Ambulnz Community Partners Ltd

Quality Report

Unit 5E Arrow Trading Estate
Cooperation Road
Manchester
Lancashire
M34 5LR
Tel: 08452 694832
Website: www.mmse.co.uk

Date of inspection visit: 03 July 2019
Date of publication: 14/01/2020

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Ambulnz Community Partners Ltd is operated by Ambulnz Community Partners Ltd. The service provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 3 July 2019.

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.

Summary of findings

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

We rated it as **Good** overall. We found the following areas of good practice:

- The service provided mandatory training in key skills and made sure that all staff completed it. This included important topics such as basic life support.
- The service had controlled infection risk well. There were sufficient amounts of personal protective equipment available for staff to use and all ambulances were visibly clean.
- Staff followed the corporate policy for waste management processes. Waste was appropriately labelled and segregated.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use equipment. The service had a system to report faults and had acted to fix faulty items when needed.
- We reviewed eight patient record forms, they were all completed accurately and appropriately.
- Feedback from patients using the service were positive and included that staff were caring and respectful.
- The service managed patient safety incidents well. Staff knew what constituted an incident and could demonstrate how to use the electronic reporting system.
- The control coordinator completed a basic risk assessment for each patient and removed or minimised risk. These were completed as part of the booking form.
- The service undertook Disclosure and Barring Service checks for all new staff.
- The service did not have any medicines on vehicles. Staff had access me Nitrous Oxide and a medical gases policy was in place and staff had received training on how to store, handle and administer it.
- The service monitored compliance against national guidance or policies
- The service had a policy in place for mental capacity, consent and best interest. This was important as it meant that staff could follow the process when documenting a best interest decision or if a patient had refused transport.
- Managers informed us that the service took account of individual needs and preferences, we saw provisions in place to support patients with complex needs and comment cards from relatives praised staff for supporting their relatives; including those living with dementia and suffering from stroke.
- The service had a vision and strategy. Managers could tell us about the service and what they were aiming to achieve moving forward. They had supporting evidence on how they were working towards objectives and their strategy.
- The service had a formal system to assess, mitigate and control both clinical and non-clinical risks. This meant risks had been identified or that controls were in place to reduce the level of risk when needed.

However

- We did not see evidence of team learning, or team briefs, from safeguards that had been raised.
- We found none of the vehicles we inspected carried paediatric specific equipment. Information provided by the provider post inspection advised there were paediatric harnesses on urgent care service vehicles.
- We found crews did not document actions when a patient deteriorated and therefore we were not assured the appropriate lines of escalation were taken.
- We found some policies did not contain references and therefore we could not be assured the information within the polices was in line with up to date and current guidance and standards.
- We found ambulances did not have equipment to transport children safely.
- We found staff were not familiar with Gillick competence. This was important as the service were able to transport children.

Ann Ford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Good	The provider was an independent ambulance service that provided patient transport services. We found that the provider employed sufficient staff with the right skills and competencies. Equipment was well maintained, and environmental checks were carried out on a daily basis. Feedback from patients and those close to them was positive and illustrated crews met the needs of their service users. Leaders were visible and there were appropriate management processes in place to govern performance and manage risks.
Patient transport services	Good	The provider is an independent ambulance service that provides urgent care services. It delivered non-urgent patient transport mainly on behalf of the local NHS ambulance trusts or local authorities. We found the provider had sufficient staff with the right skills and competencies. Staff had access to safeguarding policy and knew who and how to escalate any concerns to. Staff documented consent and were familiar with legislation supporting do not attempt cardiac pulmonary resuscitation. Leaders were visible and had processes were in place to ensure the service was managed safely.

Summary of findings

Contents

Good

Ambulnz Community Partners Ltd

Services we looked at
Emergency and urgent care; Patient transport services;

Summary of this inspection

Background to Ambulnz Community Partners Ltd

Ambulnz Community Partners Ltd is operated by Ambulnz Community Partners Ltd. The service opened in 2007 and was last inspected in 2017 but was not rated. It is an independent ambulance service in Greater Manchester. The service primarily serves the communities of Greater Manchester. The service has had a registered manager in post since November 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspectors with expertise in ambulance services. The inspection team was overseen by an Inspection manager.

Information about Ambulnz Community Partners Ltd

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder and Injury

During the inspection, we visited Audenshaw station and viewed other sites remotely via CCTV. We spoke with twelve staff including; patient transport drivers and management. We did not speak to patients or relatives. We reviewed 20 comment cards, which patients had completed before our inspection. During our inspection, we reviewed eight sets of patient records and checked four vehicles.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first rated inspection since 2017 which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (May 2018 to May 2019)

- In the reporting period May 2018 to May 2019 there were 12,131 patient transport journeys undertaken.
- In the reporting period May 2018 to May 2019 there were 2,233 urgent care journeys undertaken, of these 1,739 were mental health journeys.
- 32 patient transport drivers worked at the service, of which 7 were bank staff.

Track record on safety

- 0 Never events
- 44 All adverse incidents
- 0 Serious injuries
- 7 Complaints

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	N/A	Good	Good	Good
Patient transport services	Good	Good	N/A	Good	Good	Good
Overall	Good	Good	N/A	Good	Good	Good

Good

Emergency and urgent care

Safe	Good
Effective	Good
Caring	
Responsive	Good
Well-led	Good

Information about the service

Ambulnz Community Partners Ltd is operated by Ambulnz Community Partners Ltd. The service opened in 2007. It is an independent ambulance service in Great Manchester. The service primarily serves the communities of Greater Manchester. The service has had a registered manager in post since November 2018.

Are emergency and urgent care services safe?

Good

We have inspected provider previously, but they were not rated, we rated the service as **good.**

Mandatory training

The management of mandatory training across the service was the same for both the emergency and urgent care service and the patient transport service. All staff worked across the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

Safeguarding

The management of safeguarding across the service was the same for both the emergency and urgent care service and the patient transport service. All staff worked across the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

Cleanliness, infection control and hygiene

The management of infection control and hygiene across the service was the same for both the emergency and urgent care service and the patient transport service. All staff worked across the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

We check six vehicles and found they were visibly clean and well maintained.

During the booking process staff to identified if a patient was infectious or if any special arrangements were required during a patient's journey. This was so that staff could manage infectious patients and reduce the risk of spreading infections.

When vehicles were seriously contaminated, crews contacted the control centre for a non-scheduled deep clean. This was so that a thorough clean of the vehicle could take place.

Staff were provided with personal protective equipment, this included gloves, aprons and antiseptic wipes. All vehicles we checked had personal protective equipment.

Staff used clinical wipes to maintain cleanliness of their vehicle during the course of their shift. They cleaned down the vehicle following each patient journey, to reduce the risk of transmitting infections.

At the end of each shift vehicles were cleaned down, so that they were ready for the next day.

Environment and equipment

The management of the environment and equipment across the service was the same for both the emergency and urgent care service and the patient transport service. All staff worked across the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

Faulty equipment was reported through the incident reporting system. We saw evidence of the actions from these incidents, and feedback to crew to confirm repair of the reported fault.

Managers used a vehicle and equipment replacement programme to maintain records of medical devices, replenishment of vehicles, equipment and supplies. We saw an audit trail of equipment that was faulty and replaced, scrapped, decommissioned and tested.

The provider had a fleet of 21 vehicles, of which 14 were bariatric capable vehicles. All vehicles underwent two Ministry of Transport (MOT) tests per year, using one as a six-month safety check. We reviewed service and safety records which showed all vehicles had an up to date MOT and service completed.

In addition, the service completed daily digital vehicle checks, which recorded faults. The online system allowed managers to maintain a digital history of faults, repairs and periodic maintenance for each ambulance. This was so that they could collate information digitally on the history of each ambulance. For example, the number of faults, any repairs and periodic maintenance.

All vehicles we inspected had the appropriate equipment to transport patients safely. For example, wheelchairs clamps were also used to ensure patients were securely clamped in.

We checked six vehicles at the Audenshaw depot and found that they were all stocked appropriately with the stretcher and seating securely fastened. Each included spill kits, clinical waste bin and decontamination wipes.

The fleet contained six vehicles that were appropriate for transportation of patients who were detained under mental health act.

However, none of the vehicles we reviewed carried paediatric specific equipment. At the time of inspection, senior managers said they had not transported any children but were regulated to do so. This was raised with the senior management team who confirmed after the inspection they had purchased appropriate Group 123 baby seats.

All ambulances we checked had automated external defibrillator on the ambulances. However, we found they did not have paediatric pads because they weren't dealing with paediatrics at the time of the inspection.

Assessing and responding to patient risk

The management of assessing and responding to patient risk across the service was the same for both the emergency and urgent care service and the patient transport service. All staff worked across the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

A risk assessment was carried out when booking transport, this was to remove or minimise risks during transportation. For example, a staff member completing the assessment discussed the patient with the referring organisation to ascertain all necessary information. The outcome of the discussion was captured and stored in the journey record which was available to the crew through the journey notes section.

Standard operating procedures were in place and in date, for example the urgent care SOP covered a range of topics including right to treat, patient's condition, medication, allergies, dynamic risk assessments, airway care, safeguarding, and records management.

Staff had received sepsis training, to increase their awareness of how to manage a deteriorating patient. The training covered sepsis six and acting on national early warning scores.

All staff had received first aid training, which included basic life support training and paediatric life support training. Staff we spoke with said all ambulances held sealed first aid boxes. We saw these in the vehicles we inspected.

Staff had received basic adult life resuscitation training, where a patient's condition deteriorated, staff reported an incident and would either transport them to the nearest hospital as instructed by the control coordinator or call for an emergency ambulance.

All vehicles we checked had working defibrillators, records indicated that these had been checked regularly. We found that adult defibrillator pads were available, in date and packaged correctly on all vehicles.

However, vehicles did not have defibrillator pads for children. Guidance from the Resuscitation Council (2010) states that child defibrillator pads should be used in the event of a paediatric emergency.

Monthly audits to check if crews were escalating and actioning national early warming scores appropriately were carried out. The reason for these audits were to identify any additional training around sepsis. The audit from May 2019 showed, on nine occasions, staff did not escalate or document actions when a patient deteriorated during conveying the patient. An action plan was sent after the inspection to demonstrate the actions to address this. For example, fields have been added within the electronic patient report form to record NEWS2 Score / Sepsis Marker and NEWS2 interactive charts were made available on vehicle mobile devices.

The provider recognised additional child stretcher harnesses needed to be purchased to ensure all locations have one spare set. In addition, the provider has now added children equipment check to the daily vehicle equipment check for Urgent Care Service Types.

Staffing

The management of staffing levels across the service was the same for both the emergency and urgent care service and the patient transport service. All staff worked across the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

All staff had completed training in First Response Emergency Care lever 3. The service did not recruit or deploy paramedics and did not use any NHS Ambulance Trust staff on the bank.

Records

The management of records across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

Staff informed us that any additional documentation, such as hospital records or do not attempt cardiopulmonary resuscitation orders were transported as part of the patient records. Crews added information on the patient record form to ensure this was captured.

Patient records were stored securely at the ambulance station. Staff were required to post all completed patient record forms and body maps if completed into a secure box at the end of every shift.

Managers and staff who we spoke with understood their responsibilities to maintain patient confidentiality.

Medicines

Due to the nature of the service, no medicines were kept on site. Oxygen was stored on vehicles appropriately.

All staff had received medicine management training, if a patient required medicines during the journey, the service recorded this on the patient record form and accommodated this for the patient.

Incidents

The management of incidents across the service was the same for both the emergency and urgent care service and the patient transport service. All staff worked across the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

Managers investigated incidents and shared lessons learned with the whole team, the wider service and

partner organisations. For example, the service reported one incident relating to urgent care between May 2018 and May 2019, this was reported to an NHS ambulance provider so that learning was shared.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Good

We have inspected provider previously, but they were not rated. We rated the service as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.

Staff could access policies on tablets on the vehicle. Policies contained guidance from a range of nationally recognised bodies such as Joint Royal Colleges Ambulance Liaison Committee, National Institute for Health and Care Excellence (NICE), Health and Safety Executive (HSE), Medicines and Healthcare products Regulatory Agency (MHRA) and the Independent Ambulance Association.

Staff had access to a mental health policy which included relevant guidance about conveying and transporting patients who were detained under the Mental Health Act. In addition to this, a risk assessment was completed at booking to ensure the service worked within the constraints of the policy.

Staff had received training in restraint and conflict resolution. We were told restraint would only use as a last resort for the shortest possible time. This complied with the Department of Health guidance 'positive and proactive care: reducing the need for restrictive interventions (2014) and National Institute of Health and Care Excellence (NICE) guideline (NG10): Violence and aggression: short-term management in mental health, health and community settings.

Nutrition

The management of nutrition across the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

Response times

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

Details of the time a crew was expected for a journey and the time the crew arrived on site for each patient was documented. The service quality performance report showed jobs was being delivered within the set timeframes. the service reported no delays.

The service reported 86% of work was carried out as a patient transport service and 14% urgent care of which 11% was mental health transport.

Work was being done to improve the response times to transport mental health patients. A monthly report to the mental health trust showed delays were caused by not having the right paper work etc. but a true response rate could not be determined because the systems were not integrated. The service was working with the trust to implement a system whereby the potential journeys would be placed on the dispatch system at 23.59 and then when the patient was actually ready to travel, and the conveyance and section paperwork was available, the time would be changed to the actual booking time. The measure of time it took to convey the patient would then be collected from Emergency Departments.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

We saw evidence of meaningful appraisals, these included discussions about training, development, and objectives.

All staff joining the provider had a comprehensive induction. We saw evidence of completed personnel files.

Good

Emergency and urgent care

We reviewed nine files and found they included UK driving licence details, contract of employment, eye test appointments and a training and development logs. All were in date.

There was a comprehensive training programme for staff to complete. It involved structured training days and comprised of theoretical and practical competency assessments. Staff were regularly reviewed and signed off by the manager once they had achieved full competencies and accreditation.

Crews were given jobs according to their role and competencies. For example, community ambulance technicians were able to attend to urgent care green calls, whereas community ambulance assistants were only given patient transport service stretcher jobs.

Training was provided by an external company that offered regulated qualifications. Additional training was carried out for staff to be able to provide emergency and urgent care. These were first responder emergency care (FREC), blue light response, electro-cardiogram (ECG) reading and emergency care modular training. Evidence of competence was provided in the forms of certification which was held in the staff personnel files.

Staff had undertaken additional mental health training to support secure patient transfers. Training included restraint and PMVA (prevention and management of violence and aggression).

Multi-disciplinary working

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

Staff understood their responsibilities to communicate relevant information to other providers when needed. Staff completed patient record form which included an area for staff to write about the handover given to the provider.

Records demonstrated that booking staff worked closely with the referrer to complete a risk assessment for the patient before transfer. This was so that any information impacting patient care was communicated. For example, the control liaised with the referring mental health practitioner, psychiatrist, nursing staff to make sure they knew about the patient's needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The management of consent, mental capacity and deprivation of liberty safeguards was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

We spoke with four members of staff who understood their roles and responsibilities under the Mental Capacity Act 2005.

Staff told us they would always obtain consent prior to providing patient care. However, we did not see evidence of this during our inspection as we did not attend any patient transport journeys.

We saw that the booking form and information sent to the crews captured Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. Crews we spoke with said the patient had to have a valid DNACPR form with them during the journey, for it to be effective.On inspection, crews attending to a patient called in to the control to advise staff at the hospital could not find a patients DNACPR, this was reported as an incident, escalated to the hospital and safeguarded.

The service had a Deprivation of Liberty safeguards policy, all the information in the policy was applicable to the service that was being provided. The controller would ensure all the information relating to the DOLs information was captured on the booking form. (Deprivation of Liberty safeguard applications are made when extra restrictions are needed to deprive someone of their liberty).

We were informed that best interest decisions, consent, the Mental Capacity Act and Deprivation of Liberty safeguards training was delivered as part of safeguarding training which all staff had received.

Are emergency and urgent care services caring?

There was limited opportunity to observe patient interaction, however, we noted the following practice;

Good

Emergency and urgent care

Compassionate care

Our findings about compassionate care was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

We did not observe any direct patient interactions as there were no urgent care journeys booked for the day of our inspection.

Emotional support

Our findings about emotional was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

From comment cards, we saw that staff had recognised the importance of ensuring that patients' relatives or carers were able to travel with the patient to reduce anxiety and confusion or upset. Staff gave us examples of when patients or relatives had required reassurance during their

Understanding and involvement of patients and those close to them

Our findings about how staff understood and involved patients and those close to them was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

We did not observe any direct patient interactions as there were no urgent care journeys booked for the day of our inspection.

Are emergency and urgent care services responsive to people's needs?

(for example, to feedback?)

Good

We have inspected provider previously, but they were not rated. We rated the service as **good.**

Service delivery to meet the needs of local people

Our findings on how the service delivery met the needs of local people was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

The service had contracts in place with NHS providers to ensure that they deliver a consistent to the local population.

The service attended meetings with their contractors to gain feedback about the service they provider.

Meeting people's individual needs

Our findings on how the provider met individual needs was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

Managers and staff, we spoke with said individual patient needs were taken into consideration during the booking process, so that crews were able to meet the patient's needs. Any information received was communicated to the crews before they undertook patient journey.

The service provided transport for patients with complex needs, crews used scoop stretchers to move patients if it was necessary. These are devices used to move people with injuries to maintain stability of the trauma. They also used carry chairs, with tracking systems and banana boards to enable various options for patients with various different physical disabilities to be moved safely and securely.

Good

Emergency and urgent care

The service had suitable equipment to provide services to bariatric patients, staff were trained to use this equipment. These ambulances had equipment which were larger and could carry larger weights than standard equipment.

Access and flow

The service provided urgent care between 07:00am – 03:00am, a member of staff on control was responsible for taking bookings and informing managers if there were gaps in vehicle availability.

The provider operated a transport service for patients at the lower end of the urgent care environment and whilst undertaking urgent care shifts, crews did not respond to patients detained under section 136 of the mental health act unless for bed management purposes.

Learning from complaints and concerns

The management of complaints was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

The organisational complaints leaflet was available on the vehicles we checked.

The complaints procedure was clearly documented with timescales and we saw from reviewing complaints that lessons were learnt.

Are emergency and urgent care services well-led?

Good

We have inspected provider previously, but they were not rated. We rated the service as **good.**

Leadership of service

The leadership of the service was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

Leaders prioritised patient safety and training crews to be equipped to do their roles as an essential part of their remit as managers

The leadership team consisted of the managing director, two other directors, as well as an organisational development manager and operations manager.

The management team proactively assessed the risk of taking on additional work and the impact it could have on the operational performance. They told us they were focusing on becoming a community ambulance provider and ensuring staff were appropriately trained before they increased their workload.

We saw that managers meetings were held monthly and information such as service changes, incidents, complaints, and policy updates were communicated and discussed. We saw that information and learning was shared amongst the senior management team.

Vision and strategy for this service

The vision was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The vision included the provider operating small local stations that have access to secure digital services, standardising vehicles, equipment and staff training to ensure consistency and commit periodic volunteering to build a social licence with the community.

Leaders and staff understood and knew how to apply them and monitor progress.

Culture within the service

The culture was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

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

The service promoted equality and diversity in daily work and provided opportunities for career development. We saw that the workforce was diverse.

Governance

The governance processes were the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

Personnel files demonstrated the service ensured all documentation was up to date, this included Disclosure and Barring Service checks within the last three years, application form, references and copy of driving licence.

The service had arranged for appropriate insurance policies to be in place. This included employer's liability insurance as well as motor insurance which covered all vehicles.

We reviewed two contracts between the provider and two NHS trusts, the contracts included the service level agreement, expected reportable key indicators and a review date.

We saw evidence of external audits, these were carried out by organisations the provider had a service level agreement with. Action plans were in place for any gaps they had identified. These gaps mirrored the gaps we had identified on site. For example, safe seating for children during transportation.

The provider met with the NHS providers to discuss commissioned works. Senior managers presented a quality report to the trusts to illustrate quality and performance. At the time of inspection, we reviewed the latest quality report and found no areas of concern.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. we saw minutes to senior management meetings and staff meeting. The agenda for both included incidents, audit, complaints, staff concerns and safeguarding.

The service had arranged for appropriate insurance policies to be in place. This included employer's liability insurance as well as motor insurance which covered all vehicles.

Management of risk, issues and performance

The management of risks, issues and performance was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

The service had a formal system to assess, mitigate and control both clinical and non-clinical risks. We reviewed the risk register and found all identified risks had controls were in place to reduce the level of risk. For example, the management team recognised that crews were working extended shifts, when transporting patients to and from Derby. This meant they were repeatedly driving to Derby before and after a full shift, which was highlighted as a risk. To mitigate this risk, the provider employed and trained local staff, who work out of the Derby depot.

Health and safety risk assessments for the service, were in place, completed and in date. These included manual handling and using cleaning products.

There provider had systems in place to monitor compliance against the completion of daily vehicle checks and monthly vehicle deep cleans and vehicle servicing. We saw that all programmed cleans, servicing and MOT's were up to date.

The service had implemented a business continuity plan which included actions to take in the event of a power cut at the Audenshaw station. An alternative location was identified as the secondary station, which housed relevant equipment.

Information Management

The management of Information was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. For example, systems were used effectively to monitor and improve the quality of care.

Good

Emergency and urgent care

Managers used one system to monitor incidents, safeguarding's and complaints. This system allowed managers to link correspondences and investigative reports to each other. For example, an incident could be linked to a relating complaint. All follow up communication was embedded in the spreadsheet, so that the information was reviewed as a whole rather than separately.

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. For example, crews had individual login profiles to access policies and procedures electronically.

Training records and personnel files were stored electronically, these were only accessed by the senior management team. We saw evidence of personnel files stored appropriately.

Public and staff engagement

Our findings of the way in which the provider engaged with the public and staff was the same for both the emergency and urgent care service and the patient transport service. The evidence detailed in the patient transport service section of this report is also relevant to the emergency and urgent care service and has been used to rate the emergency and urgent care service.

Staff encouraged patients or relatives to complete a comments card at the end of every patient journey. We reviewed 30 cards that had been completed between April – May 2019, all comments made were positive and complimentary of the staff.

Feedback received by the NHS ambulance was shared amongst the senior team, but we did not see or hear of evidence that suggested it was disseminated to staff.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services.

Since taking over the business the new provider had invested in staff training to ensure all staff were appropriately trained to carry out their role and responsibility. Since 1st October 2018 the provided reported investing in 2465 training hours spread over a staff establishment of 40.

To maintain learning and improvements the provider has employed a consultant to assist them with developing further the current training programme and clinical and operational policies.

Good

Patient transport services

Safe	Good
Effective	Good
Caring	
Responsive	Good
Well-led	Good

Information about the service

Ambulnz Community Partners Ltd was acquired in September 2018, it was registered as an independent ambulance service in Manchester, Lancashire. The service primarily serves the communities of the Lancashire, Cumbria and Merseyside areas and Yorkshire. The service has had the current registered manager in post since November 2018.

Summary of findings

We found the following areas of good practice:

- The service provided mandatory training in key skills.
- The service-controlled infection risk well. Staff used control measures to protect patients, themselves and others from infection.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them and managed clinical waste well.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations.
- Patients were offered water during the journey, if they required it.
- All those responsible for delivering care, worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Comments from patient comment cards were positive.
- The service was inclusive and took account of patients' individual needs and preferences and made reasonable adjustments to help patients access services.

Good

Patient transport services

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health and social economy.
- Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities. They met to discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

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

- We did not see evidence of team learning, or team briefs, from safeguards that had been raised.
- We found none of the vehicles we inspected carried paediatric specific equipment. Information provided by the provider post inspection advised there were paediatric harnesses on urgent care service vehicles.
- We found policies did not contain references and therefore we could not be assured the information within the polices was in line with up to date and current guidance and standards.
- We found ambulances did not have equipment to transport children safely. Since the inspection group 123 child seats have been acquired.
- We found staff were not familiar with Gillick competence. This was important as the service were able to transport children.

Good

Patient transport services

Are patient transport services safe?

Good

We have inspected provider previously but they were not rated. We rated it as **good.**

Mandatory training

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

The registered manager was responsible for ensuring staff including bank staff had completed mandatory training. All staff had completed the required training at the time of inspection.

Mandatory training was a combination of e-learning, classroom taught, workbooks and observation shifts. The training covered six modules for example: principles of health and safety, equality and diversity, deprivation of liberty safeguards, mental capacity act, manual handling and medical gasses"

Safeguarding

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

There was a safeguarding policy which included information about adult and children safeguarding. The policy was in date and followed national guidance. staff liaised with the local authority safeguarding team to safeguard patients.

Staff had access to a designated safeguarding officer who was level four safeguarding trained, this was in line with current national guidance. The rest of the management team held level two.

All crew members had completed level two adults safeguarding and were currently working towards a level three safeguarding vulnerable adults qualification. The provider reported 89% of staff were trained to level three.

We saw evidence that 100% of staff had received safeguarding children training level one, two and three.

The manager confirmed changes had been put in place to improve the safeguarding referral process. The provider had clear processes to ensure responsibilities for notification of safeguarding incidents were appropriately escalated when carrying out any subcontracted work.

The service reported seven safeguarding referrals between January 2019 and June 2019. We reviewed two safeguarding referrals of the seven and saw that they were raised appropriately with the local authority and actions were fed back to staff.

Staff demonstrated knowledge of safeguarding and told us how they would report incidents. However, we did not see evidence of team learning, or team briefs, from safeguards that had been raised.

Cleanliness, infection control and hygiene

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

All vehicles were deep cleaned on a six-week cleaning cycle for patient service transport and community ambulances and 12 weeks for mental health secure vehicles. We checked six vehicles and found they were visibly clean and well maintained.

All cleaning records were up to date, and demonstrated that the vehicles were regularly cleaned

At the end of each shift vehicles were cleaned down, so that they were ready for the next day.

Hand hygiene audits were undertaken by staff to check if they complied with the infection prevention control policy. We reviewed five records which showed all staff had achieved 100%.

All depots had washing facilities for vehicles and hot running water.

All vehicles we checked had personal protective equipment available for staff to use.

Crews were made aware of specific infection and hygiene risks associated with individual patients, this information was recorded at booking and forwarded to staff when they received the information of the patient being transported.

Linen was picked up every two weeks from the Audenshaw and Derby site. Staff placed linen in appropriate blue bags, these were labelled and stored for collection.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe.

The station environment was appropriately designed and maintained, staff had access to a staff room and toilets.

Faulty equipment was reported through the incident reporting system. We saw evidence of the actions from these incidents, and feedback to confirm repair of the reported fault to the crew member who reported it.

Managers maintained records of medical devices, replenishment of vehicles, equipment and supplies, across all sites through the vehicle and equipment replacement programme. We saw an audit trail of equipment that was faulty and replaced, scrapped, decommissioned and tested.

At the point of booking, the control coordinator carried out a risk assessment of the patient to capture any information about the patient's health. This included mobility issues and the use of wheelchairs.

The provider had a fleet of 21 vehicles, of which 14 were bariatric capable vehicles.

All vehicles underwent two Ministry of Transport (MOT) tests per year, using one as a six-month safety check. We reviewed service and safety records which showed all vehicles had an up to date MOT and service completed.

In addition, the service completed daily digital vehicle checks, which recorded faults. The online system allowed managers to maintain a digital history of faults, repairs and periodic maintenance for each ambulance. This was so that they could collate information digitally on the history of each ambulance. For example, the number of faults, any repairs and periodic maintenance.

Crews had one electronic handheld device and one mobile telephone on their ambulance. These items were signed out to them at the beginning of their shift.

Vehicles had harnesses and chairs for adult patients to use during transportation. Wheelchairs clamps were also used to ensure patients were securely clamped in.

Other vehicles were stationed at one of three satellite depots. These depots could be viewed from head office via CCTV.

Access to the depots was secure. Key fobs were issued to all staff and all vehicle keys were securely stored.

Crews had access to up to date satellite navigation systems, as per 2015 patient safety alert.

The fleet contained six vehicles that were appropriate for transportation of patients who were detained under mental health act.

However, none of the vehicles we inspected carried paediatric specific equipment. Information provided by the provider post inspection advised there were paediatric harnesses on urgent care service vehicles. We did not see these vehicles as they were out.

Managers confirmed they had not transported children, however after raising concerns with the manager onsite the management team confirmed they will look at ensuring the provision for transporting children were safe. This was raised with the senior management team who confirmed after the inspection they had purchased appropriate Group 123 baby seats.

Assessing and responding to patient risk

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

The service worked within a clear inclusion or exclusion criteria. All patients were screened for suitability at booking

Routine risk assessments were carried out in the form of a safety check questionnaire to determine if the patient was fit for transportation. They documented basic information such as the patient's name, date of birth and where the patient was to be collected from, as well as their destination. In Addition, the questionnaire included the need for additional information such as wheelchair and do not attempt cardiopulmonary resuscitation order in place.

The service had a policy covering do not attempt cardiopulmonary resuscitation orders. Staff who we spoke with understood their responsibilities to carry the appropriate paperwork with patients.

Patients living with mental health were risk assessed which was completed by the controller who spoke with the

referring individual (mental health liaison) to obtain the information. The outcome of the discussion was captured and stored in the journey record which was available to the crew through the journey notes section. Notes could be updated by crews on arrival should circumstances differ. The risk assessment included if the patient was able to consent, did they know where they were going, were they on medication, were they at risk of harm and could they walk.

Defibrillators were available on all vehicles we checked, and records indicated that they had been checked regularly. We found that adult defibrillator pads were available, in date and packaged correctly on all vehicles.

All staff had been trained in first aid at work (FAW) and which included basic adult life resuscitation training, if a patient become unwell staff would call for an emergency ambulance.

All staff were trained in basic paediatric life resuscitation training this training forms part of the accredited Level 3 Non-Urgent Care, First Response Emergency Care 3 and First Response Emergency Care 4.

We also noted that the service did not provide defibrillator pads for children. Guidance from the Resuscitation Council (2010) states that child defibrillator pads should be used in the event of a paediatric emergency. At the time of inspection, the provider was not transporting children and had not previously transported children, but they were regulated to do so and therefore this was raised with the managers to action.

Post inspection, the provider informed the team that there are consumables on vehicles to support paediatric patients including a bag valve masks, oxygen therapy consumables, paediatric blood pressure cuffs already available. However, these were on urgent care vehicles.

Staffing

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

All staff were employed as community ambulance technicians, with a dual role of driver or patient support.

Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

At the time of inspection, the service employed 32 staff of which 78% were employed on permanent contracts, with the remaining 22% as bank staff.

At the time of inspection, the provider reported a 3% sickness rate. This had consistently stayed the same since September 2018.

The service reported six staff members had left the organisation between September 2018 and June 2019, this was reported as a 16% turnover rate.

All staff joining the organisation had completed a probation period, induction and mandatory training. We saw this had all been completed in the five staff records we reviewed.

Records

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

Patient record forms were clear and complete. We reviewed eight patient response forms and they were all documented with the date, time, and signature of the crew member.

All paper records were placed on the electronic system by the controller and shredded to maintain confidentiality.

The control coordinator recorded do not attempt cardiopulmonary resuscitation details on the booking form. Crew only followed the do not attempt cardiopulmonary resuscitation process if they were given the most up-to-date, signed copy of the original do not attempt cardiopulmonary resuscitation. On inspection we heard crew report to the control coordinator that they were not going to follow do not attempt cardiopulmonary resuscitation instruction on the booking form should this be needed, when picking a patient up from a hospital because they were not in receipt of the original copy. This was reported to the safeguarding team and reported to the hospital. Control followed this up and ascertained the document was in the patients bag.

Records were secure and made available to crew via electronic tablet.

Good

Patient transport services

Crews relied on the hospital or care home staff to provide information about the patient. Special notes were placed on the system to alert staff of any risks or concerns.

Medicines

Vehicles only carried oxygen and pain relief.

Oxygen cylinders were stored securely on vehicles and included in daily checks by crews.

All staff had received training on medical gases and had access to the medical gases policy.

Incidents

The service managed patient safety incidents well. Incidents relating to patient care were reported using the incident reporting system, these were categorised as clinical or non-clinical incidents. All incident reports were reviewed and investigated by the senior management team. Staff recognised incidents and near misses and reported them appropriately.

Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. Monthly messages and key learning points from incidents, complaints and safeguarding reports, were disseminated through bulletins on the intranet and at team meetings.

If things went wrong, staff we spoke with said they would need to apologise and give patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service reported identifying three top incident themes, these were vehicle damage, which were from driving long vehicles in hospital car parks, mental health section documentation which prompted additional training for crews and handover delays.

We reviewed five incidents relating to patient safety. Documentation of the investigation showed actions were in place to help ensure the incident wouldn't occur again. In addition, we saw dissemination of learning amongst staff via emails, bulletins and updates during team meetings.

We saw there were comprehensive records of all incidents, which was accessible only by the management team. This database embedded all documentation relating to the incident and any communication between staff and managers.

All staff were completed an e-learning module for being open and honest, it was completed as part of their induction.

As part of their programme to move to digital reporting of incidents, the provider was incorporating a preliminary stage to understand if moderate/severe harm might have occurred previously for past incidents. If an incident or/ event was deemed as a serious incident, managers advised an investigation would be undertaken, and the Duty of Candour policy would be followed.

The service had an incident management policy and a Duty of Candour policy, both were in date and accessible to staff. All incidents were reviewed by the manager, who followed a process to determine if the Duty of Candour regulation was activated. The management team understood the requirement to apply Duty of Candour when needed. The Duty of Candour is a regulatory duty that relates to open 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. Duty of Candour should be discharged if the level of harm to a patient is moderate or above. The manager told us they did not have any incidents of moderate or serious harm to a patient, in order to review compliance against the Duty of Candour Policy. Between January 2019 and June 2019, there had been 44 incidents reported, none were deemed to require a requirement for the Duty of Candour to be discharged.

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

Good

We have inspected provider previously but they were not rated. We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Good

Patient transport services

Staff had access to guidance from the Joint Royal Colleges Ambulance Liaison Committee, which covered key topics such as the management of different conditions and the administration of medical gases. Staff told us they were able to access it on their mobile phone when needed.

Senior managers carried out quality checks to monitor compliance with best practice. managers worked to an audit programme, that audited care and practices. For example, patient report forms were audited monthly, mainly for accuracy and to ensure that any clinical interventions were timely and appropriate. Where managers found non-compliance, the team leaders gave feedback to individuals and a copy of the feedback form was retained on the staff file.

Staff were directed to policies and procedures at the time of joining the organisation. These were available on the intranet. So that managers were assured staff read the policies, staff were asked to sign a register associated to the policy as confirmation of reading and understanding it.

The service had audited a wide range of areas across the service for example; carbon reduction, use of blue lights & sirens, clinical audit (PRF), compliance & data security audits. As a result of audits, the provider had made improvements to the patient report forms, extra sections were added to capture more detail and undertook external accredited training to improve the quality of training delivered to their staff.

The service reported reviewing their mental health service provision, through staff engagement and stakeholder workshops they captured the challenges to delivering a high-quality service. As a result of this review staff attended a training course, a new policy was devised that incorporated a flow chart to follow if a patient absconded and team leaders were given the responsibility to undertake risk assessments to that they could facilitate continuity of care.

Nutrition and hydration

Staff assessed patients drink requirements to meet their needs during a journey. Vehicles carried water bottles, for patients who needed a drink.

Response times / Patient outcomes

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

Managers had recently reviewed the number of the journeys made to an NHS trust against booking times and staffing. As a result, managers changed the week-day shift profile to an earlier start and finish, to support the positioning of vehicles during higher demand periods.

The service worked with NHS trusts to improve waiting times. In a recent project, staff in the discharge lounge at an NHS trust were given permission to view “The stack”. The stack is referred to the ambulance job list. By introducing this, discharge lounge staff could see all booked journeys, which helped them and the service better plan and prioritise patient journeys.

The service had a contract with an NHS provider, to whom they provided two dedicated discharge vehicles to. The waiting times for patients in the discharge lounges were reported monthly to the NHS trust. The service reported delays and actions were put in place to address them.

The provider was keen to improve patient waiting times, their contracts with NHS ambulance providers set parameters for the service to follow. However, information from all jobs could not always be collected due to not having an integrated system. Therefore, for some jobs there was no indication of how long patients had been waiting since the booking had been made. The provider was in the process of integrating their data system with another NHS trust, so they could time-stamp journeys and measure wait times.

Members of the management team informed us that there had been no occasions between January and May 2019 when the service had cancelled a patient journey due to not being able to meet demand.

The provider recorded data on pick up and drop off times when sub-contracting journeys for NHS Ambulance Trust. The provider reported 50% of their journeys contracted by NHS Hospitals and NHS Mental Health Trusts were booked direct on-line using online system and securely transmitted to tablets in the vehicles. The data was sent to both external providers however managers we spoke to said it was difficult to benchmark their data against the contractual arrangements of the NHS Trusts (KPI) with the CCG as they did not have sight of this.

Competent staff

The service ensured that staff only carried out care and treatment if they were skilled, competent and had the experience to perform it.

The provider offered a four-tier training programme that included accredited qualifications. Staff were offered qualifications to enhance their role. We found evidence that staff undertook accredited courses, these were seen staff human resource folders.

Staff joining the service without qualifications, were required to enrol on the level three award in ambulance patient care and non-urgent care, skills for care certificate. This training included learning about the principals of ambulance patient care, the management of medical conditions during conveying a patient, safe moving and handling of a patient, conflict resolution, administration of oxygen therapy and basic airway management.

The service had an induction programme that was followed for all new staff. All the personnel record we reviewed indicated that all staff had completed the induction programme at the start of their employment.

All staff were required to complete driving assessments at the start of their employment to demonstrate that they were competent to undertake their role. Driving assessments included basic skills such as parking and manoeuvring. Data reviewed on site showed all drivers had completed this assessment.

Staff were offered the necessary support during induction and training; the learning coordinator was available to support crews with completing their competencies work booklet. We reviewed work booklets that were completed, dated and signed by the assessor.

Training in conflict and resolution was in place for those transferring mental health patients. The training included ethical and legal considerations, the Mental Capacity Act and Deprivation of Liberty, best interests and ethical principles, authority to undertake control and restraint, restrain techniques theory and demonstration.

Crew members undertook basic life support including cardiopulmonary resuscitation, use of Automated external defibrillator, choking and management of unconscious patient, manual handling practical's, medical conditions and use of oxygen.

Managers appraised staff's work performance and held supervision meetings with them to provide support and development. We reviewed two appraisal forms, they both showed a discussion about development, future role and performance.

Multi-disciplinary working

All those responsible for delivering care, worked together as a team to benefit patients.

Managers worked effectively with commissioning and contracting services, to ensure they delivered the most appropriate care for the patients within the community.

The service attended meetings as arranged by the commissioners and attended as required. We saw minutes from meetings with NHS providers. On site we saw minutes to meetings with NHS providers and commissioners.

Staff handed over all relevant information to other providers when needed. They understood the importance of this and the impact it had on the patients care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The service had a policy in place covering mental capacity, consent and best interest. This was important as it meant that there was a process for staff to follow when documenting a best interest decision or if a patient had refused transport.

The Mental Capacity Act (2005) is designed to protect patients who may lack capacity, to make certain decisions about their care and treatment. Mental Capacity Act and Deprivation of Liberty Safeguards training was included in annual mandatory training. All staff had completed this training at the time of inspection. If a patient lacked capacity, this was captured on the booking form and sent crews.

The Deprivation of Liberty safeguards policy contained information about the process staff must follow. Managers

confirmed that they did not have the responsibility for this (Deprivation of Liberty safeguard applications are made when extra restrictions are needed to deprive someone of their liberty).

At booking, the duty controller confirmed and recorded on the booking form that consent had been taken prior to booking the transport. We saw from patient response forms, crews checked, and recorded consent had been taken.

The provider did not convey patients who were detained under section 136 of the mental health act, unless it was for bed management purposes. The purpose of the transport was always determined during booking to ensure the patient fitted the inclusion criteria. Staff said if crews attended to a patient in the community whereby the police were in attendance, crews would act as part of the bed management team and would not take the patient to hospital. They would escalate the incident to the control room and alternative arrangements would be made if necessary and they would always take direction from the police.

The service had a resuscitation and Don Not Attempt Cardiopulmonary Resuscitation Policy which outlined the skills and training staff required in relation to resuscitation. We saw that the policy considered guidance from the UK Ambulance Services Clinical Practice Guidelines and European Resuscitation Council.

The booking form captured any special requirements. If a patient was flagged to have a do not attempt to resuscitate order in place, staff would only convey the patient, if they were in possession of the original copy.

However, staff were not familiar with Gillick competence. This was important as the service were able to transport children. Gillick is a term used if a child under 16 years of age can consent to their own medical treatment without the need for parental permission or knowledge.

Are patient transport services caring?

There was limited opportunity to observe patient interaction, however, we noted the following practice;

Compassionate care

We were unable to observe patient care during the inspection which meant we were unable to speak to any patients or relatives who had used the service. This meant that we were unable to fully assess how well the service had cared for patients.

During discussion staff demonstrated their awareness of maintaining patient's dignity during transport, they gave examples of how they did this.

Staff sought patient feedback through comment cards, patient surveys and compliments. Each patient using the service had the opportunity to provide feedback, should patients not have capacity to comment on the service, family members were asked to complete the cards.

Patient feedback confirmed that staff treated their patients well and with compassion.

We reviewed 20 comment cards. All patients, or those close to them, gave positive feedback about the service and the crews attending to them.

Compliments were received either directly through emails from patients, or those close to them and from the referring providers of care.

Emotional support

We did not observe staff interact with patients but from comment cards we saw evidence of staff considering patients emotional wellbeing. For example, a comment card said crew were kind and considerate towards their parent who was living with dementia.

Understanding and involvement of patients and those close to them

We did not speak to any patients during the inspection. However, staff told us the patients were told they were eligible to use patient transport service through the referring organisation. This was usually done by staff at the care home or at the hospital.

We heard staff check and confirm if the patient was aware of the transfer and the destination when booking the job, this information was conveyed to crews.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

Patient transport services

Good

We have inspected provider previously, but they were not rated. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service covered a large area, mainly Lancashire, Cheshire and Derby and maintained contracts with local commissioning groups or local authorities.

The provider met with commissioning groups and acute trusts to discuss with them any gaps they identified in the provisions they offered. For example, the provider was meeting with a trust to discuss working with them to support patients requiring transport for regular hospital appointments or unplanned transportation, such as hospital discharges or inter-hospital moves.

The service offered transport to a wide range of service users. The management team had invested in the vehicles to ensure crews could safely convey patients.

Meeting people's individual needs

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

The service served a diverse population, with service users speaking a range of different languages. For those who did not speak English as their first language, staff accessed language line. This was a telephone translation service.

Additionally, a number of the crews in Manchester had completed British Sign Language skills and were able to communicate with those hard of hearing or deaf.

Crews had access to electronic cue cards to support nonverbal communication barriers.

At the time of booking, staff recorded any additional needs in the booking form. This was so that crews were prepared for making any reasonable adjustments when collecting patients. The form collected information on patient's disability, mobility and mental health.

Vehicles were equipped with wheelchairs, accessible ramps, stretchers, passenger seats and wheelchair restraints that were capable of securing standard electric and bariatric wheelchairs. The duty controller noted the make and model of electric wheelchairs at the time of booking so that these details could be passed on to the crew.

Those with additional needs such as dementia were allowed to be accompanied by their carer. At booking details of any additional needs were taken and passed to crews so that reasonable adjustments could be made.

Crews completed a risk assessment and compatibility check of the patients wheelchair before the patient was taken on board the vehicle to avoid any delays.

The duty controller considered and flagged physical disabilities and any other information provided when allocating bookings to the vehicles, to ensure individual needs were met.

Staff used translation services where required by phone to support any language barriers. This meant staff were able to support patients who spoke a different language.

The implementation of the digital programme also had a provision for a tablet-based Cue Cards, this was to support crews caring for patients with non-verbal communication barriers.

Access and flow

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

The service reported of the 4,104 patient journeys carried out between January and June 2019 they had not cancelled any.

When patients required transport from or to hospital, these bookings were referred to the provider via a central service. This meant the provider was not always given information about how long the patient had been waiting prior to the booking or prior to being picked up. Therefore, at times patients were not always conveyed in a timely manner

Data provided by the provider showed an upward trend in the number of journeys carried out during January 2018 – April 2019. This was due to putting on an extra vehicle per day.

Learning from complaints and concerns

Good

Patient transport services

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

People using the service were able to complain or raise concerns. Patients and relatives had access to comment cards in the vehicles if they wished to raise a complaint at the time of their journey. They could also phone or email into the office with their complaint via the referring organisation such as the hospital or care home.

Staff had access to the complaints policy via the intranet. The policy detailed the complaints process and was in date.

All complaints were investigated by the complaints manager. The service worked towards acknowledging the complaint within 48 hours, the service achieved this target.

Complaints were graded as low or high level through an informal discussion with the registered manager, so that the appropriate resource could be assigned to it. The manager and the staff were involved in the investigations. We saw that crew were asked for statements, and staff interviews, or patient interviews were carried out.

Complaints were reviewed at the monthly management meeting, and any learning disseminated through to the rest of the company via the intranet. Any individual training needs highlighted through investigating complaints were escalated to the team leaders for them to action during one to ones with their team member.

The service reported receiving 7 complaints from the 4,104 patient journeys they carried out between January 2019 and June 2019. Managers reported that there did not appear to be a trend but were conscious of communication around delays, which they believed affected the patient's experience.

If a complaint had been sent to the provider that subcontracted patient transport work to the service, managers had a responsibility to investigate the complaints within 28 days. The responsibility of the complaints was held with the subcontractor, but a full response including outcomes of the investigation was sent. The provider achieved their target.

We reviewed complaints, they showed that they were reviewed, investigated and actioned appropriately. For example, changes to the booking system and rota were made to ensure staff were on station 30 minutes before they were due out to collect patients from a nearby NHS trust. These changes were put in place on the back of a complaint from the NHS trust about crews arriving late when conveying patients from the discharge lounge.

If the service could not resolve a patient's complaint, patients were able to go to the Independent Sector Complaints Adjudication Service. This is an independent body that can make final decisions on complaints that have been investigated by the provider and have not been resolved to the complainant's satisfaction.

Are patient transport services well-led?

Good

We have inspected provider previously, but they were not rated. We rated it as **good.**

Leadership of service

Leaders understood and managed the priorities and issues the service faced. Staff said they were visible and approachable and supportive in to developing their skills so that they could take on more senior roles.

Leaders understood the challenges to quality and sustainability, and identified the actions needed to address them. For example, since acquiring the business, the role of operations support lead had been created to support the ambulance crews, senior management and team leaders. This role allowed a fluid escalation process of any operational concerns to managers.

Leaders were visible and approachable. The role of a team leader was put in to place to support ambulance crews, across the different depots. Team leaders performed appraisals and were available to offer one to one daily support.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. For example, the provider offered development programmes to crews which includes succession planning.

Vision and strategy for this service

Good

Patient transport services

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within community. Leaders and staff understood and knew how to apply them and monitor progress.

The vision was to be a service which provided patient centred, high quality, consistent care at an intermediate (community ambulance) tier which was digitally fit for purpose.

The service vision was underpinned by a strategy that included working towards a network of small-scale community ambulance services, that was supported by social licences in the communities they served.

Clear objectives supported the strategy, for example, the provider heavily invested in the efficient use of technology, so that the service could work smarter, faster and waste less.

The strategy included plans for training, digitalisation and community working, each area was distributed to a manager to oversee. For example, the strategy included improving mental health awareness amongst staff. The service had identified a lead amongst crews to support this part of the strategy.

Plans to support the implementation of the strategy were reviewed monthly, we saw that some areas of the plans had been completed, such as replacing the fleet of vehicles.

Culture within the service

During inspection senior managers told us that they recognised that crew members did not always demonstrate an open and positive culture towards them because of the recent changes within the company. We heard from managers that they were keen to change this by offering staff a range of developmental opportunities.

Senior managers addressed behaviour and performance that was inconsistent with their vision and values. The provider had clear processes to hold staff to account for any untoward behaviour. On inspection we saw evidence of this process in place.

Managers spoke positively about the high incident reporting rate. Leaders encouraged staff to report incidents and raise concerns without fear of retribution. We reviewed 10 incidents, of which all had attached emails from a manager, thanking them for reporting the incident.

We saw mechanisms in place for providing all staff with the development they required for their role. We reviewed staff files and found meaningful appraisals that included development conversations.

During the inspection staff we spoke with us gave variable feedback about the culture of the service. We heard they were well supported, and managers promoted safety and wellbeing of staff.

However, we also heard that staff did not always feel positive and informed us that recent changes to the ways of working had caused upset and tension amongst the team.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

A new governance framework had been developed since the service acquisition in June 2018. All existing company process and policies had been reviewed and developed where required, and in line with their digitalisation programme. Each document has been assigned a unique identifier and a document registry created.

The actions and progress of the digitalisation programme was reviewed on a monthly basis, managers reported the actions completed and the progress of those that had not to the directors. Evidence of these discussions could be seen from governance meetings we reviewed.

Governance processes were in place for managing and monitoring the service level agreement between NHS providers. We reviewed the current contract, this had recently been reviewed and updated.

In addition, we saw that two NHS providers had inspected the service, to ensure they were safe to transport their patients. An action plan was in place to address identified gaps. Managers we spoke to said these inspections were welcomed and saw them as another layer of governance.

For example, we saw the provider had updated there reporting policy with another step so that senior managers immediately notified the NHS provider if the incident involved an accident when transporting their patient.

The senior management team meet on a monthly basis to review core compliance against training, fleet and equipment maintenance. We saw from minutes that incidents involving equipment and training compliance rates were reviewed.

Patient response form audit outcomes, adverse events, care concerns, compliments and complaints for the previous month were reviewed at the monthly managers meetings and any areas of risk was escalated to the company risk register, so that it could be reviewed on a regular basis. We reviewed three sets of meeting minutes, February meeting minutes showed managers put actions in place from a human resources audit to ascertain all references after discovering staff references were not immediately available.

Staff at all levels were clear about their roles and understood their responsibilities.

All staff were required to have a full UK manual driving licence to drive the ambulance vehicles. License checks were carried out to confirm details. Details of drivers licences were monitored on a spreadsheet.

Staff were required to undertake an enhanced Disclosure and Barring Service check as part of the recruitment process, and the service requested a copy of the check once received.

We reviewed personnel files for four staff. We found that these had all been completed appropriately. All personnel files were held on an electronic system.

Minutes from bi-monthly team meetings showed that these were held in the morning and early evening to capture all staff. Minutes showed staff discussed general updates, information about training, and event work.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. For example, all incidents, safeguards and complaints were reviewed by the management team, actions were put in place to help mitigate future risks.

Performance issues were escalated appropriately through clear structures and processes, this was through a range of meetings amongst senior managers and reports to external organisations. For example, a monthly performance review report to NHS providers supported the managers to understand and manage any foreseeable risks, such as seasonal changes in the number of jobs they received.

The provider held its own risk register, upon reviewing it we saw that it contained high-level risks for the different depots. All risks had mitigation and a review date. This meant managers were familiar with their risks, they were mitigated, monitored and reviewed regularly through governance meetings.

Each vehicle was installed with a digital monitoring system which allowed managers to monitor individual drivers driving behaviour. For example, how they were braking and accelerating. By collecting this data, senior managers were able to monitor any risks whilst driving, however this data was unavailable at the time of inspection and therefore unable to audit this at this point.

Due to changes to the service, the provider focused on changing their provision from an emergency ambulance service to a community ambulance service, the provider carried out an internal review and adapted the workforce appropriately. This included employing substantive staff.

The management team had recognised that extended shifts were unsafe. An extended shift was a term used to describe additional driving carried out by crews to and from their base. For example, previously some staff drove from Manchester to Derby before and after a full shift. The management team mitigated this risk by employing more local staff to undertake work therefore limiting the number of extended shifts staff were undertaking.

The company had standardised the vehicle fleet and had purchased eight community ambulance vehicles to ensure they were suitable for patient transport. As a result of reviewing the vehicle stock they had disposed of a number of mixed configuration vehicles, off road vehicles and fast response cars. This meant vehicles had fewer motoring problems and managers were also assured the equipment in the vehicles was up to date.

Information Management

Good

Patient transport services

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

Electronic tablets were password protected, information could only be accessed by staff.

Managers only had access to performance management data such as staff details, vehicle servicing information, audits, training and human resource processes. This was so that they could monitor the services they offered.

The manager had invested in high-quality on-line dispatch software, so that the senior management team were able to deliver a full analysis of all patient journeys, from booking to end.

The provider submitted data to organisations they had service level agreements with, this was done through performance reports.

Public and staff engagement

Feedback received by the NHS ambulance was shared amongst the senior team, but we did not see or hear of evidence that suggested it was disseminated to staff.

We did not see a range of information displayed for staff to view such as upcoming events or feedback from incidents to share any learning or changes.

However, due to the nature of the service leaders were unable to engage with local organisations to plan and manage their services. As a subcontractor of services, they had contractual arrangements applied by NHS providers that did not allow them to engage in these activities

The service was predominantly for patient transport, but the management team was supportive of staff carrying out voluntary work in the community.

The views of patients and their experiences were gathered and acted upon. We reviewed a combination of 30 comment cards, complaints and compliments. We saw dissemination of learning from those who had raised concerns about their experience. For example, comments about the attitude of some crew were addressed with the individuals through supervision and discussed at the team meeting as an overall topic.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The provider was in it's infancy of aligning the services they offered to the national community Health care strategy. Managers discussed with the inspection team the plans in place to provide their contribution to social value.

The senior management team informed us they were putting together a new community ambulance service business plan, to present to commissioners for October 2019.

Additionally, managers were designing and developing a new unique data tool, to measure how effective patient centred secure mental health services were. The provider was working to have this completed by quarter four of 2019.

The organisation has undertaken stage one audits for ISO 9001, 27001 and 14001 and aspired to be accredited by the end of 2019. Senior managers said completion of these courses provided them more opportunities to support the organisations to grow and maintain standards.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
The provider must ensure all vehicles carry paediatric harness, so that they can travel safely.

Action the provider SHOULD take to improve
The provider should ensure crews document actions taken when attending to a deteriorating patient.

The provider should ensure all polices contain references to the guidelines and standards they have been cited from.

The provider should ensure all staff are aware of Gillick competencies.