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

Summary of findings

Letter from the Chief Inspector of Hospitals

Delta Medical Service Limited is an independent ambulance service with one location in Maidstone, Kent and primarily serves the communities of Kent and Essex. The service provides general, cardiac and secure patient transport services including transfers between hospitals, outpatient services, GPs, other medical providers, services users' residences, and with regard to secure transport only, secure units and courts. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 6 February 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.

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 had some systems, processes and practices to ensure standards of cleanliness and hygiene were maintained. The ambulances we reviewed were visibly clean, had been deep cleaned on a regular basis and had vehicle control books.
- Staffing levels and skills mixes were planned so patients received the right level of care. The service used operational employees and bank staff to fulfil staffing demands.
- Staff gave examples of providing compassionate care to patents. This was supported by patient feedback.
- All staff we spoke to reflect a passion for the service and commitment to quality.

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

- Governance: The service lacked clear governance or reporting structure. Executive team job roles, individual responsibilities and organisational structure were not clearly defined.
- Policies: There were inadequate policies and procedures available to support evidence-based care and treatment. There was no system to ensure the policies which were available contained the most up to date and relevant information. Not all polices were dated or version controlled. Protocols were introduced into the service from other providers which were not applicable to the service's structure.
- Incidents: While the service had an incident policy and incident forms available, we were not assured there was a culture of incident reporting within the service. The service had recorded no incidents in the year prior to inspection.
- Training: There was no system to ensure and monitor staff had up to date training. Staff files did not reflect that staff had completed mandatory training. Files did not reflect staff had had Mental Capacity Act and Mental Health Act training in line with policies.
- Safeguarding: The provider did not have processes to ensure staff (including the management and bank staff and the safeguarding lead) was trained to the appropriate level in line with guidance.
- Recruitment: The provider did not demonstrate a robust recruitment process. Staff files showed references were not routinely checked and Disclosure and Barring Service (DBS) checks were not in all staffing folders.

Summary of findings

- Children and young people: The provider could not demonstrate that staff had the skills, experience and knowledge or competencies to care for children and young people, although they transported a small number of children and young people during the year prior to our inspection.
- Records: Booking forms and patient records were not always complete and did not always identify risks or include an assessment of risks when the information was present.
- Secure transport operations: The service had started providing secure transport in October 2017 but had not adopted or implemented an operational policy for secure transport.

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 notices that affected patient transport services. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals London & 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)		• The service had some systems, processes and practices to ensure standards of cleanliness and hygiene were maintained. The ambulances we reviewed were visibly clean, had been deep cleaned on a regular basis and had vehicle control books. • Staffing levels and skills mixes were planned so patients received the right level of care. The service used operational employees and bank staff to fulfil staffing demands. • Staff gave examples of providing compassionate care to patents. This was supported by patient feedback. • All staff we spoke to reflect a passion for the service and commitment to quality. However, we also found the following issues that the service provider needs to improve: • Governance: The service lacked clear governance or reporting structure. Executive team job roles, individual responsibilities and organisational structure were not clearly defined. • Policies: There were inadequate policies and procedures available to support evidence-based care and treatment. There was no system to ensure the policies which were available contained the most up to date and relevant information. Not all polices were dated or version controlled. Protocols were introduced into the service from other providers, which were not applicable to the service's structure. • Incidents: While the service had an incident policy and incident reporting forms available, we were not assured there was a culture of incident reporting within the service. The service had recorded no incidents in the year prior to inspection. • Training: There was no system to ensure and monitor staff had up to date training. Staff files did

Summary of findings

not reflect that staff had completed mandatory training. Files did not show staff had had Mental Capacity Act 2005 and Mental Health Act 1983 training in line with policies.

- Safeguarding: The provider did not have processes to ensure staff (including the directors and zero-hour contract staff and the safeguarding lead) were trained to the appropriate level in line with guidance.
- Recruitment: The provider did not demonstrate a robust recruitment process. Staff files showed that references were not routinely checked and Disclosure and Barring Service (DBS) checks were not in all staffing folders.
- Children and young people: The provider could not demonstrate that staff had the skills, experience and knowledge or competencies to care for children and young people.
- Records: Booking forms and patient records were not always complete and did not always identify risks or include an assessment of risk when the information was present.
- Secure transport operations: The service had started providing secure transport in October 2017 but had not adopted or implemented an operational policy for secure transport.

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Background to Delta Medical Services Limited

Delta Medical Service Limited is operated by Delta Medical Service Limited. The service opened in 2014. It is an independent ambulance service in Maidstone, Kent. The service primarily serves the communities of Kent and Essex providing patient transport services, including cardiac care and secure transport for forensic patients. The service occasionally transported children and young people.

The service provides secure and non-secure transport services. Services are commissioned on an as necessary basis by two independent hospitals, three NHS hospital trusts, a clinical commissioning group (CCG) and a local authority. Services include transfers between hospitals, outpatient services, GPs, other medical providers, services users' residences, and with regard to secure transport only, secure units and courts.

There was no registered manager but, at the time of the inspection, a new manager had recently made an application to be registered with CQC. This process has not been completed.

The provider had not been previously inspected by CQC.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two CQC inspectors including a mental health inspector, and a specialist advisor with expertise in ambulance services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Facts and data about Delta Medical Services Limited

The service is registered to provide the following regulated activities:

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

At the time of our inspection the service transported patients including adults, children and young people and adult secure transport services. During the inspection, we visited the head office, which was also the control centre and base located in Maidstone, Kent. We spoke with seven staff including Emergency Care Assistants and managers. We also received seven 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed 46 sets of patient records.

Detailed findings

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has not previously been inspected.

Activity (January to December 2017)

- In the reporting period January to December 2017, there were 1,570 patient transport journeys undertaken. Of these, 157 were secure transport journeys.

The service employed five full time staff and 11 bank staff members. These included one Technician, eight Emergency Care Assistants and six First Aiders.

Track record on safety (January to December 2017)

- There were no never events, incidents, serious injuries or complaints reported.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The service was established in 2014 and has been registered with the CQC since 2014. It provides patient transport services to patients in the South East of England out of the headquarters in Maidstone. It works in accordance with a contract with one commissioning organisation and casual agreements with several others.

The service has five managerial /operational employees, and a bank of eleven employees who provide its operational service. These employees include first responders, emergency care assistant and a technician.

The service has six ambulances for general use, three secure ambulances and two cars.

Summary of findings

We found the following areas of good practice:

- The service had systems, processes and practices to ensure standards of cleanliness and hygiene were maintained. The ambulances we reviewed were visibly clean, had been deep cleaned on a regular basis and had vehicle control books.
- Staffing levels and skills mixes were planned so that patients received the right level of care. The service used operational employees and bank staff to fulfil staffing demands.
- All staff we spoke to reflected a passion for the service and commitment to quality.

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

- The service lacked clear governance or reporting structure. Executive team job roles, individual responsibilities and organisational structure were not clearly defined.
- There were inadequate policies and procedures available to support evidence-based care and treatment. There was no system to ensure the policies which were available contained the most up to date and relevant information. Not all polices were dated or version controlled. Protocols were introduced into the service from other providers, which were not applicable to the service's structure.

Patient transport services (PTS)

- While the service had an incident policy and incident reporting forms available, we were not assured there was a culture of incident reporting within the service. The service had recorded no incidents in the year prior to inspection.
- There was no system to monitor and ensure staff had up to date training. Staff files did not reflect that staff had completed mandatory training. Files did not show staff had had Mental Capacity Act 2005 and Mental Health Act 1983 training in line with policies.
- The service did not have processes to ensure staff (including the management, bank staff and the safeguarding lead) were trained to the appropriate level in line with guidance.
- The service did not demonstrate a robust recruitment process. Staff files reflected that references were not routinely checked and DBS checks were not in all staffing folders.
- The service could not be assured that staff had the skills, experience and knowledge to perform their duties, including caring for young people because it did not monitor check references or monitor staff training.
- Booking forms and patient records were not always complete and did not always identify risks or include an assessment of risks when the information was present.
- The service had started providing secure transport in October 2017 but had not adopted or implemented an operational policy for secure transport.

Are patient transport services safe?

Incidents

- Incident forms were available to staff, but were not being used. The service had incident report forms on vehicles. Staff we asked told us they were familiar with the forms and had seen them on the ambulances but had not used them. We spoke with staff that were able to describe the kinds of incidents that should be reported including low harm incidents and near misses. No incidents had been reported over the 12 month reporting period from January to December 2017. During the inspection we identified incidents that should have been reported under the reporting policy.
- The service reported no never events in the 12-month period prior to inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The policy around incident management did not reflect the staff that were responsible on a day-to-day basis for dealing with incidents. The service had an Incident Policy, which had a review date of 2020. The policy provided information about defining incidents and outlining roles and responsibilities for training, recording, investigating and monitoring incidents. The policy cited the Managing Director as the person with overall responsibility for ensuring implementation of the policy. However, the Managing Director was not involved in the clinical or operational part of the business. This meant the person named as responsible for ensuring clinical and operational incidents were recorded, investigated and monitored did not have responsibility for this on a day to day basis so the policy was not correct.
- There was no culture of incident reporting at the service. Managers could not be assured they were aware of incidents that were occurring and they could not use incidents as learning opportunities to improve the service. There were no records of incidents reported by any staff member for the twelve months prior to inspection. We found events that we would have

expected to see reported as incidents, for instance, where police were called, an ambulance was damaged, and a patient was not expected at the drop off point. However, none of these were incident reported and there were no records of incident reviews or learning. This meant the service could not use this information to learn when things went wrong.

- Some senior staff told us they were not assured that all staff members knew how to report incidents.
- Staff told us they did not use incident report forms but would verbally inform senior staff about concerns over patient care. They told us senior staff were available in the office or they could call the control room for support. A staff member described escalating one matter to a senior staff member and receiving advice about how to proceed.
- The duty of candour, Regulation 20 of the Health and Social Care Act 2008, relates to openness and transparency. This duty requires services of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. The service had a Duty of Candor Policy. The policy had with a review date of 2020, but no draft date. As staff had not reported any incidents in the past year the service could not be assured that the staff would know when the duty should have been applied.
- Staff told us that when things went wrong they shared this information informally with one another. However, there was no evidence of sharing information internally or with patients.Additionally, the service had no process for responding to issues highlighted by incidents and no way of ensuring that all necessary staff received communications about learning when an incident occurred.
- Staff told us they did not have a formal means of feeding back concerns to providers they contracted with if necessary. They told us they would sometimes feedback concerns to contract providers, but not always. This meant the service might not be raising concerns, which could affect care patients received from other providers.
- In response to our inspection, staff reported they were putting an incident reporting system into place. They were reporting incidents, keeping an incident log and reviewing incidents at governance meetings. We saw evidence that three incidents had been reported and discussed in the new system's first two weeks of operation.

Mandatory training

- The provider did not have assurances that staff had effective training in safety systems, processes and practices. It did not have one document where mandatory training requirements were defined. We requested a mandatory training list and were directed to the induction training policy and handbook. The policy stated the induction program would include mandatory training. The training listed in the induction program included fire training, infection prevention and control, confidentiality & information governance, manual handling, safeguarding vulnerable adults and children, securing patients and wheelchairs, resuscitation / clinical assessments.
- Staff explained the only mandatory training provided by the service was at staff induction. The induction included a face-to-face presentation of training materials relevant to the mandatory training requirements. However, the service could not demonstrate that the induction was led by a qualified trainer. This meant the service could not be assured the induction provided effective training for new starters.
- There was no system for ensuring staff were up to date with their training after induction. We saw that most staff were responsible for identifying their own training needs, organising training and submitting training certificates to the service. For example, we saw evidence of certificates for first aid, trauma, emergency driving, and pre-hospital care. However, there was no system to provide the service with assurance that staff training was up-to-date.
- Evidence of training was inconsistent. Records did not reflect all staff had relevant training and some files showed staff had training but there were no certificates to support this. This meant the service could not be assured all staff had the training required to safely and effectively transport services users.
- Senior staff told us the seven secure transport staff members all had specialised secure transport training. However, when we reviewed staff training files, we saw six out of seven staff had completed cuff intervention

and person search training and only four of seven had completed managing violence and aggression training. This meant, while only secure transport staff staffed secure transports, there were no assurances that all staff had the training required to manage secure transport users' needs.

- We saw that there were Mental Capacity Act and handcuff policies. Staff told us these were provided to staff as part of their original secure transport training. There were certificates on record to demonstrate staff had training to drive vehicles using blue lights. We were told that six staff members were trained to drive blue light vehicles. We checked two of these training files for blue light driver training certificates and saw there were certificates in both files.
- The service had identified the need to start a formal staff training program. During inspection they told us they had begun negotiations with a paramedic to provide training to staff, but they were waiting for their training certification to be awarded. We saw the service had set up a training room with a meeting area and four computer terminals so that staff would have a dedicated area to complete their training.
- In response to our feedback the service reported it was in the process of starting a new training program. Staff had developed and implemented a training matrix to monitor staff training. They had recruited a certified trainer and had scheduled the first training sessions for less than a month after our inspection. They reported the first course would include mandatory training areas including: Mental Health Act awareness level two (Level one is being completed through online learning), manual handling, safeguarding adults level 2, safeguarding children level 2, fire awareness, infection prevention and control, hand hygiene, lone working, personal safety, and company processes.

Safeguarding

- The service had safeguarding policies and procedures. However, limited training, systems and oversight of how these were managed meant the service could not be assured that patients were protected at all times.
- The service had safeguarding policies that were not always dated or version controlled and referred to outdated guidance. The service had separate safeguarding adults and children policies. The Safeguarding Adults Policy and Procedure was dated and version controlled. The Safeguarding Children and Young People Policy and Procedure was not dated or version controlled and referred to outdated guidance. The service's Reporting Vulnerable Persons Operational Procedure was not dated or version controlled.
- Staff could access basic contact information for help with safeguarding concerns in the service's Reporting Vulnerable Persons Operational Procedure which included a flowchart with contact names and phone numbers to call with concerns.
- The service was not assured that staff received effective training in safety systems, processes and practices. The service had a safeguarding mandatory training package, which included general information about safeguarding, how to identify safeguarding issues, and reporting. This was used in the mandatory safeguarding training at induction. However, the certificate staff received for the training did not identify the level of safeguarding training, senior staff were not able to say what level safeguarding training staff had and they were not able to access staff safeguarding records.
- The service was not assured the safeguarding lead had effective training in safety systems, processes and practices. The service could not provide evidence of the safeguarding lead's level of safeguarding training or that they had the training skills and experience to support staff members and patients as the safeguarding lead. This was not in line with the Safeguarding Children and Young People: roles and competencies for health care staff Intercollegiate Document 2014. This guideline requires a safeguarding lead or named professional for children and young people to have Children and Young People Level 4 training and meant the service could not be assured staff had the support necessary to manage safeguarding issues.
- Some individual staff members may have had adequate expertise with regard to safeguarding. However, the service did not have governance, systems and practices to monitor safeguarding training, manage safeguarding concerns or keep people safe.
- There were blank copies of Vulnerable Person Report forms (crew version) kept on the ambulances we

inspected. Staff told us they were aware of the forms, and gave examples of when they might raise a safeguarding concern, but had not raised concerns or used the forms.

- Staff had not raised any safeguarding concerns during the reporting period. As there were limited training, systems or practices to support staff to raise and manage safeguarding concerns, the service could not be assured the lack of safeguarding concerns was because none had arisen, rather than staff had not raised or identified them. In response to the findings of our inspection, the service submitted evidence it had stopped transporting any children and young people and recruited a new safeguarding lead.

Cleanliness, infection control and hygiene

- The service had systems, processes and practices in place to ensure standards of cleanliness and hygiene were maintained. It had an Infection Control Policy and Procedure, which was not specific to the service, referred to out of date references, for instance Health and Social Care Act (2006) rather than the up to date (2008), and did not include a draft or review date. This meant the policy could be confusing or provide inaccurate information as it referred to out of date guidance.
- We saw the service complied with their deep cleaning schedule for ambulances. We saw logs reflecting that ambulances were cleaned every six weeks (since October 2017) in line with policy.
- However, there was no evidence of additional cleaning when it was required between deep cleaning. For instance, we saw a patient report form that stated a patient with MRSA had been unwell in a vehicle. There was no record on the patient report form that the vehicle should be or had been subsequently cleaned. We asked staff if the vehicle had been cleaned after the incident and for evidence. Staff told us they believed it had been cleaned, but they were not able to provide any record of the cleaning. This meant the service could not be assured the vehicle was cleaned to ensure patients and staff were not exposed to MRSA.
- Staff told us they used a fogging machine to pump cleaning chemicals into closed vehicles at the end of a deep clean. This process was performed to ensure all surfaces were decontaminated and was meant to continue working after the cleaning was complete. Staff said only members of the management team fogged vehicles and they did this in line with guidelines. However, staff had not been trained on how to use the particular machine in use at the service and could not provide assurances they were using the fogging machine in line with guidance. This meant they could not be assured of the effectiveness of their fogging process.
- The service's offices, stores, and garage appeared to be visibly clean and tidy.
- We inspected two ambulances, which appeared visibly clean and tidy. The ambulances were supplied with gloves used for infection control when caring for patients, which were all in date.
- Cleaning equipment was stored in line with guidance. For example, there were colour coded buckets and mops with corresponding coloured handles. Medical cleaning wipes were in date and available on ambulances.
- There were infection control signs in the garage providing clear instructions about infection control processes. This meant staff had the information necessary to effectively and safely use the cleaning supplies provided.
- There was an in-date spill kit available. This meant if there was a spill staff would have the right supplies available to clean the spill efficiently and effectively.
- There was hand gel for cleaning hands in the cab of the ambulances although not in the rear of the vehicles. We saw one staff member carrying a hand held hand gel sanitiser. As we did not observe any patient care during the inspection, we are not able to comment on the use of hand gel or staff hand cleansing processes in practice.

Environment and equipment

- The service had some systems, processes and practices to ensure regular checks on ambulances took place. The service had six ambulances for general use, three secure ambulances and two cars. All vehicles had up-to-dates taxes and MOT certificates.

Patient transport services (PTS)

- Most ambulances were held in front of the ambulance station on an industrial estate or in attached garages. The secure ambulances were held at other sites. The garages could be secured although they were not secure during the day when we were on site.
- We inspected two ambulances. We saw the interiors were in good condition. There was no damage to interior and seatbelts were working.
- The service had some systems to ensure equipment on vehicles was functional but it was not clear these were always used. Staff told us they ensured equipment was working by performing user tests. Any problems would be registered in the vehicle check book and escalated. Staff would then stand down or replace the piece of equipment or vehicle with another. The faulty equipment would then be labelled. We saw the vehicle inspection and defect report book was present on both vehicles. One book was completed daily but one was new and had no entries.
- We saw the service had a designated cage where they kept equipment which was not to be used. The cage was clearly identified as containing equipment which was out of use and the equipment inside was all clearly tagged with a red tag to alert staff that it was out of use. However, we did see one piece of equipment, a stretcher, which was outside the cage and labelled as not fit for use with a white A4 page rather than a red tag.
- The service did not have systems or processes to ensure ambulances were replaced or repaired when they were damaged. One ambulance had external damage to its side and a piece of loose plastic trim. We saw the relevant motor accident report form relating to an accident on 1 February 2018. The form had been filled in, although it left out some information, and submitted to the service's insurers.
- The service kept a log of equipment and equipment servicing. Not all equipment in use had been serviced as required. We looked at two defibrillation machines. One machine was up to date with services and next due for service in August 2018. However, the second machine had been due for service in May 2017 and was still available for staff to use on the ambulance.
- There were 10 batteries available for defibrillation machines. On plugging the batteries in, nine batteries showed that they were charged. However, on one battery a notice flashed stating the battery was 'not conditioned'. This meant that the battery could fail while the defibrillator was in use.
- We reviewed seven other pieces of medical equipment and saw the servicing was up to date for six of them, but overdue for one carry chair.
- The Medicines and Healthcare Products Regulatory Agency's Managing Medical Devices (April 2015) states that healthcare organisations should risk assess to ensure that the safety checks carried out on portable electrical equipment are appropriate and reasonably practical. These include pre-use testing of new devices in addition to subsequent maintenance tests.
- We checked a random sample of devices. These had all been labelled with the dates last tested, which provided staff with a visual check that the items had been examined to ensure they were safe to use.
- There was no system to ensure staff had necessary, clean and in date equipment. We reviewed three ambulance equipment bags. Each bag raised a different concern. One bag contained pre-injection wipes that had expired in February 2017. One contained a tympanic thermometer without ear covers to utilise it. The other contained out of date triangular bandages and dirty ear covers for the tympanic thermometer. Most medical consumables were in date. We reviewed a range of medical consumable supplies and saw they were in date with the exception of three supplies including supplies in a burns kit.
- Equipment was not always available to treat all patients. Only one of the defibrillators had paediatric pads and the other did not. We saw one pack of paediatric ECG electrodes was out of date by more than two months. This meant if a staff member had to use a defibrillator on a child, they might not have the supplies to do so.
- Staff told us there was not a program for purchasing or replenishment of ambulances, equipment and supplies, but they were purchased as they were required. Staff told us they felt that the service would purchase necessary equipment although the staff member asked could not provide an example of this.

Medicines

Patient transport services (PTS)

- The service administered only two medications, oxygen and nitrous oxide. Staff explained that if a patient was bringing medicines with them, the patient or escort kept control of the medicines and they were not held, administered or managed by staff members. This was in line with Appendix 1 of the Medicines Management Policy which listed medicines carried on the ambulance as oxygen and nitrous oxide. Patient report forms (PRFs) we reviewed did not show that any other medicines were used.
- The service had a Medicines Management Policy, which was not dated and did not have a review date. This meant it might not be reviewed to include the most recent information and staff might not know if this was the latest version of the policy.
- We saw oxygen was stored on two vehicles. Both oxygen canisters had service dates and they were in date and due for servicing in 2018.
- Oxygen and nitrous oxide were stored in the garage at the service's head office in a garage that could be locked. We saw 10 bottles of nitrous oxide and 29 bottles of oxygen were stored in locked cages. The bottles were stacked horizontally on top of one another and there was no clear separation between empty and full bottles. This was not in line with British Compressed Gasses Association Code of Practice 44, 2016 Section 6.2 which stated, "Full (including part-used) and empty cylinders should be segregated within the store, the areas being identified with signage." It further stated, "Cylinders should be stored upright, when designed for this, using appropriate measures to prevent them toppling over, for example, secured by chains or lashings."
- Four bottles of nitrous oxide and four bottles of oxygen were stored upright in a separate cage. However, neither the cage, nor the garage was locked on the day that we visited. This was not in line with British Compressed Gasses Association Code of Practice 44 Section 5.7, which stated, "All stores containing gas cylinders shall be secure and access shall be restricted to authorised personnel."

Records

- Staff told us records and bookings were managed separately for secure transport and non-secure patient transport. Non-secure patient transport was managed by the control room manager who took the bookings.Patient report forms (PRFs) were completed by staff members transporting patients. The PRFs included booking information such as relevant history, risks and transfer requirements. Staff we spoke to had an understanding of what information should be on the forms and the importance of complete information.
- We reviewed thirteen patient transport booking forms and six PRFs. These were inconsistent and incomplete. We saw four of the booking forms did not record information about the requester in spaces provided including authorised person, requested by, time requested, budget code or contact telephone number.
- We saw two booking forms noted that an escort would be present for the transfer but the associated PRF did not identify an escort or document whether an escort was present.
- One PRF reviewed documented oxygen saturation levels and that oxygen was administered but did not document the amount of oxygen received. Another stated observations should be taken, but the observations were not recorded. Another stated a nurse would escort the patients but the PRF did not state whether any escort was present. Other forms included very little information about what happened on the journey. The documentation did not accurately reflect patient needs or what had occurred. This meant the documents could not be used to evidence what occurred on the journey, highlight problems or identify risk.
- The Director of Specialist Operations managed the secure transport service bookings. Staff explained that booking forms were used to transport secure patients but PRFs were not used in the secure transport of patients. We reviewed a random sample of thirty booking requests. These were completed inconsistently. Seventeen had completed booking forms, six had an email with additional information attached, and seven included an email with no booking form completed or additional information. Of the seven without a booking form or additional documents, communications were very brief and had limited risk information. This meant staff might not have the information they needed to risk assess and respond to individual secure patients' needs, which could put patients, staff or the public at risk.

- Another secure booking form reflected that a transfer was required to move a mental health patient to an outpatient appointment. The booking form stated that they, 'may be able' to offer a member of staff to assist. Senior staff explained this would have been in addition to escort staff. However, there was no specific information to tell transport staff what was required of them. This meant staff might not know what was expected of them, which could put patients, staff or the public at risk.
- We saw booking forms, job sheets and e-mails were sent securely using secure nhs.net accounts. This meant the documents were transferred in a safe manner that did not put patients' confidential information at risk.

Assessing and responding to patient risk

- Staff told us they understood how to escalate risk within the service. They said they would escalate concerns about patient risk, safeguarding, or other matters to the senior staff member in the control room. They were able to identify control room staff and how to contact them. Staff we spoke to were only able to provide one example of when they had escalated risk to a more senior staff member
- Staff told us they did not use a scoring system to evaluate the deteriorating patient but would observe the patient, ask the patient how they were feeling and take observations. Records reflected that recording of observations was inconsistent.

Secure transport

- There were no systems and processes to identify risk when taking secure transfer bookings. We saw that risk information was not always completed in the secure transfer booking forms. We looked at 30 forms. Some booking forms did not include any risk information with regard to the patient. This meant control staff might not have the information necessary to ensure they could manage the job or send the right team to manage the identified risks. Further, transport staff might not have information necessary to best identify risks and manage patients during transfer.
- When risk information was provided, there were no systems and processes to manage that risk. One booking form identified a patient with a history of violence who was currently agitated and aggressive. No further information was provided and no risk assessments were documented. This meant staff might not have the right information to manage the patient and the service would not have put protections in place to minimise the risks to staff and the patient.
- We saw one booking form where a patient had been identified at a high risk of absconding. The policy for absconding indicated a plan including staffing skill mix, gender, and training should be considered. However, there was no documentation of any plan. Senior staff told us that transferring staff performed a 'dynamic' (on site) assessment, where staff reviewed risk on site, for each transfer. However, they were not able to identify how this would be documented and we did not see documentation of 'dynamic assessments' in any documents reviewed.
- Staff explained that secure mental health patients were always escorted by a registered mental health nurse (RMN) who managed paperwork and medicines. However, there was no further evidence that RMNs were present for these transfers. The secure transport contract did not require an RMN and escort presence was not recorded anywhere, so could not be audited.
- The service had a Management of Secure Transport Services Policy and Procedure, which was provided after the inspection. It had issue and review dates and appeared specific to the service. The policy stated no patients should be handcuffed in the cell on the vehicle. This limited risk of injury to patients during transport. Staff verified that in practice patients were never handcuffed in a moving vehicle to reduce risk of injury during transport.
- Secure patients were placed in a secure ambulance with high seats keeping the patient from reaching the front. Staff told us the secure transport escort would recommend where in the ambulance the patient should be placed (whether in a cell and in which seating position) and what staff should be beside them. There was no audit of this information

Non-Secure Transport

- The service did not have systems and processes to identify and manage risk when taking non-secure

patient transfer bookings. Booking forms and patient referral forms we reviewed were inconsistent with regard to risk. They did not clearly identify risk posed or the response to risks identified.

- The service responded to patients identified as higher risk by requiring an escort. This would include any patients requiring intravenous medications, patients living with dementia, and other patients with higher care demands. Staff told us information about escorts was on booking forms. However, we saw that information about escorts was inconsistent across booking forms.
- The service did not have a system to identify high risk patients but relied on referrers to identify these patients. Booking forms did not reflect any risk assessment to determine whether escorts were required. Staff told us they relied on referrers to identify when an escort was required.
- The service did not have processes to risk assess the services they were providing. The service provided cardiac transport service to transport patients. They told us those only emergency care assistants, who had training to perform necessary observations staffed these cases. However, the service could not provide evidence on inspection that this process had been assessed for patient safety,
- Staff told us they would not transport a patient if they felt the risk was too high. They gave an example of a cardiac patient who was on medications they were not familiar with. They felt this posed too high a risk and declined to accept the patient. The local NHS trust transferred the patient instead. This provided an example of individual staff measuring risks and acting upon it when they found risks were too high for their service. However, as there were no systems and processes for risk assessment, the service could not be assured that all risks were identified and addressed.

Staffing

- Staffing levels and skills mixes were planned so that patients received the right level of care. The service had four operational employees who provided patient transport as necessary. Additionally the service used seven bank employees to fulfil staffing demands. The service had inconsistent staffing needs because health care providers used them on an as-needed basis.
- Staff explained the use of bank staff provided the flexibility necessary to staff for the demand. Records reflected the same bank staff had the same induction as other staff and were used regularly so they were familiar with the service.
- They explained that staff were scheduled to work on a rota. If demand was higher than expected, or staff were unable to fill their shift, the controller could ask other operational staff to take a call or call bank staff to assist. If they were not able to staff a given trip, they would decline the job.
- The senior clinical lead was a technician, additionally eight staff members were emergency care assistants, and six were first aiders. The role of a first aider was to risk assess, provide first aid treatment and to keep an ill or injured patient safe until more advanced medical treatment was available. These staff members were used for secure transfers with escorts.
- Emergency care assistants had more training than first Aiders. Staff explained that emergency care assistants were able to take more advanced clinical observations and administer oxygen and nitrous oxide to patients. Therefore, emergency care assistants were deployed on patient transfer and cardiac patient transport trips and with any patient who required more advanced monitoring.
- Technicians had more advanced training than emergency care assistants and the technician was the senior clinical staff member and could provide support to other staff members.
- The day we were on site we saw that two emergency care assistants were available to provide non-secure transport and four first aiders were available for secure transport.
- The service had provided five patient transfers to children and young people during the past year. There was no evidence on staff files that staff members had the training, experience or competencies to transport children or manage their specific care needs. As there were only five incidents of transport it did not appear that staff members would have maintained competencies to manage young patients if they had previously had these competencies.

- The provider could not demonstrate that all staff transporting children and young people had the competency to do so. Senior staff described how one new member of staff had competencies, but this person had only been involved in one transfer. They could not provide evidence that staff involved in the other four transfers of children were competent to do so.
- After the inspection staff informed us they had suspended care of all patients under age 18 and will only resume transport of young people when systems and governance were to support this work.

Anticipated resource and capacity risks

- The service explained they managed risk related to capacity by employing bank staff members to provide staffing for patient transfers and secure transport. They stated this gave them the flexibility to staff inconsistent workloads. Staff provided their availability to the service so that the control room manager knew who was available to work shifts a week in advance.
- The service supplied transport service using a booking method and did not provide 999 work. They were able to decline jobs if they did not have the capacity to staff them. This meant they could manage their demand to match capacity.

Response to major incidents

- There was no evidence on staff files that staff had received any training for responding to major incidents. This meant that in the event of a major incident the service could not be assured staff would be able to respond or the service would be able to provide business continuity.

Are patient transport services effective?

Evidence-based care and treatment

- Patient care, treatment and support were not delivered in line with current legislation, standards and evidence-based guidance. The service had policies that referred to out-of-date legislation and did not have specific protocols available for the care of children.
- Staff did not have access to guidelines and protocols when they were working remotely, although they could call the control centre for advice as needed.
- There was evidence that technology and equipment was used to enhance the delivery of effective care and treatment. For instance senior staff used tracking devises to track vehicles. They were able to contact patients if their vehicle was delayed and give them current information about the vehicles location.
- Staff were not able to provide clear service eligibility criteria. We saw that in response to CQC feedback the service has adopted some processes to define eligibility and minimise risk to patients since the inspection. They had started to implement a Transport Request & Escort Evaluation tool to evaluate risk posed by individual patients. The tool took the user through a series of concerns to identify if a patient was eligible for transport by this service and whether they required an escort.
- Furthermore, since the inspection, the service reported they had started to use a cardiac inclusion and exclusion chart, similar to the tool above, to evaluate risk posed by individual patients. The tool took the user through a series of concerns to identify if a patient was eligible for transport by the service, the kinds of observations necessary for the patient and whether they required an escort.
- Staff were not always made aware of patients mental health needs. Staff relied on information provided by referrers. Records we reviewed did not show the service queried referrers when incomplete or unclear referral information was provided. Staff described one incident where they did not have mental health information about a patient they were transferring from the A&E department to their home. Staff were not provided with relevant information about the patient's mental health. After an incident, staff had to contact police to ensure the patient's safety. The service had not been able to risk assess the transfer because they did not have the information necessary to do so.
- We saw the service recorded handcuff usage, cleanliness and serial numbers. This ensured that handcuff usage was documented, handcuffs were cleaned after every use, and each staff member held the handcuffs that were assigned to them.

Assessment and planning of care

- Staff told us they assessed outcomes by feedback from providers who referred work to them and patients. They

told us they generally received positive feedback from providers, although they did not keep records of this feedback. This meant that they did not have a process or structure to assess care or respond to concerns.

- There was no audit program and no audits performed to monitor quality of service and care or identify areas for improvement. This meant management of the service did not have information about how the service performed and could not use this information to identify opportunities for learning.
- Staff told us they used a pain scoring system of 1-10 to measure all patients' pain. They would ask all patients what their pain level was on a one to ten scale and document this. We did not see any pain scoring on the records we reviewed, nor was there information on the records reflecting that pain scoring was, or was not, necessary.

Response times and patient outcomes

- The service did not audit response times or patient outcomes. Senior staff told us they relied on feedback from patients and referring providers to identify concerns.

Competent staff

- The service did not have a formal process to identify development areas through staff engagement. The service did not carry out appraisals. This meant individual staff members did not have the opportunity to identify areas for improvement and request support. It also meant the service was not testing areas where staff members lacked sufficient skills and knowledge.
- The service did not have a system to monitor staff performance or practice or identify safety concerns. For instance, they did not perform documentation audits, or any other performance audit or direct monitoring. This meant the service had no formal system for collecting information about staff development areas or poor or unsafe care and did not have a system to manage these risks.
- We saw staff were required to complete an employment application including contacts for two references. The applications reviewed showed references with contact information was submitted by applicants. However, there were no references checked on any of the thirteen files we reviewed.
- Since our inspection, the service reported it had requested references for all staff and received back references for approximately 70% of staff. We were informed those without references were only working under supervision.
- We saw that ten staff files did not include information reflecting a Disclosure and Barring Service (DBS) check had been completed. DBS checks are important because they provide an employer with assurances around an applicant's criminal records which helps the service to assess risk posed by the applicant. A lack of DBS checks meant the service could not assess these risks.
- Senior staff explained, prior to inspection, they reviewed staff files and identified the gap in DBS checks. They told us they had applied for new DBS checks for active staff members. The service has since provided evidence that they have received DBS certificates for ten staff members. They have applied for the checks for seven additional staff members but have not received their certificates. Senior staff report these employees "do not work on transport or in any facility that Delta provided where by vulnerable adults may be present or confidentially information until we have copies." They had not submitted applications for three staff members as these staff members are not currently operational.
- The staff training programme consisted of a senior staff member going through a training manual with inductees. Staff members described attending the day and finding it useful. However, the service was not able to provide information about the trainer's certifications which would provide evidence about the effectiveness of training.
- There were no clinical assessments undertaken to make sure staff were competent to perform their roles. This meant the service did not have information about how the staff performed and could not use this information to identify opportunities for learning.
- The service provided some internal training after induction. For instance, we saw the service had provided training for secure transport staff including management of violence and aggression, person search and cuff intervention. However, we saw no evidence in the staff files that one of seven members of secure staff had had any of this training or two other members of

staff had had management of violence and aggression. This meant the service did not have assurances that staff had the skills and knowledge necessary to perform their roles.

- Staff told us they did not currently provide staff training directly. The service did not monitor training staff received elsewhere. Staff were responsible for identifying their own training needs, pursuing training individually and submitting certificates from training. Staff files were inconsistent with regard to training information. Some files included a variety of relevant, in date training such as emergency driving, Mental Capacity Act, and incident reporting, while some contained no certificates. Therefore, while staff might have appropriate training, the service did not have assurances that all staff had relevant training or that it was current.

Coordination with other providers

- Care was not always delivered in a coordinated way with other services. The service received referrals for jobs from health care providers that contracted with the service to provide secure and non-secure transport services. The jobs were booked on an individual basis and there was not continuity between the services provided.

Multidisciplinary working

- Staff described working closely with other professionals including taking and giving handovers to nurses in hospitals and care homes.
- Patient transport staff described working with escorts, generally nurses, to provide care on the ambulances during transfers.
- Secure transfer staff worked closely with police and other security professionals who provided escort services in the ambulance. Additionally in some cases where a police escort was required for the transfer of a patient who was held due to a mental health condition (forensic patient) to a facility, staff worked with police who escorted the ambulance.
- Secure transport staff told us they worked with nurse escorts who carried medicines and documentation if they were required.

Access to information

- We saw that information about individual jobs was communicated using booking forms. The forms did not provide clear or complete information. For instance, the arrangements for escorts and level of care needed from staff were not always defined with regard to either the secure or the unsecure service.
- Senior staff told us ambulances had navigation systems on board. The systems were used to monitor where ambulances in real time. During our inspection, staff demonstrated how they were able to monitor vehicles on a screen in the office.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure, which was in date and version controlled. The service's mandatory training policy required staff have Mental Capacity Act Training.
- The service included Mental Capacity Act and Deprivation of Liberty Safeguards in their mandatory training requirements. However, the induction timetable in the induction policy did not include this training. Senior staff told us Mental Capacity Act training did occur at induction, but there were no systems to ensure the quality of training or that staff were up to date with this. One staff member told us they had received this training during the corporate induction.
- The policy required staff to perform best interest reviews to assess mental capacity. However, it was not clear from the training documents provided that staff had the skills, knowledge or expertise to perform these reviews or that it was within the scope of their job to do so. Senior staff we spoke to could not identify any specific training provided to staff to perform these reviews.
- We reviewed 13 staff files for training information. Records only reflected one staff member had completed Mental Health Act or Mental Capacity Act Training. This meant the service could not be assured that staff had the skills and knowledge necessary to assess and manage patients with capacity or mental health concerns.

Patient transport services (PTS)

Are patient transport services caring?

Compassionate care

- Staff gave us examples of how they provided compassionate care. Staff described communicating with patients living with dementia to establish what would make them most comfortable during their journey and putting handcuffed patients into gloves so that other people would not see the cuffs.
- Prior to inspection, CQC asks patients to provide feedback about the care they have received from a provider. We received seven cards back from patients who used the service in January or February 2018. All of the feedback was positive.
- The service also collected patient feedback in the form of an internal patient survey. We reviewed eight pieces of feedback from the survey, which were all positive noting staff were "professional", "caring" and "helpful". One user stated on the service's feedback form, "I was treated with the greatest respect." Another said, "I have never felt safer in an ambulance and would feel privileged to travel with [the service] again. They made a terrifying moment in time memorable for the right reasons."
- Patients said they were likely or very likely to recommend the service.
- Staff told us they usually received very positive feedback with regard to the service provided. They told us this feedback was verbal and was not recorded in any way.

Understanding and involvement of patients and those close to them

- A staff member described helping a patient's daughter to identify and address the patient's care needs by helping her to get a carry chair she needed for short-term use.

Emotional support

- One patient's family member fed back that they appreciated a staff member allowing the patient to use the staff member's personal mobile to contact their spouse from the ambulance.

Supporting people to manage their own health

- Staff took action to support patient to manage their own health and risks. One staff member described ensuring that patients' home personal alarms were in working order and were activated before they left the patient at home. Another described ensuring patients had a care package in place and alerting control and the hospital if there were any problems.

Are patient transport services responsive to people's needs?
(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The service had one contract to provide secure transport work on an as necessary basis. Otherwise, it received work from several trusts and hospitals. Referrals came directly from these service providers. The service did not contract with local NHS Ambulance Services.
- The service identified areas where they believed there was demand for the service, for instance, patient transport and secure services. The service was not currently providing any other services although they had identified other areas where they believed there might be opportunities in the future.

Meeting people's individual needs

- There were some processes to meet patients' individual needs. For instance, staff described mental health patients traveling by secure transport having a registered mental health nurse present to respond to the patient's specific needs. However, this was not recorded or audited to demonstrate that it always happened. However staff provided examples of incidents when they stated they did not have specific guidance to follow when working with mental health patients and that they followed their understanding of how to work with the patients based on previous experience.
- Staff described how they adapted care for patients living with dementia. This included, "treating the patient not the illness", communicating with patients and verifying

understanding, working with an aggressive patient to calm their "lashing out", recording issues in notes and reporting concerns to staff when they dropped of the patient.

- We saw that there was no information on secure booking forms to identify whether male or female staff was necessary or preferable for a given patient. Staff told us they had one female member of staff for secure transport. They told us they would transfer female patients with two male staff members if there were a female escort.
- After the inspection, the provider gave us a new document Management of Secure Transportation Services Policy and procedure which stated, "All female patients should be transferred using a female escort." We saw that bottles of water were kept on the ambulance for patients.
- Staff told us that they had not had to manage communications with people who did not speak English as a first language. If they needed to, staff told us one staff member had access to the language line system and could access telephone interpreting if necessary. All other staff members would use an online translation app if necessary.
- We saw that information was available to patients on the vehicles. For instance, we saw a pamphlet providing information about the service as well as patient feedback forms.

Access and flow

- The service provided planned patient transport services. In Transport was planned in advance or booked on the day if that service was required. Staff explained that this meant they could manage staffing according to demand. Senior staff explained that there was a process for booking patient transport. The provider that needed the transport would send an email or form or call the service to book. The person booking could be a staff member from the hospital, a care home, or other provider contacting the service.
- Based on information provided the service would accept the job if they had staff available. The control room staff were aware which staff members were available to work because they requested availability information weekly from staff and bank staff for the following week. This information was kept in an availability book.
- If a provider requested transport and the service did not have enough people on the rota, they would text staff to see if anyone was available to perform the transport. If they were to find cover, they would accept the job.
- The service did not audit timeliness. Staff told us they were sometimes late due to traffic or other circumstances. In this case, they managed expectations by contacting patients or contracting providers to let them know there was a delay. They advised that they would expect to have complaints if ambulances were late, but they had not had any complaints.

Learning from complaints and concerns

- The service had a Compliments and Complaints Policy and Procedure, however it did not have a draft or review date. It assigned responsibilities to staff roles the service did not employ, for instance Director of Operations and Chief Medical Officer. This meant the complaints policy was not applicable to the service and did not provide management or staff with a framework and guidance about managing complaints and concerns.
- There were no systems or processes to ensure learning from complaints was identified or shared with staff. Further, it did not provide any process for doing so.
- The service reported they had received no complaints during the previous year.
- We saw that there were posters in the ambulances explaining how to make a complaint and feedback forms were available on the ambulances.

Are patient transport services well-led?

Leadership of service

- The service did not have a clear leadership structure with defined lines of accountability and responsibility. Before the inspection, the service submitted an organisational chart showing the managing director was

the senior accountable person for the service. The managing director directly managed the director of specialist operations who in turn managed the senior management team.

- The senior management team included the director of specialist operations, senior operations manager, control room manager, and operational support manager.
- According to senior staff members this was not the way the management structure worked. Staff explained the managing director was primarily involved in financial aspects of the business, not clinical or operational aspects. They received reports about when things went wrong but devolved responsibility for the running of the service to the senior management team. The director of specialist operations and senior operations manager were the senior managers managing operational and clinical issues.
- Staff told us the director of specialist operations had set up and held responsibility for the secure services, the control room manager was responsible for patient transport services and the senior operations manager was responsible for governance. However, these roles' accountability, responsibilities and reporting lines were not defined.
- The senior clinical staff member was a technician. Senior staff told us that he was responsible for clinical decisions. There was no structure to reflect the senior clinical staff member's responsibilities as the senior clinician. There was no formal assessment of the staff member's skills, experience and competencies to perform this role. This meant the service did not have assurances the clinical lead was able to perform this role.
- In response to our inspection, the service drafted a new, more accurate organisational chart with the director of specialist operations having oversight for clinical and operational aspects of the business. The managing director retained management of financial matters.
- Staff members we spoke to told us that members of the senior team were visible and accessible. They told us they saw them regularly. Staff stated senior staff members were supportive. They gave examples of when senior staff had provided business and logistical support. They stated they had not needed to request clinical guidance during the reporting period. However, they told us they would turn to the control room manager, the senior clinical lead, with clinical or operational concerns including safeguarding.

Vision and strategy for this this core service

- There was not a clearly defined vision, values or strategy to define and direct current care or future development.The original owner started the business as a response to poor care they received during a patient transport journey. They believed they could provide a better service with patient care at the centre of the service. Staff we spoke to at all levels told us this story about the business beginning and explained that it defined the values for the care they provided

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

- The service did not have an effective governance framework to support the delivery of safe and effective care. The service did not have local policies which were current and applicable to the service. It did have some policies, but they were not all current and often referred to roles or departments that did not exist in the service. This meant the service did not have arrangements to communicate how the service worked and staff could not access information about what was expected of them or how to perform their roles.
- Staff were not always clear about their roles and accountabilities. Although the service's policies named the managing director as the person with overall responsibility for health and welfare of employees and patients, the managing director stated they were not responsible for safety and were not able to describe risks to the service.
- The service's management structure did not define senior managers' individual governance accountabilities. Senior staff members were not always aware of which member of the senior management team was responsible for issues around risk and governance.
- The service did not have management meetings, governance meetings or any formalised senior meetings. Staff told us that senior staff met informally to

discuss business matters. These meetings were not minuted. This meant the service did not have effective governance meetings to evaluate the quality of the service.

- Staff told us they had a medical director who was a paramedic but not a member of staff or regularly involved in the service. However, this was an informal relationship between the paramedic and a senior staff member. There was no formalised agreement or contract for services with the clinical lead. Senior staff told us if they needed to liaise with the paramedic, they would have an informal meeting with the operational support manager. There was no further documentation of the relationship and no minutes or other documentation of clinical or operational discussions with them.
- The service had no process, system or structure to provide assurances or measure quality, performance or effectiveness. For instance the service did not use audits or other reviews to assure itself that staff were competent to perform their roles or were working in line with policies. There was no internal and clinical audit program to monitor quality of service and care or identify areas for improvement.
- We observed that in the past months the senior team had identified some areas which needed development and begun to implement change, for instance with regard to governance, DBS checks, redrafting the PRF form and mandatory training.
- In response to our findings, the service told us it had begun implementing systems and processes to manage the services risks. To this end, they had employed a governance manager/ head of risk. They had started weekly governance meetings (and provided minutes from the first two meetings), incident reporting and maintaining an incident log.
- The service did not have a means to identify and manage risks. For instance, whilst it had an incident reporting system, it did not have an incident reporting culture, no incidents were reported during the reporting period and the service could not use this information to identify and reduce risks.
- The service's policies did not support management of risk. Policies were not specific to the service and referred to senior staff roles and departments, which were not part of the service. Additionally, some policies referenced out of date guidance and were not dated or version controlled as outlined throughout the report above.
- Although they submitted a risk register, it did not reflect the service's actual risks. Senior staff told us that the risk register had been created by a previous staff member and was not currently being used by the service. Some senior staff members did not know there was a risk register. Further, it was not arranged to monitor risk as it did not include actions for improvement, action owners or action dates to foster the monitoring and mitigation of risks.

Culture within the service

- The service had experienced significant change to the senior management team in recent months. One senior member of staff had left and three members of the four-member senior management team had come to the service. Staff reported that the changes had had a positive effect on the culture of the business.
- Staff we spoke to were enthusiastic about the service. All staff talked about building positive culture. They described a service they were proud of that supported them to progress.
- Staff told us there was an open and honest culture and they felt that they were listened to and could turn to senior management with concerns they might have.
- Senior staff told us they encouraged positive staff attitude by implementing changes staff wanted such as changes such as regular shifts and ensuring they were stocked with supplies.

Public and staff engagement (local and service level if this is the main core service)

- There were no engagement meetings or forums with staff or public and no other formal or documented interactions with staff or public.
- Staff told us they were able to speak to the senior management in an informal setting on a regular basis. Senior management told us they informally engaged with staff about internal matters and change.
- We saw that the service had 'Great Ideas Start Here' forms available for staff to provide 'comments,

suggestions and concerns' to the management. However, senior staff told us this was a new initiative and they had not received any complete feedback forms yet.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12** 1. Care and treatment must be provided in a safe way for patients. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— A. assessing the risks to the health and safety of patients of receiving the care or treatment; B. doing all that is reasonably practicable to mitigate any such risks; C. ensuring that persons providing care or treatment to patients have the qualifications, competence, skills and experience to do so safely. **How the provider was not meeting this regulation:** **Regulation 12(2) (a & b) The provider does not have systems to ensure they collected individual risk patient's information so they could assess and mitigate risk posed by and to users. Records we saw included inconsistent information about risk.** **The provider does not have systems to assure that staff understood incident reporting and were reporting incidents in line with policy. Staff had not recorded incidents during the reporting period although they provided information about incidents that should have been reported.** **The provider does not have systems to ensure they assess, manage and mitigate risk. For instance, while the provider had a risk register, senior staff told us it was not in use.**

This section is primarily information for the provider

Requirement notices

Regulation 12(2) (c) There was no current training program and the service did not have a system to monitor staff training needs. The staff files did not include all training certificates or other evidence to reflect the staff had completed training.

There were no systems to provide assurances that staff had qualifications, competence, skills and experience to practice safely. Staff files reflected that references were not taken for staff members and there was no evidence of DBS checks on 10 staff files.

The service was not able to provide evidence or assurance that staff treating children and young people had the skills and expertise to do so.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 Safeguarding patients from abuse and improper treatment 1. Patients must be protected from abuse and improper treatment in accordance with this regulation. 2. Systems and processes must be established and operated effectively to prevent abuse of patients. The provider did not have systems or processes to ensure that staff had safeguarding training, in line with national guidance, to effectively prevent the abuse of patients. The provider did not have systems or process to ensure the safeguarding lead had safeguarding training, in line with national guidance, to effectively prevent the abuse of patients.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 Staffing

1. Persons employed by the service provider in the provision of a regulated activity must—
2. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.
    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.

How the provider was not meeting this regulation:

The provider did not have assurances all staff carrying out regulated activity held up-to-date mandatory training in key areas.

The provider did not have assurances all staff providing transport for children and young people had the training, professional development, supervision and appraisal as is necessary to enable them to carry out theses duties.

The provider did not have assurances all staff carrying out regulated activity had an annual appraisal.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17, (1), Good governance, of The Health** **and Social Care Act 2008 (Regulated Activities) Regulations 2014.** The provider did not have a management structure that provided oversight or ensured compliance with the Health and Social Care Act 2008 or other regulations. The provider did not have a clear organisational structure. The job descriptions for senior staff did not clearly define their roles. There were no formal management or governance meetings. There were no staff meetings or other staff wide communications to share information with staff. The provider did not have a governance framework that provided oversight or ensured compliance. The risk register did not identify risks specific to the provider or identify actions, timeframes or action owners to address risks. The service did not carry out audits on booking forms, patient records, vehicles, equipment or incidents. The provider did not have an incident policy or procedure that provided meaningful guidance to staff or a system to monitor

This section is primarily information for the provider

Enforcement actions

incidents or ensure they were recorded.

The service did not maintain records for staff training.

The provider had policies which were not applicable to the service and/or did not provide guidance or assurances.

The service had started providing secure transport in October 2017 but had not adopted or implemented an operational policy for the secure transport and did not have a clear governance structure for secure transport.

Patient documentation including Patient Record Forms (PRF) and booking forms were inconsistent and lacking information.