We spoke with one relative who told us they had previously been missed off the collection list. The relative did not have a direct contact number for Tascor, but was instructed to raise concerns through the day centre coordinator who passed them to Tascor on their behalf. One person we spoke with said they did not know the name of the patient transport company.

Are patient transport services well-led?

Leadership

- The leadership had the capabilities to lead and their responsibilities comprised the following. The business director was responsible for the business as a whole. The operations director role was still under review but was intended to provide operational and governance support to the registered manager. The contract manager and operations manager (the registered manager) had responsibility for all day to day operational issues including training and incident investigation. The deputy contracts Manager who was on long term leave provided administrative and business support to the operations manager. The secure transport manager – one full time and one bank managed day to day scheduling and resource issues and managed staff with the support of four team leaders.
- The registered manager was visible and approachable; staff told us there was an 'open door' culture, and felt they could go to the registered manager or deputy contract manager about any concern or issues.
- Leaders we spoke with at all levels encouraged appreciative and supportive relationships among staff. Staff shared with us examples of how they had been supported by the registered manager and team leaders. For example, when staff needed time off for one off or long term medical treatment, the registered manager had arranged transport to get them to appointments and was flexible in organising rotas so their needs could be met.
- Operational road staff told us they had frequent contact with the registered manager in the vehicle base. The registered manager completed approximately one shift per month with crews to maintain their skills and maintain their visibility.
- Some staff were unaware of the names and roles of staff at board level and said they had little or nothing to do with them.

Vision and strategy for this this core service

- There was no vision for the service. However all staff we spoke with were able to describe the organisation's purpose of transporting patients with mental health conditions some of whom were detained under the Mental Health Act 1983 and delivering a patient transport service for people with conditions such as dementia to attend day centres. Staff aspired to deliver excellent care and support to patients using the service. We saw examples of this in feedback from others who were involved in their care at the same time.
- There were elements of a vision outlined within some service documents which we saw during the inspection. Not all staff were familiar with or had read these documents. For example, in the Tascor incident investigation and management policy, Tascor described a commitment to develop a safe, learning culture within the organisation. It stated it recognised the benefits to their own 'corporate body', their clients and the public by operating within an open learning culture.
- There were similar elements of a vision in other standard operating policies, several of which were carried forward from the previous owner of the business or from the commissioning documents. However, not all of these had been reviewed within the last year. For example in a document carrying the previous owner's branding and not showing when it had last been reviewed, the provider described wanting to ensure that all post holders were fully trained, experienced and competent to carry out the specified duties.
- No formal engagement with staff had taken place to develop a clear strategy. However, the board and senior managers were planning a three year strategy meeting the week following inspection.

Patient transport services (PTS)

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The governance framework did not always ensure that managerial responsibilities were obvious. At board level it was not clear who was responsible for CQC updates, Duty of Candour or training, equality and diversity, safeguarding, or for the Mental Health Act 1983 and Mental Capacity Act 2005.
- The Registered manager was responsible for governance and was being supported in this role through the recent appointment of an operations director. The operations director had been in post three months at time of our inspection and was reviewing roles and responsibility to ensure issues were addressed with the business director and the board.
- Some quality, performance and risks were understood and managed such as regular training for control and restraint and the need for regular first aid training. However, some key policies were out of date and some processes were not effective, for example complaints. Some quality and risks were not fully understood. For example, refresher training was not comprehensive at operational level.
- Learning was shared often between team members and the registered manager. Staff told us about learning however, we did not see evidence that staff had read and understood all information available. For example written notices and internal safety alerts had not been, signed off by staff members to ensure they had read and understood the information within them.
- The registered manager was using out of date CQC guidance referring to standards rather than the regulations which were implemented April 2015. When we pointed this out the registered manager accessed the Guidance for Providers on meeting the regulations March 2015 on the CQC website to ensure they were up to date with their responsibilities as a registered manager.
- An up to date statement of purpose (a legal document required under regulation 12 of Care Quality Commission (registration) Regulations 2009) was not provided when requested prior to the inspection. When questioned the registered manager had misunderstood the pre inspection information request. When we spoke about the lack of current statement of purpose the registered manager responded quickly to update and submit it.
- The Tascor board had oversight of performance against quality standards through monthly reports. These were presented to board by the registered manager and covered a range of performance and risk areas. For example, health and safety, incidents, staff turnover, vehicle accidents, staff sickness and other absences, number of journeys made, number of journeys declined and numbers of complaints received. These reports were also reported on for the company owner's board.
- The Capita corporate board met every three months to discuss risk registers, emergency preparedness, finances, potential change and health and safety.
- Risk registers recorded some potential risks and actions needed at local level for Tascor. However, some risks identified on the inspection were not recorded at Tascor board level and on the corporate risk register. For example the potential impact of not all policies being reviewed or in date, lack of oversight of all complaints about their service, or impact of infrequent training including safeguarding and equality and diversity. When we spoke with directors about this they were aware of the risks and could describe them and actions needed.
- The registered manager and others responded to risk at an operational level. For example when Tascor management were not confident with the control and restraint training that was being provided they ensured the quality of care and patient safety was maintained through accessing different training. The training included an alternative to hard cuffs, which eliminated most injury potential that may result from the use of hard mechanical restraints or rigid handcuffs. Other examples of risk management included the paper and electronic-based and dynamic risk assessments staff carried out when accepting request and carrying our transport.

Culture within the service

- Leadership and culture encouraged openness and transparency and promoted good quality care and support. We saw this when we spoke with board members and operational managers who acknowledged areas for development and implemented action to ensure they addressed areas of patient safety and quality.

- When we raised the issue of lack of regular safeguarding training with the registered manager they took prompt action to address our concerns and commissioned new training within two days. We saw several examples of this responsive, learning culture, supporting better governance and risk management. For example, the service undertook an immediate review of the storage of patient identifiable information, safeguarding training and infection prevention control issues when pointed out highlighted during the inspection.
- Staff told us they felt respected and valued, and were very proud of the work they did. Staff described friendly and professional relationships with patients.
- The culture was strongly centred on the needs and experience of people who used the service. Staff we spoke with referred to patients having an illness which may be experienced by anyone at any time.
- There was a strong emphasis on teamwork and promoting the safety and wellbeing of staff. Teams were aware of the risks associated with their work, and felt they had built a level of trust with each other which gave them confidence when dealing with difficult or dangerous situations.
- We were told that all staff were entitled to an 11 hour break between shifts and a complete 48 hour break each fortnight, which was rigorously enforced by the management team. If a task over ran for any reason the management team advised the crew to delay return to work for 11 hours before next shift. Some staff told us they did not always get adequate breaks and time off between shifts, especially when required to work at the end of their shift. This sometimes happened when out of area transfers were required although staff were required to take a 20 minute break after two hours continuous driving. However staff could work from home on standby and finish early if there was no planned work. We saw evidence of these discussions in team meeting minutes.
- The culture encouraged openness and honesty, and staff told us they were not worried to tell the registered manager anything, including when vehicles became accidentally damaged. From the managing director through board representatives to the registered manager - managers described staff's attitude to patients as “outstanding”. They were highly complementary about the communication skills used and required to de-escalate potentially violent and volatile situations. Managers and staff spoke highly of the registered manager.

Public engagement

- We did not see any examples of patient feedback or engagement. The provider and the commissioner described how difficult it was to ensure that all patients and those close to them who used the service were engaged and involved. This was due to the transient nature of the service provided to detained patients and it was not always appropriate to seek feedback for patients who were acutely unwell.
- However the provider did not have a process for capturing feedback from the routine work they did supporting patients who attended day centres.

Staff engagement

- Staff had taken part in a staff survey in July 2017. The survey was for Capita as whole. There was a 56% response rate (of 37,833). Tascor were unique in the service they provided within Capita and represented less than 1% of the survey group so we were unable to judge the number of returned questionnaires or the type of responses.
- Tascor board members did not have any plans to conduct a staff survey locally to understand what staff felt.
- Feedback was gained informally daily by the registered manager or team leaders. Staff said this was easy to do and helpful.

Innovation, improvement and sustainability

- Services had been continuously improved and further resources had been put in place to reduce response times. This had been undertaken in partnership with the commissioners.
- More rigorous patient risk assessment and detained patient paperwork checks had been implemented which increased the timeliness and reliability of transport going ahead, with benefits to the patient of not delaying transport and raising anxiety.
- The sustainability of the service had recently been secured over the short term as the provider had an extension of their contract until August 2019.
- We were told that recruitment of staff to support and transport people detained under the MHA 1983 and for

those with mental health conditions was difficult. The registered manager and other senior managers all described staff as needing to have a 'special quality' to work with people who often had complex needs and difficult circumstances. The provider had used a range of recruitment agencies and had used an agency that specialised in supplying people with a military and other public services background which had proved quite successful.

Outstanding practice and areas for improvement

Outstanding practice

- The culture was strongly centred on the needs and experience of people who used the service. Staff we spoke with referred to patients as having an indiscriminate illness that could affect most people at any time. They showed kindness and compassion towards them.
- From the managing director through board representatives to the registered manager - managers described staff's attitude to patients as “outstanding”. They were highly complementary about the communication skills used and required to de-escalate potentially violent and volatile situations. Managers and staff spoke highly of the registered manager.

Areas for improvement

Action the hospital MUST take to improve

- Take action to address frequency and content of training in the following areas: Mental Health Act 1983, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, Equality and Diversity, infection prevention and control and Safeguarding.
- Take action to review all policies relevant to the service, to ensure that they are relevant, up to date, accessible, read and understood and applied by staff.
- Take action to submit an up to date statement of purpose.

Action the hospital SHOULD take to improve

- Review whether all local risks relevant to operations are recorded and available to registered manager and other staff.
- Review arrangements for establishing the resuscitation status of patients prior to them being transported on vehicles.
- Review lead roles for Duty of Candour, training, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and safeguarding.
- Review arrangements for retention and storage of patient identifiable information.
- Review availability and staff awareness of complaints information to give to users of the service.
- Review arrangements, including timescales for feedback from commissioners relating to safeguarding, incidents and complaints.
- Review arrangements for gaining patient feedback with commissioners.
- Review operational staff awareness of roles of personnel at board level and board level staff visibility.
- Review arrangements for carrying out vehicle inventory and checklists.
- Review access to knowledge of and arrangements for transporting temperature-sensitive medication on extended journeys.
- Review the arrangements for monitoring that staff have read important information.
- Review arrangements for achieving all driver evaluation reports in a calendar year.
- Review arrangements for staff survey relevant to numbers of staff at Keynsham Vehicle Base.
- Review staff awareness of the vision and strategy for the service.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment {C}· Refresher training in Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, Safeguarding, equality and diversity and Mental Health Act 1983 was not regular or comprehensive. Regulation 12 (1)(2)(c)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance {C}· The provider's policies had not all been reviewed, not all were in date and not all staff knew how to locate or access them. {C}· 17(2)(d) (i) (ii)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

This section is primarily information for the provider

Requirement notices

Regulation 12 Care Quality Commission (Registration) Regulations 2009 (Part 4) Statement of purpose.

· The provider did not have an up to date statement of purpose.

Regulation 12 (1)(2)

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.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...