Alpha Care Ambulance Service Limited

Alpha Care Ambulance Service

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Alpha Care Ambulance Service is an independent medical transport provider based in Moulsford, Oxfordshire. The service provides a patient transport service and medical cover at events. Services are staffed by trained paramedics, emergency care technicians, ambulance care assistants and technicians.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 14 March 2017.

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

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

Services we do not rate

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

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

- The provider did not have processes or practices in place to assess, monitor and improve quality and safety. There was not a robust system to ensure all incidents were recorded and monitored appropriately and no learning or outcomes were shared with staff.
- Systems and processes were not in place to implement the statutory obligations of Duty of Candour (DoC).
- The staff did not have current mandatory training and were not supported appropriately, either by the provider's induction or through ongoing training. Staff delivering training were not up-to-date themselves.
- Arrangements for safeguarding vulnerable adults and children were not adequate. There was a lack of safeguarding training to ensure staff were aware of their responsibilities. There was a risk that staff would not be able to recognise and report potential safeguarding concerns.
- Medicines were not always managed safely or securely. The service had a medicine management policy. However, they did not have any medicine protocols to support staff to administer medicines safely. A regular patient carried their own midazolam, which would need to be administered by a member of the crew if the patient deteriorated. Midazolam is a Schedule 3 Controlled Drug as defined by the Misuse of Drugs Act 1971 and has strict rules in place for its use.
- We found the service did not have recruitment procedures in place to ensure all staff were appointed following a robust check of their suitability and experience for the role. Neither was there evidence of robust pre-employment checks were carried out.
- There were no systems in place to ensure staff received regular appraisal on their performance or development needs or received clinical supervision. There was no evidence of an induction policy or process within the service.
- There were limited policies and guidelines to support staff to provide evidence based care and treatment.
- Managers did not have an understanding of risk and its management relating to the business and they did not demonstrate the necessary knowledge to lead effectively. The registered manager appeared to have very little understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and how these related to the business, or the consequences of not complying with them.
- There were no effective governance arrangements in place to monitor or evaluate the quality of the service and improve delivery. Audits were not undertaken and therefore learning did not take place from review of procedures and practice.

Summary of findings

- There was no formal risk register in place at the service and therefore we had no assurances that risks were being tracked and managed to mitigate risks.
- There was limited provision on ambulance vehicles to support people who were unable to communicate verbally or for whom English was not their first language.

However, we also found the following areas of good practice:

- The service had a system for handling, managing and monitoring complaints and concerns.

There were areas of poor practice where the service needed to make improvements.

Following the inspection, we used our urgent powers to suspend registration of the service until 16 May 2017. This action was taken in response to our significant concerns of the immediate risk to patients. We found that care and treatment was not provided in a safe way and there were no effective governance systems in place within the organisation. Staff providing care or treatment did not have the skills, competence and training to do so safely. For example, in medicines management, risk assessments, risks of infection control and equipment. We also found that there was a lack of systems and processes in place to protect patients from abuse and improper treatment.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements. Details are at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Alpha Care Ambulance Services is an independent medical transport provider based in Oxfordshire. The service provides patient transport, medical cover at events and school transport for special needs children. Services are staffed by trained paramedics, emergency care technicians, ambulance care assistants and technicians.

Alpha Care Ambulance Service

Detailed findings

Services we looked at
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Detailed findings

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Background to Alpha Care Ambulance Service

Alpha Care Ambulance Service is operated by Alpha Care Ambulance Service Limited. The service was registered on 27 July 2011. It is an independent ambulance service based in Moulsford, Oxfordshire. The service provides non-emergency patient transport and medical cover at events to private organisations and some NHS trusts. The service also provides school transport for special needs children. Services are staffed by trained paramedics, ambulance technicians and ambulance care assistants. The service primarily serves the communities of Oxfordshire and Berkshire.

The service has had a registered manager in post since 27 July 2011.

Alpha Care Ambulance Service fleet consists nine vehicles: six ambulances, two event vehicles and a lorry for events. Four ambulance vehicles are fitted with one stretcher and three seats. The service employs eight whole time equivalent employed staff and seven self-employed staff. The service provides cover seven days a week for its patient transport service.

Our inspection team

Our inspection team comprised of an inspector and two specialist advisors who had extensive experience and knowledge of emergency ambulance services and non-emergency patient transport services. The inspection team was overseen by Leanne Wilson, Head of Hospital Inspection.

How we carried out this inspection

We carried out an announced inspection on 14 March 2017.

During the inspection, we visited the station at Moulsford and we spoke with six staff including; registered paramedics, technicians, and ambulance care assistants. We were unable to speak to patients as part of this inspection because we did not travel with crews during our visit.

Detailed findings

Facts and data about Alpha Care Ambulance Service

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service was last inspected in December 2013 and was found to be compliant with the five outcomes inspected at that time.

Activity (March 2016 to February 2017)

There were 825 patient transport journeys undertaken.

- Children's journeys 557.
- Hospitals journeys 199.
- Private journeys 41.
- Social Services journeys 28.

The service attended 127 events.

Track record on safety

- No never events
- No clinical incidents
- No serious injuries
- No complaints

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Alpha Care Ambulance Service is an independent ambulance service, which provides non-emergency patient transport services. They also supply first aid services to public events. The service is staffed by two registered paramedics, one technician, one emergency care technician and four ambulance care assistants, one of whom worked as a mechanic.

We inspected this service as a patient transport service as this was their primary work.

The journey types and categories of patient transported included outpatients appointments, admissions and discharges to hospital, nursing and residential home transfers, long distance road ambulance transfers, hospital to hospital and medical standby for public events. The service also provided school transport for children with special educational needs.

The service is registered to provide the following regulated activities:

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

Summary of findings

We do not currently have a legal duty to rate independent ambulance services.

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

- The internal incident reporting process was not robust. There was not a system to ensure all incidents were recorded and monitored and no learning or outcomes were shared with staff.
- Staff understanding of Duty of Candour was varied. At the time of the inspection, staff had received no formal training.
- There were no infection prevention control audits conducted to ensure high standards of cleanliness were being maintained. Whilst vehicles were seen to be clean, there were a number of concerns around the deep cleaning of vehicles.
- The arrangement for safeguarding adults and children was not robust. There was insufficient focus given to safeguarding children and adults. Managers and staff lacked an understanding about safeguarding.
- There was inadequate recruitment checks on employees prior to commencement of employment.
- Medicines were not always managed properly or safely. We found several medicines out of date. One patient who was at risk of deterioration and would require the ambulance crew to administer Midazolam. This medicine is a prescription only controlled drug. The provider had not ensured staff were up-to-date with training to give this medicine.
- There were no environmental or fire safety risk assessments in place.

Patient transport services (PTS)

- Staff were not provided with mandatory training, or any additional training as required to develop or maintain the skills to provide safe care.
- The service did not have systems in place to routinely monitor how the service was performing. The service did not carry out any local audits as a way of monitoring performance and making improvements.
- There were no systems in place to ensure staff were suitably appraised or received clinical supervision. Recruitment and induction processes were also insufficient.
- There were limited policies and guidelines to support staff to provide evidence based care and treatment.
- Managers had no assurances staff were working to required standards when they were transporting patients. Staff had not been trained in the Mental Capacity Act and their responsibilities.
- There were no systems in place to ensure that the service used relevant and current evidence-based guidance standards, best practice and legislation to provide effective care.
- There was no provision made for patients who did not speak English or patients who had communication difficulties. Staff had no access to specialist communication equipment, pictorial guides, and language services to meet patients' individual needs.
- There were no effective governance arrangements in place to evaluate the quality of the service and improve its delivery.
- The managers did not demonstrate the necessary knowledge to lead effectively. The registered manager had little understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, what the business was registered for, or what their responsibilities were to ensure compliance.
- Managers did not have an understanding of risk and its management relating to the business. There were no processes or systems in place for the identification of, recording, monitoring, or managing risks associated with the business.
- The service did not always proactively involve all staff, to ensure that the views of all staff were heard and acted on.

However, we also found the following areas of good practice:

- Ambulances were visibly clean and staff followed infection control procedures, to be bare below the elbow and use personal protective equipment.
- Patient's medical records were carried in a folder whilst the patient was being transported to ensure confidentiality and when transporting children, staff carried individual information packs.
- Staff were able to plan appropriately for patient journeys using the information provided by the booking system.
- Staff we spoke with were passionate about their roles and providing excellent care.
- We saw information about how to make a complaint; which was readily available in the vehicles we inspected. Staff and patients were aware of and knew how to access the service's complaints and compliments system.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- The service had a paper-based system in place for staff to report accidents, incidents and near misses. The managers informed us that there were no incidents recorded since January 2016. We were concerned that incidents or concerns were not being reported or investigated and we were not assured incident reporting was embedded in the culture of the service.
- We reviewed the services incident log and found that there was no differentiation being made between serious incidents, never events, incidents, near misses, complaints or safeguarding concerns. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. This meant the service was unable to assess or analyse incidents, identify themes and trends or areas for improvement.
- There was no evidence of learning or changes in practice as a result of incidents and when the operational manager responsible for governance was asked, they could not describe any. Incidents were not reviewed on a regular basis and there was no system to review trends. This could put patients at risk of harm, with the possibility of similar types of incident happening again. Incidents were not formally investigated nor any learning from the incident shared with staff.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Discussions with managers and staff showed they did not have a full understanding of their responsibilities towards the duty of candour legislation, beyond the principles of openness and honesty. Staff were unable to describe the principles of the duty of candour, and were unable to give examples of when they had put it into practice.

Cleanliness, infection control and hygiene

- The five vehicles we reviewed were uncluttered and visibly clean. The ambulance station was tidy and well organised. The floors were swept clean in the ambulance parking area and there was no excess equipment so the areas uncluttered, making them easy to clean.
- We were not confident in the services infection control processes because we found there were no cleaning or deep cleaning schedules in place. There was no clearly defined process for deep cleaning or how this would be done, and using what products. There were also no audits on vehicle cleanliness present when we inspected.
- Crews were required to ensure their vehicle was fit for purpose, before, during and after they had transported a patient. Decontamination cleaning wipes were available on all vehicles.
- The crew assigned to the vehicle each day completed the day to day cleaning of vehicles. However, there were no checklists or audits completed to prove this had taken place.
- Managers and staff had access to kitchen facilities, however, there was no hand washing basin. In the garage area there was a dishwasher and there was a large sink for multiple purposes. The only designated handwashing facilities we saw were in the toilets.
- All staff wore visibly clean uniforms and were observed to be bare below the elbow.
- Staff were provided with sufficient uniforms, which ensured they could change during a shift if necessary. Staff were responsible for cleaning their own uniform, unless it had been heavily contaminated, when it was disposed of as clinical waste.
- We were informed the service did not complete infection, prevention and control audits or hand hygiene audits. This meant the service could not be assured they were compliant.
- Staff had access to personal protective equipment such as gloves and aprons to reduce the risk of the spread of infection between staff and patients.
- Cleaning materials and chemicals were available for staff use. Different coloured mops and buckets were available for different areas; advice as to which mop should be used in which area was prominently displayed to prevent cross infection.
- There was a policy in place regarding safe disposal of clinical waste and a service level agreement was in place with a waste contractor for its removal.

- Staff reported that they would be made aware of specific infection risks either on their job sheets or by hospital staff when they collected patients.

Environment and equipment

- The ambulance station provided ambulance vehicle parking facilities, an office base and kitchen facilities for managers and staff.
- The service operated nine vehicles: six ambulances, two event vehicles and a lorry for events. We inspected four ambulances and one event vehicle.
- There were no records of equipment testing or records of equipment asset management available to view. We saw some equipment had been serviced, however, we found two defibrillators on the ambulances that had been serviced but the batteries needed replacing.
- There were no fire safety risk assessments or environmental risk assessments in place. Fire extinguishers in all the ambulances and onsite had never been serviced.This demonstrated a lack of ownership and oversight of the potential risks to patients, staff and visitors.
- We inspected five vehicles. We found that the safety testing for all the electrical equipment had expired.
- Vehicles did not have current records detailing their maintenance, insurance and road tax records. We found that one vehicle's tax expired in October 2016. We received assurance that the vehicle had not been used since the tax had expired. This was raised with the management team and the tax was renewed immediately.
- We looked at the arrangements in place to service and maintain ambulances. Vehicle defect report forms were provided, which included a description of the fault or defect, action taken to resolve, and further action required. Staff informed us they reported any defects directly to the mechanic or the managers. The service employed a full-time mechanic who also worked as part of the operational ambulance crew.
- Staff stated that they would use their own personal oxygen saturation probes to check oxygen levels; this meant equipment may be used which had not been appropriately tested for suitability and accuracy. Although the manager informed us that they were less than a year old.
- We observed a driver carry out a vehicle check before using the vehicle. Staff told us vehicle daily inspection (VDI) forms were stored in the vehicle and given to team leaders at the end of the shift. There was no audit of these forms to assess compliance with vehicle checks.
- All vehicles had appropriate resuscitation equipment. However, there was not a standard equipment list on each vehicle, therefore, it was not possible for staff to check and identify missing items.
- There was a variety of equipment on the vehicles that ensured the safety of patients. This included carry chairs, slide sheets, standard safety belts and strapping to attach wheelchairs to the vehicle floor. However, we found equipment that belonged to a local NHS ambulance trust and a carry chair that was frayed and could have caused injury if used. We raised this at the time of the inspection and it was changed immediately.
- Staff knew the process to follow if their vehicle broke down or was involved in an accident, addressing the immediate needs of any patients first and then liaising with the manager on call.
- All ambulances were equipped with tracking devices so their location could be monitored and radios for communication.
- We found that vehicle keys were stored on the wall in the office and not in a key safe. All vehicles were locked when unattended.

Medicines

- During the inspection, we found examples of poor medicines management. The service was storing and administering medication, which were out of date. We found 11 medicines which had expired. Some of the medications had expired in June 2016, September 2016 and January 2017.We also found three burns dressings that had expired in 2010.
- There was a medicines logbook and stock check file, however it was not clear or robust and we were not assured that medicines were being managed appropriately. There were no recorded medication audits or checking of expiry dates of medicines.
- Medicines at the station were stored in a secure cupboard, monitored by video surveillance. However, there was no record of what was stored in the cupboard, taken out or what was returned.
- Staff had not received any training on medicines management.

- The managers informed us they did not have controlled drugs licence or a Controlled Drugs Accountable Officer (CDAO). Controlled drugs are a group of medicines that require special storage and recording arrangements due to their potential for misuse However, we found, out of date morphine (2015) being stored awaiting destruction. We have been assured that the morphine has since been destroyed correctly.
- We asked to see the Controlled Drugs (CD) register and were shown "in date" and "out of date" CD registers. We have been assured since the inspection they no longer have any controlled drugs on the premises.
- One of the regular patients transported by the service, was at risk of deterioration that would require midazolam to be administered. The service did not carry its own stock of this medicine, so would need to administer the patient's own medicine in the event of them deteriorating. The provider had not ensured staff were up-to-date with training to give this medicine.
- Medical gases were carried on each ambulance vehicle. Oxygen cylinders were appropriately secured in the ambulance. However, we found three oxygen cylinders that were out of date, dated 2016.
- The service kept medical gas cylinders in locked cages in a sheltered location. Storage of medical gases was secure and appropriate with segregation between full and empty cylinders and there were signs to alert staff and visitors to the flammable nature of the gases. However, the service had not risk assessed the location of the cages and the temperatures were not monitored for safety. Oxygen cylinders were found to be in close proximity to oil storage and the smoking area

Records

- Staff kept written records of pick up and drop off times for each patient. This was then provided to the office as part of the crew timesheets.
- Patient's medical records were carried in a folder whilst the patient was being transported to ensure confidentiality. Upon arrival at the destination, the crew handed the documentation to the relevant member of staff or carer.
- When transporting children, staff carried individual information packs, which included social services plans, however we did not see plans by the service.
- We saw patient information and patient report forms (PRFs) kept within locked cupboards in the office at the station. However, we found some PRFs in unsecured boxes in the loft area, which there was unrestricted entry, accessed by a ladder which was secured by a lock.
- The staff personnel files were stored in a locked cupboard on the service premises. We were told only the administration staff and managers had access to this key to ensure the confidentiality of staff members was respected.

Safeguarding

- Processes, training and policies did not keep vulnerable people safe. The service transported children, patients with learning disabilities and patients living with dementia, as well as persons otherwise vulnerable due to their age, mobility or illness. There were no systems or processes established or operated effectively to prevent abuse of service users, or to recognise and report concerns. There was no oversight or scrutiny of the safeguarding process.
- Staff did not demonstrate a clear understanding of safeguarding process. We were informed of one incident where concern for a child was highlighted. The child was being transported from the respite home to school when staff noticed that the child appeared distressed and contacted the mother. They took the child to hospital where it was discovered they had a fracture but at no point did staff consider reporting this as a safeguarding alert themselves. A safeguarding alert was raised by the hospital.
- The services "Safeguarding Adults and Children Policy" (November 2015) stated there should be a named individual who had overall responsibility for safeguarding. When asked on the inspection, managers were unable to tell us who this was. The service did not have an appointed safeguarding lead for vulnerable adults and children.
- There was no evidence that staff had completed or were provided with safeguarding adult or children training either as part of their induction or as part of an ongoing training programme. The services "Safeguarding Adults and Children Policy" (November 2015) stated, "patient facing staff would receive enhanced training to a minimum of level 2 safeguarding". Staff transporting children should have level 3 in line with national guidance. This meant that there was a risk staff would not be able to recognise and report potential safeguarding concerns.

Patient transport services (PTS)

- There were no procedures for staff to follow in the event of them having a safeguarding concern, and no guidance documents to support staff in identifying a safeguarding concern. Staff were not kept up to date about changes to national and local safeguarding arrangements. The policy did not give clear guidance to staff as to how to report concerns urgently and outside of normal office hours
- The incident reporting process did not give assurances that safeguarding would be appropriately investigated or escalated, if reported. The general process for investigation and learning was lacking, as detailed in the incidents section. There was no specific investigation or learning process for safeguarding.

Mandatory training

- Alpha Care Ambulance Service had a limited overview of training across the service, for example, staff we spoke with on inspection confirmed there had been no statutory or mandatory training given to staff for example on infection control, health and safety patient moving and handling, medical gas safety, fire safety or safeguarding.
- There was not clear evidence that staff had undertaken mandatory or induction training since employment with the service. There was no definition of what training was mandatory and must be undertaken by staff. The service did not have an up to date record of staff training
- We reviewed nine staff files and found all nine staff had not received mandatory or statutory training.
- The Company's Induction, Statutory And Mandatory Training Policy reviewed in March 2017, stated the "The Education and Training Department is charged by the Company to provide and/ or arrange for suitable and sufficient training for staff with regards Company Induction and Statutory/ Mandatory update refresher courses." We were informed the education and training department of the company closed six months previously.

Assessing and responding to patient risk

- Information about individual patients' individual needs was collected at point of booking and communicated to staff on their work sheets. We observed staff taking details of risk factors when making a booking for transport.
- When providing support at events, staff completed clinical observations on patients, as part of their care and treatment to assess for early signs of deterioration. If a patient did deteriorate, staff requested additional emergency clinical support.
- Members of staff told us in the event of patient deterioration they would call 999 for emergency backup. This was confirmed by the managers we spoke with.
- There was appropriate equipment on board ambulance vehicles to provide monitoring and assessment of patients. For example, patients could have oxygen saturations, non-invasive blood pressure, temperature and blood sugar recorded.

Staffing

- The staff based at the ambulance station consisted of the managing director, director of operations and an administrator.
- The service employed eight full time and seven self-employed staff, which included emergency care technicians, ambulance care assistants, paramedics and technicians.
- Senior management reviewed staffing levels and the appropriate skill mix of staff to cover shifts.
- There was a process in place for the ambulance crews to refer to a manager out of hours and in case of emergencies. They had a direct number to the duty manager on call. Staff we spoke with knew how to escalate concerns when working out of hours.
- All ambulance staff including self-employed staff had enhanced Disclosure and Barring Service (DBS) checks. Copies of these certificates were held on file.
- The service did not use agency staff but utilised the existing internal team who worked additional shifts on overtime or flexibly where required.

Response to major incidents

- A major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services and would generally include the involvement, either directly or indirectly, of large numbers of people.
- The service had a business contingency plan that identified how the service would function in the event of an emergency such as fire or infrastructure incident.
- As an independent ambulance service, the provider was not part of the NHS major incident planning.

Patient transport services (PTS)

Are patient transport services effective?

Evidence-based care and treatment

- Staff had access to Joint Royal Colleges Ambulances Liaison committee (JRCALC) clinical practice guidelines. However, there were no regular clinical audits to monitor adherence to these guidelines.
- There were limited policies and guidelines to support staff to provide evidence based care and treatment. The service was unable to assure itself that transport was provided in line with local guidelines. It was also unable to assure itself that staff assessed patient needs against protocols to provide care and transport.
- At the time of the inspection, the manager told us there were no service level agreements in place with any providers. There were no assurances staff were applying any specific national guidelines to their work.

Assessment and planning of care

- Staff were made aware of their patient's condition at the onset of their journey so they could plan their care while being transported appropriately.
- Staff were made aware of any patient with mental health problems through the booking system, in advance of accepting a booking so they could plan their care accordingly.
- Staff told us they did not transport a patient if they felt they were not equipped to do so, or the patient needed more specialist care. If a patient was observed or assessed as not well enough to travel or be discharged from hospital, staff would make the decision not to take them.

Response times and patient outcomes

- From March 2016 to February 2017, there had been 850 patient journeys.
- The service monitored pick up times, arrival times and site departure times through the crew's daily job sheets.
- There was no formal system in place to monitor the services performance to ensure they were delivering an effective patient transport service. The service did not benchmark itself against other providers. Senior managers we spoke with confirmed this.
- We were unable to analyse how well the service did in relation to patient outcomes because this information was not available.
- The service did not undertake audits, which would allow it to assess if it was meeting the needs of the patient groups it served. We found the service did not have a system in place to routinely collect or monitor information on how the service was performing.
- The staff we spoke with confirmed they were not aware of any set key performance indicators (KPIs).Although they worked hard to deliver a good and timely service.

Competent staff

- We reviewed nine staff files and found that relevant employment information such as references, reasons for the termination of previous employment, and health checks were not in place. This meant we could not be assured that all staff employed by the service were of good character and had the competency to carry the role in which they were employed. This did not adhere to the service's own Recruitment Policy (September 2016).
- Staff had not received specific basic training and competencies in respect of their roles. There were no records of competencies for staff on how to use equipment such as chairs, defibrillators or oxygen. However, all staff had undertaken enhanced training in the care and maintenance of patients with tracheostomies in order to care for a regular client. This training included the re-insertion or changing of the tracheostomy in the event of an emergency.
- Senior management informed us, that the staff had not received an appraisal. An appraisal is an opportunity for staff to discuss areas of improvement and development within their role in a formal manner.
- The service did not have an induction programme for new starters.
- The services "Managing Staff through Probationary Periods Procedure" (November 2016) stated that it was essential for managers to meet individual member of staff at least twice during their probationary period and these meetings were to be recorded. However, we did not see any evidence of this recorded in staff files.
- Paramedics are required to re-register with the Health and Care Professional Council (HCPC) every two years. They are required to undertake continuous professional development (CPD) and receive clinical supervision. We were told that the service did not provide formal clinical supervision for staff.

Patient transport services (PTS)

- There were no arrangements for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor.
- Driver and Vehicle Licensing Agency (DVLA) checks were conducted at the start of employment. All crew were aware of the need to notify the managers of any changes to their license in line with the driving standards policy.
- Staff we spoke with told us they were encouraged to undertake NVQ training in Health & Social Care. We saw evidence of completed files. This was a nationally recognised qualification and was designed to teach how to deliver care, develop a clear understanding of roles and responsibilities.

Coordination with other providers and multi-disciplinary working

- Staff we spoke with told us they had good coordination with the various managers based at the hospitals they transported patients to and from the hospitals. Staff also told us they had good relationships with the children they transported and their parents.
- We were told that do not attempt cardiac pulmonary resuscitation (DNACPR) orders were communicated in advance of journeys to PTS crew and that this would be on their job sheet. We did not see any records at the time of inspection, which included this information.

Access to information

- Ambulance staff received paper daily job sheets at the start of each shift. These included collection times, addresses and patient specific information such as relevant medical conditions, complex needs such as mobility, or if an escort was travelling with them.
- Staff felt they had access to sufficient information for the patients they cared for. If they needed additional information or had any concerns, they spoke with the managers.
- Staff told us both hospital staff and staff at the station made them aware of any special requirements. For example, they were notified if a patient was living with dementia.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Managers did not understand the relevant consent and decision-making requirements of legislation and guidance. This included the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. The provider did not have any policies or procedures that referred to obtaining consent from service users, or considerations, which should be made with regard to the Mental Capacity Act 2005.
- Vulnerable patients including children with learning disabilities and patients with mental health concerns were transported on a daily basis. There was no evidence that staff have received any initial or continual training in understanding learning disability or mental health needs.

Are patient transport services caring?

Compassionate care

- We were unable to speak with patients as part of this inspection because we did not travel with crews during this inspection.
- All staff we spoke with appeared passionate about their roles and were dedicated in providing excellent care to patients. We were given an example of staff buying milk and bread for patients out of their own wages if patients did not have any money.
- Wherever possible vulnerable patients, such as those living with dementia or a disability, were able to have a relative or carer with them while being transported.

Understanding and involvement of patients and those close to them

- Staff informed us that when they were asked to transport a new child with complex needs regularly, they would arrange to meet with the child and the parents beforehand to discuss their needs.
- Patients were treated with patience and kindness to help them understand what was happening or where they were going.Ambulance care assistants explained how some patients could be anxious or confused.They said they would try and help the patient to understand where they were going and why and how they would be looked after in the vehicle.

Emotional support

- All of the staff we spoke with demonstrated a caring and supportive attitude. We were told that should a patient become agitated or anxious staff would spend time reassuring the patient.

Patient transport services (PTS)

- On the rare occasion, a patient died in the care of the service, family members and carers were supported.Staff would contact the office and support the family until other people arrived to help.
- Staff encouraged patients to bring family members or carers on their journeys.

Are patient transport services responsive to people's needs?
(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The main service was patient transport services (PTS) which provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or referrals from care homes and private individuals. This service also provided school transport for children with learning disabilities.
- The service had two core elements, pre-planned patient transport services, and 'ad hoc' services to meet the needs of their patients and workloads were planned around this.
- On the day, bookings were responded to quickly via telephone. For the ad hoc on the day bookings office based staff identified, which drivers were, free or had finished jobs. We observed effective communication between drivers and office staff as part of service planning.
- All of the ambulances were equipped with tracking devices. The service had the ability to monitor the locations of its vehicles and to identify where they were.
- Staff told us their workload was variable, it ranged from transporting one to two patients a day to considerably more than this on some occasions, there were no trends to this variation.

Meeting people's individual needs

- For patients living with dementia and those with reduced mental capacity their support needs were assessed at point of booking. There was seating in the ambulances to allow family members or additional medical staff to travel with the patient.
- Ambulances had different points of entry, including sliding doors, steps and tailgates so that people who were mobile or in wheelchairs could enter safely.
- There was no coordinated training for staff in dementia awareness or mental health. This meant services delivered might not take account of the needs of patients and callers living with dementia or mental health, although some staff gave us examples of how they would communicate with these patients.
- The service did not provide any training to staff to raise awareness and education for patients with a learning disability.
- For patients with communication difficulties or who for whom English was not their first language, we were informed staff would use their own telephones to look up phrases and words to help them communicate. However, should they be in an area with no mobile signal, there was a potential risk to patient care if a phrase book was not on the vehicle.
- The service did not have any communication aids, to support patients who were unable to speak due to their medical condition or who had complex needs. There was a potential risk of patients not being able to explain what was wrong or understand staff.
- Information leaflets were only available in English. There was no provision for those who were hearing or visually impaired.
- Staff ensured patients were not left at home without being safe and supported.Some patients were discharged from hospital and had a package of care to be arranged at home.If the support person or team had not arrived when the patient came home, the ambulance care assistants called the hospital to find out where they were. The patient would not be left alone until either the care team arrived, or the patient was safe in the care of their family or carer.

Access and flow

- The service operated within the core hours of 6am to 10pm every day.
- The service carried out 'ad hoc' work so would assess resource requirements and capacity on an individual basis when requested. Demand fluctuated and the service only undertook work that was within their capacity.

Patient transport services (PTS)

- The' job sheets' carried by staff provided them with journey information including name, pick up point, destination, mobility requirements and any specific requirements based on individual needs.
- Staff told us that first aid and ambulance assistance at public events was organised with event organisers to ensure the needs for each event were addressed appropriately.
- Managers confirmed that patient transport services did not undertake emergency transfers and patients transported were usually clinically stable.
- The majority of patient journeys were planned by the clients. Transporting children from home to school and a return journey. The service's main target was to arrive on time for the child.
- If a journey was running, late the driver would ring ahead to the destination with an estimated time of arrival. Any potential delay was communicated with patients, carers, school and hospital staff by telephone.

Learning from complaints and concerns

- The Complaints and Compliments Policy and Procedures (November 2016) outlined the process for dealing with complaints initially by local resolution and informally. Complaints would be acknowledged within one working day.Where this did not lead to a resolution, complainants were given a letter of acknowledgement within one day of receipt; followed up by a further letter within 20 working days, once an investigation had been made into the complaint.
- The service had a system for handling, managing and monitoring complaints and concerns. For example, each vehicle had patient feedback posters. They had details of how to contact the office and how to complain.
- The managing director informed us that there had been no complaints in 2016.
- There was no evidence that complaints were used to improve the service, and learning opportunities were not identified and shared with all staff.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The day-to-day management team for the service comprised of the managing director, director of operations and an administrator who all worked full time. The managers looked after the welfare of the staff and were responsible for the planning of the day-to-day work.They also formed part of the operational staff.
- The evidence gathered during our inspection demonstrated that the management team did not understand the challenges to good quality care and could not identify the actions needed address them.
- We found that the Registered Manager of the service had not raised or reported safeguarding referrals and not undertaken investigations or acted on concerns regarding staff or vehicles in a timely way.
- The two managers we spoke with did not have a clear understanding of their role or responsibilities.For example, we asked both members of staff to tell us who the safeguarding lead was neither manager could provide a response.
- Staff spoke positively about the management team and felt able to approach them with any difficulties and issues. They described seeing the managers every time they came to the office and told us they could discuss anything with them.
- At the time of the inspection, training for staff in duty of candour had not been implemented. We were not provided with a timescale of when this training would be provided.

Vision and strategy for this this core service

- The service had a statement of purpose and a vision to "deliver a high quality, cost effective service that is patient centred with dignity and respect, by a skilled compassionate workforce who are open and honest and work as a team".
- The service had seven strategic aims based on the word "mission", motivation, inspire satisfaction, staff, and infrastructure, open and never stop listening. We observed that this was on the staff noticeboard.
- Staff understood the instability of the work through ad hoc contracts and the desire to develop a more long-term plan. However, staff we spoke with told us they did not know what the long-term vision and strategy for the service was.

Governance, risk management and quality measurement

- We found significant concerns regarding the governance and risk management processes of the service.

Patient transport services (PTS)

- There were no systems or processes in place for the registered manager to monitor the service against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Neither the managing director nor director of operations had good oversight of the quality of the business. The managing director and the director of operations were able to provide examples about equipment availability, the ambulance GPS tracking system and getting ambulances to their destinations on time. However, there was no understanding or appreciation of wider quality assurance issues such as patients being properly safeguarded against harm.
- The service did not hold a risk register or have other similar systems to identify and monitor or grade risks to the organisation, both clinical and non-clinical. This meant there was no formal process for identifying and prioritising risks and recording measures implemented to reduce the identified risks within the organisation.
- There were no systems in place to identify and act on risks to people who used the service. There were potential risks to staff and patient safety, through lack of observation and monitoring of performance.
- The service had an Incident Reporting, Risk Assessment and Risk Register Policy and Procedure (January 2017). However, there was not a robust process for the reporting analysing and learning from incidents to make improvements to safety.
- There was no system in place to disseminate learning from incidents, safeguarding and complaint outcomes.
- There was no audit strategy or plan in place for the service. This meant there was limited opportunity for the service to measure its quality against set internal or external standards. The service did not carry out audits to measure the quality and effectiveness of the service delivered, such as cleanliness and infection control.
- We observed no evidence of governance meetings taking place. The senior managers did not meet regularly or formally record any meetings.
- Recruitment procedures were not in place to ensure that staff met the requirements of fit and proper persons employed. There was no oversight of recruitment requirements regarding staff receiving appropriate support, training, professional development, supervision and appraisal.
- There was a lack of assessment of the environment and of fire safety matters, which contributed to the lack of monitoring the quality of the service, and safety risks that may be present.

Public and staff engagement

- The service had a website with information for the public about what the organisation could provide.
- There were no formal systems in place to engage with the public however, the service would enclose a patient satisfaction form when sending out their invoice. We were informed they had only received one response in a year.
- Staff reported to us that there had not had any team meetings. There was no evidence of regular forums to engage all staff, update them on any developments and share any learning.

Innovation, improvement and sustainability

- At the time of this inspection, we could not identify any evidence to demonstrate the service was committed to quality improvement and innovation. The management team told us that work volume had decreased over the past couple of years.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure robust governance and risk management systems are in place and understood by all staff. The provider must implement systems and processes to assess, monitor and improve the quality and safety of the services.
- Ensure incidents that affect the health, safety and welfare of people using services are investigated and actions taken to prevent recurrences.
- The service must improve its processes for safeguarding adults and children; to ensure that staff are trained appropriately and there are appropriate reporting arrangements in place, and that this is monitored.
- That appropriate infection control and prevention methods are used to prevent the spread of infection. Whilst vehicles were seen to be clean, there were a number of concerns around the deep cleaning of vehicles.
- Ensure that all equipment is fit for use and required checks and maintenance is carried out.
- Ensure that medicines are managed, stored and administered safely to ensure there are no risks to patients or staff.
- Ensure recruitment processes are in place so all staff employed have the experience and competence required for their role, together with robust pre-employment checks having been carried out.
- Staff are supported in their roles by effective supervision and appraisal systems and ongoing training.
- A risk register is in place with describes risks to the services and what plans are in place to reduce the risks.
- Ensure all staff understand and implement the statutory obligations of the duty of candour.

Action the hospital SHOULD take to improve

- Review the medicine management policy and the controlled drugs policy to ensure they are relevant to the service provided.
- Consider implementing assurance systems taking into account relevant and current evidence-based guidance, standards, best practice and legislation to provide effective care.
- Ensure key performance indicators are identified and monitored to provide assurance the service was meeting the target it had set.
- The service should review the way in which it engages with its staff, the public and its patients about the delivery and effectiveness of the service, which it provides.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers How the regulation was not being met: • The registered manager did not have the necessary qualifications, competence, skills, and experience to manage the carrying on the regulated activity. Requirement 7(b)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider failed to ensure that safe care and treatment was provided at all times because: • Incidents that affected the health, safety and welfare of people using services were not always thoroughly investigated and actions were not taken to prevent recurrences • Not all health and safety risks in the service had been assessed and mitigated to reduce risk to staff and patients. • Not all vehicles and equipment had been maintained to ensure they were fit for use • There were no infection prevention control audits conducted to ensure high standards of cleanliness were being maintained. • There were no systems or processes to ensure the proper and safe management of medicines.

This section is primarily information for the provider

Requirement notices

Regulation 12 (1)(2)(a)(b)(c)(e)(g)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: • Systems and processes were not established and operated effectively to prevent abuse of service users or to recognise and report concerns. • There was no oversight or scrutiny of the safeguarding process. • Staff had not received appropriate safeguarding training that was relevant to their role. • There was insufficient attention to safeguarding children and adults. Managers lacked an understanding about safeguarding and their responsibilities. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: • Equipment was not properly being maintained. Regulation 15 (1)(e)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

- The quality of incidents reporting and investigation was not adequate.
- There were no infection, prevention and control or hand hygiene audits.
- There was no risk register to ensure risks were identified and managed to ensure appropriate actions were taken to mitigate risk.
- The provider did not have systems or processes in place such as regular audits of the service provided or assess, monitor and improve the quality and safety of the service.
- The provider did not have systems or processes in place to enable them to identify and assess risks to the health, safety, or welfare of people who use the service.
- There were insufficient quality and monitoring processes in place to review systems and procedures and to take learning to make improvements.

Regulation 17 (1)(2) (a)(b)(f)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: • Staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. • There was no clear appraisal and clinical supervision system in place. Regulation 18(1)(2)(a)(c)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: • The service did not have recruitment procedures in place to ensure that all staff appointed were suitable and experienced. • There was no evidence present to demonstrate that staff working for the service were qualified, experienced or competent. Regulation 19 (1)(b) (2)(3)
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour How the regulation was not being met: • The service did not have training or processes in place to ensure that all staff were implementing the Duty of Candour.