Ms. Judith Appleton

19 Green Way

Quality Report

PO Box 6888
Eastbourne
East Sussex
BN21 9LG
Tel:01323 486888
Website:wealdenmedicalservices.com

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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

19 Green Way is operated by Wealden Ambulance Service. The service provides patient transport services and event services. This inspection only looked at the provision of the patient transport service as that is subject to regulation by the CQC.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 17 October 2017 along with an unannounced visit to observe direct patient care on 30 October 2017

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

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

Services we do not rate

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

We found the following areas of good practice:

- The condition and the cleanliness of the service's vehicles was noted to be of a high standard.
- The service had proactively used findings from other CQC inspections of similar services to carry out a gap analysis and make changes to how they were operating.
- Policies in key areas such as safeguarding, cleanliness and infection control were robust, effective and well embedded with staff.
- The availability of clinical advice from experienced paramedics ensured that staff had the confidence to carry out their roles safely.

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

- There was a lack of formal recording of meetings held amongst the management group which in turn did not demonstrate how decisions were made and communicated.
- Records of training were not always dated and original certificates were not always retained on personnel files.
- The depot environment where the vehicles were kept had no CCTV coverage and the surfaces were in a poor state of repair.

Amanda Stanford

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

19 Green Way

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Detailed findings

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Background to 19 Green Way

19 Green Way is operated by Wealden Ambulance Service. The service opened in 2007. It is an independent ambulance service with headquarters in Hastings, East Sussex and an ambulance depot in Hankham, East Sussex. The service primarily serves the communities of East Sussex. The service has had a registered manager in post since the service first registered with the CQC on 19 June 2011.

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. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspections.

How we carried out this inspection

During the inspection, we visited the service's administrative headquarters and the service's ambulance depot. We spoke with six staff including; registered paramedics, patient transport drivers and management. We spoke with one patient but were not able to speak with any relatives. During our inspection, we reviewed a random sample of 50 patient booking forms and journey records.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 once in April 2013 which found that the service was meeting all the standards of quality and safety it was inspected against.

Facts and data about 19 Green Way

Track record on safety: In the period between August 2016 and July 2017 the service reported;

- Zero Never events
- Zero clinical incidents with no harm, low harm, moderate harm, severe harm or death
- Zero serious injuries
- One complaint

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

19 Green Way is operated by Wealden Ambulance Service. The service provides patient transport services and event services. This inspection only looked at the provision of the patient transport service as that is subject to regulation by the CQC

Summary of findings

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.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

The service had never experienced a never event. 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.

Incidents were reported using a standard reporting form. Any incidents that were reported were investigated by the operations manager to determine if there was any learning to be taken from them. Any learning that was taken was used in the training of new staff and as part of the annual refresher training for existing staff. The service also had a system of safety alerts which would be emailed to all staff on a weekly basis. These would generally be about the patients they were transporting but could be about incidents that had occurred. Stocks of incident reporting forms were kept on each of the vehicles as well as a stock kept at the office where the vehicles were parked when not in use. The service reported that there had been two incidents reported in the year prior to the inspection. These both occurred on the same day and involved the same crew.

We were told about an incident where the service had assisted the local NHS trust with an investigation in to an injury sustained by a patient. We were shown how the investigation into what happened, from the point of view of the service was completed within 24 hours. The learning from that incident was disseminated to all staff and was used as part of the induction training for new staff. •We were told and saw that investigations would be done in conjunction with the providers that engaged the service. We were shown an example where the service had changed the way they transported frail elderly patients in wheelchairs in an acute hospital. This followed an incident where a patient had cut themselves on a wheelchair. The way the wheelchairs were designed meant that anyone pushing it would have difficulty seeing the front of the chair and the patients' legs and feet. It was decided that a member of crew would walk towards the front of the chair and one would push the chair to ensure that they could see the front and back of the patient. This meant that they would be able to better see the patient and avert any problems.

Although the service had not had the need to apply the duty of candour to any incidents, there was a policy that was available to all staff and was included as part of the mandatory training. Staff we spoke with were aware of the duty of candour and the need to be open and honest when things go wrong.

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

Due to the type of work undertaken by the service there was no clinical quality dashboard. Safety was monitored through the incident reporting system. Any learning from safety incidents was included into regular staff training.

Cleanliness, infection control and hygiene

Ambulance crews cleaned the vehicles prior to and after their shifts and between patients when the vehicles were in use. Deep cleans were undertaken by their own staff on a weekly basis - this was recorded on the individual vehicles cleaning log. The logs were checked on a monthly basis for audit purposes.

An infection prevention and control policy was kept on each vehicle. Each vehicle had its own colour coded mop to ensure that each was not used on more than one vehicle. Records we saw went back for approximately two months and demonstrated that the cleaning of the vehicles had been completed. If, during a shift a vehicle became contaminated to the point that the standard clean between patients would not be sufficient, the vehicle would be returned to the base to be cleaned and replacement vehicle could be collected. We inspected three patient transport vehicles. Each vehicle and the equipment such as stretchers and mattress covers within them were clean. There was clean linen, personal protective equipment, hand cleansing gel and decontamination wipes available. There were no formal hand cleaning audits carried out. We were told that the only way the managers could be sure that staff were cleaning their hands was under the direct supervision of a manager. This would be if they happened to be working with the individual staff members. As staff

were out and about on the road it was difficult to monitor hand cleaning all the time. Staff were reminded of their responsibilities in their induction and mandatory (yearly) training.

Operational crew and management staff we saw during the inspection were dressed in clean and appropriate uniform for their roles. All staff had access to spare uniform which was kept at the base, should the one they were wearing become contaminated during a shift. We saw spare uniform was stored in a clean and dry environment.

Environment and equipment

The headquarters of the service consisted of one office and a meeting room which were part of a much larger building on an industrial estate / business park. The level of security to get in to the building was effective. The inspection team were required to sign in and out, state who we were visiting and leave car registration numbers if necessary.

The vehicle station was situated around 14 miles from the headquarters within an isolated complex of garden nursery buildings. At the time of the inspection there were two ambulances parked outside as well as an ambulance car that was used for event work. Inside the building was one ambulance car and another ambulance. When the ambulances were returned following use and the station closed for the day, a large gate across the entrance was locked by the last crew to leave.

The main building had a key safe placed on the wall which contained the key to the building. When opening the door there was a small area with a desk and chairs. There were files containing records of vehicle cleaning checks. Attached to the wall was another safe which contained the keys to the vehicles that were not in use. Through the office area was a door that led to the garage where a vehicle was kept. The station itself was clean, tidy and everything stored there was well ordered. The site was shared with one other business. There was no CCTV anywhere on the site. Outdoor lighting was available but was not automatic and was turned on and off by the crews. Surfaces at the station were uneven and poorly maintained. At the time of the inspection there was a hole in the surface which was identified by a large traffic cone being placed above it. Since the inspection the provider has moved premises to a site that is fit for purpose.

Although the service stored a range of cleaning products that could be harmful to health, they did not have any policies that explained the processes for dealing with the Control of Substances Hazardous to Health Regulations. These products were stored in a secure cupboard that was clearly marked as containing substances hazardous to health. Since the inspection COSHH is covered on induction and mandatory training. Staff also had access to the Substances Hazardous to Health policy via a 'Dropbox' that had been set up.

All vehicles owned by the service were bought from new and were configured by the service to their own specification. The oldest vehicle in the fleet was four years old. The service kept a file on each vehicle in the fleet at the vehicle station. We saw that these contained records of each vehicle's MOT certificate and when vehicles had been serviced and were due for their next service. We also saw evidence that all vehicles were taxed and insured. There were also records kept of the vehicle tail lift checks which were all up to date.

The outside of the vehicles were in a good state of repair and all access doors were in full working order.

The vehicle folders contained copies of patient booking forms, an explanation of the hand brake rule (the hand brake rule related to the time the crew started and finished a patient transport journey), feedback forms, various relevant policies such as 'do not attempt cardio pulmonary resuscitation (DNACPR), safeguarding and infection control. There were also vehicle defect reporting forms, and stock replacement request forms.

The service had informal agreements with local garages to provide maintenance to the vehicles. We were told that any issues would be dealt with on the same day where possible. Any faulty medical equipment would be reported to the supplier and / or manufacturer. Any defects would be fixed as soon as possible although replacement equipment was provided until it was fixed. This included all equipment on the vehicles such as stretchers and chairs.

Medicines

We saw that the service had a controlled drugs license that was in date. The operations manager was the accountable officer. Controlled drugs were stored securely at the head office. The service also had a contract in place to dispose of any out of date drugs. Controlled drugs were only used for the event work that the service carried out. We saw that drug stocks were checked and counted.

Patient transport services (PTS)

The service gave us a copy of their medicines management policy. This was a comprehensive document that showed who had responsibility for different parts of the policy, how they would ensure it remained fit for purpose and the frequency with which each aspect would be checked. The policy was formulated in March 2016 and was subject to review every three years unless any changes were identified as being necessary within that period.

In the main part of the garage there were stocks of nitrous oxide used for event work and oxygen. There was clear segregation of the full and empty medical gas cylinders. The cylinders were stored in a secure, lockable, ventilated cupboard. Monitoring of the medical gases, including collection and disposal was dealt with by a qualified paramedic who was part of the management team. Medical gases were collected in person from a large depot around 40 miles away.

Medicines that belonged to the patient were kept with the patient. Lockable cupboards were available on all ambulances should they be needed. There was space on the patient journey form for the crew to record whether the patients had their own drugs and record who they had been handed over to at the end of the journey.

Records

There was no separate booking form and patient records form. The form, which we reviewed contained details of the booking and also left a free text space for the crew to provide any details about the journey. The records were stored at the vehicle station in a lockable cupboard before being taken back to the head office to be filed.

If patients were being transferred from hospital and there were specific requirements for them, these were added to the notes that were given to the crew before they transported them. If the patient was a social services transfer, the service would be sent a copy of their care plan which would travel with the patient. This would mean that staff were aware of any special notes. In the event of information that became apparent during the transporting of a patient, was not included in the information provided to the crew prior to the collection, an incident report would be completed by the crew. At the time of the inspection there had been no incidences where crew had had to do this.

A record of each patient journey was made and retained. We reviewed a random sample of five records and saw that they were fully completed to a high standard.

Safeguarding

The service employed a registered paramedic who had oversight of all matters relating to safeguarding, including training. All operational crew were trained to Level two in both adult and child safeguarding. We were shown evidence that all staff had completed their training. The safeguarding lead and the paramedic members of the management team were trained to level three in child and adult safeguarding. Safeguarding training was provided as part of the service's mandatory training programme. Safeguarding advice could be requested from the safeguarding lead when they were available and from the paramedic members of the management team in their absence.

Should there be any safeguarding concerns staff were required to raise them by completing a form that was held on all the vehicles. As well as completing the form, a note would be made on the patient's record. When the form had been completed it would be sent by a member of the management team to either the local authority or the NHS trust where the majority of the service's work was carried out. We were told that the service had contact details for the local authority that they could use in the event they needed to make a referral. We saw that there was a safeguarding policy in place. Staff we spoke with knew what they needed to do if they had safeguarding concerns. However, at the time of the inspection the service had not had cause to make a referral.

Mandatory training

Mandatory training consisted of safeguarding, infection prevention and control, equality and diversity, customer care, information governance, manual handling, basic life support and Mental Capacity Act. At the time of the inspection the service was looking at adding deprivation of liberty safeguards training to this. Annual refresher was due to be scheduled for all staff towards the end of October / early November 2017. At the time of the inspection all staff employed had completed their mandatory training. However, the owners of the service, who did on occasion carry out patient transport journeys, had not completed all of the mandatory training modules since 2012.

Training was provided by the operations manager who was a qualified paramedic and accredited training provider. At the time of the inspection the service was looking to incorporate some parts of the mandatory training programme on an online portal.

The operations manager was an Institute of Health and Care Development trained driver. The operations manager provided new staff with a three day training course in driving an ambulance. There was no test at the end of this but if there were concerns about the standard of driving, the operations manager would make suggestions as to what the member of staff needed to improve. Until such time as that had been done they would not be permitted to drive the vehicles while on duty.

The service had a policy of not accepting any one to drive their vehicles with more than six penalty points on their license. Records of staff driving licenses which showed how many penalty points a driver had were kept on the personnel files. Any further driving offences would have had to be declared to the operations manager.

Assessing and responding to patient risk

If crew required any clinical advice regarding a deteriorating patient they were able to contact any of the three registered paramedics that worked within the service. Contact telephone numbers for the paramedics were kept on the ambulances. They would also consider where they had come from and where they were going. This meant that if they had just left a care home they would return there to seek clinical assistance. Alternatively, if they were on a hospital premises, they would seek clinical advice from where the patient was being moved from, or to. A policy was in place regarding the process to follow when dealing with a deteriorating patient. Staff we spoke with knew the process.

The service would transport patients that had mental health conditions which may have meant they could become violent or exhibit challenging behaviour. Ordinarily the patients would travel with a mental health nurse. On the occasions where this did happen, it would be recorded on the booking form. If the patient had a mental health condition and wasn't travelling with a mental health nurse, the service would assess the risk based on the type of condition the patient had. The risk assessment would be carried out by the paramedics employed within the service. It was recognised that the staff had not had training in any de-escalation techniques. However, at the time of the inspection the operations manager was actively trying to source suitable training for their staff. The service was also developing a Mental Capacity Act flow chart which would assist staff dealing with patients with mental health difficulties.

Staffing

At the time of the inspection the service was fully staffed. They ran two, two person crews per day with one crew moving patients at a local NHS trust and the other would transport patients who were resident at local authority care homes. The crews would not be specifically allocated to a particular role but would be allocated dependent on availability and the needs of the service. The service rarely used any temporary staff and when they did it would be for event work. In the event that there were patient transport journeys booked at the weekend, staff were able to carry these out, or, if the regular staff were not available, the journey would be carried out by the owners of the company.

The service employed four patient transport drivers on a full time basis, three paramedics, two part time and one full time. The two part time paramedics maintained their competencies through their employment with the local NHS ambulance trust. The operations manager, employed as a full time paramedic was able to maintain their skills through the work they carried out on the events side of the business.

Response to major incidents

There was no formal training in respect of major incidents. However, there were guidelines to follow if any crew were involved in a major incident. If they were close to a major incident such as a multi vehicle accident, they would offer first aid and call 999 for a local NHS ambulance to attend. They would however not intervene if any delay would affect the patient they were transporting. They were clear that their patient was their primary concern.

If there were any problems with vehicles or the booking system, there were back up systems in place to ensure that the service could carry on. There were spare vehicles that could be used at short notice. Bookings were also recorded on a portable hard drive which, in the event of a computer based failure could be connected to another computer. The portable hard drive was stored in a fire safe cupboard.

Patient transport services (PTS)

Are patient transport services effective?

Evidence-based care and treatment

Policies and procedures used in the service reflected national guidance and best practice. For example, medicines management policy reflected National Institute for Health and Care Excellence (NICE), the National Patient Safety Agency (NPSA), the Medicines and Healthcare Products Regulatory Agency (MHRA), and the Home office. The DNACPR algorithm reflected guidance from the Resuscitation council.The infection control policy also reflected the Department of Health (DOH) and NICE guidelines.

Senior staff provided regular email updates to staff when changes to policies and procedures changed nationally and locally. We saw evidence of this in the staff folder at the vehicle station. Staff signed to say they had read and understood the updates.

The service used a pain management ladder based on best practice guidance to assist staff assess patients pain needs in a standardised way. Although we didn't see this in use during the inspection, the operational crews were able to demonstrate how it would be used.

The service undertook a limited number of audits. Local audits included vehicle cleanliness, hand hygiene and transport logs and assessment information. However, because of the size of the team the processes were informal rather than formally documented. This was brought to the attention of the provider during the inspection and we were provided with assurance that these processes would be formalised.

Assessment and planning of care

Before the service accepted a journey, an assessment of the patient's needs was undertaken and formally recorded on a 'booking form'. This assessment took information from the following into consideration: patient mobility, nutrition and hydration, in particular nil by mouth (NBM) status, pressure area care, do not attempt cardio pulmonary resuscitation (DNACPR), medication and personal belongings. Staff provided an additional signature to say they saw the DNACPR form in the records before transportation. This provided additional assurance that the correct action would be taken if an unforeseen event occurred.

We reviewed a random sample of fifty booking forms. We found them to be complete and fit for purpose.

Each patient journey was assessed on its individual merit. If a patient was identified as having any additional health problems for example, mental health or anxiety problems, the crew provided additional emotional support and adjusted the service to meet their needs and reduce anxiety. This could be changing their driving style, sitting and talking with the patient or, alternatively not talking to the patient if that was what they wanted.

Staff were provided with work mobiles to ensure they were contactable, as well as being able to contact senior staff for advice or support.

Response times and patient outcomes

The contract with a local NHS trust required the service to meet specific key performance indicators set out in the contract. Data provided to CQC showed that these were monitored and were being met, to ensure compliance with the terms of the contact.

The service took account of patients' nutrition and hydration status. This was evidenced by the journey booking forms we reviewed. This included being aware of conditions such as diabetes and patients who may be nil by mouth.

At the time of the inspection the type of work undertaken by the provider was short journeys between departments on a large hospital site. Patients' were not on vehicles for long and were therefore not without food or hydration for extended lengths of time.

We were unable to assess patient outcomes in this service at this inspection. This was due to a lack of measurable outcomes because of the type of work undertaken.

The provider had access to additional ambulances and could access a temporary workforce to meet unexpected surges in demand.

Competent staff

The service employed three registered paramedics, one full time and two, part time. The operations manager was employed full time and had 27 years' experience as a registered paramedic. The PTS manager had 14 years' experience as a registered paramedic and the safeguarding lead had twenty years' experience as a registered paramedic.

Patient transport services (PTS)

Staff had access to training to ensure they were able to undertake their roles and meet peoples individual care needs.

We reviewed five sets of staff records. These contained documents which were provided as part of the recruitment process such as the application form, drivers licence and disclosure and barring service (DBS) check. However, there was no date recorded for when the drivers licence check was carried out. We also saw that not every DBS certificate was an original although checks were made through an online system. This meant that there could be a possibility of the certificate having been tampered with. This was raised with the service at the time of the inspection. We were told that this would be rectified. Since the inspection the provider told us that they were in the process of setting up a driving license check system using the government online system for all staff including bank staff.

There was a total of four patient transport staff permanently employed by the service. Records we saw showed these staff had undertaken the required level of training. The training courses included, but were not limited to basic life support, ambulance driving competence and emergency first aid.

Although we had evidence of training having taken place, there were no dates recorded as to when the automated external defibrillator and basic life support training had happened. However, the service told us that the training was refreshed at the annual staff mandatory training day.

At busy times, when the service was required to provide additional back up, the registered manager and owner of the service provided additional support to the team. Training records showed that these two personnel's training had expired. We were told that update training for both staff was scheduled for the week after the inspection. We were provided with evidence following the inspection that the mandatory training had been completed by the registered manager and owner of the service.

At the time of the inspection there was a lack of formal evidence to suggest annual appraisals and supervision were being undertaken by the provider. The arrangements historically were that there would be a system of informal appraisal. However, this was identified and addressed prior to our inspection by the leadership team. We were provided with a new appraisal and supervision package that was about to be introduced to staff. This meant the service was in the process of ensuring all staff were actively involved in a formal appraisal and supervision process. This meant that at the time of the inspection there had not been the opportunity for the service to demonstrate that formal appraisals had taken place.

We were told that the size of the team meant support was easily provided to them. Staff we spoke with confirmed that advice was readily available if needed. We saw documentary evidence that crew contacted their superiors to ask for advice and guidance when they needed to do so.

The service had recently implemented a new induction programme which was being rolled out to new staff. We saw two completed induction packs during the inspection. We found it provided a sufficient level of information and guidance for new staff.

At the time of the inspection the provider was in the process of developing a new online portal for staff. This would provide easy access to guidance, on line training and other resources to aid learning and development opportunities. In the meantime the service had introduced a 'dropbox' where staff could access a full range of policies and other information that would assist them in their role.

We saw a formal electronic database of staff training requirements and expiry dates. This meant there was oversight of staff competency and training needs. However, this did not include the service's owners.

During busy times the service used temporary staff from another ambulance service. We found a lack of oversight of their skills, competency and learning needs. This was identified during the inspection and CQC received assurances that this would be addressed as a matter of urgency. Since the inspection we have been notified that the service now asks for copies of the current DBS forms for all bank staff they use and evidence the training they have received. We were also told that they only use staff from the local NHS ambulance service for bank work and any paramedics will have their registration status checked prior to starting any work.

Coordination with other providers and multi-disciplinary working

The provider had a transport contract to transport patients between departments on an acute NHS site.

Patient transport services (PTS)

The registered manager was active across the independent ambulance sector and had close links with local providers to help them understand growth and demand. At the time of the inspection the provider was in negotiations about securing a new contact with an NHS provider.

Access to information

Staff had access to patient specific information via the booking processes. If additional information was obtained before a journey was undertaken this would be added to the booking form.

Ambulance crews were made aware of any special requirement a patient may have during their transportation for example, if the patient were diabetic, epileptic or living with dementia. We saw records that demonstrated this information was made available and was taken into account for each patient using the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity training was incorporated into the induction process. Staff we talked with had an understanding of capacity, and their role in identifying and reporting any capacity concerns.

We were provided with evidence where a crew felt a patient did not have capacity and this was raised with senior staff and reported through the appropriate channels to ensure the safety of the patient.

We saw booking forms that demonstrated crews took a patient's mental capacity into account when doing their assessments prior to a journey.

Whilst there was no formal assessment tool to help staff identify such concerns, the service was in the process of developing an algorithm for staff.

We were told that this assessment tool was to be introduced after the inspection.

Consent was included on induction and as part of mandatory training courses. Staff were required to note on the patient bookings form that consent had been gained and how it was given. Booking forms were audited on a weekly basis to ensure best practice was being followed.

Are patient transport services caring?

Compassionate care

The service was provided by kind and caring professionals. This was evidenced in the service user, and external stakeholder feedback received by the service.

Service user feedback was sought, reviewed and collated to improve quality. Patients were provided with feedback forms at the end of their journeys. There was also the opportunity to provide feedback via an online survey on the service's website. This feedback was used to monitor and improve the patient experience. The comments we saw were specific to the patient transport service. At the time of the inspection there had been 12 hand-written feedback forms and one online survey completed.

Comments received included "first class service, they went above and beyond at short notice"; "staff think outside the box", "they were very understanding of my situation, "excellent care and professionalism".

We also saw feedback from external stakeholders who commission the service. The feedback was entirely positive and comments included "All the staff are exceptionally friendly and always put patients at ease", and "the team are very good, they always help, even if the task isn't their job".

Additional feedback from stakeholders included comments which implied the service worked late into the evening to ensure patients were discharged when another provider cancelled at short notice.

We saw that staff talked to patients to identify their particular preferences and concerns.

We saw written evidence that staff took patients individual care needs into consideration during their journeys. For example, we saw records that showed staff had identified patients who required additional pillows for support, blankets for warmth, pre-existing travel sickness and the actions taken to address these needs.

We also saw records that showed staff ensured patients dignity was maintained during journeys by providing additional blankets.

Understanding and involvement of patients and those close to them

Patient transport services (PTS)

The service had a 'Caring with dignity' policy and guidance for staff. This was a reference guide on the beliefs and wishes of eight common religions found in the local community.

We spoke with one patient who was a regular user of the service. They explained how the crews were aware of their specific needs and used this knowledge to make the process of transporting them a stress free experience.

Emotional support

Patients' whose records we reviewed had their emotional needs met by staff. The level of detail about patients showed that the service considered more than just the patient's physical difficulties and would gather information about the personal preferences and any areas of sensitivity.

We saw written evidence the crews took peoples emotional and psychological care needs into consideration. This was recorded on the individual booking forms. Examples included records of dealing with those who were feeling nervous, or apprehensive about their onward journeys.

Supporting people to manage their own health

Whenever possible, staff empowered patients to be independent. This included encouraging patients to use their own mobility aids, manage their blood sugar levels, and use their inhalers as they would do normally in the community. We were told individual support was provided when needed.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Service planning and delivery to meet the needs of local people

The service began their current contract with the local acute NHS trust following a tender process. The contract was initially for three months followed by a rolling monthly contract. The agreement was that the service would provide one vehicle to transport patients across the hospital site. Patients that were transported as part of the contract with the acute NHS trust were deemed eligible if the staff at the trust determined that they required assistance to move from one part of the site to another specific part of the site.

They also provided a service for the local authority to transport patients from their homes to attend hospital appointments. Patient transport journeys were requested by the local authority who, in turn were funded by a number of different local clinical commissioning groups.

The patient transport journeys carried out on behalf of the local NHS acute trust were contained to just one site and limited to a specific cohort of patients. It would be known in advance if repeat journeys were required. All other work for the NHS acute trust was done on an 'as and when' basis although one vehicle would attend one particular hospital every day, Monday to Friday.

The transportation of patients that were resident in local authority care homes was covered by a crew of two. The vast majority of the work undertaken as part of this agreement was limited to journeys that were five miles or fewer.

We were told that there were occasional longer distance journeys made to specialist hospitals. For these journeys the service would provide a wait and return service. These journeys were ordinarily booked at least a day in advance.

Meeting people's individual needs

The service did not deal with a large number of patients for whom English was not their first language. However, all vehicles had multi-lingual phrase books on them in case there were any difficulties. Staff we spoke with had never had occasion to use these books. We were told that they would review their position in this regard should they find that the patients required a different approach. The service had looked at the provision of a telephone interpreting service but considered that there were no benefits, at that time, to provide it.

Training in caring for patients with dementia, learning disabilities or those with complex needs was part of the mandatory training programme.

Access and flow

The crew that carried out the patient transport journeys at the local acute NHS hospital would report for duty and collect the ambulance at 7:45am. They would then travel to the acute hospital to collect the day's initial job sheet and then start transporting patients across the site from 9:00am.

Patient transport services (PTS)

The crew that transported patients from local authority care homes would plan their days around the times when transport had been booked although they could be used if a same day request came through.

Due to the nature of the work the service carried out, there was no tracking system which would show the staff at the headquarters where the crews were. Contact would be maintained with the team at the headquarters by phone through the course of the day.

All patient transport journeys were recorded on a job sheet. The service had what was called a 'handbrake time'. This meant that the time on scene, wherever they were, would be measured from the time the crew put the handbrake on to the time the crew took the handbrake off. All job sheets were retained, filed and stored at the depot where the vehicles were kept. Although the service had the data available they had not used it to draw any analysis of their performance or look at ways the service could improve.

All bookings outside of the standard contract the service had with the acute hospital trust were made by email. Records of all the bookings were kept on the service's computer system and backed up on the external hard drive.

Learning from complaints and concerns

Feedback forms are available on all our vehicles which allows patients and / or their carers to complain. There is also information on how to raise concerns, give praise or make comment on the service's website.

At the time of the inspection the service had only received one complaint from a patient. This centred around a dispute over payment. All correspondence about the complaint was conducted by email and stored on an email system. We saw evidence that the complaint was resolved to the satisfaction of the complainant. At the time of the inspection there had been no complaints that had to be investigated jointly with any organisation that commissioned their service.

Are patient transport services well-led?

Vision and strategy for this this core service

•The service did not have a written vision for the service. We were told by the management team that the patient was at the heart of everything they do. Our conversations with the staff supported this and gave us assurance that the patient was at the centre of what they do. They explained how they did not rush their crews and allowed as much time as was needed to complete patient transport journeys. The service was keen to build its reputation by undertaking safe, efficient journeys and provide compassionate care.

Governance, risk management and quality measurement

We were told that the management team held regular meetings however, no records of these meetings were kept. Although decisions were made, these had never previously been recorded. The meetings were informal and any decisions made were confirmed by email. It was explained during the inspection that because the service was so small, it had not been considered that records were needed.

However, the inspection team were told how, as a result of reading other reports into similar providers, the service had started to plan the frequency with which they were going to have meetings, what would be discussed and how key messages were going to be recorded. Since the inspection the service have told us how they had bi-monthly meetings with standing items that were regularly on the agenda such as standards of cleanliness, defibrillator training and patient booking form audits as well as other business that is relevant at the time of the meeting. Any decisions or changes in procedures are communicated via email and also placed in the service memo folder at the ambulance station, staff are required to read and sign the memo.

The service had begun an action plan to address a number of other issues that had been raised in other CQC inspection reports and had conducted a gap analysis. This had highlighted risks such as the lack of properly recorded management meetings and the lack of a risk register. The inspection team were shown the action plan which was held on the computer system. They also had developed a template for a formal risk register. This was also shown to us during the inspection.

The recording of the handbrake on and handbrake off times showed how the service was performing in relation to the key performance indicators given by the commissioning providers. If there were any outliers the management team reviewed at the patient record to see if the time taken to complete the journey was appropriate.

Patient transport services (PTS)

Leadership / culture of service related to this core service

The management team at the service comprised a managing director who was responsible for oversight of the whole organisation. This member of staff was employed full time. There was a safeguarding lead and operations support manager who would provide operational assistance to the crews and would lead on any safeguarding issues. This member of staff was employed part time. The operations manager and paramedic lead had day to day oversight of the operation and was able to offer clinical advice should any of the crew need it. The operations manager was also the lead for mandatory training in the service. The service also employed a PTS manager. This member of staff was part time. Their role included managing the provision of the PTS service as well as oversight of the cleanliness and maintenance of the fleet of vehicles. Three of the leadership team were registered paramedics.

We were only able to speak with two members of staff that were not part of the management team. They told us that the managers were accessible and would provide advice, whether that was operational or clinical, whenever they needed it.

We found that the organisation was open and transparent and had a strong will to do what was right for the patients.

With a small service there were limited examples of how the service would manage change. However, due to the processes of tendering they were involved in, they were putting together plans to recruit staff if they had been successful in these processes. This demonstrated an element of forward planning that would enable the service to meet the needs of those commissioning services and the patients.

Public and staff engagement

The service did not carry out any formal public engagement outside of their meetings with the commissioning providers. They did provide comment cards to all patients and had a facility of their website for patients and / or carers to leave messages about the service.

Engagement with staff was limited to the meetings the managers had with operational crew. At the time of the inspection there was no structured process for this to happen and meetings took place as and when they could. With the introduction of a formal appraisal process this would change due to the requirement for regular supervision.

Innovation, improvement and sustainability

There was a clear desire to expand the service particularly in regard to patient transport. At the time of the inspection the service had been in discussion with a local NHS trust about providing transport services as part of a trust wide initiative. Senior staff in the service had met senior staff at the trust to look at potentially agreeing a contract.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

• The provider should give consideration as to what they can do to improve the environment where the vehicles are cleaned and stored.

• The provider should implement a formal auditing system for vehicle cleaning, hand hygiene, journey logs and patient assessment information.

• The provider should ensure all staff records include original, dated documentation.

• The provider should introduce robust processes to check the competence of temporary staff.

• Continue to develop the service by embedding the processes already developed.