Immediate Care Medical Services Limited

# Immediate Care Medical Services

## 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

Immediate Care Medical Services (ICM) is a private, family-run ambulance service that provides patient transport services. They did not have any substantive contracts, but carried out various patient transport and transfer work for the NHS and other private ambulance providers on a sub-contracted ad-hoc basis. This work was tendered through a centralised clinical commissioning group (CCG).

We carried out an announced inspection of ICM on 6 December 2016. This was a comprehensive announced inspection as part of our inspection programme.

Our inspection covered four of the five domains to assess whether the patient transport services provided by ICM were safe, effective, responsive and well led. We were unable to inspect caring as there were no patient transfers scheduled on the day of our inspection. We were not able to contact any patients directly after our inspection as the provider did not hold contact details for service users. All patient transfers carried out by the provider were managed through the clinical commissioning group that the provider tendered their work through.

The provider operated from one location split between two premises. The office was based in an office block on an industrial estate in Birmingham. The vehicles were held in an industrial garage based in Smethwick. We inspected both premises as part of this inspection.

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

We found the following areas of good practice:

- There was a good incident reporting culture. The provider encouraged staff to report all concerns including patient safety, vehicle and equipment concerns.
- The provider understood their responsibilities under Duty of Candour. Staff were able to explain what this meant and when it should be used.
- The provider documented policies and standard operational procedures well and staff had access to these.
- Staff were able to describe what they would do if they had safeguarding concerns and this description was in line with ICM policy.
- There were good processes in place to prevent and control the spread of infection. All vehicles we saw were visibly clean internally and externally.
- Staff we spoke with understood what their responsibility was for prevention and control of infection.
- All vehicles had a valid ministry of transport roadworthiness test (MOT) certificates. They all had regular documented services and had valid road tax.
- The provider stored patient record forms securely on an electronic database and disposed of paper copies appropriately.
- There were good processes in place to check the registrations, disclosure and barring system (DBS) and qualifications of sub-contracted staff on appointment of contract.
- The provider was registered with an umbrella DBS organisation that allowed them to apply for DBS certificates directly.
- The service was flexible and was planned and delivered to meet the needs of their service users.
- There were sufficient resources to carry out patient transport services.
- The provider had a protocol for inclusion of patients and only accepted transfers they were equipped to assist.
- There was a good process in place to manage concerns and complaints.
- The culture of the service was open and transparent. The provider encouraged staff to give feedback in an open and transparent manner.

# Summary of findings

- Leaders had the necessary knowledge and capability to lead effectively. The registered manager had a good understanding of the Health and Social Care Act 2008.
- The leadership team were visible and accessible.
- Policies provided guidance for staff to use them and protocols were written down for staff to reference.
- All management staff were aware of their roles and responsibilities, and understood what they were accountable for.
- The provider had a private social media page to keep in touch and engage with sub-contracted staff members.
- The provider had an online booking system where patients could book directly with ICM through completing an online form, requesting a call back or calling the provider over the phone.

However, we also found areas where practice could be improved;

- There was a lack of assurance that all sub-contracted staff had completed, and were up to date with their mandatory training including safeguarding training.
- There was no documentation outlining mandatory training needs per role or to specify what level of training the provider expected staff to have as a minimum.
- The provider did not have a formal induction programme in place to assess and approve the competency of newly appointed staff.
- There was insufficient assurance in place to demonstrate people received effective care.
- There was no system in place for monitoring patients' outcomes of care and treatment.
- There was no interaction with patients and organisations requesting tenders before the provider accepted transfers. This meant there was a risk of the provider accepting patient groups that were not in their inclusion criteria.
- At the time of the inspection, none of the permanent staff ICM employed had an appraisal.
- There was a lack of assurance that the sub-contracted staff were competent to perform their role.
- There were no formal processes in place to ensure patients' needs were met for those patients living with hearing or sight difficulties and those patients where English was not their first language.
- There was no policy for staff on how to deal with violent or aggressive patients.
- The service did not appear to have a clear vision, strategy or set of values.
- There was a lack of engagement with service users, both patients and other organisations using ICM services for patient transport. The provider was not actively gaining feedback from relevant people.

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

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Immediate Care Medical Services

## Detailed findings

**Services we looked at**
Patient transport services (PTS)

# Detailed findings

## Contents



## Background to Immediate Care Medical Services

Immediate Care Medical Services (ICM) is a private organisation established in 2004, providing event cover and patient transport services to central England and the UK. They are a small service consisting of three directors, of which two have a clinical background. ICM have an office in Birmingham and an ambulance depot in Smethwick. The service does not have a permanent contract with any particular provider. They sub-contract work from a local clinical commissioning group on request and provide patient transport services for NHS and private organisations. The majority of the work ICM conducted was event cover. They also provided a range of training courses including first-aid training for individuals, companies, dentists, GP surgeries, healthcare practitioners and childcare services, both onsite and offsite. Their patient transport service was a small proportion of their activity at approximately 20% of their total yearly output in 2016.

The service offer the following patient transport services:

- non-urgent hospital transfers,
- stretcher and wheelchair bound patient transfers,
- medical appointment transfers,
- elderly transport,
- high-dependency transfers,
- emergency and critical care transport, and
- medical repatriation from countries with the European Union.

The service is also equipped to provide blue-light transfer, however the provider told us they have never had to do this.

We carried out an announced comprehensive inspection of ICM's patient transport service. During our inspection, we visited the organisation's office in Birmingham and the ambulance depot in Smethwick. We did not visit any hospital locations to speak with patients because the organisation did not have any substantive contracts with particular providers. There were no patient transport jobs provided on the day of inspection so we were unable to speak with sub-contracted staff, or accompany them on any transfers on the day of our inspection. Instead, we requested contact details of sub-contracted staff from the organisation and made contact with them in the weeks following our inspection. We were unable to speak with patients as the provider did not hold any contact details for their patients.

Event cover and private training to external providers are activities that CQC do not regulate. We did not inspect ICM's event cover service or their training courses, therefore these are not included in the report.

We inspected this independent ambulance service as part of our comprehensive inspection programme of independent providers.

# Detailed findings

## Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) Inspector and was overseen by a CQC Inspection Manager. The team consisted of one other CQC inspector and a specialist advisor paramedic with a background in ambulance service management.

## How we carried out this inspection

We carried out an announced comprehensive inspection on 6 December 2016. During our inspection, we spoke with the executive directors, including the registered manager and non –executive staff (fleet manager, HR administrator and a fleet assistant) whilst we were on site. In the weeks after the inspection visit, we spoke with two staff sub-contractors, which consisted of one paramedic and one first responder via telephone.

As part of our planning for this inspection, we requested information from Immediate Care Medical Services (ICM). We did not visit any hospitals and did not accompany any ICM personnel on any patient transfers.

We inspected ambulance vehicles, the premises, equipment and storage of equipment at the ambulance depot. We reviewed policies and procedures and looked in records, including all available staff files, incident forms and all patient transfer records.

The Care Quality Commission (CQC) does not currently have the power to rate independent ambulance services. Therefore, the report will not contain any ratings.

## Facts and data about Immediate Care Medical Services

Immediate Care Medical Services (ICM) was first established in 2004. In December 2012, the company moved from its previous premises at Newhall Court, 47 George Street, Birmingham, B3 1QA to their current premises at Suite 108, 69 Steward Street, Birmingham, B18 7AF. The ambulance vehicles were kept at a separate address in a secure industrial garage.

At the time of the inspection, ICM were registered to provide the following regulated activities:

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

The service was based in Birmingham, West Midlands, and provided patient transport services and event cover across central England and the UK. They had no substantive contracts but sub-contracted jobs on a request basis from a local centralised commissioning group. The provider had no direct contact with NHS providers or private organisations they sub-contracted work from.

The majority of ICM work output was in event cover and they provided training courses for external providers. CQC do not regulate either of these activities and therefore is out of CQC's remit to inspect and will not be included in this report. Approximately 20% of ICM's total completed jobs in 2016 were for patient transport.

Directors told us there were no fixed operating times. They operated their service dependent on the ad-hoc contracts and could provide a service at any time dependent on the requirements and the resources they had available.

# Detailed findings

## Our ratings for this service

Our ratings for this service are:

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

### Notes

1. We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.
2. We were unable to inspect the caring domain as we did not see any service users on the day of our inspection. The provider did not hold any contact details of service users for us to contact them after the inspection.

# Patient transport services (PTS)

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |
| Overall | |

## Information about the service

Immediate Care Medical Services (ICM) is a private, family-run ambulance service. They offer a small patient transport service, which includes non-urgent hospital transfers, medical appointment transport, elderly transport, high-dependency transfers, medical repatriation, and emergency and critical care transfers. The service is also equipped to provide blue-light transfers; however, executive staff told us they have never had to do a blue-light transfer.

They have no substantive contracts with any particular providers. The work ICM carried out was through a centralised local commissioning group, where the group invited ICM to tender for individual jobs on an ad-hoc basis. Through this process, ICM had provided services for both NHS and private providers.

Executive staff told us there are no fixed operating times for patient transport services. Operating times were dependent on the ad –hoc contracts. ICM could provide the service at any time depending on individual requirement of the request and the resources they had available.

Patient transport services accounted for approximately 20% of the total output in 2016. ICM carried out 391 completed jobs in 2016, of which 75 were patient transport. The provider had a total of 23 sub-contracted staff members that had carried out patient transfers during 2016.

The majority of the work ICM conducted was event cover. They also provided a range of training courses including first-aid training for individuals, companies, dentists, GP surgeries, healthcare practitioners and childcare services, both onsite and offsite. CQC do not regulate either of these activities, therefore we did not inspect and will not be including these activities in this report.

# Patient transport services (PTS)

## Summary of findings

CQC does not currently have the power to rate independent ambulance services.

We found:

- There was a good incident reporting culture. The provider encouraged staff to report all concerns including patient safety, vehicle and equipment concerns.
- The provider understood their responsibilities under duty of candour. Staff were able to explain what this meant and when it should be used.
- The provider documented policies and standard operational procedures well and staff had access to these.
- Staff were able to describe what they would do if they had safeguarding concerns and this description was in line with ICM policy.
- There were good processes in place to prevent and control the spread of infection. All vehicles we saw were visibly clean internally and externally.
- Staff we spoke with understood what their responsibility was for prevention and control of infection.
- All vehicles had a valid ministry of transport roadworthiness test (MOT) certificates. They all had regular documented services and had valid road tax.
- The provider stored patient record forms securely on an electronic database and disposed of paper copies appropriately.
- There were good processes in place to check the registrations, disclosure and barring system (DBS) and qualifications of sub-contracted staff on appointment of contract.
- The provider was registered with an umbrella DBS organisation that allowed them to apply for DBS certificates directly. The service was flexible and was planned and delivered to meet the needs of their service users.
- There were sufficient resources to carry out patient transport services.
- The provider had a protocol for inclusion of patients and only accepted transfers they were equipped to assist.
- There was a good process in place to manage concerns and complaints.
- The culture of the service was open and transparent. The provider encouraged staff to give feedback in an open and transparent manner.
- Leaders had the necessary knowledge and capability to lead effectively. The registered manager had a good understanding of the Health and Social Care Act 2008.
- The leadership team were visible and accessible.
- Policies provided guidance for staff to use them and protocols were written down for staff to reference.
- All management staff were aware of their roles and responsibilities, and understood what they were accountable for.
- The provider had a private social media page to keep in touch and engage with sub-contracted staff members.
- The provider had an online booking system where patients could book directly with ICM through completing an online form, requesting a call back or calling the provider over the phone.

However;

- There was a lack of assurance that all sub-contracted staff had completed, and were up to date with their mandatory training including safeguarding training.
- There was no documentation outlining mandatory training needs per role or to specify what level of training the provider expected staff to have as a minimum.
- The provider did not have a formal induction programme in place to assess and approve the competency of newly appointed staff.
- There was insufficient assurance in place to demonstrate people received effective care.
- There was no system in place for monitoring patients' outcomes of care and treatment.
- There was no interaction with patients and organisations requesting tenders before the provider accepted transfers. This meant there was a risk of the provider accepting patient groups that were not in their inclusion criteria.
- At the time of inspection, none of the permanent staff ICM employed had an appraisal.

# Patient transport services (PTS)

- There was a lack of assurance that the sub-contracted staff were competent to perform their role.
- There were no formal processes in place to ensure patients' needs were met for those patients living with hearing or sight difficulties and those patients where English was not their first language.
- There was no policy for staff on how to deal with violent or aggressive patients.
- The service did not appear to have a clear vision, strategy or set of values.
- There was a lack of engagement with service users, both patients and other organisations using ICM services for patient transport. The provider was not actively gaining feedback from relevant people.

## Are patient transport services safe?

**Incidents**

- The provider had no clinical incidents reported for their patient transport services.
- There was no clear distinction between events or patient transport services when reviewing the forms. Managers told us they would be able to track each incident by date to the jobs they had that day.
- The provider used a paper system for recording and filing incidents. We viewed the incidents within the folder, all of which related to vehicular issues. There were only two incident forms that had indicated a patient was harmed. However, on further reading, it was clear that this had been recorded in error. It was not immediately evident if this incident was reported for a patient transfer or for an event cover.
- Each incident form had an area at the bottom for a member of management to fill out. We saw managers had filled these sections out with details of what actions they had done.
- The registered manager told us all staff that were sub-contracted were encouraged to report incidents and that these forms were on every vehicle. We saw there were incident-reporting forms at the ambulance depot in Smethwick.
- Managers told us there was no incident reporting training provided for sub-contractors. Sub-contractors could access information on how to raise an incident on a private social media page set up by the provider. The registered manager told us they intended to include this training in an induction programme they were planning to introduce.
- Managers told us if an incident were to occur, the sub-contracted staff member would fill in an incident form and post the form in a locked post box, located at the ambulance depot. The fleet manager would collect these incident forms and take them back to the office in Birmingham the following morning. We saw incident forms were stored in a folder in paper format at the Birmingham office.
- We spoke with two sub-contracted staff who confirmed the process managers described and were able to explain how to raise an incident and where to find the incident reporting forms.

- Managers told us they do not generally share learning from incidents due to incidents mainly being vehicular issues, but they would occasionally share learning with front line staff face-to-face, via email or through the private social media page set up by the provider.
- We spoke with two members of sub-contracted staff who were not able to describe a change to the patient transport service as a result of an incident. However, they were able to describe learning and a change to the event cover service because of an incident that happened during an event.
- The provider did not record incidents on a database or categorised them by service provided. In the event of increased incidents, the provider would benefit from a system that would enable them to analyse themes. Theme analysis would be difficult with the current paper format.

**Duty of Candour**

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in April 2015. This Regulation requires a provider to be open and transparent with a patient when things go wrong in relation to their care, and the patient suffers harm, or could suffer harm, which falls into defined thresholds.
- We saw the provider had a complaints policy that they reviewed in October 2016. The review included the addition of duty of candour, explaining the responsibilities of the provider should an issue arise with patient care. The policy included the need to acknowledge a mistake and apologise to the patient, however it did not set out steps for a sub-contracted member of staff to carry out should they encounter this situation.
- We saw an information leaflet in the ambulance depot for staff on duty of candour. In this leaflet, it explained what duty of candour means, what incidents are covered by duty of candour, interpretation of the regulation and what the staff member needs to do if duty of candour applies. On the back of the leaflet was a further resource for staff to refer and the contact details of the head office in Birmingham.
- We did not see any incidents where the duty of candour threshold was met.
- Managers were able to explain what duty of candour meant and what steps they would take if a situation that required duty of candour arose.
- We spoke with two members of sub-contracted staff who were able to explain what duty of candour meant and what they should do in the event of patient harm due to staff error.

**Mandatory training**

- The provider could not provide us with assurance that all staff on record were up to date with their training because they did not proactively ask for updated training courses after the initial recruitment process.
- There was little evidence in the staff records that the provider were actively asking for updates from their sub-contracted staff on the training they had attended. There were 70 active staff on the provider's system, who covered both events and patient transport services. We looked at nine staff records where the volume of evidence ranged from no record of training courses attended to a significant range of training.
- There were no mechanisms in place to provide staff with appropriate training to perform their role, or to provide the organisation with assurance that sub-contracted staff had undertaken appropriate training.
- ICM did not offer training for their sub-contracted staff. However, the provider was registered with an external training provider to provide training courses, both on and off-site, to individuals and other organisations. Managers told us they made sub-contracted staff aware of when training courses were running and invited them to attend free of charge. This was not a mandatory requirement and the sub-contracted staff were expected to do this in their own time without pay.
- There was a discrepancy in the level of assurance the provider had relating to the mandatory training completed by their sub-contracted staff. We found that some clinical and first aid training lasted for three years and other training required an annual update. During our inspection we found good evidence in staff records that staff maintained the clinical and first aid knowledge and skill but the evidence of annual update of resuscitation and mandatory training was inconsistent.
- There were two policies, a continual professional development policy and a sub-contractor service level requirement policy, that stated the sub-contracted staff member was responsible for maintaining their qualification at their grade and skill, and to continually update their training and qualifications.
- The provider required the staff to provide them with clinical registration details on appointment of contract.

However, there was no requirement stated in the policy for the staff to provide details of their ongoing mandatory training, neither did it outline what mandatory training was expected of the different job roles. It was also unclear if the provider relied on the sub-contracted staff to supply up to date training certificates or whether the provider actively asked for these when the certificates were due to expire.

- Following the inspection, we requested training courses that ICM had provided with a list of patient transport sub-contracted staff that had attended. The courses provided during 2016 were; level 2 award in cardiopulmonary resuscitation (CPR) and automated external defibrillation (AED), level 3 award in first aid at work, and level 3 certificate in first response emergency care. From the 23 staff that had carried out patient transfers in 2016, 11 had attended the level 2 CPR and AED course, eight had attended the level 3 first aid at work course and two had attended the level 3 first response emergency care course.
- The registered manager told us that their sub-contracted staff were generally people they knew and all came from an ambulance provider, either NHS or private, where they would have received their training. They told us if there was someone they did not know personally, they would contact a friend working within an ambulance provider to see if they knew anything about the member of staff and if their practice was "ok." We did not see any other evidence to suggest the provider had assurance of staff competency after the initial recruitment process.
- After the inspection, we asked the provider to provide us with details including all the mandatory training attended by sub-contracted staff. They provided us with a list of courses staff had completed but it was not clear if the courses were part of their mandatory training.

**Safeguarding**

- ICM had a good process in place to identify and report safeguarding concerns. However, it was not clear how many members of staff had received up to date safeguarding training and the provider did not have assurance that their sub-contracted staff had received up–to-date training.
- At the time of inspection, the registered manager had a qualification for provision of safeguarding training. However, the provider did not provide safeguarding training for their sub-contracted staff. They would make the staff aware of when they were holding safeguarding training courses for other external organisations. The registered manager told us that staff were able to attend the courses free of charge if they wanted to, but this was not a mandatory requirement and was unpaid.
- We saw a safeguarding policy that contained information on how to recognise abuse, gave examples of abuse and what to do if staff suspected abuse. The provider did not clearly state in the policy who the safeguarding lead for the provider was, who the staff member had to contact if they had a safeguarding concern or what level of safeguarding training the provider would expect staff to have.
- We saw a safeguarding leaflet in the ambulance depot with information on what abuse is and what to do if a staff member suspected abuse. There was no named safeguarding lead in the leaflet but was an out of hours' telephone number to call, which belonged to the registered manager who was the safeguarding lead. On the back of the leaflet were a number of online resources and the contact details of the head office in Birmingham.
- The registered manager told us, and we saw there were safeguarding cards attached to the keys of each vehicle with contact details for when staff had safeguarding concerns. We also saw safeguarding information leaflets at the ambulance depot in Smethwick.
- The registered manager was the safeguarding lead for the provider and they were a registered nurse, who at the time of the inspection, worked as a nurse one day a week to maintain practice.
- Managers told us they did not accept any patient transfers for children, as they were not equipped to do so. However, the safeguarding policy and information leaflets included children due to the event work undertaken by the provider.
- The provider had 70 active sub-contracted staff on their system of which we viewed nine records during the inspection. From the nine staff records we viewed, only three had recorded evidence of safeguarding training. One was not specified as to the level of training and was out of date, one staff member was trained to level 2, which had expired had another staff member was trained to level 3 and was in date.
- After the inspection, we requested information about the training all sub-contracted staff who carried out patient transport jobs had completed. The provider sent

us a list containing 23 members of sub-contracted staff who carried out patient transport services. There was no evidence documented on this list that the staff had completed safeguarding training.

- After the inspection we spoke with two members of staff who said they had both received recent and in date safeguarding training from other providers they worked for. Both staff members had completed safeguarding training for adults and children recently and said this was updated every year. One staff member was trained to level 3 and one staff member was unsure of the level of training but said it was basic training. The provider did not have this training did not have this training documented on the list they sent us for either of these staff members.
- Both members of staff we spoke with were able to describe what they would do and who they would go to if they had safeguarding concerns.

**Cleanliness, infection control and hygiene**

- Immediate Care Medical Services (ICM) had appropriate policies, procedures and processes to prevent and control the spread of infection.
- We had assurance that there were reliable systems to prevent and protect people from a healthcare-associated infection.
- ICM had a policy, which provided staff with information about healthcare-associated infection and specific guidance. The provider developed this policy using relevant national guidance such as "Ambulance Guidelines: Reducing infection through effective practice in the pre-hospital environment (Department of Health; June 2008)."
- We saw clear processes set out in the policy to clean vehicles after use and to provide comprehensive cleaning on a weekly basis with regular deep cleans. Managers told us the vehicles had monthly deep cleans. We saw evidence that staff were adhering to the policy by cleaning vehicles weekly. There was also evidence of regular deep cleans on vehicles with the date recorded for when this was last done.
- We saw the vehicles were visibly clean both internally and externally.
- The provider had a colour-coded cleaning system and used single use mop-heads and alcohol wipes for inside the ambulance. Staff discarded of these appropriately.
- We saw a designated sluice area in the corner of the depot, where there was a separate large steel sink for cleaning vehicles. The staff kept the mop buckets and mop handles in this area.
- We observed that personal protective equipment was available on all vehicles and there was clear guidance on when and what staff should use in the infection control policy.
- When vehicles were seriously contaminated, managers told us they would strip the ambulance down completely and give the vehicle a deep clean using detergent including the internal walls and ceiling. The vehicles did not have a fog machine for deep cleans however, the provider told us they were hoping to raise funds so they could purchase these.
- The provider told us they would only book one patient transfer per crew, per day, therefore the vehicle would be clean before the transfer and the staff would clean it after the transfer was completed. There were alcohol wipes in the vehicles to maintain cleanliness whilst in transport.
- Staff disposed of used linen and uniform in colour-coded bins that the provider had clearly labelled. Managers told us staff would put heavily soiled linen in soluble bags and would subsequently wash them on a 60-degree wash. There was a washing machine and tumble dryer at the ambulance depot where staff cleaned linen and uniforms.
- Clean linen was stored in a cupboard in the linen room. We saw plastic sheets covering the clean linen to protect the linen from dust.
- We saw hand-cleaning facilities at the ambulance depot in Smethwick. The provider required staff to wear hand gel dispensers attached to their waist. We were unable to observe staff adhering to hand hygiene policy as there was no patient transfers scheduled on the day of our inspection. We were not able to ask patients if staff regularly used hand gel as we were not able to get any contact details to contact them directly.
- There was an infection prevention and control guidance leaflet in the ambulance depot. Within the leaflet there was information for staff on the importance of good hand hygiene, how to dispose of waste, the use of personal protective equipment and what to do in case of a sharps injury or exposure to blood and body fluids. There was no named infection control lead on the leaflet but was an out of hour's telephone number for

the staff to call for advice. This number belonged to the registered manager who was the clinical lead for the provider. There were resources on the back of the leaflet and contact details for the head office in Birmingham.

- Staff we spoke with knew their responsibilities for prevention and control of infection. Staff said they have seen the infection control policy, knew who the infection control lead was and were able to describe what they would do if they had infection control concerns. One member of staff we spoke with had attended infection control training in May 2016; however, this was not documented on the staff training profile that the provider sent to us after the inspection.

**Environment and equipment**

- Immediate Care Medical Services (ICM) operated from a medium sized office in Birmingham. The provider had access to a room on the same floor where they provided training to other external organisations. The office was sufficient for the number of permanent staff working for the provider.
- We saw a coded access system to enter the office and within the office, all records were stored in locked cabinets.
- The provider held their vehicles at a separate location in Smethwick. This premise was a large industrial garage, which had a segregated office area that required key access. There was a designated sluice area and limited storage facilities, but this was managed effectively.
- All oxygen cylinders we saw were stored appropriately and were in date. Managers told us and we saw, that staff kept empty and used cylinders in one corner of the storage cage, which was clearly labelled.
- There was evidence that staff were cleaning the vehicles regularly, which was recorded on a white board in the depot. All of the vehicles had a current ministry of transport roadworthiness test (MOT) certificate, had been serviced recently and had road tax. It was clear on the board when the next MOT and service was due. We also saw a wall chart in the Birmingham head office showing all service dates, tax dates and MOT dates for all the vehicles. Managers told us vehicles were serviced annually and were inspected six monthly for safety checks, we saw evidence of this happening.
- Managers told us they carried out vehicle oil checks weekly and we saw this recorded on the white board.
- We saw all vehicle keys were stored securely in a lockable safe box. The fleet manager had the key for this box and was always present when staff booked vehicles in and out of the depot.
- Managers told us the stock had a full stock check every month. Stock was in paper format and we saw these had dates of previous stock checks carried out.
- We saw there were detailed stock lists available, which related to the vehicle stock and the equipment bags available in the vehicles. The provider used sealed equipment bags with tamper evident seals and managers told us that after re-stocking any bag, staff would complete a check sheet to confirm that all equipment was present.
- We saw a range of consumable items, we found they were all stored in original packaging and were in date. Managers told us all equipment had monthly date checks.
- There were regular maintenance checks on lifting stretchers and managers told us if there were any marks or cracks that were unable to fix, the stretcher would be disposed of.
- We saw a file in the office that contained evidence of trolleys, chairs and stretchers servicing taking place. The providers had their trolleys serviced in October 2016 and the chairs and stretchers in February 2016.
- The provider told us they outsourced the servicing of trolleys to an external company. Managers told us they were unsure if the service provider had undertaken the necessity courses approved by the manufacturer.
- We saw two different manufactured trolleys that the provider used and were told that staff were not given training to use these. It was not clear if this caused an issue for staff or whether they knew how to use them.
- We saw the vehicles were equipped with defibrillators and monitors. We were unable to locate any mechanism for monitoring carbon dioxide levels. This would be a requirement for a ventilated patient in order to comply with Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.
- The fleet manager was responsible for the management of equipment. Managers told us if there was faulty equipment, they would take it out of service and would arrange for the equipment to be fixed.
- We saw the seat belt straps fitted to the trolleys did not meet the standards required to meet best practice. To ensure patients were safe during travel, a six-point

harness should be available in addition to two straps but these were not available. However, staff we spoke with told us they very rarely transferred patients who required a trolley for patient transfers services.
- We saw a padlock on the outside of the fire door that restricted access. This was the only fire exit within the depot. When we asked managers why the fire door was padlocked on the outside, they told us it was something the property owner insisted on having to keep the garage secure. The provider assured us they would contact the property owner to get this padlock removed. We revisited the premise on 22 December 2016 and found the padlock was still on the back of the fire escape door.
- Since our inspection, the Fire Safety Inspecting Officer for Black Country South attended the premise and is happy with the new arrangements the provider have put in place regarding the fire door access. There is now constant access to the main rear door of the depot.

**Medicines**

- ICM staff did not administer any medicines for patient transport services. The patient would carry their own medicines and if needed would self-medicate.
- Staff told us when patients carried controlled drugs with them; they would assess the need and check the amount at the start of the transfer. If the patient was able, the patient would keep the controlled drugs on them. Where patients were not able, the controlled drugs would be kept in a secure safe present on the vehicles that were not visible to the public. The amount of patient medication at the start and end of the transfer was recorded on the patients' report form.
- Staff we spoke with told us all vehicles carry oxygen cylinders. They said in the event of a patient needing to have oxygen during their transfer, they would transfer an ICM owned oxygen cylinder for the patients' cylinder and would leave the patients' cylinder in their home.

**Records**

- ICM had patient record forms (PRF) for when staff had to treat patients. Managers told us the clinical lead uploaded these PRFs into the office database at the end of each job and audited them as they were put on the system. All of the PRFs that we saw related to the provider's events service and not patient transport services.
- The PRFs were securely stored on a database that required password access. Once uploaded, the provider would shred the paper copies and dispose of them appropriately.
- Managers told us they produced a job pack for each job they take on as a sub-contractor. This contained information given about the patient by the centralised clinical commissioning group (CCG) the provider tendered to.
- The provider told us the CCG often did not give all the information they required or gave the wrong information about a patient. The provider gave us an example of when they were given the wrong address for a transfer where they found the address did not exist.
- Managers told us in the last year they have completed 75 patient transport jobs, these were all routine NHS work.
- It was not clear if there was a formal process for ensuring up to date DNAR orders were communicated to front line staff. The provider said all information given to them was from the CCG, which often only included patient name, date of birth and destination of transfer. However, staff we spoke with said at the beginning of each patient transfer they would ask the patient or their family if they had a DNAR order in place. They said if the patient did have one, the staff member would have to see the original and check it was in date. The order would then be documented on the PRF to show the staff member had seen it.
- All care and treatment given to patients during transfer was documented on patient record forms, which had carbon copies attached. Staff would hand the carbon copy of any assessments and observations carried out during transfer to the relevant care staff receiving the patient, including a verbal handover. The staff member would then document a verbal handover has taken place on the PRF for Immediate Care Medical Services' (ICM) records. If the verbal handover was a complex one, ICM staff would gain a signature from the nurse on the receiving end.

**Assessing and responding to patient risk**

- Managers told us they do not provide patient transport services for medically complex patients. The registered manager used their clinical knowledge and expertise to determine if they were equipped to accept patients of certain patient groups. There was a protocol in place for the operations manager for when both the clinical

directors were not available. This included a list of medical conditions that the provider was not equipped to provide a service for, which the operations manager used to aid them with the inclusion of patient groups. The operations manager was able to call the registered manager if there was anything they were unsure of when accepting transfers.

- The provider did not have a policy for staff to follow if a patient was to deteriorate. However, staff we spoke with were able to describe what they would do if a patient deteriorated in their care. They said it would depend on the crew carrying out the transfer, if a paramedic was on board they would have a paramedic kit with them and could assist with less immediate life threatening concerns. If a patient had an immediately life threatening concern, they would contact 999 for an emergency ambulance and would inform the managers over the phone. Staff would then record the incident when back at the depot.

**Staffing**

- The provider had sufficient staff on their system to carry out their service. The registered manager told us they would only tender for a job if they knew they had the resources to do the job safely and appropriately.
- We saw a database that showed all sub-contracted staff that were active on the system, all of which had a detailed report on checks that the provider had carried out on recruitment.
- The database we saw contained profiles of 70 active staff. Of these, four were doctors, six were nurses, seven were technicians, 14 were paramedics and 25 were first responders. The system was easy to filter the skill mix of the staff on record and contained all the information obtained during the recruitment process.
- Patient transport services only equated to 20% of the providers operational business. Managers told us they rarely undertook patient transport jobs and therefore these jobs were rare, but they use the same staff for their patient transport service as they do for their event cover. In the previous 12 months, the provider carried out 75 patient transfers of which 23 members of the sub-contracted staff assisted. Six of these staff members were paramedics. In the two weeks before our inspection, the provider did not carry out any patient transfers.
- Rotas or shift patterns were not required as work was on an ad-hoc basis. The provider took patient transfers on an individual basis through a tendering system. They never took on same day bookings to ensure they were able to arrange for sufficient cover.
- The provider did not assure us that individual jobs were allocated based on staff skill or competency. When asked, the registered manager told us that the clinical directors used their clinical knowledge and knowledge of their sub-contractors to allocate people to each job. For example, we were told the clinical lead would accept a job and think, “who would like to attend” and would offer the job to them first. These staff members would often be paramedics or technicians.
- There were five permanent members of staff at ICM; these consisted of the directors, administration staff and fleet management. The rest of the staff available to the provider were used for jobs on a sub-contracted basis.
- Managers told us they did not have a formal induction process but were working towards implementing one. However, during our inspection they had an informal preceptorship for new staff where once they had been recruited and were on their first shift, either the clinical lead would attend to observe practice, or the new staff member would be paired with a long-standing experienced member of staff.
- The provider told us they did not have internal handover arrangements, as they allocated a crew to a vehicle for the job they were attending. They told us each crew had one job per shift.

**Anticipated resource and capacity risks**

- Immediate Medical Care Services (ICM) solely provided patient transport services on an ad-hoc commissioned basis, as and when they had sufficient resources to deliver the contract.

## Are patient transport services effective?

**Evidence-based care and treatment**

- The provider based their exclusion of patients on the clinical directors’ knowledge and expertise rather than using national guidance.
- The directors assessed patient need before accepting patient transfers and there was a protocol in place for the operations manager when both the clinical directors were not available. This included a list of medical

conditions that the provider was not equipped to provide a service for, which the operations manager used to aid them with the inclusion of patient groups. In addition if the operations manager wanted additional clarity, the clinical lead was always accessible, including out-of-hours.

**Assessment and planning of care**

- The provider did not have any substantive contracts and therefore did not have any contract levels to manage. The patient transport service provided relied on tendering for individual jobs through a tendering process on an ad-hoc basis.
- Managers told us they do not accept patients living with complex medical needs or children, this included patients living with mental health concerns and bariatric patients. The provider told us they did not provide a service to these patient groups, as they were not equipped to transport them.
- There was a risk of the provider accepting transfers they were not equipped to assist as there was no interaction with patients and organisations requesting tenders before the provider accepted transfers. Managers told us that on occasions, the referring organisation had given incorrect information.
- Staff gave an example where a patient using patient transport services had low harm mental health concerns, which was not conveyed before the job was tendered for and accepted by the provider.
- We saw an example of a job for tender that had come through. The information the referring organisation provided was brief but managers told us there was more information available after the tender had been successful.
- The operations manager told us they produce a job pack for the individual transfers they tender for. This pack included all the information about the patient that the referring organisation had given to the provider. Staff confirmed all the information they received was in the job pack.
- Staff told us if they arrived at the transfer and found they were not equipped to continue, they would contact the operations manager and explain the issue. They gave an example of where this had happened and the operations manager was fully supportive of their assessment. On these occasions, the staff would explain to the patient why they cannot continue with the transfer. They would call the operations manager who would arrange for another provider to attend to the patient.
- Staff we spoke with were able to explain how they would identify if a patient was living with mental health concerns. Both staff told us they had received mental capacity act training recently from other organisations.

**Patient outcomes**

- Immediate Care Medical Services (ICM) did not benchmark and compare patient outcomes to other providers. This information was recorded for staff payment purposes.
- The provider did not analyse this information for improvement. The provider told us they had never been asked for patient outcome information by commissioners and details were only provided to commissioners for invoicing purposes.
- For the previous 12 months, the provider carried out 75 completed jobs for patient transport.
- There was no system in place for patient outcome data to be captured and analysed for improving the service. Data such as patient time on vehicles, on time patient journeys, nature of injury or illness of patients being transferred, and treatment or interventions that had been provided were routinely being collected and recorded on patients' job sheets. However, this information was not being used or analysed so that it was readily available. For example, when we asked for the percentage of patients spending excessive time on vehicles, the provider was not able to supply us with this information. The provider could find time spent on vehicles on the PRFs from using the timings staff input on the job sheet, but would have to spend a substantial amount of time to get this percentage.
- The clinical lead uploaded all patient record forms (PRF) on to a database. There was no quick or clear way of distinguishing whether the form was from a patient transport job or an event job. The registered manager told us they would check the date on the PRF with their diary to find out if the PRF was from an event cover or a patient transport job. At the time of the inspection, we were told there were no PRFs that had come from patient transport jobs.

**Competent staff**

# Patient transport services (PTS)

- At the time of our inspection, the provider had no formal process for one-to-one meetings or appraisals for permanent staff.
- Immediate Care Medical Services have five permanent members of staff who were directors, administration staff and managers. None of these members of staff had a recent appraisal. However, the registered manager told us they were hoping to start giving permanent staff appraisals in January 2017. We contacted the provider in February 2017 and were told all full time permanent staff had appraisals carried out and completed in January 2017.
- The provider told us they do not have formal meetings held on a regular basis as they are a very small organisation. They told us they held meetings to discuss and deal with issues as they arise and that these meetings were chaired by one of the clinical directors. All office staff and the fleet manager attended these meetings. Managers told us at the end of the meetings, the director offered their time for one-to-one if any staff member had any concerns. These meetings were not minuted so we were unable to see evidence of what was discussed at these meetings.
- The registered manager told us they did not take on a sub-contracted member of staff without a vigorous recruitment check, which had to be completed before a staff member became active on their system.
- During this process, the provider carried out a number of checks including disclosure and barring (DBS), national registration checks for example, general medical council (GMC) for doctors, two reference checks one of which should be a professional reference and evidence of training courses attended. We saw evidence of these checks on initial recruitment.
- The provider had a good system in place for ensuring their staff had valid DBS certificates. They did not accept staff with DBS certificate that had an issue date of more than three years. For staff that had an enhanced DBS from another organisation, which was dated within three years of issue, the provider would accept the certificate and get the staff member to sign an ICM disclosure form, which was updated on an annual basis and formed a declaration. The provider was registered with an umbrella organisation of the DBS and was able to request certificates for their staff themselves if the staff wished for them to do so. Alternatively staff would obtain a DBS certificate through their other place of employment. The provider encouraged all staff to register with the DBS update service to keep track of their certificates, if they obtained the DBS certificate through the provider. The DBS details of those staff members were checked on an annual basis. The provider kept the date of issue of all DBS certificates on staff profiles and sent a reminder to staff to update three months before their certificates were due to expire.
- The provider had a good process for checking staff professional registrations, such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPS). We saw administration staff recorded dates of the last check on individual staff profile records. Managers told us the administration staff carried out professional registration checks every three months. We saw these checks were done regularly but were not always every three months; however, checks were carried out within six months.
- The provider had a disclosure policy, which staff signed on recruitment to give the provider permission for these checks. The policy stated regular checks of staff professional registrations and updates on DBS certificates would take place.
- The provider did not have a sufficient level of assurance that their sub-contracted staff had the appropriate skills and knowledge to carry out patient transport services. The provider relied on the sub-contracted staff member coming from an NHS service or private sector ambulance service. We saw vigorous recruitment checks however, the provider did not actively seek evidence of up-to-date training.
- At the time of the inspection, there was no formal induction programme delivered to ensure the staff were familiar with the equipment used or their competency. However, the registered manager told us that they were hoping to introduce a formal induction programme in January 2017. There was a process described like a preceptorship, where the provider paired a new sub-contractor with either the registered manager or a member of staff that had been with the provider for a long time, to review the new staff member's practice. This was informal and only done at the start of recruitment and was not a continuing process to assess competency.
- The provider had a continual professional development policy given to all staff in their welcome pack. The policy stated that the provider required all sub-contractors acting as first aiders to give the provider a copy of their current First Aid at Work certificate or undergo a

three-day First Aid at Work course provided by ICM. The provider required all sub-contracted staff that were doctors, paramedics or nurses to provide their registration and licensing numbers for their relevant professional bodies. There was no requirement stated in the policy for the sub-contracted staff to provide details of their ongoing mandatory training, neither did it outline what mandatory training was expected of the different job roles. It was also unclear if the provider relied on the sub-contracted staff to supply up to date First Aid certificates or whether the provider actively asked for these when the certificates were due to expire.

- We saw evidence of staff attending First Aid at Work courses that the service had provided.

**Coordination with other providers**

- The provider did not have any substantive contracts for their patient transport services. They relied on a tendering system where a centralised CCG would offer a job for tender to five providers including ICM. ICM would then have to provide the centralised CCG with a quote, which would then be accepted or rejected.
- Managers told us all jobs they tendered for were provided through the centralised CCG, they had no contact with the organisation instructing the CCG on their behalf other than providing them with an invoice after the job has been completed.
- If a patient was in transport to an appointment and the driver was stuck in traffic or delayed, the driver would contact the operations manager who would contact the clinic and let them know their patient is on route.
- All patient transfers the provider undertook were on an individualised ad-hoc basis.

**Multidisciplinary working**

- We did not see any episodes of multidisciplinary working as on the day of inspection because there were no patient transfers taking place.
- Staff told us they gave a formal handover verbally to a nurse in charge at the patients' destination, as well as handing the nurse a copy of the patients' record form. Staff told us the verbal handover would be documented on the patient record form and if the handover was complex, the nurse would be asked to put their signature next to the verbal handover information.

**Access to information**

- Managers told us they produced job packs with all information about the patient that the referring organisation had provided to communicate with the front line staff member. All job packs were sent down to the ambulance depot prior to the patient transfer for the subcontractor to collect. Once the transfer was completed, the subcontracted staff completed the job pack and posted the pack into the secure post box on the wall of the depot, which were taken back to the office at the end of the working day.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- The provider could not assure us that all sub-contracted staff had had relevant training regarding the mental capacity act.
- The provider did not provide training for the sub-contracted staff, it was a requirement clearly set out in staff welcome packs that all sub-contracted staff were responsible for ensuring they kept up-to-date with relevant training.
- We requested the provider to send a list of evidence of completed training for the 23 sub-contracted staff that had carried out patient transfers in 2016. The list the provider gave us did not include mental capacity act training.
- Despite this, we spoke with two members of staff on the list who told us they had recent, up-to-date mental capacity act training from external organisations and were able to describe how they would gain consent and the process they would take if a patient lacked capacity.

## Are patient transport services caring?

We were not able to inspect caring as there were no patient transfers taking place on the day of our inspection. Unfortunately we were not able to contact patients after our inspection, as the provider did not keep their patients' contact details.

## 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)

- The service was planned and delivered to meet the needs of their service users and had the flexibility to respond to jobs on an individual basis due to not having a permanent contract to fulfill.
- Managers told us they would only tender for patient transfers if they had the resources and appropriate skill mix to do so.
- There was a significant number of sub-contracted staff on the provider's database and sufficient resources to carry out patient transport services, provided Immediate Care Medical Services did not have an event to cover at the same time.
- The provider did not have any standard operating service times, managers told us it would depend on the requirements of the individual jobs they tender for.

**Meeting people's individual needs**

- The provider told us they base the needs of patients on the information from the referring organisation, which was conveyed during the tendering process. . We saw a job that had come through and the information about the patient was very brief. Managers told us once a tender was successful; more information was available however this did not always include religious or cultural needs.
- The clinical directors would use their clinical knowledge and expertise to assess whether they had the resources to accept different patient groups. The provider did not accept patients with complex needs including bariatric patients, patients living with dementia, patients with mental health concerns or complex medical conditions. There was a protocol in place for the operations manager when both the clinical directors were not available. This included a list of medical conditions that the provider was not equipped to provide a service for.
- Staff we spoke with told us they would always try and accommodate patients' religious and cultural needs as long as it was safe to do so. If for any reason they were unable to accommodate, staff said they would have a conversation with the patient to explain why they are unable to accommodate and if the patient would still like to continue with the transfer. If they would not like to continue, the staff member would call the office to explain the situation and another provider would be provided.
- The provider did not provide a service for bariatric patients as they were not equipped for this patient group.
- Staff we spoke with were unsure if there was a translation service through the provider, however they said they were able to call language line or use mobile translation websites if they needed.
- There was no formal process for ensuring patients living with hearing or sight difficulties needs were being met. Staff I spoke with said they had the ability to use Makaton and one had a personal Makaton book they carried with them. This was an ability the staff members had gained personally and was not part of general service or provided through ICM.
- None of the staff we spoke with were aware of a policy on how to deal with violent or aggressive patients. All staff we spoke with had training to deal with aggressive patients through other external organisations.

**Access and flow**

- The provider had an online system that allowed patients to contact the provider directly and book transfers. The system included an online form that patients could fill out and submit, and there was an option to submit an enquiry to request a call back from the provider. The website also included the provider's telephone number for patients to book over the phone. The provider told us that all bookings they had were done through a centralised clinical commissioning group (CCG) on behalf of NHS organisations and occasionally other private ambulance services. All bookings were in advance, as the provider did not carry out same day bookings.

**Learning from complaints and concerns**

- There were good processes in place to manage complaints.
- The provider had a complaints policy, which outlined what staff should do in the event of a patient wanting to complain.
- Staff we spoke with were able to explain what they would do if a patient wished to complain. They said they would give the patient a card with the contact phone number, address and email address of the ICM office.
- One of the directors was the lead for complaints. The director told us they would contact the complainant directly to try to resolve a complaint at the earliest opportunity. They told us they would use complaints as a learning experience to improve the way they do things.

# Patient transport services (PTS)

- The provider shared learning from complaints on a private social media page that the provider set up and managed. Only sub-contracted and permanent staff were allowed to become a member and would be invited on to the page.
- Before our inspection, we requested data from the provider on the number of complaints the provider had received for their patient transport services. The provider said they had no complaints in the previous 12 months relating to patient transport services.

## Are patient transport services well-led?

### Leadership of service

- The leadership team consisted of two clinical directors of which one was a registered nurse and the registered manager of the provider, and the other a retired paramedic. An operational manager was responsible for all operational aspects and securing patient transfers, and a fleet manager was responsible for the vehicles and stock at the depot.
- Leaders had the necessary knowledge and capability to lead effectively. The registered manager was a registered nurse and had understanding of the Health and Social Care Act 2008.
- Managers told us the front line sub-contracted staff were never alone in the ambulance depot. They said the fleet manager was always there to let people in and out of the depot. On occasions when the fleet manager was not working, the clinical lead or other director went to the depot to let staff in and out.
- All staff we spoke with said they regularly see the management team, one of which told us members of the management team regularly go on jobs. Staff told us the management team were always available on the phone if they were needed.
- All managers we spoke with were aware of their role and responsibilities, and staff we spoke with knew who the different leads were and what they were responsible for. Managers understood what they were accountable for.

### Vision and strategy for this service

- The provider did not have a clear vision, strategy or set of values for the patient transport service.
- Managers told us they were hoping to find premises where they could house their ambulance depot and office at the same location.
- The provider have said they have no plans to change or increase the market share of their patient transfer services as they felt they were not big enough to fulfil regular contract needs.

### Governance, risk management and quality measurement

- Risks were not adequately controlled regarding staff training and competence. There was no system in place to ensure staff maintained their mandatory training, prior to the provider using them for PTS journeys. Although the provider could not assure itself of the level of safeguarding training staff had received, it did provide staff information enabling them to raise a safeguarding if required.
- There was a risk of the provider accepting patient groups that were not in their inclusion criterion. The provider did not have a formal action plan in place to address this issue; however, staff told us they would have a conversation with the patients on arrival and if there were any signs that the patient fell outside their remit, they would contact the office to make other arrangements. The managers told us they expected staff to do this when they arrived at the patient's address but there was no formal policy or procedure stating this.
- The provider did not use information they gathered regarding performance to improve the service.
- As there was a lack of vision and strategy, it was difficult for the provider to identify risks to the PTS service and address them.
- The management of vehicles along with the infection control and stock was well managed within the organisation.
- The provider did use complaints to improve the service although these complaints did not relate to patient transport services.
- The provider was collecting data from their patient transfers; however, this was purely used to ensure staff carrying out the transfers were paid correctly. They were not using the data collected to measure performance.
- Meetings took place amongst managers but these were not regular and not minuted. Managers told us these meetings took place as and when issues arise.
- The management staff were aware of duty of candour and the need to be open, honest and transparent. There was no training provided for sub-contracted staff on

duty of candour; however, there were information leaflets providing guidance on duty of candour in the ambulance depot. There was also a section of the complaints policy on duty of candour.
- All staff we spoke with were able to describe what duty of candour meant and when it would be used.
- The registered manager told us they added all sub-contracted staff to a private social media page set up and managed by the provider. All of the provider's policies were on this page for sub-contracted staff to read. There was also a copy of a number of policies within the paper staff records signed and dated by staff when they have read the policy. Managers told us and we saw a box of all the policies within the office of the ambulance depot.
- The provider only carried out a small number of patient transfers, all of which had been routine, therefore managers did not debrief the staff after these jobs. Managers told us if staff had a long journey or a long wait time, they would contact them to check on their wellbeing.

**Culture within the service**

- Staff we spoke with were happy to work for ICM and said the managers demonstrated openness and honesty. They said the provider was a "brilliant organisation" to work for and "the people are very genuine and transparent."
- One member of staff told us the managers were always happy and open to receiving advice from staff on how to improve the way things were done. They said whenever a staff member had a concern about anything, the managers would ensure the issue was dealt with promptly and things were put in place to resolve the issues.
- We heard from staff that the managers were very supportive of the decisions staff made whilst carrying out transfers. An example was given where a job was unsafe for staff to continue because of the patient's medical condition and not having the correct equipment to assist. The staff member called the office and spoke with the operational manager who fully supported the front line staff and contacted the CCG to arrange for an alternative provider to attend to the patient.

**Public and staff engagement**

- The provider was missing the potential for improving their service due to a lack of engagement with service users.
- The provider was not obtaining feedback from the organisations they worked for or from patients. The only feedback from patients was via the complaints process and in the previous 12 months the patient transport service had no complaints.
- The registered manager told us they kept up-to-date with all sub-contracted staff on the private social media page set up and managed by the provider.
- All sub-contracted staff had an out-of-hours' number to call should they have a concern. We saw the out of hours' number located on various information leaflets at the ambulance depot and were told the number belongs to the registered manager who is also the clinical lead.

**Innovation, improvement and sustainability**

- Immediate Care Medical Services (ICM) did not have any substantive contracts with any providers. They provided a patient transport service on an ad-hoc basis through a tendering process through the centralised clinical commission group (CCG). The CCG would invite ICM along with four other providers to tender for patient transfers. Managers told us some of tenders they win and some they hear nothing further, it was believed the CCG generally awarded the job to the provider with the cheapest quote.
- The registered manager told us they were concerned about how they could sustain the patient transport service through the tendering process.
- The provider had no plans to gain any substantive contracts for patient transport services as they felt the business was not big enough to fulfil regular contract needs. The main service provided by this organisation was the event cover and the introduction of the training courses for external providers. There was not much focus on proactively seeking patient transfers and that the provider was happy to continue tendering when approached by the CCG.
- Although the provider was innovative with other aspects of their business, there was not any innovation regarding the patient transport service provided.

# Patient transport services (PTS)

- There did not appear to be any improvements made to the service, as there was no feedback gained from service users and staff were unable to describe a change to the service resulting from incidents. The only example staff gave related to the providers event cover.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital MUST take to improve

- The location must take action to ensure they have assurance that their sub-contracted staff have carried out, and are up to date, on all of their mandatory training and training that is essential for staff members to carry out their role safely.
- The location must take action to improve the use of patient outcome data they are currently collecting.
- The location must take action to gain feedback from service users to help improve services.

### Action the hospital SHOULD take to improve

- The location would benefit from a system that would allow them to analyse incidents for themes.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>2(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.<br>The provider was not proactively checking sub-contracted staff were up to date with their mandatory and safeguarding training. |

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity (including the quality of the experience of service users in receiving those services);<br>2(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying out of the regulated activity, for the purposes of continually evaluating and improving such services.<br>The provider was not using any patient outcome data to monitor and improve the service provided. |

This section is primarily information for the provider

# Requirement notices

The provider was not seeking feedback from patients using the service.