Premier Rescue Ambulance Services Limited

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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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Premier Rescue Ambulance Service Ltd provides a patient transport service to people living in Somerset and the surrounding areas. If required, the service reaches further out into the south west to provide patient transport services. The service provides non-emergency ambulance transport for people with mental health conditions, most of who are detained under the Mental Health Act 1983. The service also provides transport for non-detained patients, for example patients who are voluntarily going into hospital for referral or treatment. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 17 April 2018.

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

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

The only service provided by this service was patient transport services.

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:

- There was a good track record of safety. Staff we spoke with understood their responsibilities to raise concerns, to record safety incidents and to report them.
- Lessons were learned when things went wrong, and action was taken as a result.
- All staff were up to date with their mandatory training. The service maintained accurate and complete staff training records.
- Staff we spoke with understood their responsibility to report safeguarding concerns.
- Vehicles and equipment were visibly clean and tidy and staff were presentable in their uniforms.
- Records showed completed and up-to-date vehicle maintenance and servicing schedules. All vehicles in use had an up-to-date MOT, vehicle tax and insurance.
- Staff we spoke with about 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.
- Staff and other services worked well together to deliver effective care and treatment through the provision of timely and appropriate transport.
- Patients' consent to care and treatment was sought in line with legislation and guidance.
- We did not observe any direct patient care. However, during our discussions with staff, they spoke about patients in a respectful and caring manner. They told us that when transporting patients, they took the necessary time to engage with patients. Patients and those close to them received the support they needed to cope emotionally with their care and support.
- The provider risk-assessed and took relevant background information into account to plan and deliver services.
- Services were delivered and co-ordinated to be accessible and responsive to patients' needs.
- Concerns and complaints were used as an opportunity to learn and drive improvement.
- The provider had a clear vision and a set of values with quality and sustainability as top priorities.

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.

Summary of findings

- The service did not undertake any driving assessments to ensure staff drove appropriately when transporting patients.
- There were no systems or procedures in place to manage the storage and removal of clinical waste.
- The service was unable to assure itself staff followed restraint policy and procedures. This was due to the lack of comprehensive reporting paperwork.
- The service had no business continuity plan that would ensure continued service provision in, for example, the event of a vehicle loss or fire.
- The service had no formal system to record, plan against or mitigate risks to the service.
- None of the eight policies we looked at had a review date. The provider was unable to tell us when they were due to review their policies and procedures.
- Some policies reviewed, such as the infection prevention and control policy, were not clearly defined as belonging to Premier Rescue Ambulance Services Ltd.
- There was no documented record of monitoring the cleaning of vehicles.
- The provider had no system in place to allow them to determine whether they were delivering an effective patient transport service.
- None of the staff employed had received an appraisal or supervision.
- Staff did not complete any competencies following induction.
- Patients were not told routinely that they could comment or complain about the service.
- There were some structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services, but they were not regularly reviewed and improved. The provider did not have a system or process in place to regularly manage the governance of the service in a formal manner.
- There were no processes to manage current or future service performance. During the inspection the provider was not able to confirm the number of patient transport journeys over the past 12 months. After the inspection the provider confirmed that they had undertaken 43 patient journeys in the previous three months.
- Mechanisms for providing all staff at every level with the development they needed were yet to be established.
- The registered manager was not able to demonstrate the arrangements to ensure the availability, integrity and confidentiality of identifiable data.

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 two requirement notices that affected Premier Rescue Ambulance Service Limited. Details are at the end of the report.

Amanda Stanford
Deputy Chief Inspector of Hospitals (South), on behalf of the 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)		We do not currently have a legal duty to rate independent ambulance services. We found the following areas of good practice: The service 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. There were systems, processes and practices in place, which were essential to keep people safe and these were communicated to staff. Transport services were planned, delivered and coordinated to take account of people with complex needs, including patients detained under the Mental Health Act 1983 and those living with dementia. However. Staff had not received an appraisal or supervision despite some staff being employed for four years. There were no systems to manage the storage and removal of clinical waste The service did not monitor through audit process or any records to provide assurance to themselves that they were performing well or improving their service. There were some structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services, but they were not regularly reviewed and improved.

Premier Rescue Ambulance Services Limited

Detailed findings

Services we looked at:
Patient transport services (PTS)

Detailed findings

Contents

Background to Premier Rescue Ambulance Services Limited

Premier Rescue Ambulance Service Ltd is a family run patient transport service which opened in 2014. The service provides non-emergency ambulance transport for adults with mental health conditions to people living in Somerset and the surrounding areas. - If required, the service reaches further out into the south west to provide patient transport services. The service is not provided to children or young people under the age of 18.

The service had a registered manager, Mr Kudakwashe Sigobodhla, an operations manager, a business support worker and 19 operational staff. The 19 operational staff included 18 support workers and one registered nurse. They were employed on a zero hours contract and contacted when their services were required.

Premier Rescue Ambulance Service Limited is registered to provide the regulated activity Transport services, triage and medical advice provided remotely.

The provider had no commissioned or contracted work. Work was acquired from private individuals requiring informal transport for referrals or admissions. Other work came from local secure care facilities or trusts requiring ad hoc work on an 'as and when' basis. The service told us they had only completed 43 transport jobs in the first three months of 2018.

This was Premier Rescue Service Limited's first inspection since its registration in 2014. 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 this inspection on 17 April 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspectorand one other CQC inspector. The inspection team was overseen by Mary Cridge, Head of Hospital Inspections.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Premier Rescue Ambulance Service Ltd opened in 2014. The service provides non-emergency transport for people with mental health conditions living in Somerset and the surrounding areas.. If required, the service reaches further out into the south west to provide patient transport services.

The provider had access to two vehicles for transporting patients. These were both people carriers with one car and one van which enabled patients space and the support of additional staff.

The provider had no commissioned or contracted work. Work was acquired from private individuals requiring informal transport for referrals or admissions. Other work came from local secure care facilities or trusts requiring ad hoc work on an 'as and when' basis. The service told us they had completed 43 transport jobs in the first three months of 2018.

Summary of findings

We found the following areas of good practice:

- There was a good track record of safety. Staff we spoke with understood their responsibilities to raise concerns, to record safety incidents and to report them.
- The service maintained accurate and complete staff training records.
- Lessons were learned when things went wrong, and action was taken as a result.
- All staff were up to date with their mandatory training.
- Staff we spoke with understood their responsibility to report safeguarding concerns.
- Vehicles and equipment were visibly clean and tidy and staff were presentable in their uniforms.
- Records showed completed and up-to-date vehicle maintenance and servicing schedules. All vehicles in use had an up-to-date MOT, vehicle tax and insurance.
- Any form of restraint used was the minimum amount necessary for the shortest possible time, and as a last resort. This was documented in the patient record.
- Staff we spoke with about 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 were aware of preventing or minimising periods during which a patient would be in a face-down (prone) position.
- When transporting patients, the crews attempted to meet people's nutrition and hydration needs.
- All new starters to the service completed compulsory mandatory training followed by shadowing as part of their induction process.

Patient transport services (PTS)

- Staff and other services worked well together to deliver effective care and treatment through the provision of timely and appropriate transport.
- Staff took the necessary time to engage with patients. They communicated in a respectful and caring way.
- Patients and those close to them received the support they needed to cope emotionally with their care and support.
- The provider risk-assessed and took into account relevant background supporting information on referral to plan and deliver services.
- Services were delivered and co-ordinated to be accessible and responsive to patients with complex needs who were accepted for transport.
- Concerns and complaints were used as an opportunity to learn and drive improvement.
- The provider had a clear vision and a set of values with quality and sustainability as top priorities.

However, we 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.
- The service was unable to assure itself staff followed restraint policy and procedures.
- The service had no business continuity plan that would ensure continued service provision in, for example, the event of a vehicle loss or fire.
- None of the eight policies we looked at had a review date. The provider was unable to tell us when they were due to review their policies and procedures.
- Some policies reviewed, such as the infection prevention and control policy, were not clearly defined as belonging to Premier Rescue Ambulance Services Ltd.
- Clinical waste was not disposed of in line with legislation. We found no clinical waste bags on the vehicles. We were told waste would be bagged in plastic bags and disposed of in general waste.
- There was no process to monitor the procedures in place regarding the daily cleanling of the vehicles or after each use.
- The provider had no system in place to allow them to determine whether they were delivering an effective patient transport service.
- None of the staff employed had received an appraisal or supervision.
- Staff did not complete any competencies following induction. Therefore the provider could not be assured of the staff understanding and skills.
- Patients were not told routinely that they could comment or complain about the service.
- There were some structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services but they were not regularly reviewed and improved. The provider did not have a system or process in place to regularly manage the governance of the service in a formal manner.
- There were no processes to manage current and future performance. For example, there was no monitoring or audit of the services provided to enable the provider to improve or develop the services.
- The service had no formal system in place to plan against and mitigate risks to the service.
- Mechanisms for providing all staff at every level with the development they needed were yet to be established.
- There was not a universal understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances.
- The registered manager was not able to demonstrate the arrangements to ensure the availability, integrity and confidentiality of identifiable data.

Patient transport services (PTS)

Are patient transport services safe?

Mandatory training

- All staff were up to date with their mandatory training. Training was delivered in a classroom and annually by an external company. It covered core subjects such as:
- First aid (renewed annually).
- Prevention and management of violence and aggression, which included communication skills, control and restraint techniques and use of soft handcuffs.
- Mental Health Act 1983.
- Safeguarding adults and children.
- Moving and handling.
- The training equipped staff to work with and transport patients with mental health needs, including patients detained under the Mental Health Act.
- The service maintained accurate and complete staff training records. We reviewed eight staff training files and could see they were accurate and up to date. The provider was in the process of improving their system to enable electronic alerts when staff were due to renew any mandatory training needs.

Safeguarding

- We were not assured people were protected from discrimination, which might amount to abuse or cause psychological harm. This included harassment and discrimination in relation to protected characteristics under the Equality Act. The provider stated they had developed an equality and diversity policy and procedure for staff. However, they were unable to locate this and provide to us either during or after the inspection.The service had a 'Safeguarding Vulnerable Adults and Children' policy which was accessible to staff. It outlined responsibilities, types of abuse and contact details. The registered manager was the safeguarding lead and had a level three certification.
- All staff had the appropriate level of safeguarding training as part of their mandatory and ongoing annual training.
- Staff we spoke with understood their responsibility to report safeguarding concerns. If they had a concern they would report this to the on-site approved mental health professional or the on-call manger.
- Staff recorded whether patients suffered any injuries as a result of the restraint methods used. There had been no injuries reported in the last 12 months.
- CQC had received no statutory notifications for allegations of abuse from the provider. This aligned with evidence from the registered manager that they have as yet not had any safeguarding concerns.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained and there were systems to prevent people from infection. The organisation had an infection prevention and control policy. It outlined standard operating procedures for cleaning of the vehicles, heavy soiling and use of personal protective equipment. The policy also included what steps to take in case of being bitten by a patient.
- The vehicles we inspected were visibly clean and tidy. Staff told us they would clean the vehicles at the start of each day. If a vehicle became heavily soiled it would be brought back to base to be deep cleaned. However, the provider did not have records of vehicle cleaning so could not be assured staff were doing this routinely and after each use.
- Staff followed infection control procedures in line with the infection prevention and control policy. This included washing their hands and using hand sanitiser after patient contact. Hand cleaning facilities were readily available, including hand wash basins at the base and hand gel on the vehicles.
- Staff had access to personal protective equipment such as gloves and aprons to reduce the risk of the spread of infection between staff and patients. Crews carried a spills kit on their vehicle to manage any small spillages and reduce the infection and hygiene risk to other patients.
- However, clinical waste was not disposed of in line with the Health and Social Care Act 2008:Code of practice for health and adult social care on the prevention and control of infections and related guidance. We found no clinical waste bags on the vehicles. We were told that waste would be bagged in plastic bags and disposed of in general waste. This posed a risk to the health of staff and waste collection agencies.
- Journey booking forms had a section to inform staff if a patient was an infection risk. This meant staff could take necessary precautions to protect themselves.

- Staff wore visibly clean uniforms. Staff were responsible for washing their own uniforms and were issued two sets on starting with the company.
- Staff completed an infection control module as part of their annual mandatory training package.

Environment and equipment

- The service was run from a suitable office which was used for administration purposes and the storage of consumables used to stock the vehicles. The office was in a shared building and maintained appropriately with both vehicles stored on site in a secure compound behind the main building. Vehicle keys were kept securely on site in a locked key store. Spare vehicle keys were kept with the registered manager.
- The service operated two unmarked vehicles. Both were people carrier style. Seating in the rear could be adapted to ensure the safe location of the patient and to lower the risk of any incidents affecting the driver.
- The provider ensured vehicles were maintained and safe for use. Records showed completed and up-to-date vehicle maintenance and servicing schedules. All vehicles in use had an up-to-date MOT, vehicle tax and insurance.
- Staff had access to appropriate consumable stock. Both vehicles carried urine bottles, vomit bowls and personal wipes.
- The provider had an exclusion criteria and therefore would only accept patients for transport if they were able to meet their needs for safe transport. The provider did not transport patients who required a wheelchair or stretcher, or bariatric patients (with a BMI over 40), and therefore did not have equipment to accommodate these patients.
- Vehicle defects were reported directly to the registered manager. The provider had an arrangement with a national garage chain which allowed prompt repair of vehicle defects. We could see from records that vehicles were regularly serviced and maintained. The garage ensured a rolling programme to service the vehicles and sent alerts to the provider when servicing was due.
- Each vehicle carried details of a 24 hours a day, seven days a week, breakdown recovery service. Staff told us if the vehicle broke down whilst a patient was on board, they would call the registered manager and request support to continue the patient journey.

Assessing and responding to patient risk

- Risks to patients were assessed, and their safety monitored and managed. The bookings staff completed a booking form with the help of the referrer to enable the service to complete a risk assessment for each patient. The risk assessment included the risk of violence, suicide, self-harm and absconding. Using the outcome of the risk assessment, the bookings staff assigned a crew and a suitable vehicle.
- We reviewed records and confirmed risk assessments were completed and actioned, specifically depending on the presentation of the patient. For example, booking staff arranged additional staff escorts if identified patient risks had increased since booking. This was in response to the initial staff allocation following preliminary assessment on referral.
- Staff were trained to deliver basic life support in an emergency. This was included as part of their annual emergency first aid qualification.
- The service did not request the weight of a patient at the time of booking. The service did not have the appropriate equipment to transport bariatric patients, therefore there was potential for an abandoned booking if on arriving to collect the patient they were found to be too large to transport safely. This could impact upon the wellbeing and treatment of the patient if their transfer was then delayed.
- Handovers were completed when collecting a patient. These ensured risks were discussed and helped staff identify any potential risks on the journey. Assessments included the patients' current mood or behaviour.
- The service was unable to assure itself staff followed restraint policy and procedures. The service did not keep completed paperwork, such as body maps and observations following restraint, together with incident forms. Therefore, the process could not be scrutinised.
- Staff told us any form of restraint they used was the minimum amount necessary for the shortest possible time, and as a last resort. This complied with guidance by the Department of Health (DoH) entitled 'Positive and Proactive Care: reducing the need for restrictive interventions' (2014) and NICE Guideline 25.

Staffing

- Staffing levels were appropriate to deliver a safe service. The service employed 19 operational staff. There were 18 support workers and one registered mental health

nurse. All staff were on zero-hours contracts; the service could access agency staff if required, but had not had cause to do so. The staff worked for other mental health providers in their substantive posts

- All staff worked on an on-call basis and so only attended the location for training or support and when allocated to a job. If no staff were available the registered manager and operational manager would attend the patient if appropriate.
- The correct staff and skill mix were determined when booking a patient. Bookings were taken and recorded on paper forms by the registered manger. Information captured included risk concerns, risk history and medications. The booking form also took into account the number of staff and grade required for the journey, for example support worker, registered general nurse or registered mental health nurse. Also considerations as to the male or female balance of staff. This was to ensure the safety of staff and the patient.
- Appropriate staff recruitment checks were undertaken prior to employment. We reviewed nine records which contained evidence of proof of identification, references, appropriate criminal records checks through the Disclosure and Barring Service, and driving license checks. The service had a recruitment policy that set out the standards it followed when recruiting staff.

Records

- Records were complete, legible and clear. We reviewed 12 journey records for mental health patients, including patients detained under the Mental Health Act. Documents were dated, timed and with a signature and booking reference number. However, the service did not audit its records for improvement or monitoring purposes.
- At the time of booking, information about the patient was recorded on a booking form by the registered manager. Drivers collected this information from the registered manager, which included a verbal journey briefing before departure. At the end of a journey all paperwork was returned to the registered manager and filed securely.
- Drivers recorded the time and mileage in which they drove on each journey. This meant the provider could monitor driving hours and any risks drivers could be at due to being tired. However, this information, while collected, was not audited.
- The service did not transfer patients with a do not attempt cardio pulmonary resuscitation order. While staff and mangers were aware of them they were beyond the scope of the business and this was reflected in the patient exclusion criteria.
- Staff transferring detained patients to hospitals or between hospitals or other locations had received training to collect detention papers to take with the patients. This was so staff could continue to transfer patients legally and staff knew that they had the legal authority to convey or transfer the patient against their will.

Medicines

- The service did not have any stock or emergency medicines on site, nor did the ambulance crews routinely administer any medicines. Staff told us they stored patients' own medicines in zipped pouches which were labelled and stored in the glove compartment during the journey.
- The provider stated that if patients were not self-medicating and required medicines during the journey, a registered general nurse or registered mental health nurse could be employed as part of the crew. Medicines administered would be recorded on the patient's journey form and handed over to the receiving centre or family members.
- Staff told us they ensured the patient's medicine was handed over and recorded on arrival.

Incidents

- There was a good track record of safety. Staff we spoke with understood their responsibilities to raise concerns, to record safety incidents and to report them. Staff would complete a paper-based incident form so the registered manager could review the information around the incident. Staff completed further statements if the manager required more information. The information was shared with others crews if necessary. Examples of incidents which had been reported included a lack of documentation to enable lawful detention and transport and use of restraint.
- There had been no never events reported in the period January 2017 to January 2018. 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.

- There had been one serious incident, which related to a breakdown in communication between staff and managers about patient needs that resulted in a distressed patient. We could see from the investigation report that lessons were learned in relation to improving communication. We could also see investigations from senior management and personal statements from staff. Information was shared with commissioners and staff which included lessons learned and apologies to all concerned.
- Lessons were learned when things went wrong, and action was taken as a result. We were shown where changes had been made following an incident. The changes were related to improved communication between coordinators and operational staff. Those changes were shared with staff through emails and face to face meetings.
- There was a limited understanding by senior staff 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. We could see where the provider had applied duty of candour and the importance of being honest and open when things go wrong.
- We were told that if staff had to use force and restrain a patient this would be recorded in an incident form. Only one incident had occurred in the last year and we could see staff had logged the use of force.

Are patient transport services effective?

Evidence-based care and treatment

- The provider had policies and procedures that staff followed in the course of their work. These included management of complaints, health and safety, infection control, management of risk and safeguarding. Staff who worked remotely had access to key guidelines and operating procedures in a folder kept in both vehicles. The folder contained details of policies, including booking procedures, escort tasks, and emergency information.
- Some policies, such as the infection prevention and control policy, were not clearly defined as belonging to Premier Rescue Ambulance Services Ltd. We found some information that was not relevant to the service provided, for example the effective cleaning and decontamination of air ambulances.
- We spoke with staff regarding transport for patients detained under the Mental Health Act 1983. They were aware of evidence-based practice in relation to control and restraint linked to patient safety; however, this was not well documented in records of patient journeys. For example, staff told us they were 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 (known as positional asphyxia). Staff told us any form of restraint was to be used at the minimum level necessary, for the shortest possible time, as a last resort, and de-escalated as appropriate.
- We were not assured processes were established to ensure there was no discrimination, including on the grounds of protected characteristics under the Equality Act. The service told us they had an equality and diversity policy, but were unable to provide us with a copy. We were not assured such a policy existed. None of the eight policies we looked at had a review date. The provider was unable to tell us when they were due to review their policies and procedures. The registered manager updated staff about new policies and procedures via a secure digital messaging group.
- The booking staff clarified the details of a patient's mental and physical health with the person booking transport, as well as any other issues, such as manual handling, violence and risk of absconding. When staff collected patients they would liaise with referring staff if the condition of the patient had deteriorated. If staff felt this posed a risk to the patient, staff would discuss transport options with the registered manager in regards to the patient's best interests.

Nutrition and Hydration

- When transporting patients, the crews attempted to meet people's nutrition and hydration needs. Bottled water was available and on some longer journeys patients were provided with lunches by hospital staff. On an extended journey, the crew would ask the staff in advance if the patient had been fed, or if there were any special dietary requirements if the need to supply food arose.

Response times and patient outcomes

- The provider had no system in place to allow them to determine whether they were delivering an effective patient transport service. As a result, the service was unable to benchmark itself against other independent ambulance services carrying out a similar service, or build on their own performance. They did collect data on their response times, however nothing further was done with this information.
- The provider had installed vehicle tracking software on both vehicles. This enabled the provider to monitor locations and estimated times of arrival to patients. Plans for transport took into account patient behaviour and preference. For example, there would be consideration of where the patient was sat in the vehicle and the closeness of the staff member.
- The service was unable to give us exact numbers of journeys made in the last year. They told us they would have to count each paper record to enable them to supply us with that information. We were told by the operation manager that between January and March 2018 they had undertaken 14 journeys.
- The service had no contracts with commissioners that required them to submit response data as part of on-going monitoring. They did not participate in relevant quality improvement initiatives, such as local and national clinical audits, benchmarking, or (approved) accreditation schemes.

Competent staff

- Staff had the skills and knowledge to deliver effective care and support. Annual training in the prevention and management of violence and aggression and how to safely use control and restraint was assessed each year. The training included mental health awareness and communicating in a way to support distressed individuals in often frightening and confusing times.
- None of the staff employed had received an appraisal or supervision. We spoke with one member of staff who had been with the provider for four years and had yet to have an appraisal. When we spoke with the provider about this they recognised they needed to review which staff had been with them for over a year and required appraisal, but there was no process for this.
- All new starters to the service completed compulsory mandatory training followed by shadowing as part of their induction process. This consisted of first aid, restraint, moving and handling, conflict resolution, safeguarding, Mental Health & Capacity Acts and health and safety at work.
- The provider checked all staff annually against the Driver and Vehicle Licensing Agency database for driving endorsements to ensure they were safe to drive the company vehicles. The provider did not undertake any driving assessments to ensure staff drove appropriately when transporting patients.
- Staff had a good understanding of how to manage challenging behaviour and told us they always tried de-escalation tactics in the first instance.
- Staff did not complete any competencies following induction. This meant the service lacked assurance about the effectiveness of training and the competence of staff to undertake the role.
- Staff told us they did receive de-briefs and support at the end of each job from the registered manager. They also spoke of on the job support from more experienced peers. Any learning from this was informal and not documented.

Multi-disciplinary working

- Staff told us they spoke with the ward staff responsible for handing over the patient to discuss the patient's immediate needs and any changes in their condition or behaviour.
- There was good communication between the booking staff and crews. Both parties spoke of a good working relationship, which ensured information was shared in a timely manner.
- There was coordination with the NHS trusts the service provided transport for, and the police. This ensured the police, trust and the patient were not kept waiting whilst staff arrived to take the patient for their onward journey. The police had previously requested the service to transport patients to a place of safety or return an absconded person to a recognised service.

- Where necessary, approved mental health professionals or mental health staff accompanied patients on the journey to or between hospitals to ensure they were transported safely and according to their individual needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent to care and treatment was gained in line with legislation and guidance. Patients who had decision making capacity were enabled to make decisions about transport as voluntary patients. The use of restraint for people who lacked mental capacity to make decisions was a last resort when other methods of de-escalation had failed. Action was taken to minimise use of restraint in accordance with the Mental Capacity Act 2005 and the Mental Health Act 1983.
- The service had a policy for mental capacity, which summarised key principles of the Mental Capacity Act (2005). It outlined the responsibilities of staff when transferring patients who lacked capacity.
- The service had standard operating guidelines for the Deprivation of Liberty Safeguards (DoLS). DoLS was introduced as legislation within the mental capacity act when it was rewritten in 2007. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The guidelines stated crews must request to see the DoLS order to ensure it was valid.
- During a booking, the bookings staff asked if a Deprivation of Liberty Safeguard was in place. This information would then be recorded on the booking sheet as a prompt to staff.
- Following a referral, the call handler made the booking form available to the crew. The form would state whether or not the patient was detained under the Mental Health Act (1983). This meant the crew were aware of their patient's condition at the onset of their journey so they could plan the transport appropriately.
- Staff explained they had received training in both restraint and aggression management, which included consent issues. They told us they always tried to calm situations verbally before resorting to any form of restraint. Mechanical restraint was always a last option and as yet staff had not had cause to use it.
- At the time of inspection, 100% of staff had completed mental health and capacity act mandatory training.

Coordination with other providers

- 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. Staff liaised with both the transferring and receiving hospital or unit to understand how the patient was at that time.

Access to information

- Staff were able to access policies and guidelines when needed. If staff required access to policies or procedures they were available in paper form in the office or on the office computer. If staff were out of the office they could call the registered manager or operational manager to refer to the policy as required. Key policies and procedures were also available in the vehicles to provide prompt availability for staff when on journeys.
- Patient records were stored securely on vehicles during transfers in hard case folders kept with the driver.
- Bookings staff completed booking forms electronically, but printed these for drivers and escorts so they could review the information before leaving the base station.
- A 'live' satellite navigation system was provided for staff to track the ambulance journeys to ensure vehicles were reaching jobs as requested. Staff confirmed this was an effective system.

Are patient transport services caring?

Compassionate care

- Although we did not observe any direct patient care during this inspection, staff explained how they took the necessary time to engage with patients. They told us they communicated in a respectful and caring way, taking into account the wishes of the patient at all times.
- Staff were passionate about their roles and were dedicated in providing a service where the patient came first. Staff enjoyed their roles as they felt they were making a difference to the patients' lives.
- Staff told us they always made sure 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 their property was secure.

- The service used unmarked vehicles and staff wore uniforms with minimal logos or writing. The service believed in making sure their presence was as low-key as possible to maintain the patient's dignity when arriving outside their homes.

Emotional support

- Patients and those close to them received the support they needed to cope emotionally with their care and support. Staff understood the effect that a person's care, treatment or condition would have on their wellbeing and on those close to them. They told us they often transported patients who had very few visitors, besides social workers.
- Staff told us that, due to the nature of the illnesses the patients had, they tried to spend time building a relationship with the patient's family or carer, as well as the patient. Staff understood how families and carers could be affected.
- Patients were given appropriate and timely support and information to cope emotionally with their care. Staff explained how they would describe each step of the journey and any delays to patients in their care. Staff recognised how distressing and confused some patients could be when having a mental health crisis and supported them with ongoing conversations and distractions.

Understanding and involvement of patients and those close to them

- Staff told us they were respectful and encouraged the input of family members. They asked family members about the patient's likes and dislikes and how best to interact with the patient. This meant staff could provide a more personalised approach to transporting the patient.
- We were given examples of how patients were involved in decisions about their care and treatment. Crews gave clear explanation of what they were going to do with patients and the reasons for it. Staff told us they checked with patients to ensure they understood and agreed.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The main service was a patient transport service for patients with mental health conditions. They provided non-emergency transport for patients who were unable to use public or other transport due to their condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or referrals from care homes and private individuals.
- Capacity to transport patients was planned to meet demand when people requested transport. The registered manager or on-call manager calculated the journey time to review if they could meet the transport request. Information was shared within a secure mobile messaging service for staff to ask who was available to commit to the journey. Because the provider employed staff on zero hour contracts they were unable to plan staff availability to meet demand more than three to five days in advance.
- Patients' eligibility was communicated at the time of booking. We were told that when a bookings call was taken, part of the conversation was about the eligibility criteria. Therefore patients, or those making the booking for them, were told if their circumstances met the criteria for transport. This would include exemptions such as stretcher or wheelchair users. This was because the vehicles were not adapted for these patients.
- The provider ensured it risk assessed and took relevant background supporting information on referral to plan and deliver services. This enabled them to reflect the needs of the patients transported by using staff with appropriate qualifications and work experience. Continuity of care was supported by using staff with correct backgrounds in mental health care, for example registered mental nurses or staff with significant experience in care. The provider also established relevant information by using a risk assessment to plan the make-up of the crew regarding numbers and gender to support continuity of care.
- The provider was aware of when they could not meet requests for transport. However, they were not

monitoring when they were unable to meet referrers needs and why and so were unable to properly identify and inform how services could be improved and developed.

Meeting people's individual needs

- Services were delivered and co-ordinated to be accessible and responsive to patients with complex needs who were accepted for transport. The provider's vehicles were not able to transfer patients who needed stretcher transport. They were also unable to meet the needs of patients who were significantly over weight. The provider had a wheelchair available for assisting mobility, but was unable to apply reasonable adjustments to their current vehicles to accommodate someone remaining in a wheelchair. Where relevant, the provider would decline a request for transport if they could not meet a patient's physical or mental health needs. Other providers were available with vehicles converted to provide transport in these instances.
- Staff told us that patients were supported during transfer between services and discharge to their homes. When we spoke with the registered manager and staff, and reviewed feedback previously received by the provider from patients,, it was clear the provider had an understanding of the needs of patients with mental health illness. This included patients with complex needs including learning disabilities, dementia and older people with complex needs.
- The provider used a paper risk assessment and referral tool which enabled them to identify the information and communication needs of people with a mental health care need, disability or sensory loss. The information was shared with the booking staff to help plan the most appropriate crew. We were told that when staff arrived to collect a patient they asked the approved mental health professional or other staff on site to ensure the patient understood they were going on a journey and where they were going. Patients were given a copy of the information but were not asked if the information could be shared as this was expected to have been already completed by the person who referred the patient for transport.

Access and flow

- The provider was aware of the time of arrival, length of time on-scene, and turnaround times of vehicles. The registered manager and on-call managers used an electronic application to track vehicles and monitored this when required. This supported resources being where they needed to be at the time required. However, they did not monitor these through audit or any other means to provide assurance they were meeting their own performance indicators.
- We were told services almost always ran on time, and people were kept informed about any disruption. During our inspection we observed services running on time and where a delay was starting to develop the provider kept the requester of the transport informed. We also saw patients with the most urgent transport needs had their transport request prioritised. We were told if staff were unable to meet a planned transfer the registered manager and on-call manager were able to do the work and ensure appointments for care and treatment were not cancelled or delayed unless absolutely necessary.

Learning from complaints and concerns

- Patients were not routinely told they could comment or complain about the service. We were aware that in some instances this may not be appropriate at the time due to the nature of the mental health issue being supported. It was not clear how patients were provided with information they could refer to after their journey had they not been satisfied with the service provided.
- Concerns and complaints were used as an opportunity to learn and drive improvement. We saw the outcome of investigations shared with staff and appropriate action taken. Information had been shared previously in a newsletter to staff, but this was not regularly done. Staff were also told about learning from events through a mobile telephone application which all staff had access to.
- The provider had received only two complaints in the previous twelve months. The first complaint we reviewed included evidence it had been handled effectively and in line with policy. However, while acknowledging it would be difficult to share with the patient the circumstances surrounding the incident, the provider had not shared the outcome with the patient involved. The patient was not aware that other providers had complained about events surrounding the patient transfer. It was not clear how the provider made a judgment as to whether to share information with patients or not.

- We were shown a second complaint where we noted apologies had been issued in writing and an explanation of how things went wrong and changes made since the complaint to prevent them happening again.

Are patient transport services well-led?

Leadership of service

- Leaders had most of the skills, experience and the integrity needed. The leadership team was made up of three people. The registered manager, who was also the managing director, was a registered mental nurse with child and adolescent mental health experience. The second member of the leadership team was also a registered mental nurse with adult forensic experience. They provided clinical, professional and some administrative support to the registered manager. The third member had significant mental health care experience and advised on logistic and vehicle matters. All three were on-call managers who were available to staff and other providers 24 hours a day, 365 days a year, and were jointly responsible for running the business.
- However knowledge in some areas was not adequate. For example the provider did not have a system or process in place to regularly manage the governance of the service in a formal manner. The registered manager was also not able to demonstrate the arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were in line with data security standards. The registered manager was also not familiar with the introduction of the general data protection regulation changes planned for May 2018.
- Leaders understood the challenges to quality and sustainability, and could identify the actions needed to address them. For example, when we discussed areas where there was no objective evidence of potential good practice or where improvement could be identified, leaders were able to acknowledge and discuss those issues. They acknowledged that formal recording of key performance indicators, staff debriefs and formally recording risks and associated actions to reduce the risk would be useful.
- Staff told us leaders were visible and approachable. The on-call manager always met the crew when they returned a vehicle after a journey and spent time debriefing and discussing what went well or what could have been improved on the journey. However, this was not recorded or used in other one to one or appraisal opportunities.

Vision and strategy for this this core service

- The provider had a clear vision and a set of values with quality and sustainability as top priorities. Their vision was growth through high quality services and customer care, with innovation and a brand that was associated with high quality. The provider also had a commitment to serve the community and people with mental health difficulties. There was a strategy for achieving the vision and priorities, and to be able to deliver quality sustainable care. Progress against the delivery of the strategy and plans were not monitored and reviewed.
- The stated values of the business were accountability, integrity, respect, team spirit and transparency.
- The vision, values and strategy had been developed when the company was started four years ago. The registered manager told us the vision and strategy had been developed with their business partners, one a registered mental health nurse, another with significant care support experience in mental health work and transport. People who used the service, staff, and external partners had not been involved in its development. This was because there were no staff, patients or external partners to engage with at the start.
- Staff we spoke with talked in terms of working with patients and other professionals with accountability, integrity, respect, team spirit and transparency. We saw evidence of other professionals commenting positively about the work the provider's staff carried out, which supported all of the values.

Culture within the service

- The staff and leadership culture was very positive. Staff we spoke with felt supported, respected, valued and proud to work for the provider despite there being no formal system of supervision or appraisal. We spoke with staff who had spent a few months with the provider and those who had been with the business from the start. They spoke highly of the managers. Managers spoke positively about all staff.

Patient transport services (PTS)

- The culture of the business was centred on the needs and experience of people who used it. We saw other professionals had commented positively about the service. The vision and values also supported the sense of a patient-centred organisation.
- Mechanisms for providing all staff at every level with the development they needed were not in place. There were not records of high-quality appraisal and career development conversations. However, we saw written records that showed action had been taken to address behaviour and performance that was inconsistent with the vision and values of the provider. Leaders and staff understood the importance of staff being able to raise concerns.
- There was a strong emphasis on the safety and well-being of staff. This was achieved through initial patient risk assessment, some shared learning from incidents and how the managers informally monitored vehicle tracking and spoke with staff.
- Staff told us when they encountered difficult or upsetting situations at work they could speak in confidence with the managers and had support from both managers and colleagues.

Governance

- There were some structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services, but they were not regularly reviewed and improved. The provider did not have a system or process in place to regularly manage the governance of the service in a formal manner.
- Governance processes and arrangements were disjointed and some were absent. Risks to patients were identified and managed, but there were no arrangements for identifying, recording and managing broader risks to and from the operation of the provider. For example, there was no formal system to record identified risks, but managers were aware of risks and could talk about them. There was a risk management strategy policy paper but no governance meetings were held.
- Developments to services or efficiency changes were considered but there was no allocated staffing / management hours to understand the impact on quality and sustainability.

Management of risk, issues and performance

- There were no processes to manage current and future performance. Key performance data was not collected or formally monitored, for example patient time on vehicle. Despite this, the leadership and staff who provided patient transport were clear about their role and understood what they were accountable for, and to whom. Part of the reason why some assurance and governance processes were not fully implemented were lack of allocated staffing or management hours to monitor and develop the service. Lack of time and support staff was provided as an explanation to there being no systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken.
- The service did not have a formal risk register or any other system to effectively record and manage risks. A risk register is a management tool, which enables an organisation to understand its risk profile, as risks are logged on the register and action taken to respond to the risks. This meant they were unable to notice trends in incidents and put systems in place to lower any risks to patients, premises or the business.
- The service had no business continuity plan. This meant that in the event of an IT failure, catastrophic fire to premises or vehicle theft, there would be no plans to enable the business to continue.

Information management

- There was not a universal understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances. There was not an effective arrangement to ensure information available to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. This was because there were not clear service performance measures, which were audited, reported and monitored.
- There were information technology systems used to monitor the quality and provision of care. The registered and on-call managers were aware they had a significant quantity of valuable information to inform care through their vehicle tracking system and other records. They realised it could be used better.
- The registered manager was not able to demonstrate the arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were in line with data security

standards. No data security breaches had occurred to the registered manager's knowledge. The registered manager was not familiar with the introduction of the general data protection regulation changes planned for May 2018

Public and staff engagement

- Patients and people who used the service, those close to them and their representatives were not actively engaged and involved in decision-making to shape the service. However, there was some positive feedback from professionals involved with the service on behalf of patients. They had completed paper 'tell us what you think' forms and had sent comments by email to the service.
- The registered manager and on-call managers met regularly with staff at the end of every day they worked. They engaged in a debrief of what went well and not so well. However, this information was shared verbally at the time and occasionally through the electronic messaging group used for staff. There was no formal record of where staff had been able to be involved in the planning and delivery of services and in shaping the culture.

Innovation, improvement and sustainability

- Staff did not regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance. The development of the business had been the responsibility of the registered and on-call managers.
- The provider had plans to continually develop the service. The registered manager told us how the independent ambulance market was currently very competitive and proving a very challenging time for the business. Despite this, they were determined to maintain their standards.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that mechanisms are in place to provide all staff at every level with an appraisal and regular supervision.
- Ensure a documented system to monitor the cleaning of company vehicles used to transport patients, including the management of clinical waste.

Action the hospital SHOULD take to improve

- Review the structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services
- Ensure a universal understanding of performance, which sufficiently covers and integrates patients and those close to them.
- Have driver assessments and a minimum standard of driving clearly defined.
- Actively engage with patients and people who use the service, and involve them in decision-making to shape the service.
- Involve staff in the planning and delivery of services, and in shaping the culture.
- Improve assurance and governance processes to ensure there were formal systems in place to develop and monitor the service provided.
- Ensure patients are made aware how to complain or comment about the service.
- Consider how patients are made aware when a complaint is raised about their transfer.
- Consider access to translation services for patients where English is not their first language.
- Review processes to enable the identificationof improvements and development opportunities.
- Ensure that equality and diversity is promoted within and beyond the organisation.
- Ensure all staff are aware of, and following, general data protection regulations and other data confidentiality processes.
- Improve understanding of the duty of candour regulation.
- Revise policies and procedures and ensure they are appropriate for the service delivered.
- Consider development of systems and processes to ensure that when taking booking the needs of the patient could be met by the service and abandoned bookings would not have a detrimental effect on the patient.

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 18 HSCA (RA) Regulations 2014 Staffing 18(2) Persons employed by the service provider in the provision of a regulated activity must— (a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. None of the staff employed by Premier Rescue Ambulance Service Limited had yet to receive an annual appraisal or direct supervision.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **15**(1) All premises and equipment used by the service provider must be— (a) clean The provider kept no documented system to evidence that the vehicles were clean and protected staff and patients from the risk of infection. Additionally there was no safe system for the removal of clinical waste.