A&E Life Support Ltd

Quality Report

15 Forythia Drive
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Date of inspection visit: 4-5 November 2019 and 25 November 2019
Date of publication: 20/01/2020

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

Ratings

Overall summary

A&E Life Support Ltd is an independent ambulance service that mainly provides patient transport services across the North West region. This includes transport of patients detained under the Mental Health Act (1983).

The service also provides emergency services for patients that may require transport from events to a hospital. This is only a small part of overall activities.

We carried out a focussed responsive inspection at the provider's premises in Blackburn, Lancashire on 4 and 5 November 2019. We took enforcement action and issued the provider with an urgent suspension notice on 8 November 2019. We also carried out a follow up inspection on 25 November 2019.

We carried out a focussed responsive inspection because of concerns identified following a registration inspection of the service in September 2019. We also received concerns about the service through our routine monitoring of enquiries and concerns from members of the public and other stakeholders.

We inspected specific key lines of enquiry for safe, effective and well-led. We did not inspect caring and responsive as part of this inspection.

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 rate

We did not rate the service because this was a focussed responsive inspection. We found the following issues that the service provider needs to improve:

- The service did not provide mandatory training in key skills to all staff and did not make sure everyone completed it.
- Patients were not always protected from potential abuse because not all staff had been trained on how to recognise and report abuse.
- The service controlled some infection risks. Whilst staff kept equipment and the premises visibly clean, staff did not receive formal training in infection prevention and control and the service did not carry out audits to monitor infection control processes.

Summary of findings

- We were not assured that all equipment used by the service for providing care or treatment was safe for such use. The service had not carried out suitable assessments of the premises to ensure they were safe. Compressed gas cylinders were not securely stored, or risk assessed to ensure they were safe.
- Staff did not complete and update risk assessments for each patient to remove or minimise risks.
- The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not keep detailed records of patients' care and treatment. Patient care was not planned to take into account patient's individual needs.
- The service did not make sure all staff were competent for their roles. Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development.
- Staff did not always support patients to make informed decisions about their care and treatment. National guidance to gain patients' consent was not always followed because there were no records to demonstrate if consent had been sought. The service had no records to show whether staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Whilst leaders had the skills and abilities to run the service, we were not assured they managed the priorities and issues the service faced effectively.
- The service did not have a formal documented vision for what it wanted to achieve or a formal strategy to turn it into action.
- Leaders did not operate effective governance processes. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service. The service did not have effective processes in place for assessing the suitability of company directors.
- The service did not have systems to manage performance effectively. There was no process in place to manage risk. Staff did not identify and escalate relevant risks and issues or identify actions to reduce their impact.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also took urgent enforcement action against the provider and issued an urgent suspension notice on 8 November 2019 because we identified significant concerns that posed a potential risk of harm to patients. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North Region), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services		The main activity provided by the service was patient transport services. The service also provided emergency services for patients that required transport from events to a hospital. As this was only a small part of overall activities, this has been reported under patient transport services. We did not rate the service because this was a focussed responsive inspection.

Summary of findings

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Summary of this inspection

Background to A&E Life Support Ltd

A&E Life Support Ltd has been registered with the Care Quality Commission (CQC) since June 2016. The provider's registered address is 15 Forythia Drive, Clayton-le-Woods, Chorley, Lancashire, PR6 7DF.

As part of its registration, A&E Life Support Ltd has one registered location; Event City, Barton Dock Road, Urmston, Manchester, Lancashire, M41 7TB.

Since February 2019, the service has been operating from another location; Units 5/6, Point 65 Business Centre, Greenbank Way, Blackburn, Lancashire, BB1 3EA. This location has not yet been registered by the service.

The service has not had a registered manager in place since 16 February 2018 when the previous registered manager cancelled their registration. An application for a new registered manager has been submitted to the Care Quality Commission (CQC) in May 2019 but this was refused in October 2019. The service is in the process of submitting a new registered manager application with the CQC.

Our inspection team

The team that inspected the service on 4 and 5 November 2019 comprised of a CQC lead inspector, one other CQC inspector and a CQC enforcement inspector.

The team that inspected the service on 25 November 2019 comprised of a CQC inspection manager and a CQC inspector.

The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about A&E Life Support Ltd

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

During the inspection on 4 and 5 November 2019, we visited the premises at Blackburn, Lancashire. We spoke with the nominated individual and looked at five ambulance vehicles. During our inspection, we reviewed 60 sets of patient records and looked at policies and other records held by the service.

During the follow up inspection on 25 November 2019, we visited the premises at Blackburn, Lancashire. We spoke with the nominated individual and looked at the premises and ambulance vehicles. We also reviewed records held by the service.

We carried out a review of the service prior to the inspection because a CQC registration team inspection of the service in September 2019 identified concerns about the services provided. We also received concerns about the service through our routine monitoring of enquiries and concerns from members of the public and other stakeholders.

This was the first time we have inspected this service since registration with CQC in June 2016.

Activity (January 2019 to October 2019)

- In the reporting period January 2019 to October 2019 there were at least 60 patient transport journeys undertaken. This included the transport of patients detained under the Mental Health Act (1983). This included one patient aged under 18 years.
- There were at least two patients transferred to hospitals from events in the reporting period and these were adult patients.

Summary of this inspection

The service was managed by the nominated individual (also the operations director). The service had appointed a finance director and a business director in October 2019. The nominated individual and one other staff member were involved in the non-emergency transport of patients with mental health conditions. The service also had five additional staff that were involved in events cover. The nominated individual was directly employed by the service. All other staff had other substantive employment and mainly worked for the service on a contractual basis.

Track record on safety (November 2018 to October 2019)

- No never events
- No serious injuries or incidents
- No incidents

Patient transport services

Safe	
Effective	
Well-led	

Are patient transport services safe?

We did not rate safe for the service as this was a focussed responsive inspection.

Mandatory training

The service did not provide mandatory training in key skills to all staff and did not make sure everyone completed it.

The service had a staff training and development policy that outlined the process and responsibilities for staff training and development. The policy did not provide details of the training requirements for staff working within the service. The policy did not define the type of training required for staff, the frequency of this training or how training completion would be monitored.

The nominated individual managed the training and development processes for the service. Training and recruitment records for staff working at the service were maintained on an electronic system. We also found paper-based training records were maintained for two members of staff.

During the inspection, we looked at the electronic and paper-based training records for two staff that were involved in the non-emergency transport of patients with mental health conditions. We also looked at the training records for an additional five staff that were involved in events cover and the record for the finance director.

We found some evidence of training in areas such as mental health and first aid. During the inspection, the nominated individual was unable to provide evidence to demonstrate the mental health training (May 2019) course materials reflected current best practice guidelines. We carried out a follow up inspection on 25 November 2019 and were provided with information to show the content of the mental health training course was suitable and reflective of the services provided.

The training records we looked at did not show evidence that staff had received formal training in key topics such as information governance, infection control, equality and diversity, manual handling, medicines management or health and safety contrary to relevant requirements.

We only found evidence of life support training in three of the files we looked at. We also found that where training had been completed, this was not recent or up to date. For example, the records for one staff member showed conflict resolution training and ambulance driver training had been completed in 2009 as part of their previous role. There was no evidence to show this had been updated.

The nominated individual told us they were in the process of recruiting additional staff and planned to put in place a system for mandatory training for new starters, as part of their induction process. However, it was not clear if this process would include training for the existing staff.

Safeguarding

Patients were not always protected from potential abuse because not all staff had been trained on how to recognise and report abuse.

The service had a safeguarding policy that provided guidance for staff on how to identify and report safeguarding concerns for vulnerable adults and children. The nominated individual had contact details for local authority safeguarding teams in the localities the service operated from. The nominated individual told us there had been no safeguarding incidents reported by the service in the past 12 months.

The nominated individual and one other member of staff were involved in the transport of patients with mental health conditions.

The nominated individual was the safeguarding lead for the service and had completed children's safeguarding (level three) training in November 2016 and adult's safeguarding (level two) training in October 2019.

Patient transport services

At the time of our inspection, we found the nominated individual's training was in line with Intercollegiate Document 'Adult Safeguarding: Roles and Competencies for Health Care Staff': August 2018 and Intercollegiate Document 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019'.

We found no evidence the other staff member involved in the transport of patients with mental health conditions had completed adult or children's safeguarding training. The nominated individual was unable to provide evidence of training for this individual during the inspection.

We looked at the training records for an additional five staff that were involved in events cover and may be involved in transferring patients off site. We found one individual had completed safeguarding children training (dated October 2016) and another individual had completed safeguarding adults level one training (January 2018) and safeguarding children level one training (December 2017). There was no further evidence to show staff had completed adult or children's safeguarding training.

We also found there was no evidence to show female genital mutilation (FGM) training or 'prevent' (anti-radicalisation) training had been completed by all staff.

We carried out a follow up inspection on 25 November 2019 and were not provided with any further evidence to show further safeguarding training had been completed.

Cleanliness, infection control and hygiene

The service controlled some infection risks. Whilst staff kept equipment and the premises visibly clean, staff did not receive formal training in infection prevention and control and the service did not carry out audits to monitor infection control processes.

There had been no cases of Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, Clostridium difficile (C.diff) or Escherichia coli (E. coli) reported by the service in the past 12 months.

We found staff had not completed formal or mandatory training in infection prevention and control.

The service had an infection prevention and control policy which provided guidance for staff on hand hygiene, personal protective equipment, aseptic non-touch technique and management of sharps.

There was a cleaning schedule in place which provided instructions for staff on cleaning ambulance vehicles and equipment. The nominated individual told us staff cleaned the ambulance vehicles and equipment. However, we found no records (such as completed cleaning checklists) to demonstrate staff had cleaned vehicles or equipment and how often this had been done or how this was checked.

The ambulance vehicles we inspected were visibly clean and tidy. The nominated individual told us staff cleaned the vehicles using chlorine based cleaning solutions and equipment was cleaned in between use using disinfectant wipes. We found the ambulance vehicles included spillage kits for cleaning up spills from bodily fluids (such as vomit).

Clean linen was available in each vehicle and was appropriately stored in cabinets to protect from exposure to air-borne particulates in the open environment. The nominated individual told us soiled linen was segregated in bags and exchanged for clean linen from NHS hospitals the provider worked with.

There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. Portable sharps bins were available in each vehicle we inspected. The service had an arrangement with an external contractor for the removal of clinical waste.

We saw evidence the ambulance vehicles had undergone a deep cleaning process (process involving steam washing of interior of vehicles). Records showed four of the five ambulance vehicles had undergone deep cleaning on 11 October 2019 and the next scheduled deep clean was on 22 November 2019. The nominated individual was unable to provide evidence to show vehicles had undergone deep cleaning prior to 11 October 2019 even though the service had regularly used at least one of these vehicles during the past 12 months.

There was no formal infection control audit process in place for monitoring compliance with infection control processes. The service did not carry out hand hygiene audits.

The nominated individual was the infection control lead for the service but was not aware of duties relating to infection prevention and control lead, as outlined in national infection control guidelines (The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance).

Environment and equipment

We were not assured that all equipment used by the service for providing care or treatment was safe for such use. The service had not carried out suitable and detailed assessments of the premises to ensure they were safe. Compressed gas cylinders were not securely stored, or risk assessed to ensure they were safe.

The service operated from a location based at Blackburn, Lancashire. The premises consisted of an office area with an adjacent room used for equipment storage. The nominated individual told us they had access to a training room and toilet facilities located at the rear of the premises. We found the premises were clean and well maintained.

We saw a lease agreement which showed the provider had leased the premises in Blackburn, Lancashire since 15 February 2019.

We saw an electrical safety certificate for the premises and a fire equipment testing certificate for the premises had been completed. These certificates were located on a notice board at the back of the premises. The nominated individual told us they had not previously requested these or any other safety certificates or risk assessments relating to the premises from the landlord to assure themselves the premises were safe.

We saw fire extinguishers on the premises and on the vehicles were stored securely and had been serviced, we also saw information displayed relating to fire evacuation points at the premises. Health and Safety Executive guidelines advise that employers (and/or building owners or occupiers) must carry out a fire risk assessment and keep it up to date. Based on findings of the assessment employers must ensure adequate and appropriate fire safety measures are in place to minimise the risk of injury or loss of life in the event of a fire. Part of the risk assessment should identify what could cause a fire to start and who might be at risk. We saw evidence provided a fire safety certificate for the equipment but there was no fire risk assessment undertaken by the service.

The nominated individual was unable to show evidence of risks assessments or records for health and safety, gas safety, water supplies safety or fire risk assessments in relation to the premises during our inspection on 4 and 5 November 2019.

We carried out a follow up inspection on 25 November 2019. The nominated individual provided us with a health and safety risk assessment dated 1 April 2019 and a company vehicles assessment dated 1 April 2019. The nominated individual did not provide any further evidence in relation to gas safety, water supplies safety or fire risk assessments.

We looked at the health and safety assessment. This was a general policy document which outlined the action and arrangements in place in relation to emergency procedures, maintaining safe working conditions and preventing accidents. This did not include specific details on how health and safety risks were managed. For example, in the section for preventing accidents, the documents stated, 'ensure safe clean environment for staff'. There was no supporting assessment of how risks that could cause accidents in the premises or ambulance vehicles were identified and mitigated.

The equipment storage area was cluttered with sterile items and equipment stored on shelves as well as several items (such as grab bags and equipment used for training) placed on the floor.

We found one pack of blood glucose test strips and several swabs that had expired in a grab bag that the nominated individual stated was ready for use. This bag also included single use sterile tubing and wound dressings that were not kept in their sterile packaging.

We looked at items stored in plastic storage shelves that were labelled with the minimum expiry date and found several items such as sterile wound dressings, burns kits, cannulas and tubing that were expired or not kept in their sterile packaging.

The nominated individual told us staff carried out a weekly audit to check and remove expired items, but this had not been done correctly. We saw a weekly equipment check

sheet that showed five instances between 30 September 2019 and 1 November 2019 where staff had checked and signed to indicate there were no items or equipment that had expired.

During the follow up inspection on 25 November 2019 we found that expired sterile single use items had been discarded or used for staff training purposes.

We found medical gasses stored at the premises, including three empty oxygen cylinders and two nitrous oxide and oxygen cylinders (Entonox). These were all C size cylinders that were stored horizontally on metal shelves (as per manufactures guidelines) in the equipment store area. The full and empty cylinders were segregated; they were not chained or clamped to prevent them from falling over or off the upper shelves where they were stored. The provider was not following the health and safety executive most up to date guidance for the storage of oxygen cylinders and the British Compressed Gasses Association guidelines.

There were no records or evidence from discussions with the nominated individual during the inspection on 4 and 5 November to demonstrate appropriate risk assessments had been carried out for the storage and transport of medical gas cylinders.

During the inspection on 25 November 2019 the nominated individual showed a medical gas cylinders risk assessment dated 1 April 2019. Whilst this provided some evidence that medical gasses (such as oxygen) were stored in line with manufacturer recommendations, we found this was not a comprehensive risk assessment and did not assess the risk of when transporting oxygen and mitigating actions.

There was a small sluice room located next to the toilet facilities. This contained cleaning items such as mops, buckets and disinfectant. This room did not have a separate hand wash sink; the nominated individual told us staff used the sink in the bathroom adjacent to the sluice room for hand washing.

The service had five vehicles at the time of the inspection and these were parked in a secure parking area at the premises. The nominated individual told us one ambulance was for providing non-emergency patient transport services for mental health patients, one emergency ambulance vehicle was used for events and three patient transport ambulance vehicles had been recently purchased and were not yet in service.

The vehicles were locked when not in use and vehicle keys were kept securely in the office area. The age of the vehicles ranged from six years to 11 years old.

Records showed the vehicles had appropriate MOT, tax, service and insurance certificates in place. The three recently purchased vehicles and the ambulance vehicle used for events were not in operation at the time of the inspection and required some repair work. For example, one of the recently purchased vehicles had a damaged window that was awaiting repair. We inspected each vehicle and found these were generally well maintained.

The nominated individual confirmed vehicle faults and breakdowns were monitored and any vehicle with frequent issues would be decommissioned and replaced.

We saw that equipment such as chairs, stretchers and slide sheets were well maintained and within service dates. There was an arrangement with an external contractor to service equipment on an annual basis and we saw evidence equipment such as automated external defibrillator (AED) devices had been serviced within the past 12 months. Equipment and single use items were available for both adults and children.

There were no records to show if staff carried out vehicle checks to confirm the vehicles were fit for purpose and stocked with the correct equipment and consumable items.

Assessing and responding to patient risk

Staff did not complete and update risk assessments for each patient to remove or minimise risks.

The main activity carried out by the service was the non-emergency transport of patients with mental health conditions. This included patients detained under the Mental Health Act (1983). The nominated individual told us all patients requiring transport were referred by 365 response (an external referral and booking provider).

We found evidence to show there had been at least 60 patient journeys undertaken by the service involving the transport of patients with mental health needs between 23 January 2019 and 25 October 2019.

We looked at 60 booking referral records which showed the service had transported potentially vulnerable patients

with high risks identified in the booking form from the referring organisation. This risks included risk of absconding, risk of self-harm and risk of violence and aggression.

The referral forms identified patients with specific needs such as known infection risks, risk of suicide, self-harm or absconding. The referral forms indicated if any additional persons were required to accompany the patient during the ambulance journey, such as escorts or carers. This information was completed in the form of tick boxes. We saw no evidence that staff carried out any additional risk assessments to identify and mitigate any patient risks. The nominated individual told us they used the details on the referral form as the risk assessment and did not maintain written records for any additional risk assessments.

The service had a mental health policy which provided guidance for staff on how to manage the transport of patients with mental ill health.

The service type specification outlined the expectations of external referring organisation for providers for mental health transport services. The clinical triage section within the service type specification clearly stated: "The provider will then undertake a mental health risk assessment on the journeys requirement as part for the transport pathway." This indicated there was an expectation for the provider to complete risk assessments as part of the service type specification requirements. We found no documented evidence such risk assessments were completed by the service.

The booking forms included a section titled 'risk assessment'. The top of the page of this section included the following statement: "365 response are not responsible for carrying out any risk assessment, or in any way triaging the requirements of the service user, the information below will be passed to the provider to inform their risk assessment and subsequent choice of resource".

This indicated there was an expectation that the service carried out their own patient risk assessment. We found no documented evidence such risk assessments were completed by the service.

There was no record of on-going risk assessments undertaken by staff or records of observations during the patient journey. The nominated individual gave examples of dynamic risk assessments through staff practice, such as where a patient became agitated during the journey and required restraint. The nominated individual gave examples of where handcuffs had been used us they were only used when transferring from the pickup location to the vehicle and not during the journey. The referral records we looked at showed there were at least two instances where patients referred were identified as requiring handcuffs. The nominated individual told us there were no written records to evidence any interactions between staff and patients or how risks were managed and how the decision for use of restraints was risk assessed and authorised.

We saw there was an emergency ambulance driver policy in place. The nominated individual told us there were two staff members that were qualified to drive ambulance vehicles, including the nominated individual and one other staff member. The nominated individual told us he was the main driver of ambulance vehicles and the other staff member only provided events cover and did not routinely drive ambulance vehicles.

Staff records showed both individuals had suitable category C1 driving licences in place (required to drive ambulance vehicles). However, the staff records we looked at only included copies of photocard driving licences and did not show if driver history (such as driving points and penalties) were checked as part of the recruitment process.

The nominated individual told us there had been no recent driver competency assessments carried out to assess the competency of any staff driving ambulances. The nominated individual provided evidence to show his driver competencies, however these were dated 2009 as part of the nominated individual's previous role in an NHS ambulance trust.

We saw the ambulance vehicles were equipped with safety harnesses and anchorage points for securing wheelchairs. The vehicle for transporting patients with mental health conditions was a secure celled vehicle. The nominated individual told us this was formerly a Police vehicle.

The nominated individual told us during the inspection there was no written risk assessment (such as for ligature risks) for the vehicle used for transporting mental health patients. Following the inspection, the provider submitted evidence to show a risk assessment had been completed in April 2019 for ligature risks and anchor points. This risk assessment identified two hazards; ligature risks and anchor points. For ligature risks the mitigation stated,

'category B home office approved cell section of the vehicle has no ligature points.' For anchor points the mitigation was that service users would be accompanied and monitored by staff.

We found this document demonstrated some level of risk assessment had been undertaken. However, the risk assessment was not comprehensive and consisted of a brief statement that stated there were no ligature risks. This did not show evidence that a detailed ligature risk assessment had been carried out.

We looked at the service type specifications from the external referring organisation which detailed the requirements for providers transporting mental health patients and non-emergency patient transport. These detailed patients that would be excluded for transport by the provider, including: -

- An emergency level response requirement requiring the senior clinical skills of paramedics.
- A journey where clinical interpretation of observations is required (i.e. over and above recording of observations during the care episode).
- Direct patient calls.
- The administration of drugs with the exception of prescribed oxygen.
- Any type of syringe driver that is not directly managed.
- Journeys where advanced life support and airway management has been assessed as being a risk.

The nominated individual told us they only transported low risk patients that did not have complex medical needs and where patients required care and treatment, they were accompanied by a health professional.

The nominated individual told us if a patient's condition deteriorated during transport of the patients with mental health conditions, they would transfer the patient to the nearest hospital emergency department. The nominated individual told us there had been no instances where a patient's health had deteriorated during the transport and required emergency intervention and transfer to hospital.

The service had a document titled 'dynamic risk assessment record for events'. This was intended for staff to assess and mitigate patient risks whilst providing cover at events. The nominated individual was not able to show any evidence to show this risk assessment record had been completed by staff prior to the inspection on 4 and 5 November 2019.

Staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service was managed by three directors. The nominated individual had overall responsibility for managing the service and was also the operations director. The service had appointed a finance director and a business director in October 2019.

The nominated individual and one other staff member were involved in the non-emergency transport of patients with mental health conditions. The service also had five additional staff that were involved in events cover. The nominated individual was directly employed by the service. All other staff had other substantive employment and mainly worked for the service when required.

The nominated individual told us they were in the process of recruiting additional staff to undertake patient transport journeys as part of the provider's plans to expand the service. The nominated individual confirmed they were able to allocate from the available staff, so any short notice sickness and absence could be managed without disrupting services. The nominated individual confirmed the booking requests would be declined if there was insufficient staff available.

The service had a recruitment and selection policy in place. The policy referred to interviews and an interview assessment matrix. We found no documented evidence to show interview records were in place for any staff.

The recruitment and selection policy stated the checks to verify the identity of all prospective employees included verification of identity checks, right to work checks, professional registration and qualification checks, employment history and reference checks and criminal record checks.

The recruitment and selection policy also stated that 'two references will be sought after the interview has been conducted and when the appointment panel has decided.'

We looked at the recruitment records for the staff working at the service. We found some evidence of checks to determine qualifications and training prior to working with the service. For example, the recruitment records for the nominated individual included first response emergency

care (FREC 3) qualification (obtained in 2016) and evidence of qualifications obtained in 2009 from their previous role as a technician in an NHS ambulance trust. The recruitment records for the other staff member involved in the transport of mental health patients included evidence of qualifications such as a diploma in clinical health support (2012) and first aid instructor qualification (2016).

Recruitment records showed that valid disclosure and barring service (DBS) checks had been carried out for all staff. However, we found no evidence to show further recruitment checks (such as employment history and reference checks) had been conducted in line with the recruitment and selection policy,

We carried out a follow up inspection on 25 November 2019 and were not provided with any further evidence to show further recruitment checks had been completed.

Records

Staff did not keep detailed records of patients' care and treatment. Patient care was not planned to take into account patient's individual needs.

The nominated individual told us the referral record from the external referral and booking provider and the invoice was the only record kept by the service in relation to the transport of patients.

There was no written record or evidence to show how the service assessed the risks to the health and safety of patients prior to undertaking the booking or any records to show care plans had been put in place taking into account patient's individual needs.

We found there were no written records to show details of the ambulance journey, including the arrival or drop-off times, which ambulance vehicle or staff involved in the patient journey or if there were any observations or untoward events during the ambulance journey. The nominated individual told us they did not record this information and relied on the information provided in the referral form.

The nominated individual told us there had been two instances where patients were transported from an event to hospital as an emergency transport. The nominated individual told us the service did not keep patient records detailing the assessment of these patients and details of any care or treatment provided whilst the patient was transported from the event to hospital. The nominated individual told us patient records were kept at the event site and the provider did not keep a copy or maintain their own records for the patient. We saw an incident record form (dated November 2018) in relation to the transport of one patient from an event to hospital. This included some information about the patient assessment by medical staff and the reasons for transporting the patient from the event to hospital. The nominated individual was not able to provide any records in relation to the second instance where a patient was transported from an event to a hospital.

The nominated individual told us they had previously used journey log records but had stopped using them from January 2019 onwards as the external referral and booking provider had advised them they did not need to keep written records apart from the referral form.

We carried out a follow up inspection on 25 November 2019 and the nominated individual had developed a journey log record and risk assessment to document information such as the arrival or drop-off times, which ambulance vehicle or staff was involved in the patient journey and if there were any observations or untoward events during the ambulance journey.

We found the proposed journey log and risk assessment would be suitable for recording some information relating to the patient journey. However, the journey log and risk assessment record was developed after our inspection on 4 and 5 November 2019 and the nominated individual was not able to provide any further evidence to show whether staff had been trained to complete this record or how staff compliance in the use of this record would be monitored.

Medicines

The service did not store, prescribe, or administer any medicines.

The nominated individual told us they did not store any medicines, except for oxygen and Entonox. Patients that required medicines during the transport journey were expected to self-administer or were accompanied by a healthcare professional who could administer their medicines. The nominated individual told us they were accompanied by medical staff when providing ambulance cover at events and any medicines administered would be prescribed and administered by the medical staff.

Patient transport services

The nominated individual told us oxygen and Entonox could be given to patients in an emergency but there had been no instances in the past 12 months where oxygen was administered to patients by staff working for the service. The nominated individual told staff were trained to administer oxygen in an emergency as part of their first aid training.

Incidents

Whilst staff recognised incidents and near misses and reported them appropriately, managers did not always investigate incidents or share lessons learned with the whole team.

The service had an adverse incident reporting and management policy. This provided guidance for staff on how to identify, report and investigate incidents, accidents and near misses. Incidents were recorded using a paper-based incident report forms. The nominated individual was responsible for the management of incidents.

There had been no never events or serious incidents reported by the service during the past 12 months. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

The nominated individual told us there had been no incidents reported during the past 12 months. We saw an incident report for November 2018 in relation to the transport of one patient from an event to hospital. This included information about the patient assessment by medical staff and the reasons for transporting the patient from the event to hospital. The provider reported this was not an incident and they recorded information about the transfer of the patient using an incident report form as there were no patient report forms available at that time.

The nominated individual was aware of the basic principles of duty of candour and guidance relating to this was displayed on a notice board at the premises. The nominated individual told us there had been no incidents reported by the service that had resulted in moderate or above patient harm that would trigger the duty of candour process.

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.

Are patient transport services effective?
(for example, treatment is effective)

We did not rate effective for the service as this was a focussed responsive inspection.

Competent staff

The service did not make sure all staff were competent for their roles. Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development.

The staff recruitment and training records we looked at did not show evidence that any staff had undergone induction training.

The nominated individual told us a formal induction process was being developed; however, this was planned for new recruits only and the nominated individual was unable to show any evidence to demonstrate the formal induction of existing staff had taken place.

The nominated individual told us staff received training and competencies as part of their role. We saw evidence the nominated individual had completed competency based training and development as part of their continued professional development This included competency assessments through the use of the self-testing on the UK ambulance services clinical practice guidelines (CPG) developed by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).

The nominated individual planned to implement this competency based training to staff across the service, but we saw no evidence this training or other competency based training had been undertaken for existing staff. We did not see any records to indicate staff competencies were routinely assessed (such as ambulance driver competencies) to ensure staff were competent to undertake their specified roles.

Patient transport services

The nominated individual told us there was no process for staff appraisal or supervision and no appraisals had been undertaken for existing staff. The nominated individual told us they planned to commence staff appraisals following the recruitment of additional staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. National guidance to gain patients' consent was not always followed because there were no records to demonstrate if consent had been sought. The service had no records to show whether staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The service had a consent to care and treatment policy that included guidance for staff on how to obtain consent and what steps to take if a person lacked the capacity to make their own decisions. This policy stated that: -

- Before you examine, treat or care for patients you must obtain their consent.
- Patients can change their mind and withdraw consent at any time.

We found no records to show consent was sought by the provider before or during the transport journey.

The nominated individual told us patient consent was the responsibility of the referring organisation (such as an NHS Trust) and the provider did not maintain records of any consent sought by their staff.

We looked at 60 booking forms from the external referral and booking provider. The consent information recorded on these forms was only for consent to share patient information with third parties. The booking forms included a section for consent and eligibility that consisted of two statements with the option to tick one of these: -

- Has the service user given their consent to pass their details to a third party?
- If the answer to the above question is no, has the Mental Health Professional given consent to pass information the third party?

The nominated individual told us the referring organisations (such as NHS trusts) carried out patient consent; however, the booking forms we looked at did not specifically include any other information on patient consent apart from the consent to share patient information.

The nominated individual told us if patients lacked capacity to make their own decisions they would be accompanied by a carer or health professional that could make best interest decisions on their behalf. However, we found no written evidence during the inspection to show actions taken by staff if a patient lacked the capacity to make their own decisions.

The service had a duty of care policy which provided guidance for staff on the use of medical escorts, maintaining patient confidentiality and the use of 'do not attempt cardio-pulmonary resuscitation' (DNACPR) orders. We saw no written evidence to show how staff identified or managed patients that had a valid DNACPR order in place.

Are patient transport services well-led?

We did not rate well-led for the service as this was a focussed responsive inspection.

Leadership

Whilst leaders had the skills and abilities to run the service, we were not assured they managed the priorities and issues the service faced effectively.

The nominated individual had overall responsibility for managing the service and was also the operations director. The service had appointed a finance director and a business director in October 2019. These two directors were not involved in the day to day management of the service.

The service had not had a registered manager in place since 16 February 2018 when the previous registered manager cancelled their registration. An application for a new registered manager had been submitted to the Care Quality Commission (CQC) in January 2019. This was rejected because the application had not been completed in line with CQC guidance. A further application was made in May 2019. This was reviewed by the CQC registration team and the application was refused in October 2019. The nominated individual told us they had identified an individual to take on the role of the registered manager and planned to submit a new application with the CQC.

Patient transport services

The nominated individual had overall responsibility for the service in the absence of a registered manager. We found during the inspection the nominated individual had a large area of responsibility including developing policies and procedures, managing patient bookings and the management of vehicles and equipment. The nominated individual was also directly involved in the transporting patients as part of the regulated activities.

We identified a number of significant concerns during the inspection relating to patient safety, staff recruitment and training, and governance and risk management processes which showed the service was not managed effectively.

Vision and strategy

The service did not have a formal documented vision for what it wanted to achieve or a formal strategy to turn it into action.

The nominated individual confirmed they did not have formal documented vision and values for the service.

The nominated individual told us there was no formal documented strategy or objectives for the service but was able to articulate the service objectives verbally. The nominated individual told us about the purchase of three additional patient transport vehicles and plans to recruit additional staff as part of their plans to expand the service in North Wales.

Governance

Leaders did not operate effective governance processes. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service. The service did not have effective processes in place for assessing the suitability of company directors.

We found the service did not have effective governance processes in place. There was no policy or procedure to describe how governance processes were managed. There had been no formal meetings undertaken by the service in the past 12 months to review and discuss governance, performance and risk management processes. There had been no formal staff meetings undertaken to share information with staff across the service relating to governance, performance and risk management in the past 12 months.

During the inspection on 25 November 2019, the nominated individual told us a directors / senior management meeting had taken place after the inspection on 4 and 5 November 2019. However, the nominated individual did not provide an agenda or meeting minutes to demonstrate the purpose or contents of this meeting.

The nominated individual was responsible for creating and managing policies and procedures. We found policies did not always reflect staff practice. For example, we found evidence the consent to care and treatment policy, the recruitment and selection policy and the risk management policy did not reflect staff practice or the policies were not being followed correctly by staff.

We found policies were not effectively managed. We looked at 14 policies during the inspection. We found that three of these policies (medicines policy, health and safety policy and infection control policy) did not include any version number, effective date or review date. The remaining 11 policies did not have version numbers or effective dates listed on the document; however, these policies had review dates and all these policies were within the specified review dates.

The service did not have a fit and proper person's (FPPR) policy or process in place for assessing the suitability of company directors. There were three company directors appointed, including the nominated individual (also the operations director), a finance director and a business director.

We saw the nominated individual had a valid disclosure and barring service (DBS) certificate in place. No other records were in place or provided to demonstrate appropriate checks had been carried out on the suitability of the company directors. We found there were no records to demonstrate the suitability of the directors had been assessed, including whether they were of good character, had the competence, qualifications and skills to perform the role and whether there had been any history of misconduct or mismanagement.

Following the inspection, the nominated individual provided further evidence of checks performed on the two directors. This included companies house registration information for the finance director and the business director, an accountancy qualification and registration certificate for the finance director and evidence to show DBS checks had been requested for the finance

director. The provider also submitted signed self-declarations from the finance director and the business director. These included a self-declaration from each director that they were competent to carry out the role of a company director. These had been completed after the inspection on 4 and 5 November 2019 and there was no additional evidence provided to show these self-declarations had been assessed or validated by the provider.

There was no additional evidence provided to show any further fit and proper person checks had been performed for the nominated individual or the two directors.

To meet this requirement, we would expect that policies and procedures for recruitment of directors meet these requirements and that all recruitment checks are carried out to ensure that people who have director level responsibility for the quality and safety of care are fit and proper to carry out this important role.

We found the additional evidence from the nominated individual was not sufficient to demonstrate there was an effective process for carrying out fit and proper person checks for the directors of the service.

Management of risks, issues and performance

The service did not have systems to manage performance effectively. There was no process in place to manage risk. Staff did not identify and escalate relevant risks and issues or identify actions to reduce their impact.

The provider did not have an effective risk management process in place. We found no evidence to show risk assessments (for patients or organisational risks) had been completed. The premises did not have a comprehensive health and safety risk assessment or fire safety risk assessment.

The service had a risk management policy in place. This stated; 'When new risks are identified by the board or a staff member, these will be referred to the operations director who will update the risk register accordingly and will also annually review the risks identified in the company risk register.'

The nominated individual did not have a risk register or equivalent process for documenting the identification, management of risks to the service or patients.

We found no evidence to demonstrate the nominated individual had an effective system to monitor the quality of the services provided. There was no quality monitoring or audit programme for key processes such as infection control, management of equipment and staff records. The nominated individual also told us there was no formal audit schedule to show how compliance against relevant standards was monitored and improved.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must implement effective processes for assessing the suitability of company directors, in line with fit and proper persons requirements. (Regulation 5 (2) (3)).
- The provider must ensure patient care is planned to take into account patient's individual needs. (Regulation 9 (1)).
- The provider must take actions to ensure effective systems are implemented for obtaining patient consent and staff ensure staff obtain consent from patients and this is appropriately documented. (Regulation 11 (1)).
- The provider must take actions to ensure patient risks are identified, assessed and managed effectively. (Regulation 12 (2) (a) (b)).
- The provider must take actions to ensure infection prevention and control risks are managed effectively (Regulation 12 (2) (g)).
- The provider must take actions to ensure staff complete training in the safeguarding of adults and children. (Regulation 13 (2)).
- The provider must take actions to ensure the equipment and premises are fit for purpose and risk assessed to minimise risks to patient safety. (Regulation 15 (1)).
- The provider must take actions to ensure effective governance processes are implemented, including meetings to discuss and monitor performance and risk management. (Regulation 17 (1)).
- The provider must take actions to ensure effective risk management processes are implemented; including the identification, assessment and management of risks to the services and patient safety. (Regulation 17 (2) (a) (b)).
- The provider must ensure detailed records of patients' care and treatment are kept. (Regulation 17 (2) (c)).
- The provider must take actions to ensure effective systems are put in place to identify training needs and for the monitoring of training compliance for all staff. (Regulation 18 (1) (2) (a))
- The provider must take actions to ensure staff complete mandatory training. (Regulation 18 (1) (2) (a)).
- The provider must take actions to ensure staff are competent for their roles and staff competency is assessed. Regulation 18 (1) (2) (a)).
- The provider must take actions to ensure staff undertake formal appraisal and supervision to provide them with support and development. (Regulation 18 (2) (a)).
- The provider must take actions to ensure effective recruitment processes are implemented and monitored in relation to the assessment of qualifications, skills, training and experience of staff. (Regulation 19 (1) (2)).

Action the provider SHOULD take to improve

- The provider should develop formal vision and values and a strategy for the service.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing

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