LIFELINE Medical Transport Service Limited

LIFELINE Medical Transport Service Limited

Quality Report

Double Row
Seaton Delaval
Whitley Bay
NE25 0PP
Tel: 03335778899
Website: www.lmts.co.uk

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

Summary of findings

Letter from the Chief Inspector of Hospitals

LIFELINE Medical Transport Service Limited is operated by the provider, which is also called LIFELINE Medical Transport Service Limited. The company provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 21 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:

- Staff were committed to providing the best quality care to patients. Staff displayed a caring and compassionate attitude and took pride in the service they were providing.
- Staff checked patients' requirements prior to transporting them to ensure that they were able to meet their needs.
- We observed good multidisciplinary working between crews and other NHS staff when moving patients.
- The management team worked with a local NHS hospital trust to provide services which met the needs of local people.
- Staff were well supported by the management team; they told us the management team were friendly and approachable.

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

- Equipment used on the ambulances had not been regularly serviced to check it was safe for use. The systems in place for checking the equipment had not picked up on faults identified during the inspection.
- Vehicles had an MOT and road tax, however there was no service history available, or other audit system in place, to monitor that the vehicle remained safe for use.
- Infection control practices were in place, but staff had not received training in relation to cleaning ambulances and there were no monitoring or audit systems to check that cleaning was effective.
- There was an incident reporting system that ambulance crews had instigated and co-ordinated with the NHS Trust they worked with. However, these reports were not reviewed by the provider to identify actions which could minimise the chance of recurrence.
- Staff were unaware of the Duty of Candour at the time of the inspection. However, we were assured by the management team that they supported all staff to work in an open and transparent manner.
- Staff followed an induction programme and had completed some relevant training to ensure that they had skills to carry out their role. However, training was inconsistent; some staff had not completed relevant training to an appropriate level for their role.

Summary of findings

- Relevant background checks had been carried out during recruitment processes. This included, for example, a full Disclosure and Barring Service (DBS) check. However, we found that driving licence checks had not been carried out for two members of the ambulance crew staff.
- There were limited plans in place for managing potential disruption to the service, for example, in the event of flood or fire, at the time of the inspection.
- The service did not currently seek feedback from patients to monitor the quality of the service.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements. We also issued the provider with two requirement notices in relation to breaches of the regulations that affected patient transport services. Details are at the end of the report.

Ellen Armistead

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The only service provided was in relation patient transport.

LIFELINE Medical Transport Service Limited

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Detailed findings

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Background to LIFELINE Medical Transport Service Limited

LIFELINE Medical Transport Service Limited is operated by LIFELINE Medical Transport Service Limited. The service opened in 1997. It is an independent ambulance service in Seaton Delaval, Tyne and Wear. The service primarily serves the communities of South Tyneside.

The service works with one NHS trust providing patient transport services. They move non-urgent patients between hospitals, homes and care facilities.

The service has had a registered manager in post since 2012.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector, and a specialist advisor with expertise in patient transport services and emergency and urgent care.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

LIFELINE Medical Transport Service Limited is an independent ambulance service with an operational base and offices in Seaton Delaval, Tyne and Wear. There are two ambulances at the base, although only one was operational at the time of our inspection.

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

The service employs five people in the patient transport services; two in managerial roles and three providing transport services as ambulance care assistants and drivers. The ambulance crew are employed on fixed-term contracts. There was also a mechanic employed by the service and working in the garage at the location.

The service's track record on safety from January 2017 to November 2017 showed:

- No never events
- Two incidents
- No complaints

In the period January 2017 to November 2017 there were 705 patient journeys undertaken. The service only works with adult patients.

During the inspection on 21 November 2017, we visited the ambulance base and offices in Seaton Delaval. We spoke with four members of staff including a frontline ambulance crew and members of the management team. We spoke with four patients. During our inspection, we reviewed a sample of 20 patient records. We checked one vehicle and a member of the inspection team observed care on one ambulance.

The service had a contract with one NHS hospital trust at the time of the inspection. This contract was for patient transport services during the winter months (October 2017 to March 2018) when the trust expected additional demand on their service. The provider had delivered the same length of service to the trust in previous years.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected three times; the most recent inspection took place in July 2014. This had been a focussed inspection to check that the service had improved standards of training and patient confidentiality. We also checked that the service had effective systems to assess and monitor the quality of the service. The inspection found that the service was meeting all standards of quality and safety it was inspected against at that time.

Patient transport services (PTS)

Summary of findings

Are patient transport services safe?

At present we do not rate independent ambulance services.

We found the following areas of good practice:

- There were sufficient numbers of suitably qualified staff to meet patients' needs at all times.
- Staff carried out simple risk assessments of their patients as part of the booking procedure. This included screening questions to identify if the patient needed additional clinical support during the transfer.
- There was a standardised form for recording information related to each patient that had been transported on the ambulance. These forms were completed well and provided an historical record of the number of patients transported and the time taken to transport each patient.

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

- Some staff involved in cleaning ambulances had not completed infection and prevention and control training. None of the staff had completed training in how to specifically clean ambulances. There was no written guidance for cleaning the ambulances and no systems for monitoring the effectiveness of cleaning.
- We found faulty equipment on the ambulances on the day of the inspection; the equipment had not been regularly serviced. Systems for visually checking the equipment on a daily basis were not formally recorded and had been ineffective at identifying faults.
- The provider had not maintained a vehicle service history for the ambulance that was in use on a daily basis.
- Staff training was inconsistent. For example, one member of staff had not completed safeguarding training to an appropriate level and one member of staff had not completed training in the Mental Capacity Act (2005).
- Background checks for staff were being carried out, but were inconsistently applied. Two staff driving ambulances had not had a driver's licence check.

- Aspirin was stored for patient use on the ambulance. However, there were not staff protocols, or medicine management policies, to support its safe administration and use.
- Staff were unaware of the requirements of the Duty of Candour and how it applied to their work. This was a breach of a regulation. You can read more about it at the end of this report.

Incidents

- The service had an incident reporting template, although there was no formal incident reporting policy.
- The ambulance crew we spoke with had co-created an incident reporting record with the NHS Trust that the service was contracted to work with. Two incidents were recorded in October 2017.
- The operations manager was aware of this new system and the feedback given by the ambulance crews to the NHS Trust in relation to these incidents.
- However, the registered manager was only made aware of this process on the day of the inspection.
- There was no internal system for reviewing incidents in order to identify learning points that could prevent a recurrence.
- However, we found the ambulance crew had used the incident reporting record to develop shared learning with the NHS Trust. We observed one example on the day of the inspection. The ambulance crew had kept a record of an incident where they had transported a patient to a care home on a stretcher and found that the stretcher could not access the care home. On the day of the inspection, the crew had been asked to transport another patient on a stretcher to the same care home. On this occasion, they were able to raise this as a concern with the NHS Trust prior to transporting the patient so that suitable arrangements could be made in advance of the journey.
- The service had not recorded any never events or serious incidents in the past year. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The service did not have a Duty of Candour policy. The staff we spoke with, including the registered manager and ambulance crew, were not aware of the Duty of Candour. However, they assured us that the service always operated in an open and transparent manner.
- 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. Duty of candour should be discharged if the level of harm to a patient is moderate or above.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The provider did not maintain a clinical quality dashboard or other, similar method for monitoring clinical outcomes.

Cleanliness, infection control and hygiene

- The service did not have a formal, infection and prevention control (IPC) policy. However, the staff we spoke with were aware of their responsibilities related to IPC.
- Personal protective equipment (PPE) was available on all ambulances. This included, for example, disposable clinical gloves and aprons. Staff were aware of when these should be used and we observed that they were appropriately used.
- Linen was supplied by the NHS hospital trust that the service held a contract with.
- All ambulances, garages, staff areas and offices were visibly clean and tidy.
- We observed that staff completed a visual check of the ambulance prior to their shift. However, a checklist and record of how this was carried out was not in use.
- The ambulance base had a store room where cleaning products were stored. A colour coding system was used which separated equipment that was to be used in different areas. For example, in ambulances and in non-clinical areas. There were posters located next to all cleaning equipment to support staff in identifying the correct equipment to use.

Patient transport services (PTS)

- The service had a uniform policy which outlined the roles and responsibilities of all staff members. Staff had an awareness of the need to wash their uniforms separately to all other clothes so that the risk of contamination was reduced.
- All vehicles had decontamination wipes which were in date. We observed ambulance crews cleaning down the equipment, such as wheelchairs and stretchers, after the transfer of a patient to ensure the vehicle was clean for the next patient.
- Ambulance crews fully cleaned their vehicles at the end of their shift. The service only transported patients with a high risk of infection at the end of the shift so that the vehicle could be cleaned prior to contact with another patient.
- Two out of three of the ambulance crew staff had completed some IPC training within the past three years, however, none of the staff had any training specifically related to the cleaning of ambulances.
- The registered manager deep cleaned the vehicle every week. However, they had not completed any formal IPC training. They did not follow a checklist or carry out an IPC audit to monitor the quality of the process. There were no systems in place for checking the effectiveness of the cleaning process, for example, by taking a swab sample to measure the number of bacteria present.

Environment and equipment

- The services had two ambulances, but only one of these was operational at the time of our inspection.
- We found the ambulance stations, including the garages and equipment storage areas, were clean and well laid out. They were well lit, tidy and fit for purpose.
- The station had bathroom and toilet facilities for staff to use during their shifts.These were well maintained.
- The station had security in place, which included a key coded outer door and CCTV in use on all entry points into the building.
- Consumable stock was stored on shelves in a store room. The level of stock was managed by the registered manager. The staff we spoke with told us there was never any problem replacing used consumables.
- Hazardous substances were stored in a locked room, or a locked cupboard, at the various locations. There were appropriate Control of Substances Hazardous to Health (COSHH) assessments in place.
- The vehicles had a tracking system to enable the provider to monitor their location and driver performance. Feedback on driver performance was given to each member of staff on a weekly basis.
- We observed that the ambulance crew and mechanic were responsible for completing a daily vehicle check before every shift. This included checking if the vehicle was in a good state of repair and had the correct equipment available. The daily vehicle checks were not carried out using a structured checklist or recorded on a form.
- Our inspection of the operational ambulance found that the stretcher had a faulty rail, although straps were available. The carry chair straps were missing. None of the equipment had been serviced since 2015. Other equipment required for moving and handling patients, such as a turning disc, moving belt or 'banana' board were not present on the ambulance.
- The Ministry of Transport (MOT) test due dates and servicing schedules were on a database maintained by the operations manager. We checked both ambulances and found that the MOT and road tax was up to date. However, the provider did not have access to a full service history for their vehicles and it was unclear when the last service had taken place.
- We raised our concerns about the safety of the equipment and the ambulance, in the light of the lack of servicing and adequate safety checks, with the registered manager and operations manager on the day of the inspection. They were responsive to our concerns and arranged to have the ambulance serviced before commencing the next shift. They carried out a restricted service on the day after the inspection so that unserviced and faulty equipment was not in use. Thereafter they hired a new vehicle, with fully serviced equipment, for the remaining duration of the patient transport contract with the NHS Trust until March 2018.

Medicines

- The service did not have a medicines policy at the time of the inspection. However, staff were able to describe how they handled patients' own medicines during transfer and understood the importance of handing them over to nursing or medical staff correctly.
- Oxygen was stored in a separate, lockable facility, with cylinders stored off the ground.All of the cylinders we checked were in date.
- Staff we spoke with knew about their responsibilities when administering oxygen. The amount of oxygen that patients required was requested as part of the booking procedure and the relevant information was passed to staff prior to transport.
- Staff were booked to receive specific training in use of oxygen in December 2017.
- One member of the ambulance crew had formal training in medical administration, although we noted that this was not needed for the patient transport services provided at this location.
- The ambulance that we inspected was stocked with oxygen and aspirin, and relevant first aid materials. However, we noted that there was no written protocol for administering aspirin, including, for example the checking of patient allergies.
- The ambulance crew told us that the oxygen was checked on a daily basis to ensure that it was in good working order. The registered manager showed us evidence related to an external contractor inspecting and servicing oxygen equipment.

Records

- The service used standardised "Patient Transfer and Risk Assessment Sheets" for patient transfers. These recorded patient details, with dates and times of transfers. Notes were kept recording any oxygen administered, and other actions taken.A dynamic risk assessment considered whether additional clinical advice was required prior to transfer.
- We reviewed a sample of 20 patient records that had been completed within the past month. We found that these had all been fully and clearly completed.
- The ambulance crew suggested some areas for improvement on the form, such as more space for accompanying notes.
- During shifts, the patient records were held on a clipboard in the back of the ambulance and updated by the crew member. At the end of the shift these records were taken back to the ambulance base and posted into a locked box in the ambulance crew staff room. These were then collected by the registered manager the following morning.
- Information about special notes, such as, Do Not Attempt CardioPulmonary Resuscitation orders (DNACPR) were included as part of the patient records.
- Staff understood the need to review and hand over any patient information, including hospital notes, when a patient was transferred to a new provider.

Safeguarding

- The provider had provided staff with safeguarding guidance. Two out of three of the ambulance crew staff were adequately trained in safeguarding children (Level 2) and vulnerable adults. One member of staff had only completed level-one training.
- The registered manager was the safeguarding lead and they had completed training in safeguarding children (Level 3) and vulnerable adults to an appropriate level.
- The ambulance crew staff room displayed a flow chart for raising safeguarding concerns which included relevant contact details for referrals in the local area.
- The staff we spoke with gave us examples of what constituted a safeguarding concern and were able to describe the process for reporting this.
- Staff told us they would report safeguarding concerns at the time that they occurred directly to the NHS Trust that they worked with, and to the service's safeguarding lead. The ambulance crew we spoke with stated there had been no safeguarding concerns requiring formal referral since the new patient transport contract with the NHS trust had commenced in October 2017.
- Staff were not aware of guidance related to specific safeguarding issues. For example staff could not describe the legal requirement for reporting incidents of female genital mutilation (FGM). They were also unaware of the 'PREVENT' strategy for identify and preventing radicalisation.

Mandatory training

Patient transport services (PTS)

- The registered manager told us they provided induction and mandatory training for all staff.
- The registered manager told us mandatory training included infection prevention and control (IPC), basic life support, moving and handling and safeguarding training.
- We noted that all of the ambulance crew staff were booked to complete training in the use of oxygen in December 2017.
- There was an induction checklist to ensure that all staff had completed relevant training prior to becoming operational on the ambulance.
- We reviewed the staff files for all three of the ambulance crew members. We found completion of training was inconsistent. Staff had all completed some safeguarding training, but not to the required level. Two members of staff involved in cleaning vehicles had not completed infection and prevention control training. There was no mandatory training in relation to the Mental Capacity Act (2005), although two out of three members of the ambulance crew had completed this training. Staff had not been trained in, and were not aware of, the requirements of the Duty of Candour.
- The service provided staff with some driver training as part of an induction process. This training was delivered in-house by another experienced member of staff. Drivers were only using the ambulance for patient transfers carried out at normal road speeds.
- We discussed driver training with the registered manager. They told us that they had provided some training in the past, but had not provided this more recently. However, the ambulance crew told us that they had received a half-day of driver training as part of their induction.
- The operations manager showed us that the quality of driving was monitored through the use of a global positioning system (GPS) that was present on all vehicles. The operations manager produced a driver feedback report for each member of staff on a weekly basis. This showed how frequently a member of staff exceeded the expected speed limit. The report was used to support discussions on the quality of driving with each staff member.

Assessing and responding to patient risk

- Basic risk assessments were undertaken as part of the booking procedure. The ambulance crew completed a patient transfer and risk assessment form. This included some screening questions to identify if the patient needed additional clinical support during the transfer.
- The ambulance crew we spoke with had a clear understanding about what to do if a patient deteriorated during a journey. They told us they would pull over their ambulance and dial 999 for emergency assistance. Staff could also call the hospital they were working with to access clinical advice.
- The ambulance that was in operation for patient transport services was equipped with an automatic external defibrillator (AED) and oxygen that could be used in the event of an emergency. This equipment was checked daily by staff and we observed that they were in good working order on the day of the inspection.
- All staff received first aid training as part of their induction. This included providing cardiopulmonary resuscitation (CPR) and the use of oxygen in an emergency situation.
- Staff had an understanding of DNACPR (do not attempt cardio pulmonary resuscitation) orders, what the documentation looked like and the requirement to carry the relevant paperwork with patients at all times.
- Both of the ambulance crew we spoke with had prior experience and training in working with disturbed or violent patients; they were confident in their abilities to manage and de-escalate these types of situations, but this had not been required as part of the new contract with the NHS partner that commenced in October 2017.

Staffing

- The service employed two managerial staff and three ambulance care assistants, all of whom were also drivers.
- The registered manager told us that, as part of the staff recruitment process, they carried out appropriate background checks. This included a full Disclosure and Barring Service (DBS) check as well as driving license checks. We reviewed the staff files and found that these checks had usually been completed. However, there were two members of the ambulance crew staff for whom a driving licence check had not been completed.

Patient transport services (PTS)

- At the time of the inspection, the provider held one contract for patient transport services with an NHS Trust from October 2017 to March 2018. This was for transporting patients from a discharge lounge throughout the working week (Monday to Friday) for a single shift between 12.00pm and 8.30pm.
- Two ambulance crew were required for each shift. This work was allocated to two, named members of staff for the entire period of the contract. There was a third member of staff who was available to work on the ambulance on an ad hoc basis to cover sickness absence and holiday leave.
- Staff did not have set breaks during the eight and a half hour shift. The staff we spoke with told us they would take a break if there was a natural lull in the discharge service.

Response to major incidents

- The service had a local business continuity plan which could operate in the event of an unexpected disruption to the service due to adverse weather conditions.
- We asked the registered manager about a wider plan to cover other areas of potential disruption, such as fire or telecommunication system failure. They showed us that there was a system for backing up the computers. The back-up disc was taken off site each night to ensure continuity should the operations base become unusable. They told us that there was a 'disaster recovery plan' but were unable to locate and show this plan to us during the inspection. After the inspection, the registered manager confirmed with us via email that they were in the process of reviewing and updating an older recovery plan.
- The registered manager told us they had held discussions with their local hospital NHS Trust regarding supporting and assisting other services in the event of a major incident.

Are patient transport services effective?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Staff followed local protocols, agreed with an NHS hospital trust, for providing safe transfer and transport of patients.
- We observed co-ordinated care and team working between crews and other NHS staff when moving patients and transferring care from one service to another.

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

- Not all staff had received training on the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards as part of their induction.

Evidence-based care and treatment

- Staff followed local protocols put in place by the provider and the hospital NHS Trust for whom the patient transport service was provided. For example, we observed that there were guidance documents displayed in the NHS hospital discharge lounge which described the process for "Referrals to LIFELINE for scoop stretcher" and a "LIFELINE and discharge lounge handover flow chart".
- The ambulance crew that we spoke with were aware of this guidance and were working to implement the processes accurately.
- The organisation had received accreditation from The International Organisation for Standardisation (ISO) 9001:2008 for quality management systems and the ISO 14001:2015 for environmental management systems.

Assessment and planning of care

- The service was contracted to one NHS hospital trust to transport patients between the hospital and the patient's own home, or another service provider. The contract was for one vehicle working one shift, Monday to Fridays.
- Patients were referred directly to the service from the discharge lounge. The service used a standardised patient transfer and risk assessment form to inform the plan of how to manage each patient during the transfer process. This included any special requirements, such as if oxygen was required and whether a DNACPR order was in place.

- Staff used this information, together with discussions with staff at the discharging service, the patient and their relatives, to plan each journey and complete the transfer safely and with minimum discomfort to the patient. We observed staff discussing patients' requirements prior to moving patients. This included identifying any diagnoses that might affect the type of care provided, such as the presence of dementia or mental health diagnoses.
- The ambulance crew were also sensitive to other needs, such as nutrition and hydration. In one example, the crew asked the discharge lounge staff if it was possible to bring food from the hospital into the ambulance for a longer journey.

Response times and patient outcomes

- The registered manager showed us they kept a record for each patient that included the time that they were discharged from hospital and the time that they arrived at their destination. The vehicle tracking system could also be used to monitor each vehicle's progress. However, a formal audit of patient journey times had not been carried out.
- The staff in the discharge lounge at the NHS hospital where the service picked up patients provided the ambulance crew with a list of patients requiring transfer on a daily basis. The ambulance crew told us there was an expectation that the list was completed by the end of the shift. They held discussions with the discharge lounge staff if this was not reasonably practicable.
- The registered manager told us they held periodic meetings with manager at the NHS Trust to review performance, although, these meetings were not minuted.
- We saw that the registered manager kept records of the number of patient journeys made to support discussions at these meetings. A review of the patient journeys showed that 178 journeys were made in October 2017; an average of eight journeys per day.

Competent staff

- The registered manager told us there was an induction programme followed by new staff. We saw that all of the ambulance crew had followed an induction process as a record was kept in the staff files. The induction programme included training provided by the management team as well as external trainers.
- The ambulance crew confirmed that the induction programme included training in the use of oxygen, moving and handling, safeguarding children and vulnerable adults, as well as training on using the ambulance and its equipment.
- Staff had only recently started on an NHS contract related to the regulated activity of transporting patients, so no appraisals had yet been carried out. The registered manager told us that these appraisals would happen after the first three months of the contract had been completed (i.e. due in December 2017 or January 2018).
- The process for checking driving licences was not robust. We found that two out of three staff files reviewed did not record the completion of a driving licence check.
- Our review of the staff files showed that completion of the induction and mandatory training was inconsistent. Not all staff had been trained to the same level and in the same topics despite carrying out the same role.
- One member of staff had completed an additional NVQ level three qualification in health and care that ensured that they were competent in their role.

Coordination with other providers and multi-disciplinary working

- The provider had good working relationships with the NHS providers. For example, the registered manager told us that they had recently held a contract review meeting with representatives from the NHS trust.
- We observed good multidisciplinary team working between crews and other NHS staff when managing patients. We saw co-ordinated care and transfer arrangements when handing the care over to NHS staff.
- There was guidance displayed in the NHS discharge lounge that outlined a flow chart for working with the staff from LIFELINE Medical Transport Service Limited. This described handover procedures from one provider to the other.

Patient transport services (PTS)

- The ambulance crew had proactively developed a communications record book to improve the working relationship with the NHS hospital trust. This recorded incidents and other pertinent information which could be referred to when planning patient journeys.
- We spoke with staff in the hospital discharge lounge where the ambulance crew were picking up patients. They were happy with the handover process and commented that LIFELINE staff were helpful and caring.
- We observed that ambulance crew asked hospital staff appropriate questions to make sure that they understood the patients' needs.
- Staff checked that they had received the correct documentation at handover points and raised issues about the completeness of information, if necessary.

Access to information

- Staff used a mobile phone to communicate with the NHS hospital trust during patient journeys. The ambulance was also equipped with a satellite navigation system and an electronic tracker (global positioning system (GPS)) to enable communication and monitoring of the vehicle whereabouts.
- Ambulance crews were provided with key information and special notes regarding care plans. For example, staff were aware of the importance of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders. We observed instances where staff checked this documentation and liaised with other providers to ensure best practice in this area.
- There was a staff handbook containing some key policies. For example, there were policies related to patient dignity and respect, driving safely, and patient transfer policy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service did not have a formal policy or a standard operating procedure for mental capacity, consent, best interest decisions or deprivation of liberty. However, the staff handbook had a section on 'communication' which instructed staff to identify themselves, and give clear explanations prior to providing any care. The registered manager sent us evidence via email, after the inspection, that they had developed a policy in relation to mental capacity. They told us they had shared this with all of the staff.
- We observed that the ambulance crew did give clear explanations and enabled patients to make decisions about their care. In one example, a patient was supported to choose the type of moving and handling aid that they preferred and verbal consent was obtained. However, in other cases we saw that staff operated 'presumed' consent rather than checking that patients were actively consenting to each action.
- Two out of three ambulance crew staff had completed formal training in the Mental Capacity Act (2005). The remaining member of staff had not completed this training.
- Staff that we spoke with had some knowledge of mental capacity, best interest decisions and deprivation of liberty safeguards. However, there was no clear process for staff to follow when documenting a best interest decision.

Are patient transport services caring?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- We observed examples of staff providing compassionate care to patients. The staff we spoke with showed a commitment to providing high-quality care.
- Staff demonstrated an awareness of involving patients in decisions that were made about their care.
- We observed examples of staff giving support to patients who became anxious or upset during their journey.

Compassionate care

- The provider had a formal 'Patient Dignity Policy' which it had shared with members of staff through its inclusion in the staff handbook.

Patient transport services (PTS)

- We observed examples of staff providing patient transport services from the discharge lounge at a local hospital. They worked with patients in a respectful and considerate manner.
- Staff asked the patients and hospital staff appropriate questions to ensure that they understood each patient's needs and that these were taken into consideration.
- All of the staff we spoke with during the inspection showed a commitment to providing the best possible care.
- Staff showed an awareness of the importance of maintaining patients' privacy and dignity. For example, during the patient transfers, staff ensured that patients were covered in blankets.
- We observed that staff were sensitive to their patients' physical discomfort. In one example we saw staff check that a patient was comfortable and put the heating on in the ambulance to keep them warm. In another example, we observed that staff checked if their patient was sitting comfortably and subsequently supported them into a new position in their chair.
- Staff were also concerned about continuity of care after patients' transfers were completed. For example, they checked with patients about the availability of ongoing care and support after the transfer had been made from hospital to home.
- The patients we spoke with told us that the staff they had met were professional and kind.

Understanding and involvement of patients and those close to them

- Staff demonstrated an awareness of involving patients, and their relatives or carers, in any decisions that were made about their care.
- The ambulance crew were supportive of patients and remained committed to involving them in their care at all times. We noted they spoke with the patient by name and explained what was happening as they were being moved.
- In one example, we observed staff explaining to a patient about the ways in which they could use equipment to support them to move from a wheelchair into a bed or comfortable chair at their home. The patient was able to make a decision about the type of aid they wanted to have.
- The patients we spoke with told us their experience with the ambulance crews was that they were friendly and respectful; they were mindful of their dignity and attentive to their needs.

Emotional support

- Staff understood the impact that they could have on patients' wellbeing and acted to emotionally support their patients during transfers.
- We observed instances where the ambulance crew offered verbal reassurance during patient transfers.
- We observed staff accompanying one patient into a new care home. The patient was understandably nervous and staff spent time supporting the patient to get settled in their new environment.

Are patient transport services responsive to people's needs?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- The service worked with a local NHS hospital trust to provide services that met the needs of local people.
- Staff checked patients' requirements prior to transporting them to ensure that they were able to meet their needs
- The service monitored the number of patient journeys made and liaised with the local hospital about their performance.

Service planning and delivery to meet the needs of local people

- At the time of inspection the service held a contract with one NHS hospital trust. This was to transport patients from a discharge lounge to their own home or to the care of another service. One ambulance with two crew

members were required during the winter period of peak demand. The contract was from October 17 to March 2018 for a single shift, Monday to Friday from midday to 8.30pm.

- The patient journeys were all made in the local, South Tyneside, area. The ambulance crew were given a list of patients who required transport each day by NHS staff working in the discharge lounge.
- The staffing levels, shift patterns and availability of vehicles were maintained in line with the NHS trust contract's requirements.
- The management team told us they had ad hoc meetings with representatives from the NHS Trust to check that they were meeting the agreed number of contracted hours and to review the number of patient journeys made.

Meeting people's individual needs

- There were measures in place to ensure staff could meet patients' needs.
- We observed that ambulance crew held discussions with NHS staff at handover points and reviewed paperwork to ensure that relevant booking information was collected and understood prior to moving patients. Practical adjustments were made, to meet individual needs, prior to transporting patients.
- Staff understood the importance of DNACPR orders and regularly checked for the presence of these when working with patients.
- Staff had access to an interpreter service through the NHS hospital trust that they worked with to support the discharge of patients who did not have English as their first language. The ambulance crew we spoke with gave one example of having used this service two weeks prior to the inspection.
- We saw evidence in a staff file that one member of the regular, two-man ambulance crew had completed a level three National Vocational Qualification (NVQ) in health and care. This staff member told us that this qualification included specific training in elderly and dementia care to support patients during the transfer process.
- Both crew members also commented that they had previous experience of working with disturbed patients and had received guidance on this topic. They gave some examples of how they had successfully managed these types of issues during patient transfers.
- The ambulance crew and registered manager told us they had made some special arrangements for moving bariatric patients. There was additional equipment and provision of an additional member of staff to help support the patient transfer service.
- Staff were able to escalate concerns to the NHS hospital trust to access advice if a patient's health deteriorated during transfer so that an appropriate plan for management could be made. Staff told us that they followed a protocol of pulling over to the side of the road and dialling '999' for emergency services if they observed a rapid decline in a patient's health.

Access and flow

- At the time of the inspection, one ambulance, with two crew members, was required for transporting patients from a discharge lounge at a local hospital service. Patients were allocated and referred to the service by the NHS hospital trust.
- The service had one additional vehicle at the ambulance base. However, this vehicle was not operational at the time of the inspection. We asked the management team how the service could continue in the event of the ambulance breaking down. They told us that they had previously used an external contractor that supplied fully-equipped ambulances at short notice, to cover the service.
- Staff performance was monitored by the operations manager through the use of a vehicle tracking system. Feedback on driver performance was given to each member of staff on a weekly basis.
- The NHS trust that the service worked with did request information about performance, for example, in relation to the number of patients transported each day. The service kept a record of each patient transported each day and patient transfer form recorded information about the time taken to move each patient.However, this data was not used for formal internal auditing.

Learning from complaints and concerns

Patient transport services (PTS)

- There was a formal complaints policy and a standardised form that staff could use to record any complaints.
- The registered manager told us that they had not received any complaints in the past year, but that they would be responsible for investigating complaints should they arise.
- Information about how to complain was not visible on the ambulance. However, the ambulance crew told us that patient complaints would be picked up by staff in the discharge lounge of the local hospital where they picked up patients. We observed there were clearly visible procedures for making a complaint in the discharge lounge related to any aspect of the care they received, for NHS or private providers. The staff working in the discharge lounge assured us that they would feedback directly to the ambulance crew information about complaints to carry out a joint investigation.

Are patient transport services well-led?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Staff found the culture of the service to be friendly and approachable.
- The service had a good working relationship with the local NHS hospital trust that had been built up through provision of a winter contract in repeated years.

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

- The service had limited systems to monitor the quality and safety of the service. The use of audits, risk assessments and recording of information related to the service performance was inconsistent. This was a breach of a regulation. You can read more about it at the end of this report.

Leadership / culture of service related to this core service

- The leadership structure was clear with a registered manager and an operations manager in place who were responsible for co-ordinating the work of the ambulance crew.
- Staff told us they worked with the leadership team and knew what their roles and responsibilities were. They were comfortable raising concerns with the leadership team. They told us the culture of the service was friendly and approachable.
- We observed members of staff interacting well with the leadership team during the inspection.

Vision and strategy for this this core service

- The staff handbook set out the core values for the service which included a commitment to the Department of Health's 6C's model of care: care, compassion, competence, communication, courage and commitment. There was also a clear "Privacy, Dignity and Respect" policy for staff to follow when working with patients.
- The ambulance crew worked in a way that demonstrated their commitment to providing high-quality care in line with this vision.
- The registered manager told us they were satisfied with the six-month contract for patient transport services with the NHS hospital trust. They had no plans to expand the service further or seek additional contracts for patient transport.

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

- The service had limited systems to monitor the quality and safety of the service. The use of audits, risk assessments and recording of information related to the service performance was inconsistent.
- The management team held bi-annual meetings to review the service. The most recent had taken place in September 2017 where planning for the new contract with the NHS trust was discussed. However, we found these meetings had not covered a sufficiently wide range of key governance issues to ensure the quality and safety of the service.
- There was a risk register in place, but this had not been reviewed in the current year. We found examples where risks to the service had not been sufficiently mitigated.
- In one example, the registered manager showed us an audit of complaints for 2016 which had led to an action for staff in terms of recording verbal concerns on the

patient report forms. However, this related to staff in place for the previous winter (2016) and new staff had not been informed about this system for the current year (2017).

- The systems for checking the safety of the vehicles and the equipment used on it were not robust and had not identified concerns noted by the inspection team during the site visit. For example, the system of daily visual checks were unrecorded and did not find clear faults with the equipment, such as the lack of straps on the carry chair. There had not been an internal system for noting when the equipment was due for servicing; the equipment had not been serviced for two years.
- Similarly, the systems in place for carrying out infection and prevention control activities, as well as monitoring the effectiveness of these, were inadequate. For example, not all staff had been correctly trained and there were no written protocols to follow either for the daily cleaning of the ambulance or to monitor that all aspects had been completed.
- The management team had not kept up-to-date with key changes in the regulations. For example, they were unaware of the Duty of Candour requirement.
- The system for monitoring staff training was not robust resulting in inconsistencies in levels of training for staff performing the same role.
- Similarly the system for carrying out background checks, including driving licence checks, had been inconsistently applied.
- The service did not have a comprehensive set of policies to enable staff to carry out their role effectively. For example, there was no formal infection and prevention control (IPC) policy or medicines management policy for staff to follow.

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

- The management team met periodically with representatives from the local NHS trust with whom they worked. They were given feedback on their performance during these meetings.
- The management team and the ambulance crew staff told us that they held informal discussions on a daily basis to ensure a flow of information about the operation of the service. However, we found areas where these discussions had been ineffective. For example, incident reporting systems had been instigated by the frontline ambulance crew, but the registered manager was unaware of these systems or the content of the record.
- The ambulance crew told us the management team were responsive to their feedback and they were comfortable raising concerns as they arose.
- We asked the registered manager about how they sought feedback from patients who had used the service. They told us that they did not currently have a formal process to collect feedback with a view to monitoring the quality of the service.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The management team told us that they were proud that the service had worked with the local NHS Trust to provide additional cover during the winter months. They had provided this service in previous years and been recommissioned for the current year. This showed that it was a reliable service and that the Trust was satisfied with their performance in previous years.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must take appropriate actions to identify, assess and minimise the risks arising from the use of vehicle and equipment required for safe patient transport.
- The provider must take appropriate actions to identify, assess and minimise the risks associated with infection prevention and control.
- The provider must take appropriate actions to identify, assess and minimise the risks arising from the inconsistent carrying out of background checks and training of staff working closely with patients.
- The provider must take appropriate actions to monitor the quality of services, including the monitoring of incidents, the use of relevant audits, and the monitoring of feedback from service users.
- The provider must maintain records necessary for the management of the regulated activity including records related to the employment of staff as well as governance arrangements, such as policies and procedures.
- The provider must ensure that staff are aware of their responsibilities in relation to the Duty of Candour.

Action the hospital SHOULD take to improve

- The provider should review plans for managing potential disruption to the service, for example, in the event of flood or fire.
- The provider should ensure all staff are appropriately trained in safeguarding according to the requirements of the Intercollegiate Document and that they are aware of the requirements in relation to FGM and PREVENT.
- The provider should consider reviewing the use of aspirin during patient transport and provide staff with appropriate, written protocols to support its safe administration and use.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The provider did not have comprehensive systems for assessing and monitoring the quality of the service with a view to improving the quality and safety of patient care. This included systems for monitoring incidents, the use of relevant audits, and the monitoring of feedback from service users. • The provider did not have effective systems in place to assess, monitor and mitigate the risks arising from the use of vehicles and equipment required for safe patient transport, infection prevention and control and the carrying out of background checks and training of staff. • The provider did not maintain other records necessary for the management of the regulated activity, including a full range of policies and procedures. This is a breach of Regulation 17 (1) (2) (a) (b) (d).

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met:** • The provider did not ensure that all staff were aware of their responsibilities under the Duty of Candour. This is a breach of Regulation 20 (1).