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Prime Care Ambulance Service

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Prime Care Ambulance Service is an independent ambulance service provider based in Wigan, Lancashire. Prime Care Ambulance Service is registered to provide patient transport services. Prime Care Ambulance Service offers ambulance transport on an 'as required' basis and provides pre-planned transport. PTS service are provided on request from a local NHS ambulance trust.

We inspected this service using our comprehensive inspection methodology. We carried out a scheduled comprehensive inspection on 5 December 2017. The service had one registered base and a separate station to park ambulance vehicles which we inspected.

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

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

The main service provided by this service was patient transport.

Services we do not rate

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

Professor Edward Baker

Chief Inspector of Hospitals

Prime Care Ambulance Service

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Background to Prime Care Ambulance Service

Prime Care Ambulance Service is operated by Prime Care Ambulance Service. The service opened in 1998. It is an independent ambulance service in Wigan, Lancashire. The service primarily serves the communities of Lancashire. However, patients are transported across the UK as required. The service predominantly provides patient transport services to adults only and also provides bariatric transport with all vehicles equipped with bariatric equipment.

The service provides medical patient transport services to NHS Trusts. The service provided ambulance provision for event work; however this was a small portion of the work carried out.

- The service is registered to provide the following regulated activities:Transport services, triage and medical advice provided remotely

We last inspected Prime Care Ambulance Service in April 2014. Suitable arrangements were in place to ensure people using the service were provided with effective, safe and appropriate personalised care.

The service has had the same registered manager in post since 2011. This person is also the managing director.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection (North West).

How we carried out this inspection

During the inspection, we visited the registered location ambulance station in Wigan. The service was managed from this location. Ambulances and other vehicles were securely garaged at a separate location which we also inspected.

We spoke with two staff members of the management team. We conducted random spot checks on three ambulances and inspected cleanliness, infection control practices and stock levels of equipment and supplies.

During our inspection we looked at five patient records. We reviewed other documentation including policies, staff records, training records and call log sheets.

Detailed findings

The CQC has not completed any special reviews or investigations of this service. The service has been inspected once, and the most recent inspection took place in April 2014, which found that the service was meeting all the standards of quality and safety it was inspected against.

Track record on safety

- There had been no never events reported by the organisation.
- There were no serious clinical incidents or serious injuries reported by the service.
- There were no complaints.

Facts and data about Prime Care Ambulance Service

We requested information in relation to the number of patient transport journeys undertaken from the period of September 2016 to September 2017. The provider informed us that from January to December 2017, there had been 2165 patient journeys. Of these 100% were categorised as 'same day' bookings.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Prime Care Ambulance Service was initially established in 1998 by the current managing director. The company provides patient transport to meet the needs of NHS Hospital trusts. The company employs four PTS staff, and an additional two office and management staff, operating a fleet of 10 ambulances.

Summary of findings

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

- Although there were processes in place for reporting incidents, staff did not receive feedback and shared learning to prevent them from occurring again and to ensure the safety of people using the service.
- Staff were not up to date with training in duty of candour, basic life support and safeguarding, to ensure they were safe to carry out the duties they were employed to perform.
- Safeguarding procedures and processes did not ensure patients were protected. Not all staff were up to date with safeguarding training.
- Pre-employment checks for staff were not in place prior to undertaking employment including fit and proper persons assessments for directors.
- Systems and processes in place were not in place to implement the statutory obligations of duty of candour.
- We found concerns regarding the governance and strategic risk management processes of the service.There were no effective governance arrangements in place to evaluate the quality of the service or to improve the quality and safety of the services provided.
- There was no formal risk register in place at the time of the inspection and therefore we had no assurance that risks were being tracked, managed or mitigated.
- A vision and strategy for the service had not been developed.

We found the following areas of good practice:

Patient transport services (PTS)

- Staff were knowledgeable about how to report an incident and had access to incident reporting forms including whilst on ambulances. We saw evidence and examples of incident reporting.
- The service ensured a minimum of two staff were allocated to each patient transfer depending on risk and need. The staffing levels and skill mix of the staff met the patients' needs.
- All vehicles and the ambulance station were visibly clean and systems were in place to ensure vehicles were well maintained.
- All equipment necessary to meet the various needs of patients was available.
- Services were planned and delivered in a way that met the needs of the local population. The service took into account the needs of different people, such as bariatric patients or people whose first language was not English, and journeys were planned based upon their requirements.
- We observed good hand hygiene, and infection control processes.
- The service had a system for handling, managing and monitoring complaints and concerns.

Are patient transport services safe?

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

- Although there were processes in place for reporting incidents, staff did not receive feedback and shared learning.
- Appropriate recruitment checks were not completed for employees prior to commencing employment.
- System and processes were not in place to implement the statutory obligations of duty of candour.
- Records confirmed staff were not up to date with mandatory training.
- Reliable safeguarding systems were not in place, to protect adults, children and young people from avoidable harm.
- Staff were not aware of the requirement to notify the CQC when there was an allegation of abuse concerning a person using the service.

However, we found the following areas of good practice:

- Staff were knowledgeable about reporting incidents and had access to incident reporting forms whilst on ambulances.
- Ambulances and the station were visibly clean and staff followed infection control procedures. Staff used hand sanitiser gel in clinical areas to maintain good hand hygiene and used personal protective equipment.
- Systems were in place to ensure ambulances were well maintained with equipment to meet the needs of patients.
- Systems were in place to identify, assess and manage patients whose condition deteriorated.

Incidents

- The service had an accident and incident reporting policy. The policy described how accidents and incidents should be reported. It made reference to a company incident reporting form and that all incidents were to be reported immediately.
- Staff were required to report and record incidents via a paper record and also called the office to log the incident. Each vehicle had a folder containing accident

and incident reporting forms. From June 2016 to December 2017, the service had five recorded incidents; two vehicle accidents and three clinical incidents. No near misses were recorded.

- In the three clinical incidents that we reviewed we did not see evidence how the service had investigated or reviewed them to prevent recurrence of a similar incident. There was no evidence of sharing of any lessons learnt following these incidents with the wider staff team.
- Staff we spoke with were able to describe the procedures for reporting incidents. They stated they were confident to report any accidents, incidents or near misses. Staff who worked remotely could speak with the on call manager.
- The service reported that there were no never events in the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Vehicle accidents and equipment defects were recorded on a separate defect report. From January to March 2017, 20 defects had been recorded. We saw examples of minor accidents, which managers had discussed with staff.
- The service did not have a duty of candour policy (2016). Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for a registered person to ensure staff act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Staff did not receive training in duty of candour. Despite their lack of training, the registered manager told us they would be open and honest with people if things went wrong and would immediately seek support if a patient experienced avoidable harm.

Cleanliness, infection control and hygiene

- All the ambulances we looked at were uncluttered and visibly clean. The ambulance station was tidy and well organised. There was no excess equipment so the areas were not cluttered, making them easy to clean.
- There was an infection control policy in place which was last reviewed in November 2016. Crews were required to ensure their vehicle was fit for purpose, before, during and after they had transported a patient. Decontamination cleaning wipes were available on all ambulances and we were informed that staff cleaned surfaces, seats and equipment after each patient use.
- The crew assigned to the ambulance each day completed the day to day cleaning of the vehicle. We found the daily cleaning sheet record on all ambulances had been completed consistently but cleaning standards had not been audited.
- The records showed that ambulances had gone through a regular deep clean through a contract with an external company every six weeks. This included all fixtures and fittings internally including seats, interior lighting, grab rails, flooring and foot wells.
- Cleaning materials and chemicals were available for staff use. Different coloured mops and buckets were available for different areas; advice as to which mop should be used in which area was prominently displayed to prevent cross infection. The station room was divided into clean and dirty areas by signage.
- Staff followed infection control procedures, including washing their hands and using hand sanitiser gel after patient contact.
- Hand washing facilities were available at the ambulance station.
- We saw no evidence of infection, prevention and control audits or hand hygiene audits within the service. This meant the service could not be assured staff were compliant. However, the service was looking at bringing in a pulse check, covering a spot check on staff which would be completed by the duty manager looking at uniforms, completing ambulance checks and if waste streams were being used appropriately.
- There were arrangements with the local hospitals for disposing used linen and restocking with clean linen.
- The service followed operational procedures in relation to infection control. Staff told us that if a patient was known to be carrying an infection, they were not transported with another patient. The ambulance would be cleaned afterwards in accordance with infection control policy and procedures.

Patient transport services (PTS)

- Staff had access to personal protective equipment such as gloves and aprons to reduce the risk of the spread of infection between staff and patients. Crews carried a spill kit on their ambulances to manage any small bodily fluid spillages such as blood or urine, and reduce the cross infection risk to other patients.
- Staff did not routinely have to manage clinical waste. However, clinical waste bags were carried on each ambulance and full bags were disposed at the hospital or at the ambulance station. The ambulance station had facilities for depositing and disposing of clinical waste through an external contractor.
- Staff were provided with sufficient uniforms, which ensured they could change during a shift if necessary. Staff were responsible for cleaning their own uniforms, unless it had been heavily contaminated and was disposed of as clinical waste.

Environment and equipment

- The premises were clean and tidy with adequate space to safely store the ambulances. In addition, the unit had a suitable office space for taking bookings and there were facilities for staff, cleaning and separate storage areas.
- The keys for the ambulances were stored securely. There was secure access to the station building and within that to the offices. Staff attended the office to collect the designated ambulance keys. All ambulances were locked when unattended.
- Managers told us that all drivers had their driving licence and eligibility to drive vehicles checked prior to employment and on an ongoing basis by the Driver and Vehicle Licensing Agency. We saw evidence of these checks. Ambulances were covered by a current Department of Transport safety test certificates as required and a central log was kept at the station.Managers also ensured newer ambulance vehicles were covered by a first Department of Transport safety test certificates after 1 year as required in law. Records showed that drivers had the correct licence category, Category B for the weight of the ambulances driven.
- Prime Care Ambulance Service had 10 ambulances for the transport of patients. Systems were in place to ensure that all ambulances were maintained, serviced, cleaned, insured and taxed appropriately.
- Where ambulances were off road awaiting repair, this was clearly displayed on the ambulance to prevent staff from using the ambulance. Ambulance defect report forms were provided on each ambulance, which included a description of the fault or defect, action taken to resolve, and further action required. Staff informed us they reported any defects directly to the managers, we saw when staff had completed these. A local garage performed ambulance inspections every seven months so staff were aware of any faults and action needed.
- There was a system for reporting equipment defects and staff had received appropriate training to use equipment safely. Some of the ambulances had an on-board wheelchairs available for patient use and this was secured with fasteners. Equipment had been safety tested; stickers showed when the equipment was next due for testing and records were available to support their suitability for use. The seatbelts and trolley straps were in working order in the three ambulances we checked.
- Ambulances were all equipped with tracking devices and a mobile phone was provided in each ambulance where staff received messages from the on call duty manager.
- The ambulances we inspected were fully equipped, with disposable single use equipment stored appropriately and in-date.
- Patients with mental health needs were not transported by Prime Care Ambulance Service.

Medicines

- Emergency medicines were not carried on the patient transport services (PTS) ambulances and PTS staff did not administer medicines. Patients or their accompanying carers were responsible for their own medicines administration whilst in transit.PTS staff would ensure medicines provided by the hospital for patients to take home would be stored securely in a bag on the ambulance.
- Oxygen cylinders were carried on vehicles. An appropriate health care professional had to prescribe

the oxygen so staff could administer it or the patient had to have a home oxygen order form in place. We saw completed documentation when staff had administered oxygen to patients.

- Medical gases were managed properly. The service kept medical gas cylinders in a locked cage in a location outside the office area. Storage of medical gases was secure and there were signs to alert staff and visitors to the flammable nature of the gases. Full and empty cylinders were appropriately segregated.
- Oxygen cylinders were appropriately stored on the ambulances. Oxygen stock was replaced frequently by a medical gas company.

Records

- PTS drivers received work sheets at the start of a shift, which were completed by the on call duty manager and included the basic details of the journey to be completed. These included collection times and addresses. Patient specific information such as relevant medical conditions, mobility, and if an escort was travelling with the patient, patient's health and circumstances were assessed by the NHS Hospital trust and this information was given to PTS drivers during the handover process.
- A records management policy was in place.
- The local NHS hospital trust provided ambulance crews with patient details such as 'do not attempt cardio pulmonary resuscitation' (DNACPR) information and any special notes or instructions, which stayed with the patient. The booking process meant people's individual needs were identified and took into account the level of support required, the person's family circumstances and communication needs.
- Patient information was stored in the driver's cab out of sight, respecting patient confidentiality.
- Records were held securely in the station office. Storage was in locked filing cabinets and in a secure post box and through password protected computer systems.
- Staff personnel files were stored in a locked cupboard on the service premises. We were told only the administration staff and managers had access to this key to ensure the confidentiality of staff members was respected.

Safeguarding

- Reliable systems, processes and practices were not in place to protect adults, children and young people from avoidable harm and abuse. The service had appointed two safeguarding leads for vulnerable adults and children. Although there were safeguarding alert forms available for staff to complete to record safeguarding concerns, which were given to the duty manager, we were not assured correct safeguarding procedures were followed. Following an incident, a safeguarding referral was not made to the responsible local authority, although the NHS trust responsible for the patient was contacted by the provider.
- Both managers were not aware of their responsibility in making a safeguarding alert to the responsible local authority safeguarding team and were not aware of the legal requirement to notify the CQC. They informed us they would contact the hospital where the patient was transported from and seek advice, and if required would contact the police. They informed us they relied on hospital staff from where the patient was collected from to make the safeguarding referral.
- Out of the six files we checked, all six members of staff had completed level two safeguarding training. However, the two safeguarding leads for the service for vulnerable adults and children did not have safeguarding certificates in place, to evidence their completion of level three safeguarding training, although the provider informed us they had completed the training.
- There was a safeguarding policy in place which was last updated in January 2017. Although the policy informed staff of what to do if they suspected a child at risk of abuse, it did not include information on what to do if they suspected an adult at risk of abuse. The policy was not up to date with current legislation and did not include the ten categories of abuse.

Mandatory training

- The service had a comprehensive mandatory training programme. Mandatory training consisted of patient handling, data protection, equality and diversity, infection control and personal safety which included basic life support. The majority of mandatory training was delivered through a mixture of e-learning and face to face training. All staff were required to complete and

record their mandatory training. We found that not all staff were up to date with their training. For example we found that two out of the six members of staff not had completed the training in Mental Capacity. Out of the six members of frontline PTS staff, two members of staff had not received up to date basic life support training. Not all staff were up to date with infection control training, as only three out of the six members of staff had received this training.

- Patient transport services staff who drove the ambulances completed an in-house driving assessment on commencement of employment and would undertake a further assessment once they felt confident to transport patients.
- Although senior management were able to review records to see the training staff had completed and when training was due for renewal, we were not assured that this was taking place as a high proportion of staff training was out of date.

Assessing and responding to patient risk

- PTS staff requested detailed information on risks posed when transporting patients at the time of the booking. Basic risk assessment screening questions were asked at this time.
- When transporting patients PTS staff would use their first aid knowledge to assess if a patient's condition was deteriorating which was also covered in their basic life support training evidencing that staff had the skills and were knowledgeable on escalation processes to ensure the safety of patients.
- PTS staff had access to clinical advice from an on call member of staff or they would divert to a hospital. There was an escalation process in place for the management of deteriorating patients. Staff informed us they would stop the vehicle as soon as it was safe to do so, call the on call manager for advice and inform the organisation where the patient was collected from. They would then support the patient as best they could until help arrived from 999 emergency services.

Staffing

- The service employed four PTS staff, two of which were qualified paramedics and also completed event work. In addition there were two members of office and management staff.
- There was a process in place for the ambulance crews out of hours and in case of emergencies. They had a direct number to the duty manager on call. Staff we spoke with knew how to escalate concerns when working out of hours.

Response to major incidents

- A major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services and would generally include the involvement, either directly or indirectly, of large numbers of people.
- As an independent ambulance service, the provider was not part of the NHS major incident planning. However management staff informed us they would be utilised to transport patients home if the NHS hospital trust had a major incident.
- The provider assessed that current means of communication for instance mobile phones, land lines and other telecommunication was robust enough to allow partner agencies to make contact during a major incident.

Are patient transport services effective?

Evidence-based care and treatment

- The service had a set of up to date evidence based policies and procedures in place, they were used to guide staff in their daily work. Policies were accessible as a hard copy for staff to readily access and on the computer system.
- The policies and procedures referred to best practice guidance including the department of health and the Joint Royal Colleges Ambulance Liaison Committee.
- Ambulance crew members carried their pocket book which was based on guidance from the Joint Royal Colleges Ambulance Liaison Committee clinical guidelines for pre-hospital care. Carrying a pocket book was in line with company policy.
- The NHS ambulance trust set or assessed patient's eligibility to travel on patient transport in line with the guidelines in the Department of Health 'Eligibility criteria for patient transport services' document. The eligibility criteria were set nationally and it was the

responsibility of the providers booking patient transport to make sure it was used for patients who met the criteria which Prime Care Ambulance Service complied with.

Assessment and planning of care

- The patient transport service provided non-emergency transport for patients who required transferring between hospitals, transfers home or to another place of care. During the booking process, basic journey information was gained regarding the collection address and discharge destination.
- Staff did not transport a patient if they felt they were not equipped to do so, or the patient needed more specialist care. PTS staff were not clinically trained, but did seek advice from clinical staff at the hospital as necessary or the manager on call for the service.If a patient was observed or assessed as not well enough to travel or be discharged from hospital, the PTS staff made the decision not to take them.
- Where necessary, health professionals accompanied patients on the journey to or between hospitals to ensure they were transported safely and according to their individual needs.
- If distance or rural journeys were scheduled, the journey would be pre-planned with stops for toileting, refreshment food and drink. Ambulances held bottled water to provide for patients as required during a journey.

Response times and patient outcomes

- From January to December 2017, there had been 2165 patient journeys. Of these 100% were categorised as 'same day' bookings. The level of activity was increasing each month and managers reviewed data in relation to themes and trends to ensure the correct level of provision was provided.
- Staff called the on call duty manager to report any difficulties, so the manager on call was always aware of any issues that maybe causing delays.
- The provider met with local commissioners at least once a month. We saw evidence that the service had an internal set target of answering calls within 25 to 32 seconds; if they were unable to answer calls within 18 to 20 seconds an automated introductory message was played. The management team informed us that the service was currently answering calls within the desired response times.
- Where booking staff recognised that they did not have the staff capacity or vehicles at the correct locations to accept a job, they would refuse it and could suggest the referrer contact the local NHS ambulance service or other providers. The governance lead told us this rarely happened.

Competent staff

- All new PTS staff were required to undertake a set induction programme plus a workbook that refreshed and tested knowledge on safeguarding, manual handling, infection control and health and safety. Personnel files showed staff had completed the induction training. One staff member was in the process of completing the induction programme. During the induction process, staff accompanied a two-person PTS crew for three days to observe and learn from. If a new member of staff felt they wanted a longer period of being the third crew member, this was at the discretion of the manager. Staff were observed during the induction processfor a four week period and at the end completed a formal review with the registered manager.
- All staff were required to complete an in-house driving assessment on commencement of employment which was carried out by the by the registered manager. This included an observation of their driving skills. However, the service had no arrangements in place for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor, who had not undertaken a training course. The management team told us, that if they had a concern about the standard of a crew member's driving they would address any poor practice. Any additional staff training or refresher training may then be identified.
- An appraisal system was not in place. This was discussed with the registered manager and they informed they would introduce an appraisals process for all for staff.

Coordination with other providers and multidisciplinary working

Patient transport services (PTS)

- Staff at the local NHS hospital trust reported good working relationships with PTS staff and the registered manager of the service. We observed effective co-operation between different providers to coordinate patients' transport around their care, treatment and discharge.

Access to information

- Information was obtained from hospital staff and entered onto the patient journey forms. These included collection times and addresses.
- A 'live' satellite navigation system was provided for staff to track the ambulance journeys to ensure vehicles were reaching jobs as requested. Staff confirmed this was an effective system and acted a safety mechanism.
- Feedback from the hospital was that handovers between the ambulance and hospital staff were detailed, professional and appropriate. The management team reported they had a good working relationship with the hospital staff as they generally visited the same wards and departments on a regular basis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a policy in place covering the Mental Capacity Act. However, we were not assured that staff had read and understood the policy. We were also not assured that staff knew when to complete a mental capacity assessment.
- The registered manager informed that if a patient became distressed while transporting them they would divert to the nearest hospital and would not use restraint. A restraint policy was not in place.

Are patient transport services caring?

Compassionate care

- The staff we spoke with demonstrated a good understanding of people's personal, cultural, social and religious needs.
- The staff were clear that patients' privacy and dignity was key in the provision of a good service.
- Staff we talked to were passionate about patient care and were proud of the service they delivered. Staff talked about prioritising patients before themselves and making a difference in people's lives, they had a strong commitment to choice regarding treatment and equality.
- The registered manager informed us the service had not completed any patient surveys but they were introducing them to improve how they care for individuals.
- The provider's website had opportunities for the public to give feedback about care provided by the service. However, this had not been used.

.Understanding and involvement of patients and those close to them

- As part of the booking system, NHS ambulance staff assessed eligibility and if patients were eligible the details were passed on to Patient Ambulance crews. The service therefore had little contact with patients until crews picked them up. Whilst this was the case we were told crews were supportive of carer involvement and welcomed carers on journeys when appropriate.

Emotional support

- The staff we spoke with were all aware that patients faced emotionally stressing events in hospital environments due to illness or examination.
- The manager of the service was particularly proud of patient care and said patients emotional support was a priority. He felt the staff team would go "the extra mile", to support patients if they were upset or distressed or needed re assurance.
- The patient feedback forms which the service were going to implement were going to enable staff and managers to evaluate if patients felt valued and listened to.
- We were told that crew ensured patients were supported at the end of journeys to get safely into their homes if required. The crew would ensure patient support would be provided either by a carer or family if the patient needed it.

Patient transport services (PTS)

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The main service was a patient transport service which provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or referrals from care homes and private individuals.
- The service had two core elements, pre-planned patient transport services, and 'ad hoc' services to meet the needs of patients. Workloads were planned around this.
- The service worked with the NHS Trust to support them to meet demand by having regular telephone conversations. Prime Care Ambulance Services could respond using four wheeled drive vehicles due to changing weather conditions as required.
- Patient transport services were provided to a NHS acute hospital trust. Journeys were provided on an ad hoc basis. The service supported hospital discharges across the Wigan and Bolton region.
- The managers worked an on call rota and managed all bookings from 8am to 10pm. PTS staff worked from 8am to 10pm.Were journey were booked in advance, shifts were allocated a week in advance to staff.
- On the day bookings were responded to quickly via telephone. For the ad hoc on the day bookings, office based staff identified which drivers were available. We observed effective communication between PTS and office staff as part of service planning.
- All of the ambulances were equipped with tracking devices. The service had the ability to monitor the locations of its vehicles and to identify where they were.
- Meetings were held with senior managers and commissioners of the service to ensure the provision of the service remained satisfactory.

Meeting people's individual needs

- PTS staff ensured patients were not left at home without being safe and supported. Some patients were discharged from hospital and had a package of care to be arranged at home. If the support person or team had not arrived when the patient came home, PTS staff called the hospital to find out where they were. The patient would not be left alone until either the care team arrived, or the patient was safe in the care of their family or carer.
- Staff told us that, at the time of booking, the question was asked if the patient required a relative or carer to support them. Staff told us this service was put in place to meet the patient's individual needs and level of risk. This ensured that an appropriate ambulance was allocated to ensure seating arrangements were suitable. The ambulances had equipment to support bariatric Staff confirmed they were competent to use this equipment, which was generally planned in advance so staff were aware of the patient's needs.
- The registered manager told us that they were able to access support for patients with communication difficulties or whose first language was not English through a telephone based interpreting service and staff also accessed google translate by using their personal phones.
- If long journeys were scheduled, the journey would be pre-planned with stops for toileting and refreshments. Ambulances held bottled water to provide for patients as required during a journey.

Access and flow

- Patients could access their care in a timely way. The provider was able to ensure that resources were where they need to be at the time required. From taking a booking to providing the ambulance service, the registered manager informed they aimed to be there within the hour, although this was not a formal performance target set by the local NHS trusts they were providing services to. This was monitored by the on call duty manager. 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. Any potential delay was communicated with patients, carers and hospital staff by telephone.
- Patient transport requests were received on an intermittent rather than a contractual basis and the service responded at short notice. Long journeys or night transfers were required to be pre-planned.

Patient transport services (PTS)

Learning from complaints and concerns

- Staff knew how to advise a patient if they wished to complain and written information of how to make a complaint was present on the ambulances.
- The service had a system for handling, managing and monitoring complaints and concerns and outlined the process for dealing with complaints initially by local resolution and informally. Where this did not lead to a resolution, complainants were given a letter of acknowledgement followed up by a further letter within 25 working days, once an investigation had been made into the complaint.
- The service had not received any complaints from patients within the last 12 months.

Are patient transport services well-led?

Vision and strategy for this this core service

- A written statement of vision, strategy and guiding values had not been developed. The management team informed us their strategy was to continue to evolve as a company seeking to always be better, striving to be excellent at what they did.
- The two managers we spoke with had a good understanding of the commercial aspect of the PTS, ensuring they remained competitive. This was demonstrated by the service trying to secure new contracts.

Governance, risk management and quality measurement

- Areas of non-compliance or areas for improvement were not identified and action could not be taken to make improvements. Therefore, a formal risk register was not in place at the time of the inspection and we had no assurance that risks were being tracked, managed or mitigated.
- There had been three operational office meetings from June 2016 to August 2016 to discuss finance, recruitment, safeguarding and health and safety. There had been no operational meetings to discuss the running of the organisation in 2017.
- Recruitment systems did not ensure that robust pre-employment checks for PTS staff were in place prior to undertaking employment. Proof of identification, references and qualifications were not sought for all staff.
- Fit and proper persons assessments were not in place. For example, checks on the directors qualifications, competence, skills and experience, proof of identity, a full employment history, information about any physical or mental health conditions relevant to a person's capability were not in place.
- All ambulance staff had valid enhanced DBS checks.We were able to see evidence that a check with the DBS had been carried out prior to staff commencing duties, which involved accessing patients and their personal and confidential information.
- A written diarised rostering system was used to plan shifts and ensure staff adhered to the European working time directive. Shortfalls in cover were shown on this system and staff could request to work additional shifts. The diarised rostering tracked sickness and holidays. If a short notice booking was received, the service would not accept it if they could not supply two staff. We were informed that staff were allocated time for rest and meal breaks by the registered manager.

Leadership / culture of service

- The leadership team consisted of managing director who was the CQC registered manager, an operations assistant, an operations director and the clinical compliance manager who both worked as PTS staff. The managers looked after the welfare of the staff and were responsible for the planning of the day to day work.
- The service had a clinical director, who was an accident and emergency department consultant. Their role and responsibility was to advise the service on clinical matter. We were informed that the clinical director did not have scheduled days at the station but there was a plan to meet with them at least once a month.
- The managing director went out on transfer cases as required. This allowed them to maintain their practice as a PTS staff member.

Patient transport services (PTS)

- We saw records which showed that some staff had additional qualifications. The managing director had completed a first person on the scene qualification as an additional qualification which was not required to become a PTS driver .
- Staff team meetings were not held. There were limited opportunities for staff engagement and to make suggestions on how the organisation could improve the services.
- The managing director told us learning was cascaded to staff. All staff members had a work email account.Noticeboards in the ambulance station displayed staff briefings, education updates, alerts regarding equipment and information on staff wellbeing.

Public and staff engagement

- The service's publicly accessible website contained information for the public about what the service was able to offer.
- The registered manager informed us they had not completed any patient surveys but they were introducing these. The provider's website had opportunities for the public to give feedback about the service.
- Staff were able to access information such as duty rotas, policies and procedures electronically.

Innovation, improvement and sustainability

- There was genuine positivity about the future of the service with a desire for the service to expand.
- Senior managers considered the sustainability of the service during contract negotiations.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure CQC are notified without delay of all incidents that affect the health, safety and welfare of people who use services. Incidents must include any abuse or allegation of abuse in relation to a service user
- The provider must ensure staff receive the appropriate training, to enable them to carry out the duties they are employed to perform that is relevant and at a suitable level for their role, updated at appropriate intervals.
- The provider must ensure they have robust safeguarding procedures and processes that make sure the patients are protected. It must ensure the safeguarding policy is up to date with current legislation and staff are knowledgeable on safeguarding.
- The provider must ensure that staff undergo checks prior to undertaking employment to ensure they only employ 'fit and proper' staff who are able to provide care appropriate to their role.
- The provider must ensure there are systems and processes in place to implement the statutory obligations of duty of candour and ensure all staff are trained and understand their responsibilities.
- The provider must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided.
- The provider must introduce an appraisals process for all staff .

Action the hospital SHOULD take to improve

- The provider should consider sharing learning from incidents to prevent them from occurring again to ensure the safety of people using the service.
- The provider should consider how it can implement robust systems to assess, monitor and improve the quality and safety of the services provided.
- The provider should consider introducing team meetings.
- The provider should review its strategy and the process for implementing a central risk register.
- The provider should consider developing a vision and strategy for the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider had not ensured that there was effective governance, including a risk register, assurance and auditing systems or processes in place. These must assess, monitor and drive improvement in the quality and safety of the services provided. **This was breach of regulation** Regulation 17(2) (a)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider had not reported to CQC all incidents of abuse or allegations of abuse. **This was breach of regulation** Regulation 18 (2)(e)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:**

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Requirement notices

The provider had not ensured staff had received that appropriate training, to enable them to carry out the duties they are employed to perform that is relevant and at a suitable level for their role. An appraisal system was also not in place.

This was breach of regulation

Regulation 18 (2)(a)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met:** The provider must ensure there are systems and processes to implement the statutory obligations of Duty of Candour and ensure all staff are trained and understand it. **This was breach of regulation** Regulation 20

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 **How the regulation was not being met:** The provider had not ensured robust safeguarding procedures and processes that made sure the patients were protected. • The provider did not ensure the safeguarding policy was up to date with current legislation. **This was breach of regulation** Regulation 13 (2)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The provider had not ensured staff were properly vetted prior to undertaking employment including fit and proper persons assessments. **This was breach of regulation** Regulation 19 (2)(a)(b)(3)(a)(b)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors **How the regulation was not being met:** The provider had not ensured directors were properly vetted prior to undertaking employment including fit and proper persons assessments.