Medicar European

Medicar European

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

Medicar European is an independent provider based in Ashford, Kent. The service provides patient transport and a repatriation service. The service employed trained paramedics, ambulance technicians and ambulance care assistants.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 28 November 2017.

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

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

Services we do not rate

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

We found the following areas of good practice:

- The service had an internal incident reporting process. There was a system to ensure all incidents were recorded and monitored, with learning and outcomes shared with staff.
- Vehicles had appropriate safety checks, were maintained and checked daily.
- Equipment was available and appropriately serviced and maintained.
- Staff understood their responsibilities to protect patients from avoidable harm. Staff knew about safeguarding and what constituted abuse.
- Policies and procedures were in place for cleaning and deep cleaning ambulances. Ambulances were visibly clean and staff followed infection control procedures including being bare below the elbow and using personal protective equipment.
- Patient records were held securely and included appropriate information.
- Staffing levels were sufficient to meet patient needs.
- Staff were confident in assessing and managing specific patient risks, and processes were in place for the management of a deteriorating patient.
- Staff could plan appropriately for patient journeys using the information provided by the booking system.
- Disclosure and barring service (DBS) checks were complete and meant the service were fully assured patients were protected from receiving care and treatment from unsuitable staff.
- Staff were trained in mental capacity and showed awareness of consent issues.
- Staff helped patients feel comfortable and safe. Staff responded with compassion when patients needed additional help or support.
- Patients and their relatives/carers received emotional and practical support from ambulance crews. Staff respected the needs of patients, promoted their well-being and respected their individual needs.
- Staff respected patient's dignity, independence and privacy.
- Staff we spoke with were committed and passionate about their roles. They provided excellent care.
- The service used its vehicles and resources effectively to meet patients' needs. Specially adapted ambulances were available to accommodate bariatric patients.
- Staff knew about the complaints and compliments system, and provided patients with information on how to make a complaint or extend a compliment.
- The service had a process in place to respond to feedback from patients and members of the public.

Summary of findings

- The staff we spoke with enjoyed working for the service. There was an open culture and staff were focused on providing person-centred care.
- Staff felt supported by the managers of the service and said the managers were competent, approachable and accessible should they require any advice.

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

- A combined safeguarding policy for children and young people, and adults at risk had not fully reflected the differences for each group clearly.
- A few staff had no up-to-date safeguarding children training.
- No policies and guidance stated a review date.
- There was no evidence to show staff had read policies and guidance related to their roles.
- There was no documentation of key decisions at director and senior manager meetings, staff briefings and external stakeholder meetings.

Information on our key findings and actions we have asked the provider to take is listed at the end of the report.

Catherine Campbell
Head of Hospital Inspections (South East)

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		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.

Medicar European

Detailed findings

Services we looked at
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Detailed findings

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Background to Medicar European

Medicar European registered with the CQC in August 2011. It is an independent ambulance service based in Ashford, Kent. The service provides non-emergency patient transport services and repatriations to and from Europe. All repatriations to and from Europe are through insurance providers.

The CQC regulates repatriations where arrangements were self-funded. CQC does not regulate repatriations made on behalf of service users by their employer, a government department or an insurance provider with whom the service users hold an insurance policy. The main service was repatriations to and from Europe through insurance providers. Therefore, this service was not inspected. We regulate independent ambulance services but we do not currently have a legal duty to rate them.

The service fleet consists of 13 ambulance vehicles; each fitted with one stretcher and three seats. One ambulance was a high dependency vehicle staffed by a crew that included at least one paramedic or technician. They transported patients with more complex needs, who may require support from trained staff during their journey. The service employed 9.25 whole time equivalent staff and 14 self-employed staff. The service provided a seven days' a week service for its patient transport service with core office hours between Monday and Friday, from 9am to 5pm.

The volume of patient transport service by Medicar European is a smaller element of the main business of repatriations.

The location has had a registered manager in post since 2011. Mr Christopher Jones is the registered manager who is also the owner and director. Registered managers have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, another CQC inspector and a specialist advisor with expertise in non-emergency patient transport services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspections, South East.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Medicar European is based in Ashford, Kent. They are an independent ambulance service, which provides non-emergency patient transport. Their main service is to provide repatriations to and from Europe through insurance providers, which is not regulated by CQC.

We inspected this service's non-emergency patient transport service; although the volume of this service was a smaller element of the main business, this was a regulated activity.

The types of patient transport journeys included outpatient appointments, admissions to and discharges from hospital, nursing and residential home transfers, hospice transfers, long distance road transfers, hospital to hospital transfers, critical care transfers, and repatriation of patients for insurance companies to and from Europe.

The service is registered to provide the following regulated activities:

- Diagnostic and Screening Procedures
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

The provider told us they were registered for the regulated activities of diagnostic and screening procedures, and treatment of disease, disorder or injury for their repatriation service only.

There were no special reviews or investigations of the service ongoing by the CQC during the 12 months before this inspection. The service had been inspected in May 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (1 February to 31 October 2017):

- There were 1,214 non-emergency patient journeys undertaken in the reporting period
- No never events
- No clinical incidents
- One non-clinical incident of no harm
- No serious injuries
- No complaints
- One safeguarding concern

During the inspection, we visited the provider's only location in Ashford, Kent. We saw three of the vehicles. We spoke with seven staff and saw feedback provided by nine patients and three relatives. We reviewed the service's policies and procedures. We reviewed 16 patient booking and record forms, and 10 staff files. We looked at documentation including relevant monitoring tools for training, staffing and recruitment. We also analysed data provided by the service and information provided by the public, both before and after the inspection.

Patient transport services (PTS)

Summary of findings

Patient transport services were a smaller proportion of the provider's activity.

The main service was repatriations to and from Europe, all funded through insurance providers which CQC does not regulate. CQC only regulates repatriations where arrangements are self-funded. It does not regulate repatriations made on behalf of service users by their employer, a government department or an insurance provider with whom the service users hold an insurance policy.

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 good areas of practice at our inspection. The service had an effective incident reporting system, which encouraged staff to report any incidents, and lessons were learnt from these. Enhanced disclosure and barring service checks were complete. Equipment and vehicles were clean, regularly checked, serviced and maintained. Staff understood their responsibilities to protect patients from avoidable harm. Patients' individual needs were met. There was an open culture and staff were focused on providing patient-centred care.

However, we also found areas that needed improvement. The safeguarding policy combined children and young people, and adults at risk in one document. A few staff had out of date training for safeguarding children. Most of the service's policies and guidance did not have review dates. There was no documentation of key decisions at meetings held within the service or with external stakeholders.

Are patient transport services safe?

Incidents

- The service had a paper-based system in place for staff to report accidents, incidents and near misses. Staff told us they reported any incidents to the senior management team. We saw evidence of learning from incidents and staff gave examples of change happening as the result of an incident. This meant the service had a system to identify themes and trends, or areas for improvement and share learning from incidents.
- The provider reported one non-clinical incident, which resulted in no harm within the reporting period between February and October 2017. There were no serious incidents reported within this period. We saw an analysis of the non-clinical incident that had taken place and documentation of learning within the investigation notes. Two staff we spoke with who were not directly involved in the incident said lessons learnt were verbally shared, and they could describe the nature and learning from the incident. This demonstrated a good incident reporting and learning culture within the service.
- Incident reporting was included in the provider's 'Reporting of Accidents and Incidents' policy and procedure (issued September 2016 with no review date).
- Staff could describe the differentiation between incidents, near misses, complaints and safeguarding concerns.
- 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.
- Staff described the process of being open and transparent clearly. They understood their responsibilities to be open and honest with patients if things went wrong, and to seek immediate support from their manager if a patient experienced avoidable harm. The service reported no incidents where they had to apply the duty of candour. We saw that the provider's 'Duty of Candour Policy POL-005' (March 2017) described the purpose and process.

Patient transport services (PTS)

- The Duty of Candour Policy was type written on a plain template without a company logo, an author's name or a review date. This meant staff could not gain assurance the policy was current and related to the service.

Cleanliness, infection control and hygiene

- We saw the station was visibly tidy, organised and clean.
- We observed three vehicles, which were tidy and visibly clean.
- Staff told us they followed infection prevention and control (IPC) procedures, including washing their hands and using hand sanitiser before, during and after patient contact. We observed all staff wore visibly clean uniforms and were bare below the elbows.
- We saw the results of IPC audits for November 2017. It showed the provider was 100% compliant with its policy and procedures. This meant the provider had assurance staff followed internal IPC policy and procedures, and the provider had assurance continual improvements could be made when required.
- The service provided staff with sufficient uniforms, which ensured they could change during a shift if necessary. Staff were responsible for cleaning their own uniform.
- Staff had access to personal protective equipment such as single use gloves and aprons to reduce the spread of infection between staff and patients. We saw crews carried a spill kit on their vehicle to manage any small spillages and reduce the spread of infection to other patients.
- Cleaning materials and chemicals were available for staff use. Different coloured mops and buckets were available for different areas; advice as to which mop to use in which area was prominently displayed to prevent cross infection.
- Safe disposal of clinical waste was included in the provider's IPC policy and the provider had a service level agreement with a waste contractor for removal.
- The provider's IPC policy did not contain an author's name, issue or review date. This meant staff could not gain assurance the policy was current and related to the service.
- Crews were required to ensure their vehicle was fit for purpose, before, during and after they had transported a patient. Sanitising wipes were available on all vehicles. We saw staff completed the daily vehicle check records for the three months prior to our inspection. This showed two omissions staff had rectified. For example, they ensured an adequate supply of equipment was on board the vehicles.
- Staff who completed the day-to-day cleaning of the vehicles recorded daily cleaning sheets. We saw staff completed these after each vehicle use. We reviewed eight weeks' worth of cleaning sheets. This meant the service was assured of reducing the spread of infection and staff were compliant with the provider's policy.
- A deep clean involves cleaning a vehicle to reduce the presence of certain bacteria. The service had an internal deep cleaning procedure for staff to follow. Vehicles were deep cleaned when necessary or once a month. The three vehicles we checked had a record of a deep clean a month or less before the inspection.
- Staff reported they were informed of any specific infection risks either on their job sheets or by hospital staff when they collected patients.
- The service followed operational procedures about IPC. Staff told us if a patient was known to have an infection, they were not transported with another patient.

Environment and equipment

- The ambulance station provided ambulance parking facilities, an office base and facilities for managers and staff.
- We saw the service had a closed circuit television and video surveillance of the surrounding premise. This meant the premises and equipment were kept secure.
- The service operated 13 ambulances. We inspected three ambulance vehicles on site during our visit.
- There were systems in place to monitor servicing and the Ministry of Transport (MOT) testing of vehicles. All ambulances had an up-to-date MOT and service, and were insured.These were recorded in a log kept at the station. We observed that vehicle keys were stored securely in a number coded safe. Staff told us the number code was changed frequently. This meant only relevant staff within the service could access them.

Patient transport services (PTS)

- We saw staff reported vehicle defects to the managers and recorded these in their daily job sheets. There was an up-to-date ambulance defects log and the provider had ambulance service and maintenance arrangements. Equipment had been safety checked and serviced; labels showed when the equipment was next due for testing and servicing, and records were available to support their suitability for use. The high dependency ambulance had resuscitation equipment on-board.
- We saw various equipment on the vehicle to ensure patient safety. This included carry chairs, slide sheets, standard safety belts and strapping to attach wheelchairs to the vehicle floor. We observed these to be in good working order. Although the service did not transport young children, we saw appropriate seats were available for them to be safely transported if required. We observed these to be in good condition.
- Staff knew the process to follow if their vehicle broke down or was involved in an accident, addressing the immediate needs of any patients first and then talking with the manager on call.
- Staff had the use of mobile telephones while on shift.
- There was a standard equipment checklist on each vehicle, and we saw staff had completed these. This meant staff could identify missing items easily.
- The ambulance vehicles we inspected were fully equipped, with disposable single use equipment stored appropriately and in-date.

Medicines

- The provider told us they did not use medicines other than medical gases for their patient transport service.
- Each ambulance had medical gases on board. We found oxygen cylinders were safely secured within the vehicles and were in date. We saw medical gases were stored on-site in a secure metal cage and was pad locked. The metal cage was kept within a locked compound and was in in view of the service's closed circuit television and video surveillance camera. This meant the service had a safe and secure storage of medical gases.
- All oxygen cylinders we checked were within date. We saw a record of medical gases removed from and returned to the external supplier.
- Staff completed daily checks as part of the ambulance inspection to ensure they had the correct medical gases and quantities on their vehicle.
- There was guidance in place for staff to follow regarding the administration of oxygen to patients in the course of their work. We saw posters prominently displayed in the premises and on board ambulance vehicles.

Records

- Staff received relevant information about the patients' health and circumstances during the planning process. For example, information about access to property or the patient's mobility requirements. Staff gave an example where they had requested further information to ensure ease of access to the patient's property.
- The service ensured that up-to-date 'do not attempt cardio pulmonary resuscitation' (DNACPR) orders were in place and ensured the information they received included end of life care planning.
- Staff received job sheets at the start of a shift. These included collection and drop off times, addresses and patient specific information such as relevant medical conditions, mobility, and if an escort was travelling with the patient. Information was stored in the driver's cab out of sight, respecting patient confidentiality.
- There were no completed patient record forms on ambulances in the cab area, which were open to view when the ambulance was unattended. We saw patient information and patient record forms kept within locked metal cupboards at the station. The operations and accounts manager had access to the key, which was kept in a separate locked cupboard bolted on the wall.
- The service audited patient record forms (PRF) and would discuss any anomalies with the staff. The operations manager provided feedback to the staff on both the content of the PRF and the care they provided to patients.
- Staff personnel files were stored in a locked cupboard within a key coded office in the service premises. The service told us access to these files were limited to the registered and operations managers, to ensure the confidentiality of staff members was respected.

Safeguarding

Patient transport services (PTS)

- The service had one policy (October 2016) combining safeguarding children and young people, and adults at risk. Although this outlined the guidance on how to report concerns, staff could not gain assurance if procedures were group specific.
- The operations manager was the safeguarding lead for adults at risk and children, and had completed adults and children safeguarding training at level three.
- All staff had a good understanding of safeguarding. Staff we spoke with could describe the signs of abuse, knew when to report a safeguarding concern, and knew how to do this. We saw a recent safeguarding concern the service had raised to the local authority and we saw this had been investigated, with outcome and learning from this shared with staff.
- Safeguarding adults at risk and child protection was part of mandatory training. The operations manager told us all staff had completed adults safeguarding level two.
- We saw 21 required staff had completed appropriate children's safeguarding training levels one and two. Of these, five had out of date training. We raised this with the operations manager at the time of inspection who told us he would urgently organise for the five staff to complete a refresher. Information provided to us post inspection confirmed all five staff had booked a refresher course to be completed by end of December 2017.

Mandatory training

- The "Induction policy and checklist" (October 2017) included the type of induction training required by staff. It covered a range of topics including fire safety, health and safety, infection control, waste and manual handling procedures.
- We saw the "Induction policy and checklist" did not have a review date but the operations manager told us they periodically reviewed it.
- Staff told us face-to-face induction training was provided to all new staff at the time of commencement. We saw induction checklists signed and dated for all staff. They contained a list of induction topics with appropriate content and depth for each topic.
- The service kept a log of completed mandatory training for staff. This meant the provider had assurance that staff had completed all required mandatory training, and could review when their training was due for renewal.
- We were told mandatory training for all staff employed was delivered by a combination of e-learning and face-to-face training. The provider required all staff to complete and record their mandatory training. We saw information from the provider showed 100% training compliance for all required staff.

Assessing and responding to patient risk

- At the point of booking transport, staff collected information about the patients' needs and communicated to staff on their job sheets or via mobile telephones. We saw staff completed job sheets and recorded risk factors when making a booking for transport or ensured information received included patients' needs and risk factors.
- Staff told us that in the event of patient deterioration they would call 999 for emergency backup. This was in line with the process the senior management told us staff should follow.
- There was appropriate equipment on board the ambulance to provide monitoring and assessment of patients. For example, patients could have oxygen saturations, non-invasive blood pressure, temperature and blood sugar monitored and recorded.
- The service had a risk assessment for staff to follow when transferring patients, which included risks to be assessed before, during and post transport of patients. For example, ensuring there were hospitals to divert patients to in case of an emergency.

Staffing

- Staff based at the ambulance station were made up of the director who was also the registered manager, an operations manager, an operations co-ordinator, operational and administrative staff.
- The service employed 9.25 full time equivalent and 14 self-employed staff, which included ambulance care assistants, paramedics and registered nurses.
- The operations manager reviewed staffing levels and appropriate skill mix of staff to cover transport bookings.

Patient transport services (PTS)

The majority of transport bookings were ad hoc and some were made in advance. The service would not undertake any journeys if there was inadequate staffing levels and inappropriate skill mix.

- There was a process in place for the ambulance crews to follow out of hours and in case of emergencies. They had a direct number to the duty manager on call. Staff we spoke with knew how to escalate concerns when working out of hours.
- All ambulance staff required enhanced Disclosure and Barring Service (DBS) checks which was included in the provider's 'Recruitment and Selection Policy' (issued 2017 with no review date).
- The service used an external agency for DBS enhanced checks. We saw all staff had undergone the requested checks. Whilst the external agency completed the checks, we saw the provider had not added the outcome review sections as these were blank on the paperwork. We raised this with the operations manager at the time of inspection who took immediate action to recall the DBS documents from all staff. We saw a request text message sent to all staff at the time of inspection. Information provided to us post inspection had indicated all outcome reviews and dates were complete. This meant patients were protected from receiving care and treatment from unsuitable staff.
- Staff did not raise any concerns about access to time for rest and meal breaks.
- The service did not use agency staff but used the self-employed staff and the existing internal team who worked additional shifts on overtime or flexibly where required.

Response to major incidents

- A major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services and would generally include the involvement, either directly or indirectly, of large numbers of people.
- Senior management considered the impact of different resource and capacity risks and could describe the action they would take.
- The service managed anticipated resource risks by scheduling transport bookings in advance, managing pre-planned holidays, and other leave.
- The service carried out 'ad hoc' work so would assess resource requirements and capacity on an individual basis when requested. Demand fluctuated and the service only carried out work that was within their capacity.
- The senior management team could describe how the service would function in the event of any emergency such as fire and flood incidents. We saw a business contingency plan that identified how it would function in the event of an emergency.
- As an independent ambulance service, the provider was not part of the NHS major incident planning.

Are patient transport services effective?

Evidence-based care and treatment

- The service had policies and guidance to support evidence based care and treatment. The majority of the documents we looked at were recently written (October 2017) and none had review dates.
- The service's policy on Do Not Attempt Cardiopulmonary Resuscitation was based on and referred to the Resuscitation Council (UK) guidance (2016).

Assessment and planning of care

- Staff adhered to relevant national and local protocols for their role, when assessing and providing care for patients. We observed this when we interviewed staff on the inspection. This also aligned with our review of the information that the provider made available to us prior to the inspection.
- During the booking process, patient information was obtained regarding mobility aids, whether or not a stretcher was required and details of any oxygen required. Staff told us they could make dynamic assessments of the needs of patients at the point of pick up and make adjustments where necessary.

Patient transport services (PTS)

- Staff told us they were made aware if patients had a mental health problem through the booking system in advance of accepting a booking so they could plan accordingly.
- Staff did not transport a patient if they felt they were not equipped to do so, or if the patient needed more specialist care. They described if a patient was observed or assessed as not well enough to travel or be discharged from hospital, staff made the decision not to take them.

Response times and patient outcomes

- From February to October 2017, there had been 1,214 non-emergency patient transport journeys. The level of activity fluctuated each month.
- The service monitored site pick up and departure times, and destination arrival and departure times through the crew daily job sheets.
- There was a system in place to monitor the service's performance to ensure they were delivering an effective patient transport service. The service told us they benchmarked itself against other providers from the information they received from the commissioners. The operations manager told us that they were given a positive comparison against other organisations.
- We were unable to analyse how well the service did in relation to patient outcomes because this information was not available.

Competent staff

- We saw 100% staff had received their appraisals at the time of inspection, or had a review date booked. An appraisal is an opportunity for staff to discuss areas of improvement and development within their role in a formal manner.
- All new staff were required to undertake a set induction programme that tested knowledge on manual handling, infection control and health and safety.
- The operations manager told us they checked that all required staff had registered with the appropriate professional body, and we saw these were within date.
- The service conducted Driver and Vehicle Licensing Agency (DVLA) checks at the start of employment. All crew knew the need to notify the managers of any changes to their license in line with the driving standards policy.
- There were arrangements for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor. Staff told us that if they had a concern about the standard of a crew member's driving they would inform the senior management team.
- The operations manager told us that some permanent staff were appropriately trained to 'drive under blue lights' even though this was not used for the patient transport service. Staff would summon the 999 service if there was an unexpected or unplanned emergency.
- Staff told us they did not transfer patients with mental health problems and the operations manager told us they would use a mental health staff supplied by the commissioning body if required.

Coordination with other providers and multi-disciplinary working

- Staff we spoke with told us they had good communication with the hospital managers and effective handovers with the hospital staff when they transported patients to and from the hospitals.
- Staff told us they worked in a multi-disciplinary manner with staff from local trusts and repatriation companies when patients were transported from another country.

Access to information

- Ambulance staff received job sheets at the start of each journey. These included collection times, addresses and patient specific information such as relevant medical conditions, complex needs, mobility, or if an escort was travelling with them.
- Staff felt they had access to sufficient information for the patients they cared for. If they needed additional information or had any concerns, they spoke with the hospital who had made the transport bookings.
- Staff told us both hospital and booking staff made them aware of any special requirements. For example, they were notified if a patient was living with dementia.

Patient transport services (PTS)

- We saw staff had access to company policies via their work mobile telephones and in the staff room at the ambulance station.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training in the Mental Capacity Act 2005. Information provided by the service showed all staff had completed the training provided face-to-face, with the exception of five staff due to complete a refresher course before the end of year. Information provided to us post inspection confirmed they had completed this on 6 December 2017
- Staff we spoke with showed awareness and understanding of the Mental Capacity Act (2005) code of practice and consent processes. They described how they would support and talk with patients if they initially refused care or transport. For example, they told us they would seek the patients' consent before they fastened their seatbelts.

Are patient transport services caring?

Compassionate care

- We reviewed the folder of feedback that the service received from patients and their relatives, which included appreciative and positive comments about the service they had received and the caring staff attitude.
- The feedback we saw from patients and their relatives demonstrated staff were kind and compassionate. Examples of comments were; "On behalf of all my family and my dad, we cannot thank you enough". "The staff were very helpful and very attentive to my needs, no problems what so ever", "Service very good and very helpful" and "Thank you for the care and assistance you gave my wife".
- Staff told us they maintained patients' privacy and dignity. Patients conveyed to hospital were covered in a blanket to maintain their modesty and to keep them warm while on a stretcher or in a wheelchair.
- Vulnerable patients, such as those living with dementia or a disability, could have a relative or carer with them while being transported wherever possible. All staff we spoke with were passionate about their roles and were dedicated in providing excellent care to patients.

Understanding and involvement of patients and those close to them

- We saw from the patient report forms staff involved patients in decisions about their care and treatment. Ambulance crews gave clear explanation of what they were going to do with patients and the reasons for it. Staff checked with patients to ensure they understood and agreed.
- Staff told us they provided clear information to patients about their journey and informed them of any delays.
- Patients commented they had confidence in the staff providing their care, and patients were involved as much as possible when planning their journey to and from the hospital.
- Staff said they asked permission to enter the patients' home, when they collected or delivered patients from and to their homes to take them to and from hospitals.
- Staff told us they showed respect towards relatives and carers of patients and knew about their needs; explaining in a way they could understand to allow them to support their relative.

Emotional support

- Staff checked on patients' wellbeing, in terms of physical pain and discomfort, and emotional wellbeing during their journey.
- Ambulance crews did not routinely transport patients who were near the end of their life. However, staff knew about the need to support family or other patients should a patient become unwell during a journey.

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

Service planning and delivery to meet the needs of local people

- Patient transport services (PTS) was a smaller part of the provider's main service, which provided non-emergency transport for patients who were unable to use public or

other transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards, or referrals from care homes and private individuals.

- The service had mostly 'ad hoc' transport bookings with some that were planned in advance. They planned the needs of patients and their workloads around this. The feedback from patients and their relatives demonstrated the service was good at responding to requests, even on short notice bookings.
- On-the-day bookings were responded to quickly via telephone. For these bookings, office based staff identified which drivers were free or had finished jobs and were nearest for the next job.
- Staff at the station would take bookings Monday to Friday from 9am until 5pm. Out of hours, the on call manager would manage bookings.
- The senior management team told us they encouraged all staff to take appropriate breaks. This was in line with staff we spoke with who told us they took appropriate breaks and said the provider constantly reminded them to do so.
- Staff told us their workload was variable, it ranged from transporting one patient a day to considerably more than this on some occasions, there were no trends to this variation.

Meeting people's individual needs

- The booking process meant people's individual needs were identified. For example, the process took into account the level of support required, the person's destination set-up, communication needs and family circumstances.
- For patients who did not speak English, staff informed us they would use the translation service provided by the commissioning body.
- The service allowed a relative or carer to accompany patients who were unable to speak due to their medical condition or who had complex needs. This aided communications for patients who were not able to understand or explain what was wrong.
- The service had one ambulance equipped with a bariatric stretcher and other specialist equipment to support heavy patients. Staff told us the commissioning body provided them with relevant information at the time of booking so that journeys were planned to support heavy patients.
- For patients living with dementia and those with reduced mental capacity their support needs were assessed at the point of booking. There was seating in the ambulances to allow family members or additional medical staff to travel with the patient.
- Staff we spoke with told us they would respond appropriately to patients' religious needs. For example, if patients were being transferred for a long distance, they would provide time for patients to pray if needed and use multi faith rooms at airports when repatriating patients.
- We saw equipment available on board the vehicles to meet toileting needs. Staff told us that they also made toilet stops for patients when required.
- Ambulances had different points of entry, including sliding doors, steps and tailgates so that people who were able to walk and in wheelchairs could enter safely.
- Staff told us they would transport a patient in their own wheelchair if possible, rather than transferring them to a trolley, so they were more comfortable.

Access and flow

- All 16 patient booking and patient record forms we reviewed during inspection recorded collection and drop off times, and all journeys showed they ran on time.
- All staff we spoke with told us if a journey was running late the driver would ring ahead to the destination with an estimated time of arrival and keep the patient and the hospital informed. Any potential delays was communicated with patients, carers and hospital staff by telephone.

Learning from complaints and concerns

- The service had a system for handling, managing and monitoring complaints and concerns. For example, the service used a customer satisfaction sign-off sheet and contact details were available to patients on the provider's website if they wished to make a complaint.

- The provider reported no formal complaints in the last 12 months prior to inspection. Staff we spoke with described they would quickly resolve patients' concerns when required. For example, a crew provided a patient who felt cold an extra blanket to use during a journey. The learning from this was to stock extra blankets on all vehicles.
- Information provided to us before the inspection outlined the process for dealing with complaints initially by local resolution and informally. Where complaints did not lead to a resolution, the service would investigate and respond to the patients' complaints within seven days. The service would contact patients to inform them if they required more time for further investigation.
- The service kept a log of all written and verbal complaints to help them identify any trends or themes. We could not identify any trends or themes at this inspection as there had only been one verbal complaint in the last 12 months about the blanket. We saw the operations manager and staff had responded to this empathetically and thoroughly.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The registered manager who was also the owner and director, and the operations manager led the service. They ran the day-to-day management of the service and had support from the operations coordinator and administrative staff who worked full time, and two operational staff who worked 30 hours per week. The director had an oversight of the business, was available daily from September to May, and was off-site one week in three during the summer months. The operations manager looked after the welfare of the staff and was responsible for the planning of the day-to-day work.
- Staff felt they could raise any concerns with the operations manager and found the operations manager easy to contact. All the staff we spoke with during our inspection said the company and the director were good to work for and they felt they were well looked after.
- Staff said they were proud to work for the service. They wanted to make a difference to patients and were passionate about performing their roles to a high standard.
- Staff told us they could speak in confidence with the director and operations manager when they encountered difficult or upsetting situations at work.
- The service had a "Freedom to speak up: raising concerns whistleblowing Policy" (October 2017). It contained internal and external contact details and outlined a clear process for staff to follow if they wished to raise any concerns. This meant staff could provide feedback internally or to external regulators about aspects of the service.

Vision and strategy for this this core service

- The service's vision is, "to be an outstanding healthcare provider, committed to improving quality, and caring with compassion".
- The strategy and focus was to develop and improve the quality of the service. The director informed us they had plans to keep the repatriation service but had no plans for expansion.
- Staff understood the instability of the work through ad hoc activity and the desire to develop a more long-term plan.

Governance, risk management and quality measurement

- The operations manager was the lead for governance supported by the director. Although the director and operations manager met and spoke regularly, there were no records of any governance meetings.
- A review of the risk register (November 2017) showed entries related to topics such as vehicle damage and fluctuation of fuel prices, with mitigating actions such as the hire of vehicles and to notify customers of potential cost increase. This meant the service had a mechanism in place to identify and manage risks to the organisation.
- The provider had an overview of all incidents and could identify themes and trends for learning. This meant the service had a system to share learning from incidents, safeguarding and complaint outcomes.

Patient transport services (PTS)

- The operations manager told us they monitored all job sheets; information and learning was shared. The service also carried out audits to measure the quality and effectiveness of the service delivered such as cleanliness and infection control. This meant potential risks to staff and patient safety, were monitored and actions were taken to mitigate the risks.
- Staff told us informal discussions took place in relation to operational, recruitment and office matters but the operations manager told us that they were not documented. Minutes of these meetings were not available when requested. This meant the provider could not be assured if key actions were taken for any issues raised, or if they could monitor the service performance.
- The service relied on patient feedback to monitor the quality of the service. The operations manager told us the quality of the patient transport service was monitored by the commissioners and only complaints were sent to Medicar European. Medicar European reported no complaints in the past 12 months and told us they would investigate and respond to complainants within seven days.
- The provider had a service level agreement with an external supplier to review policies and provide medical advice.

Public and staff engagement

- Patient feedback was encouraged by staff on ambulances. All the thank you notes we reviewed were complimentary about the care and treatment they had received from staff.
- The service had a website with information for the public about the services the company provided, including their contact details.
- The operations manager told us the service held informal staff meetings due to the small team and availability of the self-employed staff. They used regular communication via mobile telephones and emails as a medium for staff to access information. This meant there was a forum for communication to staff in person. Staff we spoke with described the good communication they had with the senior management team.

Innovation, improvement and sustainability

The service took prompt actions to address any issues we found at the time of the inspection and this was supported by our findings and information provided to us during and after the inspection**.**

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should develop a system to ensure all required staff had up to date training in safeguarding children.
- The provider should consider safeguarding policies for children and young people, and adults at risk to reflect the differences for each group clearly.
- The provider should standardise the format of their local policies and guidance.
- The provider should develop a process to reflect all staff had read policies and guidance related to their roles.
- The provider should document key decisions from all meetings held.