Falck UK Ambulance Service Limited

Falck (London)

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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?	Insufficient evidence to rate
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out a comprehensive inspection of FALCK (London) on 21 and 23 September. Following the inspection, we issued a warning notice on 7 October under Section 29 of the Health and Social Care Act 2008.

We rated it as requires improvement because:

- Leaders and teams did not have a local risk register to manage performance.
- Governance processes were not always fully effective.
- The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. Managers investigated incidents but lessons learned were not always shared with the whole team and the wider service in a timely way.
- We found processes to assess, monitor and improve the quality and safety of the service were not embedded.

However:

- All staff received an induction before beginning work for FALCK, and mandatory training was given to ensure staff kept up-to-date with key skills.
- Staff felt supported by the management team and enjoyed their work.
- The registered manager and the management team welcomed feedback and used it to make improvements to the service. We found the leadership team were responsive to our concerns
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Requires Improvement 	We carried out a comprehensive inspection of FALCK (London) on 21 and 23 September. Following the inspection, we issued a warning notice on 7 October under Section 29 of the Health and Social Care Act 2008. We rated it as requires improvement because: • Leaders and teams did not have a local risk register to manage performance. • Governance processes were not always fully effective. • The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. Managers investigated incidents but lessons learned were not always shared with the whole team and the wider service in a timely way. • We found processes to assess, monitor and improve the quality and safety of the service were not embedded. However: • All staff received an induction before beginning work for FALCK, and mandatory training was given to ensure staff kept up-to-date with key skills. • Staff felt supported by the management team and enjoyed their work. • The registered manager and the management team welcomed feedback and used it to make improvements to the service. We found the leadership team were responsive to our concerns • The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Summary of findings

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Summary of this inspection

Background to Falck (London)

FALCK (London) is one of three locations operated by FALCK UK Ambulance Service Limited. The main office control office is based in Milton Keynes and it serves its London contracts with NHS hospitals from an operational base located in Wembley. Staff either took vehicles home or they were stored at the Wembley base.

FALCK UK Ambulance Service Ltd provide non-emergency patient transport, predominately for patients travelling into and out of hospital for routine treatment such as dialysis, outpatient appointments and discharges following inpatient or emergency care.

They provide transport for patients requiring various ambulatory needs from patients able to walk with assistance, patients travelling requiring a wheelchair or wheelchair assistance, and stretcher patients. No treatment is provided by FALCK employees in these instances.

The service does not operate a blue light service.

This was the first inspection for FALCK (London) since they registered with CQC in 2020. At the time of the inspection, the provider had 257 vehicles and 463 staff.

How we carried out this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services. Action the service MUST take to improve:

- The service must ensure it has effective systems and process for assessing, monitoring and mitigating the risks to patients and others. Regulation 17, (1)(2)(a)(b)

Action the service SHOULD take to improve:

- The service should ensure oxygen cylinders are stored appropriately. Regulation 15
- The service should ensure learning from incidents is shared across sites. Regulation 17

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires Improvement	Good	Insufficient evidence to rate	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Insufficient evidence to rate	Good	Requires Improvement	Requires Improvement

Requires Improvement

Patient transport services

Safe	Requires Improvement
Effective	Good
Caring	Insufficient evidence to rate
Responsive	Good
Well-led	Requires Improvement

Are Patient transport services safe?

Requires Improvement

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.

Staff received and kept up-to-date with their mandatory training. Mandatory training was delivered through a mixture of e-learning and face-to-face training. Face-to-face training had re-started since these were stopped during the peak of the pandemic.

The mandatory training was comprehensive and met the needs of patients and staff. Training consisted of various topics including but not excluded to infection prevention and control, equality and diversity, medical gases (Oxygen only), adult basic life support, information governance mental capacity act and deprivation of liberty safeguards (DoLS) and clinical waste management.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw the system in place for this.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

Most staff had received training specific for their role on how to recognise and report abuse. Safeguarding training covered both adults and children. The ambulance crews and registered managers had level two safeguarding training. The safeguarding lead had level four training; however this had expired. We escalated this on inspection saw evidence the safeguarding lead had completed level four training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were knowledgeable about the types of abuse and the signs to show it may have taken place. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Requires Improvement

Patient transport services

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 followed infection control principles including the use of personal protective equipment (PPE). There were hand sanitising gel dispensers located at points throughout the vehicle garage. We observed staff cleaning their hands as appropriate. PPE such as gloves, masks, aprons and goggles were readily available on vehicles we checked.

Vehicles were visibly clean and clutter free. Vehicle make ready operatives (VMROs) were responsible for cleaning and preparing patient transport vehicles for use. All vehicles checked had trolley and mattress coverings that were clean and intact.

The providers infection prevention and waste management policy detailed how and when equipment and surfaces within ambulances must be cleaned. This included the process to follow between each person transported, and when a 'deep clean' would be required. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly and in accordance with the providers policy. Decontamination wipes were available in all vehicles and hand sanitising gel was available.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The premises were secure, supported by a closed-circuit television system and coded entry locks.

We checked three vehicles. All were in good condition and were well maintained. The vehicles were appropriately fitted with equipment in accordance with their relevant vehicle checklists and the equipment was in good working order.

There were fire extinguishers on each of the vehicles. These were appropriately stored and in-date.

Staff carried out safety checks of equipment. Records confirmed equipment was checked and tested daily and supplies topped up as needed. Stock was kept in the ambulance stations and staff collected items as needed to ensure the ambulance had the correct stock on board. All the ambulances we checked had the correct stock on board.

There was a fleet manager who was ultimately responsible for ensuring fleet maintenance. Vehicle servicing and road safety test data, defects and repairs were recorded on an electronic system. This notified the maintenance team when a vehicle was due for a road safety test or service. Records indicated all vehicles in use were within their service dates and had up-to-date MoT certificates.

Staff disposed of clinical waste safely. There were secure yellow bins for the disposal of clinical waste and sharps on board each of the vehicles. These were appropriately signed and dated. All clinical and non-clinical waste was correctly separated into different coloured bags. Clinical waste was securely stored in locked bins while awaiting collection for disposal. There was an arrangement with an external contractor for the removal of clinical waste.

The vehicle garage area was also being used to store items under control of substances hazardous to health (COSHH) and oxygen canisters. There was a dedicated secure area for the storage of oxygen canisters. Canisters were secured in locked metal 'cages' to prevent unauthorised access, with separate cabinets for full and empty canisters. Whilst the oxygen canisters were stored securely, we were not assured they were protected from extremes of temperature as there was no way of regulating temperature variations.

Assessing and responding to patient risk

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

Staff shared key information to keep patients safe when handing over their care to others. Basic risk assessments were carried out before confirming they would transport patients at the time of the booking. Booking forms identified patient's mobility needs, medication details, oxygen requirements, medical conditions, COVID-19 status and MRSA status. There were inclusion and exclusion criteria for the service meaning that staff only accepted patients who were appropriate to be safely transported based on the available equipment and skill level of the staff working in the service. They also considered and completed individual risk assessments on all other needs such as patients with mental health concerns, infections, mobility and access to their homes.

The provider also transported high dependency patients for the local hospital within the locations they operate. These patients were accompanied by a qualified healthcare professional provided by their commissioning provider or the service's staff.

Staff responded promptly to any sudden deterioration in a patient's health. All staff were trained in emergency first aid which included basic life support training. The service had a deteriorating patient procedure which included a deteriorating patient flowchart providing guidance to staff on what actions they should take. Staff were aware of the policy and told us they would pull over and call 999 if they had any concerns about a patient who became acutely unwell during a transport journey.

Vehicles carried oxygen administered by intermediate care technicians for high dependency transfers and staff used these as part of their first aid skills. A crew would stop and call 999 for urgent medical attention if they believed that a patient in their care had deteriorated beyond first aid.

Staffing

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 and gave staff a full induction.

The service had enough staff to keep patients safe. Managers could adjust staffing levels daily according to the needs of patients and number of journeys booked. The service employed 463 patient transport drivers. During our inspection we saw the required numbers of staff were available to transport and care for patients safely. Planned and actual staffing levels were reviewed daily.

The service had a staff member onsite who worked solely as a scheduler who used an electronic system to identify patient transport jobs and the availability of staff to ensure all jobs were staffed to the correct level. We saw the scheduler documented all jobs on an electronic system app, which all staff had access to.

Requires Improvement

Patient transport services

We reviewed 10 staff employment files; all records we reviewed contained evidence recruitment checks were undertaken before employment. This included proof of identification, references and with the appropriate criminal records checks through the Disclosure and Barring Service (DBS).

The service had a high turnover rate of 27.8% and most of the staff that had left had been employed for two to three years. Leaders were aware of the high turnover of staff and indicated the high turnover may have been due to recruitment over the furlough period and some staff leaving the service to return to work at their previous employers before lockdown.

Staff told us they were allocated time for rest and meal breaks.

Records

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

Records were comprehensive and all staff could access them easily. Transport bookings were made over the phone and recorded information provided on an electronic booking system. Staff received information on their hand-held devices before conveying patients. This included patient details, medical conditions, collection and destination addresses, as well as any specific needs of those patients, for example, if they required any additional equipment. Staff could also access risk assessments for further information about the patient and potential hazard in their home environment. We reviewed 10 records which had been completed fully.

Staff gave examples where they had escalated concerns where information on patient notes required updating by calling the dispatch office or logging details on the global emergency monitoring system.

Medicines

The service did not provide any medicines.

We were told that patients carried their own medicines unless the patient was not able or lacked capacity. There was adequate storage for medicines within the vehicles.

In all of the vehicles we checked, oxygen gases were stored securely and were in date.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. Managers investigated incidents but lessons learned were not always shared with the whole team and the wider service in a timely way. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them, however near misses were not always reported. Staff were aware of their responsibilities in raising concerns and recording safety incidents. Staff were able to give us examples that if there were any incidents, they would phone the office to inform management and would fill out a reporting incident form electronically. Staff used an electronic reporting system to log incidents and near misses.

Requires Improvement

Patient transport services

Staff did not always receive feedback from investigation of incidents. Staff said they did not always receive feedback on incidents raised by their colleagues or that they raised themselves. We reviewed 18 incidents reported and found three received formal feedback, although investigations into the reports had taken place.

Staff reported serious incidents clearly and in line with the provider policy. The service had reported 1,757 incidents from September 2020 to September 2021. Between July 2020 and July 2021 there had been 27 serious incidents at the service. The service was aware that incidents and patient harm was a key organisational risk, and this had been on the risk register since March 2021. The service had implemented some actions to increase staff training and enhance risk assessments for patients as a result. We reviewed 15 serious incidents and found that although actions had been taken to share learning incident review reports had not been signed off.

There was evidence that changes had been made as a result of serious incidents. The service had identified a theme of trip and falls from its incidents throughout the whole service and had investigated these at an organisational learning group meeting. The service put an action plan in place to address concerns and implement learning. These actions were monitored monthly at subsequent meetings. However, we found learning from incidents across sites was not effective. Staff we spoke with were not aware of incidents that had happened at other sites.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The service had a duty of candour policy that clearly described the purpose and process. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff clearly described the process of being open and transparent. We reviewed three serious incidents that resulted in patient harm and found that these had been investigate and duty of candour had been applied in these cases.

Are Patient transport services effective?

Good

We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies we reviewed referenced up to date legislation and or national guidance, however some polices had not been reviewed. Following the inspection, we saw evidence that these policies had been updated.

Staff could access all policies and procedures on an electronic format. This was issued to each employee at the start of their employment. We saw staff followed the service's policies to carry out their roles. For example, staff would not transport a medically unwell patient, and they knew the process to report any safeguarding concerns.

Nutrition and hydration

Staff gave patients enough drink to meet their needs and improve their health.

Staff assessed patients' drink requirements to meet their needs during a journey**.**

Bottled water was provided for patients, as appropriate. Patient journeys were not long enough to suffice the need to carry food.

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Staff recorded the time they left base, the time they arrived at the destination to pick up the patient, the time they left to transport the patient to their destination and the time of arrival at the destination. Staff also recorded subsequent timings in relation to waiting and returning as appropriate, to the next job, or back to base.

Managers used information from key performance indicators to improve care and treatment. Key performance indicators (KPIs) were managed individually to each NHS trust contract. KPIs were monitored by contract managers and KPI data was presented at monthly contract meetings. Performance against these KPIs were discussed at monthly meetings with the NHS trust, and any areas of improvement were identified.

Competent staff

The service made sure staff were competent for their roles, however at the time of the inspection, managers had not appraised staff's work performance due to the COVID-19 pandemic.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff were provided with appropriate training and competency checks. Records we reviewed confirmed this. Staff received driving competency assessments, training courses, shadowing sessions where staff could observe experienced staff carrying out the roles and assessing staff competency in using the equipment on the ambulances.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff received specific, dementia and learning disability awareness training as part of their induction and an update in their yearly refresher training.

Managers normally supported staff to develop through yearly, constructive appraisals of their work. At the time of the inspection 43% of staff had received an annual appraisal. We were told the appraisal process had paused during the pandemic and an action plan in place projected all staff would receive an appraisal by the end of December 2021. Leaders were implementing ride-outs and there was a plan for all staff to receive a ride out by September 2022.

Managers made sure all staff had a full induction and understood the service. Staff records showed all staff had received a full induction when they started work.

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 from across disciplines worked well together to meet the needs of the people who used the service. All staff we spoke with told us they received relevant information and instruction. They told us they communicated regularly with managers and other professionals to help keep people safe and provide good quality service.

Staff worked with the local authority and NHS organisations when raising safeguarding concerns and followed these up at contact meetings.

Requires Improvement

Patient transport services

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 understood the need to gain patients' consent and did so verbally and throughout their interactions. Staff gave us examples of using patient detail, risk assessments and information shared from transferring bodies to help them plan how to approach patient's being transported in a supportive way.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff completed consent, Mental Capacity Act training and Deprivation of Liberty Safeguards (DoLS) training as part of their mandatory training and all staff had completed this.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. All staff we spoke with understood how to support patients to make informed decisions and explained the process of gaining consent from a patient before transporting them. Staff demonstrated an understanding of capacity and told us this was ever changing, how people had capacity to make choices which may sometimes be viewed by others as poor choices. Staff understood the need to check capacity and then check ability to understand information given to them. Staff referred to people being able to weigh up and retain information.

Are Patient transport services caring?

Insufficient evidence to rate

We did not have enough evidence to rate caring. Due to COVID-19 restrictions we were unable to observe care within vehicles.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were able to describe how they protected people's privacy and dignity when they provided care. They gave examples such us using blankets and curtains in the ambulance to give privacy and protect dignity.

All staff we spoke demonstrated how they took time to communicate to patients and would use their experience to adapt their communication style for each patient. We were told how ambulance care assistant would sing along with a patient to put them at ease during their journey.

We saw thank you cards written to members of staff from patients and loved ones demonstrating staff taking time to relax patients and praising their 'excellent' communication.

Emotional support

Requires Improvement

Patient transport services

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

Staff understood the need to give emotional support to people and those close to them. Staff explained the importance of talking to family members and carers when loved ones were being transported. All staff we spoke to were passionate about providing patient centred care and taking time to talk to patients with empathy.

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.

Staff described being patient focused and involved them in discussions about and throughout their journey. Patients and loved ones, family members or relatives were permitted to travel with patients when assessed as appropriate.

Are Patient transport services responsive?

Good

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.

Managers planned and organised services so they met the changing needs of the local population. The service undertook over 500,000 transport journeys from September 2020 to September 2021. The operations manager ensured there were enough vehicles and crew numbers that met the needs of local people and their contracts. They offered a variety of patient transport services such as transfers to or discharges from hospital including high dependency transfers between hospitals, outpatient and renal appointments.

The service had the ability to monitor the locations of its vehicles and to identify where they were. They also had the ability to monitor the hours crews had driven to ensure they took appropriate breaks. Staff felt satisfied they often managed to take breaks and managers encouraged them to do so.

Meeting people's individual needs

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

Patients' individual needs were identified before each journey, and the information passed to the crews by the booking request form was available on mobile handheld devices. These forms detailed information such as age, gender and any

specific information related to individual needs or requirements, for example specific health conditions, or equality and diversity considerations. The service had also included risk assessments for patients that had complex needs. This enabled crews to check they had the necessary equipment, understanding and resources to meet those needs. They were able to report this back to the control room if needed, for example if further support or guidance was needed.

The service had a diverse workforce and some staff were multilingual. If a patient required a translator, the service had access to a telephone translator tool and used visual communication aids.

Access and flow

People could access the service when they needed it, in line with most key performance indicators, and received the right care in a timely way.

The service operated within the core hours of 8am to 8pm every day. They also provided out of hours service when required. Staff had access to job information which provided them with journey information including the patients' name, date of birth, pick up point, destination, mobility requirements and any specific requirements based on individual needs.

Patients had access to timely care and transport. Staff calculated all journey times at the time of booking to allocate enough time in between all patient transport journeys to allow for unexpected delays. This ensured any delays did not impact on bookings later the same day.

If a journey was running late the driver would ring ahead to the destination with an estimated time of arrival and keep the patient and the hospital informed. Crews always communicated any potential delays with patients, carers and hospital staff by telephone.

Managers confirmed that patient transport services although they did high dependency transfers, they did not do emergency transfers or provide critical care, and patients transported were usually clinically stable.

There were systems in place to measure response times. Contracts with partner NHS trusts included key performance indicators (KPIs) which detailed the level of expected performance. KPI performance was monitored at monthly meetings. We had sight of contract meeting minutes and saw that where performance was below KPI action plans were in place to make improvements.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

People could raise a complaint and all patients were encouraged to complete a feedback form following every journey. People could also provide feedback on the provider website or by phone. The provider received over 100 complaints a month and a consistent theme related to poor behaviour of staff. The senior management team had investigated these complaints, took actions to make improvements and shared learning. For example, they shared learning with staff through regular team messages and provided staff regular training that covered communication.

Requires Improvement

Patient transport services

Are Patient transport services well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They generally 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.

Staff felt supported by managers and their colleagues. The management team was made up of two registered managers, operation managers and contract managers. The provider also had a centralised governance team that worked across all Falck sites.

Leaders were visible within the organisation. Most of the operational staff and vehicles were based at the Wembley location as well as a registered manager along with operation managers and contract managers. The senior leadership team and the dispatch team were based in the Milton Keynes office or were homeworking. We found the leadership team were responsive to our information requests and were honest with us when information was out of date which demonstrated integrity and a commitment to improve.

Staff spoke highly of local leadership. Staff provided us with examples of how the service was managed so that they had the skills and resources to do their jobs well. We spoke to staff who were being supported to develop within the organisation and had been encouraged to progress into to senior positions. Leaders had stopped ride-outs with their staff due to COVID-19 and had just started to reintroduce this audit of staff competency.

Leaders were committed to the wider FALCK vision and values. They recognised the challenges faced by the organisation and also the day-to-day challenges faced by staff. Leaders were aware of the need to promote an open culture where staff were encouraged to report incidents and concerns. Although we noted areas of improvement that the leadership team had not yet addressed and was responsive when we raised these concerns.

Leaders told us appraisals had been suspended due to COVID-19 and had a plan to make sure staff would receive an appraisal by the end of March 2022.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Staff were aware of the company's vision but not all were aware of the strategy.

The service had a 5-year plan to 'be viewed by all as the UK's best provider of patient transport'. The strategy focussed on 'delivering a consistently great patient experience', being 'outstandingly well-led', to take responsibility for delivering social value and to grow the business sustainably.

Requires Improvement

Patient transport services

The service had adapted its way of working in response to COVID-19 and was continuously monitoring the impact on its service and its ability to provide transport for patients that rely on regular patient transport such as renal patients.

All staff we spoke to were aware of the services commitment to deliver high quality patient care and their role within the organisation. Leaders had plans to develop the service and use technology to provide more responsive information about journey details including live monitoring of transport such as vehicle and driver information.

There was a strategic plan to continue to expand and consolidate the business. Staff were aware of the vison and their contribution to it however some staff were not aware of the 5-year plan and the strategic priorities that the service had set out.

Culture

Staff felt respected, supported and valued. They were focused on the needs of people receiving care.

Staff told us they felt respected, supported and valued. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff described a positive working culture. They spoke positively of their roles within the organisation and highly of their colleagues.

The senior management team were visible and approachable. They had started to increase engagement with staff to discuss any concerns and provided emotional support when required.

The service had an anonymous whistleblowing reporting system where staff could raise concerns without fear.

Staff explained how they took time to explain to patients and their families if they were unhappy with the service and gave information of the helpline if they needed to make a complaint. We saw incidents reported by patients and family members.

Staff said they were encouraged to report incidents and near misses however as described within the safe domain staff did not always report near misses.

Governance

Governance processes were not always fully effective. Staff at all levels were clear about their roles and accountabilities and had started to implement regular opportunities to meet, discuss and learn from the performance of the service.

There was a governance framework in place. There were monthly organisational learning group meetings across all FALCK services which were chaired by the head of health safety environment and quality. We were told operation managers, the communication and engagement manager and quality and governance director attended; however, the minutes of the meeting did not document attendees. We reviewed minutes for the previous three months which included standard agenda items and any other business.

Requires Improvement

Patient transport services

Contract managers met with NHS hospitals to review all areas of the contract. We saw evidence that serious incidents and complaints, key performance indicators and finances were reviewed to monitor performance.

Incidents were investigated; however, final investigation reports were not always signed off in a timely manner. Staff were encouraged to report incidents however some staff did not always receive feedback on issues reported. We looked at 18 incidents and found three had not been investigated at the time of the inspection.

The service had implemented staff forums to improve engagement and monitor ongoing issues at the site in Wembley. The service had monthly staff forums where information relating to key performance indicators was discussed and where staff could raise issues.

Some of the provider's key documents such as policies and procedures were out of date. There was a risk that as the documents had not been reviewed, they may not reflect current best practice and guidance. We escalated concerns about the out of date polices and saw evidence to show these had been subsequently reviewed.

Managing risks, issues and performance

Leaders and teams did not have a local risk register to manage performance. There were some systems used to manage risk that identified actions to reduce their impact. They had plans to cope with unexpected events.

The service did not have a local risk register and, following our inspection we issued the service a warning notice. We were told local risk was being monitored through individual contracts with the hospitals, we reviewed minutes from the previous contract meetings and saw the oversight of risk was not robust. There was no way of monitoring how long risks had been open for, nor did they include when they had been reviewed. We saw the lack of a local risk register meant there was no way of monitoring environmental risks identified during our inspection.

A service wide risk register was reviewed by the senior leadership team at the risk and policy group meeting. We had sight of the service wide risk register. Risks were given a score out of 25 and at the time of our inspection, there were 14 risks on the risk register; four of these had a score of 12.The key risks reflected new ways of working under COVID-19 and the management of patient risk from harm, including the need to increase support to ambulance care assistants to reduce the occurrence of serious incidents.

The service had developed a new framework to assess driver competency with senior ambulance care assistants monitoring the work of their peers. We reviewed 15 completed records of ride-outs and saw forms were not completed in a robust way. For example, we saw evidence that a driver had not cleaned the vehicle between patients in line with the provider policy and no action was documented to address this. There was also scope in the ride-out assessment for managers to set out specific, measurable, achievable and timely (SMART) objectives however these were not completed appropriately so that performance could be effectively monitored.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Patient transport services

Staff reported that the hand-held devices they used contained accessible job and patient information. The service used an online patient booking/allocation system which was available for staff out on the road using their hand-held devices. These were all password protected so that information was secure. There was also a fleet check system which contained all the required information on the vehicles.

Staff understood information governance and the importance of securely storing patient information. Electronic patient detail was stored securely and only accessible to those with permission to do so.

Engagement

Leaders engaged with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service's website had the ability for people to give feedback about the service.

The service communicated to staff via email, video messages from leaders and at huddles. Senior managers said they had an open-door policy and that staff could approach them at any time. There was a 24 hour on call system that staff could use if they had concerns of issues that needed urgent resolution.

Leaders engaged with staff through a variety of methods. The Chief Executive of FALCK and directors held regular townhall meetings to engage with staff about issues relating to the business. The service introduced staff forums in April 2021 and encouraged staff to raise issues through staff forum reps and a dedicated mailbox. The service also sent regular newsletters by email.

Patient feedback forms were available on all vehicles and staff supported patients to complete forms by asking questions and inputting responses on their behalf. Patients could also scan QR codes to access an electronic form to complete or access the form by the text messages that confirmed their booking. Patient feedback was also reviewed at monthly contract meetings with NHS hospitals. Information from these forms were collated and results shared with staff and used for themes, learning and improvement.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service had invested in an app that would provide patient with detail of their booking and provide real time information about the location of their vehicle and driver. The service was also investing in a system where patient records would be integrated with hospital records, so the service had better quality information to support patients with the right support on their journeys.

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	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure it has effective systems and process for assessing, monitoring and mitigating the risks to patients and others. Regulation 17, (1)(2)(a)(b)