

EMC Medical Services - Blewbury

Quality Report

Downside Farm
Woodway Road
Blewbury
Didcot
OX11 9EX
Tel: 01235 430466
Website: www.999emc.com

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

Ratings

Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

EMC Medical Services Blewbury is operated by EMC Medical Services Limited. The service predominantly provides patient transport services on an when required basis for local authorities, private patients and NHS trusts. EMC Medical Services Blewbury also provides event cover. However, we do not currently regulate event medical cover. A small proportion of the service's activity was the transfer of patients from events sites to hospital. This activity is regulated by us. We inspected this service using our comprehensive inspection methodology. We carried out the announced (24 hours' notice) part of the inspection on 2 March 2020.

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.

The main service provided was patient transport services. Where our findings on patient transport services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the patient transport service level.

We rated it as **Requires improvement** overall.

- There were limited governance systems to improve service quality and maintain high standards of care.
- The provider did not have an effective system in place to identify, limit and control clinical and non-clinical risks. The managers were able to identify several risks. However, there was limited evidence to demonstrate the managers identified all service risks including some we identified during our inspection.
- The recruitment records did not provide assurance that all staff had the required employment checks completed before they commenced work.
- Most staff understood how to protect patients from abuse. However, the managers were unsure of who the safeguarding lead was.
- Although medicines were stored securely, the patient group direction did not include pharmacist sign off and medicine storage temperatures were not monitored.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The provider controlled infection risk well. Staff assessed risks to patients and acted on them.
- Managers made sure staff were competent for their roles.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Staff were focused on the needs of patients receiving care. The provider engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with four requirement notices that affected both patient transport and emergency and urgent care services. Details are at the end of the report.

Summary of findings

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South) on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Emergency and urgent care

Requires improvement



Urgent and emergency services were a small proportion of activity. The main service was patient transport services. Where arrangements were the same, we have reported findings in the patient transport services section. EMC Medical Services Blewbury is an independent ambulance service who transferred patients off event sites when required. The service primarily serves the community of Oxfordshire. The service had no formal contractual or service level agreements but worked with both NHS ambulances and NHS Trusts. We rated this service as requires improvement overall because it required improvement in safe and well led and was good in responsive. We did not have enough evidence to rate effective and caring.

Patient transport services

Requires improvement



EMC Medical Services Blewbury provided patient transport services for a local NHS hospital and a local NHS ambulance trust. They also provided privately funded transfers. We rated this service as requires improvement overall because it required improvement in safe and well led and was good in effective, caring, and responsive.

Summary of findings

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Requires improvement 

EMC Medical Services Blewbury

Services we looked at

Emergency and urgent care; Patient transport services

Summary of this inspection

Background to EMC Medical Services - Blewbury

EMC Medical Services Blewbury is operated by EMC Medical Services Limited. The service opened in May 2011. It is an independent ambulance service in Blewbury, Oxfordshire. The service primarily serves the communities of Oxfordshire. The service provides planned patient transport services for adults over the age of 18 years, private organisations, privately funded patients and for some NHS acute trusts and NHS ambulance trusts.

EMC Medical Services Blewbury also provided medical cover on event sites. In England, the law makes event organisers responsible for ensuring safety is maintained at events. This meant event medical cover comes under the remit of the Health and Safety Executive. Therefore, we do not regulate services providing medical cover at events. However, the transport of patients from an event to hospital is a regulated activity.

We visited the service on 2 March 2020 and gave the provider 24 hours' notice. This was the first inspection for the urgent and emergency care service. We completed a comprehensive inspection for both the urgent and emergency care and patient transport services.

The main service provided was patient transport services. Where our findings on patient transport services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the patient transport service report.

We previously carried out a comprehensive inspection of EMC Medical Services Blewbury patient transport service in November 2018. Following that inspection, we issued the provider with a requirement notice:

- The registered person must ensure there is a system to assess, monitor and improve the quality and safety of the service provided and assess monitor and mitigate any risks.

Following this inspection, the above requirement notice had not been met and the service, while some information was gathered, did not have a comprehensive system to assess, monitor and improve the quality and safety of the service provided.

The service is registered to provide the following regulated activities:

- transport services, triage and medical advice provided remotely
- treatment of disease, disorder and injury
- diagnostic and screening procedures

The governance and management arrangements were the same across the emergency and urgent care and patient transport service.

At the time of inspection, the provider had been without a registered manager from October 2019 but there was an application in process. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a service. Like registered providers, they are 'registered persons. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC inspection manager and a

specialist advisor with expertise in emergency and urgent service and patient transport services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Summary of this inspection

Information about EMC Medical Services - Blewbury

The main service provided was patient transport services. Where our findings on patient transport services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the patient transport service level.

During the inspection, we visited the Blewbury base. We spoke with 10 staff including; registered paramedics, patient transport drivers and management. We spoke with one patient and one relative. During our inspection, we reviewed eight sets of patient records.

Patient transport staff were contracted as part time or full time staff and all the event staff were bank staff with zero hours contracts.

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 twice, and the most recent inspection took place in November 2018. We found the service in November 2018 was not meeting all standards of quality and safety it was inspected against.

Activity (March 2019 to February 2020)

- In the reporting period March 2019 to February 2020 there were 43 emergency and urgent care patient journeys undertaken (urgent and non-urgent conveyances off an event site).
- There were 5530 patient transport journeys undertaken. (None of these journeys were for children under the age of 18 years).

The provider employed 20 staff for their patient transport service. They also had a bank of temporary staff to cover event work.

Track record on safety

- Clinical incidents: 39.
- Four complaints

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Not rated	Not rated	Good	Requires improvement	Requires improvement
Patient transport services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

Emergency and urgent care

Safe	Requires improvement 
Effective	Not sufficient evidence to rate 
Caring	Not sufficient evidence to rate 
Responsive	Good 
Well-led	Requires improvement 

Information about the service

The main service provided by this ambulance service was patient transport services. Where our findings on patient transport services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the patient transport services section.

The number of emergency and non-emergency patients that were transferred from an event site between March 2019 and February 2020 were 43.

Summary of findings

Everything we found in urgent and emergency care was the same as in patient transport services except:

We found the following issues that the service provider needs to improve:

- The safeguarding policy did not reflect national guidance and the leadership team were unclear about who the safeguarding lead was. The service did not always complete the required checks prior to staff commencing employment, for example some staff references were not checked prior to employment.
- The provider did not gain sign off authorisation from a pharmacist for the patient group direction or monitor the temperature of the storage spaces to ensure medicines were kept at the correct temperature.
- Bank staff did not receive a corporate induction.

However, we found the following areas of good practice:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff kept detailed records of patients' care and treatment. Records were clear and up-to-date.
- The service ensured all staff were up to date with their mandatory training.

Emergency and urgent care

- Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.
- Managers regularly reviewed and adjusted staffing levels and skill mix to keep patients safe from avoidable harm.
- The service had systems and processes to safely administer and record medicines and stored medicines securely.
- The service planned and provided care in a way that met the needs of local people and the communities served.
- People could access the service when they needed it and received the right care in a timely way.

Are emergency and urgent care services safe?

Requires improvement 

We rated safe as **requires improvement**.

Mandatory training

The service ensured all staff were up to date with their mandatory training.

Event staff were used sporadically throughout the year and the provider did not require event staff to complete mandatory training as bank staff were substantially employed by an NHS ambulance trust or provider and provided up to date evidence of their training.

The provider relied on bank staff completing their mandatory training within their substantive posts. Bank staff were asked to supply evidence of their mandatory training to the service each year. We saw evidence supplied by five bank staff. If bank staff were unable to provide evidence of completing their mandatory training within their substantive posts the provider ensured all bank staff had access to the providers own e-learning platform for statutory and mandatory learning.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Although staff had training on how to recognise and report abuse, and they knew how to apply it. Policies did not reflect national guidance and it was not clear who the safeguarding lead was. The service did not always complete the required checks prior to staff commencing employment, for example some staff references were not checked prior to employment.

Managers ensured event staff understood the process for safeguarding referrals. They briefed them before the start of events. Event staff raised safeguarding concerns with the overall event lead. The lead was responsible for making any safeguarding referrals and managers discussed this information with event staff at the start of an event.

Emergency and urgent care

See information under this subheading in the patient transport section.

Cleanliness, infection control and hygiene

See information under this subheading in the patient transport section.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them.

The provider had a contract for the removal of clinical and hazardous waste. This was with an external company. Hazardous waste included sharps bins. Sharps are items that can cause cuts or puncture wounds. For example, needles and broken ampoules. Managers and staff reported they disposed of sharps safely and in line with their policy.

The service had a good supply of disposable consumables. For example, bandages, swabs and syringes. They were all within expiry date and stored in the base. However, we identified one set of adult defibrillation pads that had expired in February 2020. These were immediately removed by management from the vehicle and placed into a box clearly labelled for training use.

Crews for events would stock the ambulances from the base before arriving at the event site. This ensured all consumables were available for each event the service attended.

The service provided resuscitation equipment such as defibrillators and this would be used, if required, to provide clinical intervention for patients who were being transferred.

See information under this subheading in the patient transport section.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

During events staff completed clinical observations on patients, as part of their care and treatment to assess for

early signs of deterioration. If agreed with the event coordinator the service transferred the patient off site and took them to the nearest local NHS accident and emergency department.

If the patient deteriorated during the journey staff would alert the accepting accident and emergency department so hospital staff were aware before the patient arrived. Staff attending events would be aware of the contact details for the nearest accident and emergency department.

Managers reported staff assessed patients using the Joint Royal Colleges Ambulance Liaison Clinical Practice Guidelines (JRCALC). The Joint Royal Colleges Ambulance Liaison Committee regularly update the clinical practice guidelines.

Event managers held a briefing on the day of the event, to ensure all staff were clear about the risks and knew how risks would be managed.

The events manager booked events using an independent guide which risk assessed an event using a scoring system and recommended the number and type of staff required for the event. The provider would agree this number and cost with the event co-ordinator.

The service had an up to date and version-controlled policy covering do not attempt cardiopulmonary resuscitation orders. Staff we spoke with understood their responsibilities to carry the appropriate paperwork with patients.

Staffing

Managers regularly reviewed and adjusted staffing levels and skill mix to keep patients safe from avoidable harm.

The provider used bank staff for events and every bank member of staff held a substantive position within the NHS at the time of our inspection. Recruitment processes confirmed references, pre-employment Disclosure and Barring Service (DBS) checks, qualifications and training, and driver licence checks, had been completed.

The service estimated they had between 50 and 70 event bank staff currently on their books. Some staff were active, and others were dormant. If a staff member

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showed dormant on the system, the system would not allow them to book the staff member. This assured the service that staff used on events were up to date with their mandatory training and registrations.

Managers regularly reviewed staffing levels and ensured there was enough staff to cover events in the event of a booking.

Records

Staff kept detailed records of patients' care and treatment. Records were clear and up-to-date.

Staff completed patient report forms (PRFs), based on the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) clinical practice guidelines. We reviewed one PRF where a patient was conveyed from an event site which was clear, up to date and complete.

The service stored PRF's securely in a folder in the ambulance. They handed them to the team leaders after each event. Team leaders scanned them onto their electronic system. Staff disposed PRFs securely in confidential waste.

For each event, team leaders reviewed patient report forms for one member of staff and feedback was given regarding the quality of their patient report forms either face to face or using an email.

Medicines

The service had systems and processes to safely administer and record medicines. While the provider securely stored medicines, the provider did not gain sign off authorisation from a pharmacist for the patient group direction or monitor the temperature of the storage spaces to ensure medicines were kept at the correct temperature.

The service had a version controlled up to date medicines management procedure for staff to follow for the order, receipt, administration and disposal of medicines.

Medicines were securely stored in a locked key coded access area which was only accessed by team leaders, management and registered clinicians.

The service had one patient group direction (PGD). All other medicines were administered under the guidance of JRCALC. The JRCALC provided guidance for healthcare practitioners on what medicines can be used according

to the staff members qualification. PGDs allow certain healthcare professionals to supply and administer prescription-only medicines without an individual prescription. A PGD as defined by the Human Medicines Regulations 2012, should be drawn up by a multi-disciplinary group involving a doctor, a pharmacist and a representative of the professional group expected to administer or supply medicines under the PGD.

The medical director and the clinical director had signed the PGD. However, there was no pharmacist sign off which was required, and we were unable to see evidence of which staff had signed to say they understood how to administer the medicines.

The clinical director took responsibility for the ordering and collection of the medicines from the pharmacy. They also ensured the medicine tally sheets in each medicine bags were kept current and recorded the medicines batch numbers in the instance that medicines were recalled for safety reasons. Staff completed patient report forms when they administered medicine to a patient..

We reviewed the contents of one medicine bag and found it to contain in date medicine and the tally against the sheet was correct. Staff collected the medicines bags prior to an event and signed each bag in and out which we saw evidence of.

Staff would know which medicines they could administer dependent on their role and scope of practice, as this was outlined in the medicine's management procedure JRCALC, which was up to date.

Staff placed expired or partially used medicines in a sharps container which staff had dated and assembled correctly. There was a waste disposal agreement for the safe disposal of clinical waste.

During the winter period the medicine bags were not used and therefore no audits were completed. Managers advised us the bags were checked on a weekly basis during the event season which was predominantly between June and September. We saw evidence of these checks during inspection.

The oxygen cylinders were stored upright and securely. They were labelled correctly with signage that confirmed they were compressed gases and how to store and

Emergency and urgent care

maintain them. Empty and full cylinders were stored separately. This was in line with the Department of Health guidance set out in Medical Gases Health Technical Memorandum (2006).

The medicines policy did not contain storage and temperatures requirements. Within the office the provider was not monitoring the temperature of where medicines were stored even though the area had climate control, which could affect the effectiveness of medicines.

Incidents

See information under this subheading in the patient transport section.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Not sufficient evidence to rate 

We had insufficient evidence to rate effective for urgent and emergency care services

Evidence-based care and treatment

See information under this subheading in the patient transport section.

Pain relief

Staff reported they asked patients about their level of pain using a scoring system. Zero for no pain up to 10 for the worst possible pain and recorded the pain score on the patient report form.

For patients who had difficulty with communicating staff told us they would use a visual aid with sad and smiley faces to help patients to communicate their level of pain.

Response times

The service did not monitor the response times for conveyancing patients from events and the service did not carry out any emergency (999) work, so was not required to monitor performance against the national targets.

Patient outcomes

Due to the small numbers of patient conveyed to acute hospitals the service did not participate in any national audits.

The director reported the services' main aim was to not convey patients away from events and to treat and discharge patients' home from the event site. It was reported at one event; 600 patients were treated by the team and only three were conveyed off site.

Competent staff

Bank staff did not receive a corporate induction.

Managers reported bank staff did not currently receive an EMC Medical Services Blewbury induction. This was not in line with the corporate and local induction policy, although the managers also said there were plans to reintroduce this.

A bank staff member we spoke with reported the service reviewed their clinical qualifications each year to ensure they were registered and had the required qualifications and competencies for the role.

Staff told us the service provided an event specific induction on the day, which covered for example, welfare including, professional conduct, deployment, uniform, security for the event, the expectation for patient reporting and when the patient needed to see a clinician, and medication administration.

All bank staff were offered an annual personal development review (appraisal). An appraisal is an opportunity for staff to discuss areas of improvement and development within their role in a formal manner.

Basic first aiders received in house training as EMC Medical Services Blewbury was able to provide qualified trainers to provider first aid training.

All members of staff who carried out driving duties, including emergency driving, had evidence of additional driver training.

For event work, the service reported they would always ensure a new member of staff worked with an experienced member of staff.

All event staff received major incident training within their substantive roles. Both directors had received silver response training and were silver commanders. (The silver commander is the tactical commander who

Emergency and urgent care

manages tactical implementation following the strategic direction given by gold commanders and makes it into sets of actions that are completed by bronze commanders). Both directors attended events where there was an attendance of 4,000 people or above.

Multidisciplinary working

Staff reported good working relationships with the other teams within the event site and the receiving emergency departments within NHS trusts.

See information under this subheading in the patient transport section.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

See information under this subheading in the patient transport section.

Are emergency and urgent care services caring?

Not sufficient evidence to rate 

We did not rate caring for emergency and urgent care services as we were unable to observe any episodes of care during the inspection.

Are emergency and urgent care services responsive to people's needs? (for example, to feedback?)

Good 

We rated responsive as **good**.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

The service had provided 43 emergency and non-emergency transfer's off an event site between March 2019 and February 2020. Events the service covered ranged from small events to events with more than 4000 attendees.

Managers planned and organised services in partnership with event planners, to provide safe transport to hospital or other providers' if needed at events the service covered.

The events manager booked events using an independent guide which risk assessed an event using a scoring system and recommended the number and type of staff required for the event. The provider would agree this number and cost with the event co-ordinator.

The provider had enough time to plan for events as most were planned well in advance. This helped them to ensure they had the right number of vehicles, equipment and staff to effectively plan to keep people safe.

Meeting people's individual needs

See information under this subheading in the patient transport section.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

The organisation's internet page described clearly how to make bookings and enquiries. Event planners could make bookings through the website, by email or telephone call.

Patients used the service by attending the onsite medical centre and being assessed by staff. Staff would attend calls from around the event site for patients who were unable to attend the medical centre.

The service was potentially available seven days a week depending on the requirement of the event.

Learning from complaints and concerns

See information under this subheading in the patient transport section.

Are emergency and urgent care services well-led?

Requires improvement 

We rated well-led as **requires improvement**.

Leadership

Emergency and urgent care

See information under this subheading in the patient transport section.

Vision and strategy

See information under this subheading in the patient transport section.

Culture

See information under this subheading in the patient transport section.

Governance

See information under this subheading in the patient transport section.

Management of risks, issues and performance

See information under this subheading in the patient transport section.

Information management

See information under this subheading in the patient transport section.

Public and staff engagement

The service engaged well with the local community and provided free (non-accredited) first aid training for bespoke local mother and toddler groups, as well as free first aid support to the local PRIDE events.

See information under this subheading in the patient transport section.

Innovation, improvement and sustainability

The service was developing and rolling out new technology for event work including automatic dispatch systems, radio's to be able to speak to identified individuals instead of over the airway and electronic patient report forms.

See information under this subheading in the patient transport section.

Patient transport services

Safe	Requires improvement 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Requires improvement 

Information about the service

The number of patient transfers for the local NHS and ambulance trusts were 5,530.

Summary of findings

We found the following issues that the service provider needs to improve:

- Some policies did not reflect national guidance and the leadership team were unclear about who the safeguarding lead was. The service did not always complete the required checks prior to staff commencing employment, for example some staff references were not checked prior to employment.
- The service had a vision for what it wanted to achieve but they did not have a strategy to turn it into action.
- There were limited governance systems to improve service quality and safeguard high standards of care.
- The service had limited systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected limited data and did not analyse the information collected to understand performance, make decisions and improvements.

However, we found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Patient transport services

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean. Staff managed clinical waste well.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them.
- Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.
- Staff kept records of patients' journey logs. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service followed best practice when giving, recording and storing oxygen.
- The service mostly provided care and treatment based on national guidance and evidence-based practice.
- The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service monitored response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.
- The service made sure staff were competent for their roles, and managers appraised the patient transport staff's work performance.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff spoke to patients with compassion and kindness, showing they respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal needs. Staff provided emotional support to patients to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received.
- The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders had skills and ability to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Leaders and staff actively and openly engaged with patients and staff, to plan and manage.

Patient transport services

Are patient transport services safe?

Requires improvement 

Our rating of safe went down. We rated it as **requires improvement**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

New staff completed their mandatory training face-to-face on induction, and on line through an accredited company. The training comprised of subjects including but not limited to, introduction to risk assessments, personal safety, communication skills and handling information, equality and diversity, information governance and person centred and duty of care. We reviewed six staff records and found all had completed this training.

Induction was split into formal and informal. Formal was where staff attended a corporate induction to learn about the company and complete face-to-face mandatory training and informal was with their team leader to learn about vehicle and yard familiarisation, cleaning equipment including control of Substances Hazardous to Health training and equipment training.

Team leaders monitored their team's compliance. They sent reminder emails three months before mandatory training needed to be updated.

Mandatory training rates were currently between 70% to 100% completion for the various subjects against a 95% target rate. The director explained this was due to some staff absence and staff only working one shift a week as well as the introduction of new courses, for example level three adult safeguarding.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Although staff had training on how to recognise and report abuse, and they knew how to apply it, policies did not reflect national guidance and the leadership team were unclear about who the

safeguarding lead was. The service did not always complete the required checks prior to staff commencing employment, for example some staff references were not checked prior to employment.

The service had a safeguarding policy for adults and children which was available for staff to access. This included how to report a safeguarding concern and where to send safeguarding referrals. The policy contained contact details for the local authority and adult safeguarding team. However, the policy did not include details for the children's' safeguarding team.

The policy did not reference the intercollegiate guidance on 'Safeguarding children and young people: roles and competences for health care staff' (January 2019), or the safeguarding policy protecting vulnerable adults (2015). It also did not contain information on female genital mutilation (FGM) or child sexual exploitation (CSE). However, we saw that FGM and CSE training was included in the staff online learning package.

Staff completed safeguarding children and adults training level two and three (adults only) as part of their mandatory training programme. This was in line with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019 and Adult safeguarding: Roles and Competencies for Health Care Staff 2018. Staff compliance was 70% for safeguarding children level 2 and 100% for safeguarding adults' level 2.

Between March 2019 and February 2020, there had been nine safeguarding referrals made to the local council and each had an allocated investigating officer. Staff were able to tell us the correct process from the organisation's policy on how to report a safeguarding concern.

It was unclear who the designated lead for safeguarding was. Two members of the management team were trained to level three for children's safeguarding, which was in line with the intercollegiate document.

Inside and outside of office hours, staff could contact the on-call manager to share their concerns, who would make the safeguarding referral.

The service undertook pre-employment checks to ensure that staff unsuitable for the role were prevented from working with vulnerable groups, including children. The provider had policies and processes to complete Disclosure and Barring Service (DBS) checks for all staff as part of their

Patient transport services

pre-employment checks and repeated these checks every three years. The service maintained a spreadsheet to monitor compliance and this showed that all staff checks were up to date. This helped protect patients from receiving care and treatment from unsuitable staff.

The providers recruitment process included checking the knowledge and suitability of staff for the roles required through a review of the application form, interview, review of qualifications and by providing training and assessments.

However, we noted that out of six staff records we reviewed only two had evidence of references obtained and checked prior to the staff member commencing employment. Staff explained this was because they were currently chasing the references. This went against the providers recruitment policy which stated all employees should have two reference checks before they commenced working for the company.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean. Staff managed clinical waste well.

Infection control was part of the mandatory training e-learning package. Topics included handwashing techniques and vehicle cleaning schedules. We saw that 100% of staff had completed this e-learning.

New starters buddied permanent staff for their first two shifts. This was to provide assurance that they understood infection prevention and control standards to help keep patients safe.

The service had standard operating procedures for staff to follow. This included guidance on cleaning their vehicles, which was supported by a vehicle cleaning, schedule and standards document that were kept on the ambulances. We observed the cleaning schedules were completed.

Staff carried personal protective equipment in carry pouches. For example, clinical gloves and aprons to reduce the risk of cross infection. Staff had received training on how to use this and knew when and where to use it.

Team leaders completed audits of the cleanliness of the ambulances and equipment twice a week. We reviewed the

results of three of the audits which showed actions taken by team leaders to rectify issues. For example, a poster was placed in the crew room regarding the bagging of dirty linen.

All vehicles were deep cleaned every 12 weeks by an external company. Evidence of the deep cleaning schedule was provided after the inspection.

A colour-coded mops system was in use to reduce the risk of cross contamination and the base had a designated ambulance wash-down area to ensure infection free ambulances.

We observed Control of Substances Hazardous to Health (COSHH) documentation was available for all staff to access, to ensure they minimised the risk of harm when working with certain chemicals and medical gases. Safety data sheets were available for all staff to review and COSHH products were locked away.

There was a system for safe segregation and disposal of waste. There was a designated area for the safe storage of waste. We saw that staff disposed of waste in line with the organisations policy. We saw evidence that an external company removed general waste every week, and clinical waste every month.

An external contractor cleaned the offices. We observed all areas of the site were visibly clean.

The service provided uniforms including shirts, trousers and t-shirts to all staff and photo identification badges were issued at the beginning of their employment. It was the staff's responsibility to launder their uniforms at the appropriate temperature settings

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them.

The service had a fleet of nine ambulances currently on the road and other vehicles that were 'in hibernation' and one off road being repaired. In addition, the service had equipment for transporting bariatric patients which was stored at the local NHS hospital. Bariatric equipment is designed to carry larger weights than normal equipment.

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The ambulances had a range of equipment designed for the safe transfer of a wide range of patients. This included straps for the safe transfer of a child on a stretcher. Stretchers and wheelchairs were fitted with locking mechanisms to stop them moving during transit.

The base site consisted of two buildings. One housed the crew room and included an office and training space and the other was used as a team leaders office. This office had two computers where were used for staff training and a storage area for medicines, consumables and equipment. There was ample covered and uncovered parking for the ambulances and staff cars.

Staff reported an external company serviced equipment such as stretchers and wheelchairs. We saw evidence of email trails between the provider and external company with regards to when servicing or calibration was next due.

There was a system for tracking the vehicles servicing, MOT due dates and insurance. A review of these records indicated all vehicles received a service, had an up to date MOT and were fully insured.

Staff told us they would inform the on-call manager if an ambulance had a fault. The ambulance would be removed from service until the fault was resolved. This ensured all ambulances were safe for use.

The provider used a local garage. This meant any repairs were generally completed on the same day. They also had an agreement with a vehicle recovery service which helped ensure there was a swift response if any of their vehicles broke down.

The team leader was able to track each of the vehicles using the Personal Digital Assistant (PDA) system which automatically updated. This provided assurance in the case of emergencies managers could contact the relevant crews.

We saw staff documented any equipment for vehicle faults on the daily vehicle inspection sheet within the PDA and it was reported to the on-call manager. The service would remove faulty equipment immediately and send it for repair.

We found the ambulance station and all vehicles were visibly tidy and free from clutter.

There was enough parking in the yard for the ambulances. Vehicles were locked and ambulance keys stored inside the

office in a locked key box, when not in use. The office had closed-circuit television (CCTV) externally and staff accessed the offices using a key. This reduced the risk of unauthorised access to the ambulances and base.

Crew members told us they used their own phones in situations when they could not get a signal on the Personal Data Assistants (PDAs) and sometimes used their phones to access the online training.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff performed dynamic risk assessments or used the risk assessment of the provider for the patients they transported. Dynamic risk assessment is a continuous process of identifying hazards, assessing risk and acting if needed, to reduce or eliminate risk.

The service required all staff to complete a first aid at work qualification which included adult and children basic life support before they could crew an ambulance. This ensured they were able to administer basic life support if a patient was to deteriorate.

During the booking process staff completed in-depth risk assessments of patients including but not limited to their mobility, any infections, medical conditions and if they were subject to a do not resuscitate order. If there were concerns around access to a patient at their place of care, EMC Medical Services Blewbury staff would visit the place of care to risk assess the transfer before booking the journey. This ensured the appropriate equipment and staff were available to safely transport the patient.

The crew would commence basic life support if a patient deteriorated during a journey. They called 999 for further ambulance support. This was detailed in the clinical operation guidance (COG). They recorded patients' observations and commenced treatment in line with their level of training.

Staff were able to seek specialist operational or clinical advice through their duty manager or the bookings desk at the local NHS trust.

Staffing

Patient transport services

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The staff at the ambulance base consisted of a clinical operations manager, an education lead who worked one day a month, two directors, a business development manager, an administrative assistant and four non-emergency patient transport leads.

The patient transport service had approximately 20 employed ambulance care assistants (ACA) with several bank staff employed on zero hours contracts. Two ACA's would attend each journey.

EMC Medical Services Blewbury used a shift management software package and crew members could access their rotas and request shifts from an application on their phone. Bank staff were able to leave their availability within this system. Team leaders would contact them to cover the shift if required.

The four team leaders shared the on-call cover. The crew could contact them by telephone. This ensured staff had a point of contact for advice and reassurance 24 hours a day.

The crew members generally worked three days on and three days off. This was between 7am to 6am Monday to Friday and 12 hours on a Saturday. The shifts were twelve hours with staggered start times. Staff told us they received breaks and they liked their working pattern.

For the period of March 2019 – February 2020 there were 44 days of sickness reported which was covered using the existing members of staff. At no time were there less than two staff members staffing each vehicle,

Records

Staff kept records of patients' journey logs. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Staff did not routinely keep patient records as they were providing the transport and others were providing the care.

Information regarding the patient journey was stored in the Personal Data Assistants (PDAs) on the ambulance. Patient information included the patient's mobility, any infections,

oxygen requirements, access to the property and pick up location and time. Staff would input their arrival time at the patient's home, arrival at the hospital and the time they were available for the next patient.

Medicines

The service followed best practice when giving, recording and storing oxygen.

Medical gases were the only medicines used within the patient transport service. Staff told us they would only administer oxygen if they had been trained to do so. We reviewed six staff records. We saw that they had received training on oxygen administration.

The oxygen cylinders were stored upright and securely. They were labelled correctly with signage that confirmed they were compressed gases and how to store and maintain them. Empty and full cylinders were stored separately. This is in line with the Department of Health guidance set out in Medical Gases Health Technical Memorandum (2006).

Patients or their accompanying carers were responsible for their own medicines' administration when being taken to and from their appointments.

Incidents

The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

We saw a record of 39 incidents between February 2019 and March 2020. Managers recorded when the incident occurred, the type of incident, the service it related to, when the investigation started, who the investigating manager was and when the incident was closed.

Staff were able to input in to the PDA any incidents that may have occurred and explanations of why they may have collected a patient later than booked. Managers analysed and used the information in feedback to the NHS trusts or in audit to make improvement to the service.

Managers shared lessons learned with the whole team and the wider service through a variety of communication methods.

Patient transport services

Staff told us that they apologised and gave patients honest information and suitable support.

Staff reported incidents electronically and raised them with the on-call duty manager. Staff were confident reporting accidents, incidents and near misses.

Staff told us about an incident where a patient received a minor injury from a wheelchair. The incident was immediately explained, and they apologised to the patient. The incident was shared with staff as a reminder to be careful when placing patients in the wheelchair.

Another example of learning from an incident that involved a patient being tipped over (by another provider) when staff were placing the stretcher on an ambulance. Following this, the provider contacted the stretcher manufacturer to confirm the correct way to place a patient into the ambulance. They updated their COG and placed a sign in the crew room to remind staff of best practice. They also emailed all staff to share the related best practice.

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

Good 

Our rating of effective stayed the same. We rated it as **good**.

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice.

Clinical and Operational Guidance Sheets (COGS) were based on national guidance and evidence based practice. They were available for staff to use to ensure patients were provided with the most up to date care.

Staff were able to access policies and COGS on the Personal Data Assistant (PDA). This ensured staff had immediate access to the information required to carry out their role.

The service had recently implemented a new electronic review of policies process. Policies included a version date and the electronic record displayed when the review was due. However, two of the seven policies we reviewed did

not include or refer to up-to-date guidance and not all policies were relevant to the service. One referred to staff positions that did not exist in the service, for example the safeguarding and corporate and local induction policy.

Any updates or changes to national guidance were managed by the clinical director and staff updated as required. For example, by face to face updates. They gave us an example of a recent change to practice. This was related to the use of ReSPECT instead of "do not resuscitate" orders. ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.

Response times

The service monitored response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

The service worked predominantly with local NHS trusts and NHS ambulance trusts and privately funded patients or care homes.

The service monitored its response times. The management team presented the information to staff by an electronic database. They used a large screen that was available in the crew room. We reviewed journey times for a three weeks period. The longest wait-time for a patient was 11 minutes.

We saw evidence that the business manager shared the response times with staff. They praised them for their good results and encouraged them to continue to improve.

The service did not benchmark itself against other providers. This meant they were unable to compare patient outcomes against other services. However, the management team told us they believed the service provided was good due to the low number of complaints received.

When staff worked for NHS trusts the trust monitored the services response times. The trust would report by exception any concerns. We did not see evidence of any concerns raised by the trust. The electronic system was able to provide accurate real time performance information to the local NHS trust.

Competent staff

Patient transport services

The service made sure staff were competent for their roles, and managers appraised the patient transport staff's work performance.

Staff in the patient transport service were all qualified with the first aid at work level 3 certificate and were either a First Response Emergency Care (FREC) three or four practitioner.

The service had a corporate induction programme that all new staff followed, and we saw evidence of five staff records who had completed this. We also spoke with three staff who all reported they had received an induction and felt it was comprehensive.

All new patient transport staff completed an induction programme as part of the compliance process before they could be scheduled for any shifts. This included the first aid at work qualification, basic life support and mandatory training.

An appraisal is an opportunity for staff to discuss areas of improvement and development within their role in a formal manner. We reviewed the record of staff appraisals and out of 20 staff six were outstanding. We were advised this was because these staff members worked one day a week and managers were catching up with the individual staff to complete them.

The service conducted Driver and Vehicle Licensing Agency (DVLA) checks at the start of employment and reviewed this every year. Staff knew that they were required to notify the managers of any changes to their license.

The provider employed one member of staff with a police background to undertake the driving assessments. This ensured consistency regarding the assessments of staff that were undertaken.

The provider reported they were a member of the Federation of Small Businesses which they were able to use for advice regarding disciplinary action. This allowed managers to be supported and to lead any disciplinary actions.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff reported good working relationships with the local NHS ambulance trust and NHS trusts. The service had direct contacts for the NHS trusts and spoke with them daily.

Staff understood their responsibilities to hand over all relevant information to other providers when needed. For example, when a patient was transferred with a do not resuscitate order, staff reported they would alert the receiving team to the order.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff received updated information regarding the Mental Capacity Act 2005 during the induction session. This provided assurance that staff understood how to apply it when caring for patients with reduced capacity for making decisions.

Staff completed training called Mental health, dementia and learning disabilities which enabled staff to adapt their approach to meet the patients differing needs.

Staff received training to assess the capacity of patients to consent and to act in the best interests of the patient. Staff recorded whether they had received a patient's consent on the patient record form.

Staff were able to explain to us the actions to take if a patient had a Deprivation of Liberty Order in place. These orders were introduced to ensure that people receive treatment without infringing on their liberty.

We observed staff asking for a patient's consent. They explained who they were and what they were doing in a way that easy for patients to understand.

Are patient transport services caring?

Good 

Our rating of caring stayed the same. We rated it as **good**.

Patient transport services

Compassionate care

Staff spoke to patients with compassion and kindness, showing they respected their privacy and dignity, and took account of their individual needs.

We observed the crew when they attended to one patient. The crew were attentive and friendly towards the patient. They offered to contact the patient's GP with regards to explain the patient's condition and to obtain further advice from the GP on the patient's behalf. However, the patient had already done this.

We saw that staff treated the patient with kindness, compassion and patience. Some staff told us they had a real passion for their work.

We saw recent feedback forms completed by patients or commissioners. Comments included: "Excellent all round brilliant staff, lucky to live in the UK, first class service" and "Good craic".

We noted the crew drove safely and there was always a separate member of staff in the back of the ambulance to accompany patients. This staff member checked on the patient's wellbeing throughout the journey.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal needs. Staff provided emotional support to patients to minimise their distress.

Staff understood that ambulances were normally associated with unhappiness and understood that they needed to give patients emotional support and make the patient journeys as positive as possible.

Staff had a good understanding of why a patient may be nervous, frightened or distressed when travelling by a patient transport service ambulance. They recognised that the vehicle could disorientate patients, especially when travelling at night. The staff explained how they would talk to patients to help them feel calm. They explained everything to patients and understood why this was important.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

The operational administrator took all the details for the crew when they took the booking details. This helped them to understand as much as possible about the patient before they arrived to transfer them.

The staff involved all the relatives and patients in their conversation about the journey details and timings. They took the patient's advice on how they liked to be moved and encouraged as much independence as possible. They gave clear instructions when help was needed. They checked to ensure that patients understood the information.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good 

Our rating of responsive stayed the same. We rated it as **good**.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

The service planned and provided services in partnership with the local NHS acute trust, and the acute NHS ambulance service. They managed this through informal contractual arrangements. EMC Medical Services Blewbury also took direct bookings from clinical commissioning groups, individuals or care homes.

Managers and team leaders planned and organised services well to provide safe transport to hospital or other providers.

The service had not cancelled any patient transport bookings in the period between March 2019 and February 2020.

Meeting people's individual needs

Patient transport services

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

The service considered people who spoke different languages and staff had access to an emergency phrase book. This translated into seven different languages. It also contained a pictorial scale for assessing pain. For example, a smiley face indicated a low pain score and a sad face indicated a high pain score. They used pictures in the communication book such as a toilet, snowflake (indicating too cold) and a bottle of water (indicating thirst). This meant they could assist patients who had difficulties with communication.

Vehicles had different points of entry. They included a sliding door and tailgate. This meant patients who were mobile or in wheelchairs had equal access to enter the vehicle safely.

Staff encouraged a family member or carer to accompany patients when possible. This was to help reduce the patient's anxiety. For example, staff encouraged carers or family members of patients living with dementia to accompany them in the ambulance.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

There was clear information on how to make bookings and referrals on the services' internet page. Patients and independent providers could make bookings through the website, by email or telephone.

The service could be available seven days a week. This depended on the requirement of the local NHS trusts or NHS ambulance providers.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

The provider had a complaints policy that was version controlled and in date. It included timescales for acknowledging a complaint which was five working days, with a response time of 25 working days. However, the

complaints policy also stated the service could refer complainants to the CQC for individual investigation which is the incorrect procedure as the CQC do not have the legal power to investigate individual complaints.

The service reported that from March 2019 to February 2020 the service received four complaints. The service responded to all four complaints within their target time of 25 working days.

We saw information on each ambulance about how to make a complaint. There was also information on the service's website.

We saw evidence that complaints were on the agenda of the governance meetings. Staff we spoke with confirmed managers shared learning from complaints during team meetings or by email.

The service received seven responses from a customer feedback questionnaire in 2019. Seventy one percent of the seven customers would recommend EMC Medical Services Blewbury to a friend or colleague and 57% were satisfied, 14% somewhat satisfied and 28% neither satisfied or dissatisfied with the service.

Are patient transport services well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as **requires improvement**.

Leadership

Leaders had skills and ability to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service had not had a registered manager since October 2019. They also did not have a nominated individual. The business manager and clinical operations lead was applying for the registered managers post at the time of inspection. The Health and Social Care Act 2008 states that registered providers must have a registered manager.

Patient transport services

The leadership team consisted of two directors, a business development manager, an education lead and a clinical operations manager who had been in post since January 2020.

Staff described leaders as approachable and visible. They were able to describe the role of each manager or lead. This demonstrated that they understood the leadership structure.

There were opportunities for staff members to develop their leadership skills and progress to team leaders. This could be discussed during their yearly appraisals. The service had recently introduced a pay review which was related to performance and reviewed at the yearly appraisals.

We observed members of staff interacting well with the management team during inspection.

Vision and strategy

The service had a vision for what it wanted to achieve but did not have a strategy to turn it into action.

The service did not have a documented strategy, but the director reported their vision was to get the data and evidence collection correct before they moved on to accept any further new business. They had no desire currently to grow the business but were focused on getting the information collecting process right.

Culture

The service had an open culture where patients, their families and staff could raise concerns without fear.

The service provided patients and their families with clear information on their websites and within their ambulances on how to raise concerns.

Staff we spoke with during inspection reported they enjoyed working for the service which had an open culture of reporting.

Managers across the service said they promoted a positive culture that supported and valued staff and they gave the example of the staff awards and social events they had put on for the crews. Staff we spoke with reported they appreciated this.

The service had a whistleblowing policy and staff reported they felt able to discuss concerns with managers.

Following feedback from staff the service created an ambulance services amenity point which included an area dedicated to infection prevention and control and an area for safer storage of chemicals. It also included an area where staff could meet for a coffee before they started their shift.

The management team had a scheme in which they nominated an employee of the month who received a certificate and a voucher.

Governance

There were limited governance systems to improve service quality and safeguard high standards of care.

There was no system which provided effective assurance that the service was safe and provided good quality care. There were some meetings and procedures which provided some evidence, but this was not brought together into an effective assurance framework.

While there was a governance framework, it was described by the provider as under development. There was a monthly governance meeting with key agenda items to trigger conversation around information the organisation held to help them understand the quality of the service provided. This included complaints, incidents, audit outcomes and staffing. However, information we reviewed demonstrated gaps within some processes were placing the provider at risk of not having full oversight of the service. For example, the policy review process, the recruitment processes, the lack of a safeguarding lead and the medicines management.

The monthly governance meeting was attended by the two directors, the clinical operational manager, the business development manager and the education lead.

We reviewed the governance minutes for three months between November 2019 and February 2020. There was evidence of discussion of the actions plans and allotted actions to specific persons following the meetings with evidence these actions were completed by the next meeting or carried over.

The team leaders held a monthly meeting chaired by the clinical operations manager. We reviewed the minutes of three meetings. These included for example, staffing and equipment issues but had no set agenda. Team leaders discussed issues and concerns and communication from

Patient transport services

the directors would be added to the agenda. Team leaders forwarded the minutes to the directors for discussion in the governance meeting and we saw evidence of a flow of information between the two meetings.

The service carried out some audits but there was limited evidence provided of how the managers used the results to improve quality. A comprehensive audit schedule had been developed to cover the services provided, but this had not been implemented at the time of inspection.

There were no formal meetings held between the two directors, although an accounts and finance meeting were held twice a year and decisions regarding the business were made during the monthly governance meetings.

Management of risks, issues and performance

The service had limited systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service had a risk register with two risks related to recruitment and retention of staff and lack of CQC registered manager. However, the risk register did not reflect the risks that we identified during inspection. These included business continuity and the change from paper and spreadsheets to an electronic system. We were not assured the service was managing risks well which could impact patient safety. Additionally, we noted in two of the three governance minutes we reviewed, there was no evidence of a discussion on the contents of the risk register.

However, when asked managers were able to talk about the risks to the service and could report on risks assessments that had taken place. This included the winter pressures audits to ensure the service was fully prepared for the winter season. This provided some assurance the management team had some oversight of risks within the service.

The management team and the staff told us that their greatest risk was recruitment and retention of staffing. However, they were trying to mitigate this risk by continually advertising for staff online and by word of mouth.

There were limited risk management processes to identify or manage potential risks. For example, there was no documentation regarding environmental risks such as slip hazards or risks relating to loss of staff or business, including vehicles, the base and manual handling.

The service had a current version-controlled business continuity policy which contained details around fleet, facilities and equipment as well as the contact with crew and information communication technology. However, it did not describe what actions staff should take if there was a major incident where there was a loss of premises, information technology or severe weather for example.

Information management

The service collected limited data and did not analyse the information collected to understand performance, make decisions and improvements. The information systems however, were integrated and secure.

During inspection, we saw limited evidence of data collected. For example, we requested to see staff induction rates, equipment registers with servicing dates, deep clean schedules amongst other data requests which the provider was unable to provide. This could indicate the provider might not have a full insight into the service's performance and would be unable to use this evidence to make decisions and improvements. However, after the inspection the provider was able to provide information such as audit results and deep clean data.

The provider collected information using a newly introduced electronic monitoring system. Upon review of this system it appeared that staff had not uploaded all information and there was evidence of gaps in the information.

For example, we saw a wheelchair that required a repair in 2019 was still sitting on the system as unrepaired when staff reported it had been repaired, the recruitment records had not all been successfully uploaded, and the director reported there was a possibility when documents were transferred between systems they may have been overwritten. This meant important information may have been lost.

Managers were unable to meet our requests for some information during the inspection. There were numerous times when they were unable to find the information. This meant some managers did not have access to or were unable to locate information. This is information that was required to understand performance, make decisions and improvements to the service.

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The service used Personal Data Assistants (PDA's). These devices could track patient journeys and recorded information as well as giving mobile crew access to policies and procedures.

Access to electronically held records and information was password protected. This meant only authorised members of staff had access to the information. We saw that all staff locked computers when left unattended. The services information security was governed through the General Data Protection Regulation (GDPR) policy.

All information held by EMC Medical Services Blewbury was cloud based which offered storage resilience which was in line with GDPR.

The director told us they had not needed to notify any external bodies of any issues. This meant there was no related information for us to review. However, the management team were able to report what notifications needed to be reported to external bodies such as the CQC.

Public and staff engagement

Leaders and staff actively and openly engaged with patients and staff, to plan and manage services.

Staff reported they were able to suggest improvements to the service and felt listened to by the senior managers. Staff gave us examples of when their suggestions had been implemented to improve the service. For example, a personal infection control pouch for staff to wear. They contained all infection control consumables. The service had also introduced bags to store patient referral forms and ensure these were securely held during the transport journeys.

Team leaders described the opportunity for funded team building days or evenings out for their teams to maintain staff morale. Staff reported these helped with team building.

We reviewed the latest staff survey from 2019. It was generally positive. Twelve out of 20 staff responded and 92% of staff were happy with the crew's facilities at the service.

The director reported they had set up a coffee and cake drop in – to meet staff and share any concerns they may have. The first one was held in January 2020 with the next one booked in May 2020.

The directors told us they shared any business updates through a secure internet application, and they emailed staff. This ensured the service kept staff up to date with regards to any policy and service changes.

The service had an easily accessible website where the public were able to leave feedback and contact the service. This demonstrated patients were able to engage with the service online and verbally.

Innovation, improvement and sustainability

The service had developed an online system where they could measure performance and patient outcomes. It was reported the system could be used to capture a better picture of the service. However, it was still under development.

After the inspection, we were told the service had introduced an online recruitment portal that replaced paper application forms to speed up the recruitment processes.

Managers told us the service was committed to providing a caring and safe service to their patients and the company's success and sustainability was measured by being recommissioned for the patient transport service and private bookings for their events.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must have a governance process that provides assurance for the safe running of the service. This must include a full oversight of the audit processes and key performance indicators to improve practice and patient outcomes. (Regulation 17(2) (a)).
- The provider must ensure it has effective recruitment processes to ensure all staff employed have had pre-employment checks completed and recorded before commencing work. (Regulation 19(2)).
- The service must ensure there are monitoring systems so that areas for improvement are identified in a timely manner. (Regulation 17 (2) (a)).
- The service must have methods of identifying and capturing risks. (Regulation 17 (2) (b)).
- The service must ensure there is a safeguarding lead identified as per national guidance. (Regulation 13 (1)).

- The provider must ensure a pharmacist is involved in the sign off process of all PGD's.(Regulation 12 (2) (g)).

Action the provider **SHOULD** take to improve

- The provider should monitor the medicines storage area temperature.
- The providers safeguarding policy should contain references to the intercollegiate document – “Safeguarding Children and Young People: roles and competencies for healthcare staff and safeguarding policy protecting vulnerable adults (2015) and detail to what level their staff should be trained.
- The provider should update all policies to reference and reflect up to date legislation and national guidance.
- The provider should consider a set agenda for their governance meetings and team leaders’ meetings.
- The provider should have oversight of the mandatory training rates to be able to reach the 95% mandatory training compliance rate.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

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

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

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

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity

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

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

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

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed