Eleanor Care Transport Ltd

Eleanor Care Transport Ltd - Hanwell

Quality Report

157 Uxbridge Road
Hanwell
London
W7 3SR
Tel:0208 579 5455
Website:www. eleanorcaretransport.co.uk

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Eleanor Care patient transport service is based in Hanwell in West London and offers transportation for non-emergency patients. The service provides a range of patient transport vehicles including ambulances with wheelchair securing devices and ambulances with stretcher facilities. The service has 14 vehicles and 28 staff members which includes three office staff and 25 drivers.

We carried out the inspection as part of our comprehensive independent health inspection programme. The announced inspection took place on the 6 July 2016. This was followed by an unannounced inspection on the 15 July 2016.

We saw areas of good practice including:

- There was good coordination with other providers.
- We saw staff treating and caring for patients with compassion, dignity and respect.
- Staff were passionate about their roles and dedicated to ensuring people were provided with good care.
- Staff felt valued and proud to work for the service.
- Staff felt supported by their manager.

However, there were also areas of poor practice where the service needs to make improvements:

- Incidents were documented in an incidents folder. However, we found no evidence that incidents were properly investigated and action plans put in place. Therefore, we were not assured the service was learning from incidents.
- Staff had a limited understanding of duty of candour. Duty of candour was also not embedded in the serious incident investigation process.
- Staff were not trained to the recommended level of safeguarding training, as per national guidance. Staffs understanding of safeguarding was varied.
- The safeguarding policy was out of date and did not include updated national guidance.
- There were no hand hygiene audits.
- Staff had a limited understanding of consent.
- We found limited evidence that complaints were being investigated thoroughly.
- There was no formal process in place for identifying and mitigating risk to patients.

Importantly, the service must ensure:

- Staff are appropriately trained in safeguarding adults and children. The service needs to establish systems and processes to effectively respond to any safeguarding concerns raised and prevent abuse and improper treatment of service users.
- The safeguarding policy is up to date and incorporates relevant national guidance.
- All staff receive training on duty of candour and understand their role with regards to the regulation. Duty of candour must be incorporated into the serious investigation process.
- Establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users . Any complaints received must be investigated and necessary and proportionate action taken. The service should ensure responses to complaints are recorded.
- That staff are following appropriate infection prevention and control practice and this is being audited to ensure compliance.

In addition, the provider should:

- Patients receiving oxygen have a documented patient care record to say how much oxygen is being given on the vehicle.
- Establish a process to identify and reduce risk to patients.

Summary of findings

The above list is not exhaustive and the service should examine the report in detail to identify all opportunities for improvement when determining its improvement action plan.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Eleanor Care Transport Ltd - Hanwell

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Detailed findings

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Background to Eleanor Care Transport Ltd - Hanwell

The patient transport service (PTS) is based in Hanwell in West London and offers transportation for non-emergency patients. They provide a range of patient transport vehicles including ambulances with wheelchair securing devices and ambulances with stretcher facilities. The service provides transportation between community provider locations, hospitals, events such as weddings and patients' home addresses for children and adults. The service has 14 vehicles and 28 staff members which includes three office staff and 25 drivers.

The majority of the services work involves crews being subcontracted to other patient transport services (clients). Journeys are made to various locations within London, although longer journeys occur on a regular basis. All referrals and bookings for this type of work are done by the provider location to the client PTS rather than Eleanor Care themselves.

Our inspection team

Our inspection team was led by:

Two inspectors from the CQC, an ambulance operations director and an ambulance operations manager within the NHS.

How we carried out this inspection

We visited the patient transport service (PTS) for a one day announced inspection 6 July 2016 and for an unannounced inspection a week later 15 July 2016. We gathered further information from data provided by the service.

During the inspections, we spoke with ten members of staff including PTS crews, the office administrator, the office clerk, the office transport manager and the service director. We also spoke with five patients and relatives, as well as one member of healthcare staff whose patients used the PTS service and a manager of one of the client patient transport services (PTS). We also inspected four of the PTS vehicles and observed PTS staff transporting patients.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

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

Our key findings are:

- There was no formal or comprehensive incident reporting form or system. Incidents were not consistently reported or acted upon. Staff wrote statements on blank A4 paper which they handed over to the office manager. Staff received no feedback following incidents. This limited learning and service development.
- The safeguarding policy was not up to date with changes in national guidelines and staff were not trained to the appropriate level of safeguarding training. Staff awareness of safeguarding processes and procedures was varied and we had concerns about under reporting of safeguarding alerts.
- The service were not conducting hand hygiene or infection prevention and control audits to assess compliance.
- There was no formal process for ensuring complaints were thoroughly investigated.
- We had no assurances risks were being tracked and managed, with plans to mitigate risks.

However:

- All ambulances we inspected were clean and well maintained.
- All staff had completed mandatory training.

Patient transport services (PTS)

- Staff had a strong focus on providing caring and compassionate care. We observed staff acting in professional and respectful ways when engaging with patients and their families.
- Staff felt valued by their peers and managers and reported good levels of support. The managers organised social events for the staff which helped with team bonding and cohesiveness.

Are patient transport services safe?

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

Summary

- Although staff told us they would report incidents we found some incidents which had no record. The service had no formal incident reporting form or system. There was no feedback following incidents which meant staff were not always aware of learning and changes or improvements needed in practice.
- Awareness of safeguarding processes and procedures was varied among patient transport service (PTS) staff; some were able to describe what would constitute a safeguarding concern, whereas other staff were unfamiliar with the term, and what they would do if they had safeguarding concerns about a patient they were transporting.
- Safeguarding training was not to the recommended level as per national guidance. Staff should be trained to level two and the safeguarding lead should be trained to level four. All staff had only received training equivalent to level one.
- The safeguarding policy was written in 2014 and did not include more recent national guidance. The policy had no information regarding the level of training staff needed to be trained to.
- There was also no information governance training for staff.

However:

- We observed good hand hygiene practice amongst staff when transporting patients.
- All vehicles were clean, well maintained and had up to date MOT's.
- There were good staffing levels for the workload of the service.

Incidents

- Incidents were initially reported via telephone to the patient transport service (PTS) control centre to the

transport manager. Staff told us that should an incident occur they would call the office and speak to one of the managers. Eleanor care contracted ambulances out to other patient transport services and staff told us they would also let the contractor know about any incidents.

- Some staff told us they would complete incident forms when they returned to the office. However, we only found evidence of three completed accident forms relating to two staff injuries and one patient injury in 2015. There were no other records stored prior to this.
- We found a separate incidents folder that contained written records of incidents that had taken place. PTS crews would provide written statements once they returned to the office. The transport manager would then send these statements to the company who contracted the ambulance for that day. There was no evidence of additional communication between Eleanor Care and the contractors. Therefore, there was no evidence that incidents had been investigated and there were no recorded action plans. Some staff told us they did not receive feedback from incidents. This meant staff were not aware of learning from incidents and changes or improvements needed in practice.
- Some staff said they would report every incident to ensure they were covered. However, during the inspection we were made aware of an incident with no documented record. One staff member told us about an incident in which a patient had vomited and the staff member had had to take remedial action to ensure the safety and physical well-being of the patient. We could not find any information about this in the incident folder.
- There was no formal document for staff to complete for incidents which would help the service ensure all key details were captured. Incidents were hand written on blank pieces of paper.
- From April 2015, all registered providers of health and social care services are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- 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.
- There was no duty of candour training for staff. All of the staff we spoke with could not describe what duty of candour was. The service director told us there were plans to incorporate duty of candour into the serious incidents process.

Mandatory training

- Staff received mandatory training upon beginning employment with Eleanor Care as part of their induction process.
- Staff told us this training included moving people and safer patient handling, securing wheelchairs into specialist vehicles, wheelchair tie down and occupant stretcher belt systems, ambulance equipment and their uses in patient transport, safeguarding vulnerable adults and children, infection control and prevention, emergency first aid at work, first aid at work and paediatric first aid. We reviewed the training database and saw there was a 100% compliance rate with all training.
- Training was delivered by an external organisation and was face to face.
- Staff did not receive training in Basic Life Support (BLS) or Intermediate Life Support (ILS). However, staff had First Aid at Work Level two training.

Safeguarding

- Safeguarding vulnerable adults and children was part of mandatory training and once completed lasted for three years. We saw no evidence that staff participated in yearly refreshers for safeguarding training, which meant there was no assurance that staff were up to date with changes in national guidelines and recommendations.
- We spoke with the external training manager regarding the level of the safeguarding training and we were told it was equivalent to level 1. There was no level 2 training for staff. National guidance from the Intercollegiate Document for Healthcare Staff (2014) recommends that all ambulance staff including communication staff should be trained to level 2. This applies to all clinical

and non-clinical staff that have contact with children/ young people and parents/carers. Staff told us it was rare they would transport children and young people but it did happen.

- The service director was the nominated safeguarding lead for Eleanor Care. The director had received the same training as the PTS staff, which the service reported to be equivalent to level 1. This did not meet national guidance, as named professionals within services should be trained to safeguarding level 4.
- Awareness of safeguarding processes and procedures was variable among PTS staff. Some were able to describe what would constitute a safeguarding concern and provide examples. However, other staff were unfamiliar with the term and made comments such as "what is safeguarding?", "is it making sure the patient is safe enough to travel in the ambulance?", "making sure we as drivers are not at risk?"
- Staff told us if they had any concerns they would call control and report it to their manager. The service director told us there had been no safeguarding concerns in the past 12 months. However, during the inspection we identified two potential concerns which had not been raised as safeguarding concerns within the service. The services policy states that any safeguarding concerns must be documented and report to the services director. They should then be reported to the appropriate local council.
- One incident had been reported within the incidents folder and staff had called the police. However, there was no evidence this was raised as a safeguarding concern and there had been no communication between Eleanor care and other services to follow this up.
- Staff informed us about a second incident where a patient had been taken back to the hospital due to there being no food within their home. Staff told us they reported this to the hospital, however there was no written record identifying this as a safeguarding concern.
- The safeguarding policy for the PTS service was displayed on one of the notice boards within the office. Within the footnote of the document we could see the document was produced in August 2014, however the policy had no dates recorded for when it was due to be revised. The policy did not include the Working Together 2015 government guidelines and the London Child Protection Procedures 2016. Therefore, it contained no information regarding female genital mutilation (FGM). The policy contained no guidance as to the level of safeguarding training staff would require.

Cleanliness, infection control and hygiene

- Day to day cleaning of PTS vehicles was completed by the crew assigned to the vehicle each day. It was the crew's responsibility to ensure the vehicle was clean and presentable at all times. Additional internal deep cleans were completed by a subcontractor on a six monthly basis and were done at a local carwash.
- Staff wiped down the leather seats and equipment between patients.
- PTS staff followed infection control procedures, including washing their hands and using hand gel after patient contact. Staff were observed to be bare below the elbows.
- Some personal protective equipment (PPE), such as gloves was available on PTS vehicles. However, none of the vehicles we inspected had aprons available. When we asked staff about the use of PPE one staff member said they did not wear PPE as they did not want to make the patient uncomfortable. This meant that if a patient was infectious the driver would be at risk.
- We saw no evidence of infection, prevention and control audits or hand hygiene audits within the service. This meant the service was not assessing compliance through this method.
- We were provided with details of the cleaning spray that was provided to staff for vehicles. This spray did not protect against Clostridium difficile (C.diff) and methicillin-resistant Staphylococcus aureus (MRSA).
- There were no robust processes for the cleaning of contaminated waste. For example, there were not always clinical waste bags provided on the vehicles and no formal arrangements for the disposal of clinical waste. Staff told us they would dispose of clinical waste at the hospitals when they dropped patients off. One staff member told us if a patient vomited at the end of the day they would double bag the vomit and leave it in the vehicle overnight to be cleared the following day which was a potential infection control risk.

Patient transport services (PTS)

Environment and equipment

- There were three different makes of vehicle used for the PTS service. Staff told us that vehicles were normally replaced once they started to require a lot of upkeep and it became expensive to maintain. The oldest vehicle in the fleet was from 2010 and the service had purchased six new vehicles in 2016.
- PTS vehicles were on a planned four monthly service schedule.
- A paper based calendar indicated which PTS vehicle MOTs were due for renewal. All vehicles held a valid MOT.
- Daily inspections of vehicles took place and were recorded and submitted to the control office. All drivers completed the vehicle checks which included: damage to the vehicle, cleanliness, checks to see if the ramp and step were functioning properly, engine oil levels, coolant level, brake fluid level, windscreen water level, and tyre checks and if oxygen was available. Each driver needed to submit this information to the office each day.
- Some of the vehicles had an on-board wheelchair available for patient use and this was secured with fasteners.
- Some of the PTS vehicles could transport patients on a stretcher bed.
- We saw unsecured oxygen cylinders on one vehicle, which posed a risk. If the vehicle was in an accident an unsecured oxygen cylinder could be thrown around inside the vehicle placing the patient or staff at risk of harm. This was escalated to the manager during the inspection. We was told drivers had been reminded to ensure any oxygen is made secure.
- Equipment did not have stickers on it to show when the last service had been completed. For example we looked at oxygen lines in a number of vehicles and could see no information regarding previous service dates.

Medicines

- The service policy stated that medications should not be stored on vehicles and patients should keep their own medication safely. If a patient left a medication on a vehicle staff were required to report this to control and return it to the hospital.
- Oxygen canisters were available on board the vehicles. The canisters we looked at were in date.
- The service did not complete patient report forms for the use of oxygen on patients. If a crew member gave a patient oxygen and something went wrong the service would have no record of the amount of oxygen that had been given. We raised this concern with the director on the day of the inspection.
- The director of the service informed us that oxygen is taken from the hospitals and that the service does not purchase oxygen themselves.

Records

- The majority of Eleanor Care's work involved crews being subcontracted out to other patient transport services (clients). This meant the bookings for the majority of patients was not done by Eleanor Care.
- Private bookings were taken via an online system.
- Staff were provided with patient details such as mobility needs and any special notes or instructions via the clients.
- On PTS vehicles, drivers kept written records of pick up and drop off times for each patient. This was then provided to the office as part of the crews' timesheets.
- Drivers used company mobile phones and we was told the system transmitted patient data through secure systems to company smart phones. The data transmitted consists of patient name and from and to address only.
- Staff told us that one of the clients encouraged them to download a mobile phone application so they could be sent patient information.
- The service did not provide information governance training for the staff. The commercial third parties information governance toolkit published by the Department of Health says all staff should have training on information governance requirements, the service was not meeting this recommendation.

Assessing and responding to patient risk

- Patients' needs were not assessed by Eleanor Care themselves and were completed by the clients. However, there was no assurance that this was being done as it was not something the service monitored.

Patient transport services (PTS)

- There was no formal risk assessment completed by the crews.
- Staff told us they would do visual assessments of patients, as there were no kits to take observations. If a patient was deteriorating staff said they would call 999 and inform the control of the client. However, we were unable to determine how many times this had happened in the past as there was no formal records of these types of incidents.
- PTS crews were alerted by the clients control centre if a patient they were transporting had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place. PTS crews told us they would confirm this upon arrival to collect a patient.

Staffing

- The PTS staff consisted of the director, office manager, a clerk and an administrator within the office.
- All the PTS drivers were on zero hour contracts. All PTS staff had valid DBS checks.
- PTS staff could work in either one person or two person crews.
- There was no lone working policy in place for the PTS, however there was a section in the Health and Safety policy regarding lone working. The director told us when crews were subcontracted out they had no idea who they were picking up or where they would be going that day. Vehicles could be tracked so the office staff could see where the vehicles were and whether they were moving or stationary. Staff were not in regular contact with the office unless any issues occurred.
- During the inspection we were shown no contractual arrangement or mechanism in place to manage expected ways of working and staff safety between the service and the main clients. Therefore, the service had no assurance about the crew's status during the day and whether they were working efficiently against contractual obligations.
- Staff told us they took they were able to take their breaks during shifts.

Anticipated resource and capacity risks

- The service had no anticipated resources and capacity risks as all PTS staff were on zero hour contracts. The service would only take jobs if they had the capacity to do them.

Are patient transport services effective?

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

Summary

- At the time of the inspection the manager told us there were no service level agreements in place. There were no assurances staff were applying any specific national guidelines to their work. This also meant the service was not monitoring standards of the service and expectations when staff were working with another patient transport service (PTS). Following the inspection we were sent a carrier agreement between the service and another PTS service from August 2012 which set out some criteria for work with one of the clients. However, we were not provided with SLA for other clients.
- Staff had little understanding of consent and the Mental Capacity Act and there was no formal training for this.
- Staff spoke positively about their training, however there was no evidence that staff had refreshers and updates.

However,

- The service had one KPI which was to arrive at the clients' first job on time and they achieved this the majority of the time.
- Staff were provided with patient information via the clients' control. This provided them with all the key information they would need to know for the job.
- We spoke to a transport manager at one of the hospitals Eleanor Care transported patients to and they were very positive about the service.

Evidence-based care and treatment

Patient transport services (PTS)

- The service subcontracted out their vehicles to other patient transport companies (clients). This meant the majority of patients' eligibility assessments were completed by the client.
- Staff were unsure of any specific national guidelines that applied to their work.
- The director told us there were no service level agreements in place at the time of the inspection.
- Following the inspection we was sent a service level agreement that was in place with one of the clients. The service level agreement set a number of standards the service had to meet. This included patients being collected from the collection point and dropped off at the drop off point requested. Patients need to be collected within 45 minutes of time advised. Vehicles shall be clean internally and externally and roadworthy. Drivers shall be courteous and safe and assist patients whenever necessary.
- However, there were no agreements outlining certain eligibility criteria for using PTS, based on national guidelines for the non-emergency transportation of patients.

Assessment and planning of care

- There was no formal training around the Mental Health Act. Staff said they were made aware of patients' needs via information from the client.
- The director told us the service did not transport patients with mental health diagnoses. However, one staff member said they had a regular mental health patient and had built a good rapport with them. The service level agreement had no written criteria for the types of patients the service would and would not transport.

Nutrition and hydration

- The service did not routinely provide food or drink to patients using the service.
- However, the service did some long distance transfers and one staff member told us they would take water and cups for patients so they could have a drink.

Patient outcomes

- The service had one key performance indicator (KPI) which was achieving customer start times. That means getting to the clients first job on time or within an hour. The service achieved 98% for April 2016, 97% for May 2016 and 95% for June 2016. The manager told us any patient movement throughout the day is then managed by the client.
- The service did not monitor patient outcomes.
- The director said the clients monitor their own KPIs and it was not something Eleanor Care monitored.
- At the time of the inspection the director told us there was no service level agreements. Therefore, standards of the service and expectations were not monitored.
- The service did not carry out any clinical audits such as infection, prevention and control and hand hygiene.

Competent staff

- All new PTS staff were inducted upon commencement of employment with the service.
- It was the responsibility of the office manager to assess when training needed refreshing and when new training was needed. The office manager recorded training dates on a database and we was told once the date was three years old the staff would be out forward for their updates. This was monitored manually via the use of outlook reminders.
- Staff spoke positively about the training they had received. However, there was no evidence staff undertook yearly refreshers.
- Staff said the service offered them the opportunity to train to be an emergency medical technician (EMT). Staff were able to complete parts of the EMT syllabus but not the whole course.
- We spoke to the director about staff appraisals. We were told 60% of the drivers had not been at the service for 12 months. The service had not previously completed formal appraisals and noted that this is something that would be undertaken in the future.
- Staff had no formal training on dementia or learning disabilities.

Coordination with other providers

- Eleanor care did not work with healthcare providers directly as they subcontract their vehicles out to other patient transport services.

- However, at one of the hospitals we visited we got positive feedback from the transport manager regarding Eleanor Care.
- We had some concerns regarding communication between Eleanor Care and the clients. Working was not coordinated for example with formal processes or procedures in place for incident reporting and feedback and complaints procedures and feedback.

Access to information

- Staff were provided with patient information from the clients which indicated any specific patient requirement, such as whether the required wheelchair access. They could call the control if they required further information.
- Staff told us they had access to a driver's handbook for information. However unless they asked or came to the office there was no other access to policies.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was no formal training for consent, mental capacity or deprivation of liberty. Some staff did not know what we meant by mental capacity.

Are patient transport services caring?

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

Summary

- Staff treated patients and relatives with kindness and compassion. Staff were professional and communicated effectively and in a polite and respectful way.
- Staff we spoke with were very passionate about their roles and dedicated to making sure the people they cared for were provided with the best care possible.
- Staff treated those using the service with dignity and respect.

Compassionate care

- Throughout our inspection, we observed staff had natural empathy and demonstrated compassion towards patients. We observed staff greeting patients on arrival in a warm and welcoming way.
- Staff addressed patients politely and in a respectful manner and treated them with kindness during the journey.
- Staff maintained patient dignity at all times, one staff member covered a patients legs with a blanket when they were being transferred.
- We spoke with five patients and relatives who were very positive about the staff. Some of the comments included: "They are good", "I am really happy I couldn't fault them", "They care for my partner I have no complaints", "I find them very helpful".
- We spoke to a transport manager who said the crews were very professional, competent and caring towards the patients.
- One staff member bought bottles of water and provided patients with cups if they were thirsty during a journey.

Understanding and involvement of patients and those close to them

- Staff ensured patients knew what was going on during their transportation.
- Each vehicle had feedback cards for patients and relatives to complete. Feedback cards were given back to the service and filed in a folder.

Emotional support

- Staff gave an example of returning a patient to the hospital because the home was cold and had no food.
- We spoke with a transport manager at a hospital who told us the crews go above and beyond to meet the needs of the patients.
- We observed patients meeting patients individual needs, one staff member accompanied a patient to an appointment, as they preferred to try to walk rather than use a wheelchair.

Are patient transport services responsive to people's needs?

Patient transport services (PTS)

(for example, to feedback?)

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

Summary

- We observed staff meeting patients' individual needs. Staff were provided with key information from the clients' control regarding the needs of the patients.
- We saw information about how to make a complaint available in the majority of the vehicles we inspected.

However:

- There was no formal process for following up on complaints that were made to the clients. The service took written statements from staff and forwarded them to the client but there was no feedback mechanism in place. This limited the services ability to look for themes from complaints and use this to change practice.

Service planning and delivery to meet the needs of local people

- Patient transport service (PTS) workloads were planned in advance and based upon work that came in via the client. The director told us this accounted for 99% of the service's workload.
- We spoke to one of the contractors who said they were happy with access to vehicles for subcontracted work.
- Private work, which accounted for 1% of the service's workload allowed for vehicles to be booked in advance.
- PTS crews told us the work was variable and some days were busier than others.
- Staff told us they collected patients from a range of different places and therefore it would be difficult to plans services to meet local needs.

Meeting people's individual needs

- Patient information was communicated to the PTS staff directly from the clients. This told them the address of pick up, drop off point and any other key information the crew might need to know.
- There was a satellite navigation system to enable the crew to travel efficiently between their destinations.
- Bookings for private patients were completed online where patients could request specific requirements.
- Patients travelling with a DNACPR order in place were always transported individually. Staff told us this was to protect other patients. Staff told us if a patient passed away they would stop, call 999 and inform the office and control.
- For patients with communication difficulties or who do not speak English, no provision was made to assist their communication throughout the journey. Staff told us some colleagues could speak other languages, which helped at times. Otherwise, staff would rely on the patient's relatives or use hand gestures.
- Information leaflets were available in English. There was no provisions for those who were hearing or visually impaired. However, there had not been a need for this within the service.
- Staff told us if a patient was violent or aggressive they would refuse to complete the job and report it to control. There was no formal training on how to deal with violent and aggressive patients. However, the service had a violence and aggression process pack which they said supports staff should they encounter any issues.
- Staff had no formal training in mental health, learning disabilities and dementia.

Access and flow

- The majority of patient journeys were planned by the clients. Therefore, the service did not have to plan journeys so patients could access them at times that suited them. The service's main target was to arrive at the first appointment on time for the client.
- The service had no response time targets as this was managed by the client.
- For private clients, bookings could be made for a time that suited them.
- The service had one KPI, which was to arrive at the patients' first appointment on time for the client. There were no further quality measures for the service. Following the inspection the service sent us a carrier

agreement it had with one of the PTS services. This agreement had a number of KPIs such as patient time of vehicle, vehicles being on time, patients collected within 45 minutes of the time advised. However, this was not something the service was monitoring itself. The agreement was dated 1st November 2013.

Learning from complaints and concerns

- Information about how to make a complaint was available in the vehicles, however this leaflet was not seen in all the vehicles we inspected.
- If a customer made a complaint to one of the clients, the complaint would be forwarded to Eleanor Care. The office manager would then take statements from the staff involved and forward these statements back to the client. There was no further documented evidence of what happened next. The service did not receive any feedback about complaint investigations from the client. Therefore, this was not fed back to staff which limited learning from complaints and concerns.
- The office manager said staff would be spoken to on an individual basis, however there were no documented records that this was being done.
- If a complaint was raised directly to Eleanor Care this would be investigated by the director of the service who would aim to respond within three days.

Are patient transport services well-led?

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

Summary

- There was no formal vision or strategy for the service.
- There was no formal process in place for risk management.
- There was a lack of structure and formal processes in place regarding the investigation of incidents and complaints. This prevented the service from learning when things go wrong and making changes to ensure it does not happen again. Staff had no understanding of the duty of candour at the time of the inspection.
- The service was not following processes and procedures regarding safeguarding concerns. This meant patients were not properly being protected.
- The manager told us the service did not transport patients with mental health difficulties. However, staff feedback suggested this occurred on a regular basis. The service had one service level agreement in place with the clients and this had no clinical criteria for the types of patients they would and would not transport. Once the vehicle and crew had been sent out the service had no information about the jobs the crews would be completing. Therefore, there were no safeguards in place to ensure staff and patients were safe.

However:

- All staff said they were supported by the director of the service and said the director was very accessible and present should they require any advice.
- All staff were very passionate and dedicated to their work, and a number of staff said it felt like a family.

Leadership of service

- There was one service director and an office manager responsible for overseeing the day-to-day management of PTS. The managers looked after the welfare of the staff and were responsible for the planning of the day to day work. However, the actual patient pick up and drop offs were organised by the client.
- PTS staff spoke very positively about the management team and felt able to approach them with any difficulties and issues. They described seeing the managers every time they came to the office and told us they could discuss anything with them during this time.
- Some positive comments included: “I feel very well supported”, “My manager is friendly and supportive I can go to them about anything”, “Managers are approachable and I feel valued”, “The manager is friendly and helpful”.

Vision and strategy for this service

- We spoke with the director of the service who told us the vision was to become a more profitable service. However, this was not something that the staff have been made aware of as it is not something that had been written down.

- Staff we spoke with told us they did not know what the vision and strategy for the service was.

Governance, risk management and quality measurement

- There were no clinical governance structures in place.
- We saw evidence of individually scored risk assessments for some equipment but no evidence that plans were put in place to mitigate risk. The risk assessments we saw had been completed in February 2016. The director told us there were plans review them in 12 months' time to see if risk had gone down.
- There was no lone working policy for the PTS service and no service level agreements regarding the monitoring of staff behaviours and staff safety. We discussed this with the director on the day of the inspection and were told plans were being put in place with one of the main clients to make these arrangements.
- There was also no clear clinical criteria in the service level agreement setting out the types of patients the service would and would not transport. Staff told us they were transporting patients with mental health difficulties. The service could be transferring patients with mental health difficulties, learning disabilities and dementia on a regular basis with was no formal training around this. This meant there were no safeguards in place to protect staff and patients from risk.
- Incidents and complaints were not formally investigated. We found no evidence of action plans being put in place to improve practice and ensure learning from when things go wrong. There was also no process in place to ensure this was feedback to staff.
- There was no staff awareness of duty of candour. The director told us this was a new initiative within the service and something that would be integrated into the serious incident process.
- We had concerns patients were not being properly safeguarded against harm. The service was not following its own safeguarding policy regarding the reporting of safeguarding concerns to the local authority. We was told the service had raised no safeguarding concerns during the past 12 months. However, during the inspection staff told us about incidents which constituted a safeguarding concern. Staff had not raised these incidents as safeguarding concerns and they had not been escalated to the local authority.

Culture within the service

- Staff told us because the company was small it felt like they were a family, with good support from everyone.
- Staff told us there was no bullying and harassment within the service, everyone was respectful of each other.
- There was a strong emphasis on staff well-being and the director organised a number of social events for the staff to do as a team.
- Staff said they were proud to work for the service.

Public and staff engagement

- There was a drivers' meeting which took place in February, April and March 2016. These meetings provided information around a variety of topics such as time sheets, the roles of the office roles and operational updates. In one of the meetings there was a space for discussion around new ideas and ways the service could improve. However, there were no minutes form these meetings so we were unable to see who attended and also what was discussed.
- Each vehicle we inspected had comment cards for patients to complete, this allowed the public to give feedback about the service. The majority of the cards we looked at were complimentary about the staff.
- The service rewarded staff with a £20 voucher for every three compliments they received.
- Staff said the managers asked for their opinions on the vehicles.

Innovation, improvement and sustainability

- There was no evidence of audits looking at the quality of the services meaning there were no action plans put in place to improve quality. This meant the service was not monitoring improvements.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- There are systems and processes to effectively respond to any safeguarding concerns raised and prevent abuse and improper treatment of service users.
- The safeguarding policy is up to date with relevant national guidance.
- All staff receive training on duty of candour and understand their role with regards to the regulation. Duty of candour must be incorporated into the serious investigations process. The manager will need to ensure a written record is kept, investigation reports are documented and patients receive a written apology.
- Establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users . Any complaints received must be investigated and necessary and proportionate action taken. The service should ensure responses to complaints are recorded.
- That staff are following appropriate infection prevention and control practice and this is being audited to ensure compliance.

Action the hospital SHOULD take to improve

- Patients receiving oxygen have a documented patient care record to say how much oxygen is being given on the vehicle.
- Establish a process for identifying and mitigating risk to patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Systems and processes were not established and operating effectively to investigate immediately upon becoming aware, of any allegation or evidence of abuse because:** • Staff were not trained to the appropriate level of safeguarding. • Staffs understanding of safeguarding and their responsibilities varied. • The safeguarding policy was not followed effectively and guidance that was being used was not up to date and changes to guidance had not been taken into consideration. • We found two examples of potential safeguarding concerns which the service had not identified and raised as safeguarding concerns. **This was a breach of regulation 13 (1) (2) (3)**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance

This section is primarily information for the provider

Requirement notices

Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided because:

- The quality of incidents reporting and investigation was not adequate.
- The quality of complaints investigation was not adequate.
- There were no infection, prevention and control or hand hygiene audits.
- Risks were not always identified and managed to ensure appropriate actions were taken to mitigate risk.

This was a breach of regulation 17 (1)(2) (a)