Wealden Ambulance Services

Quality Report

Unit 10
Vantage Point
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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

Overall summary

Wealden Ambulance Services is operated by Ms Judith Appleton. The service provides non-emergency patient transport services that help people access healthcare in England.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 14 December 2019, along with unannounced visits to the service on 12 December 2019, 23 December 2019 and 9 January 2020.

Summary of findings

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

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

The main service provided by this service was patient transport services.

We have not previously rated this service. We rated it as **Requires improvement** overall.

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

- We found medicines were not always securely stored. The service's controlled drugs licence had expired in October 2019, although the service had applied for renewal in January 2020.
- Not all staff had a valid 'disclosure and barring service' (DBS) check prior to working with patients.
- Although the provider had a verbal contract, they did not have a formal contract or service level agreement with an external provider of level 4 safeguarding advice.
- Records of vehicle cleaning were not always recorded by patient transport services crews.
- Although there was a procedure which staff could explain, there was no formal policy or procedure for care of deteriorating patients.
- Staff told us they were not always provided with basic information about patients.
- Although all vehicles were audited annually, including patient transport services vehicles, prior to the events season, these were not always effective, as we found out of date dressings and equipment on vehicles.
- The service did not have a formalised system for monitoring patient outcomes.
- Staff had not received mental health awareness training although the service were transporting increasing numbers of patients with mental health needs.
- Staff did not have access to regular supervision or team meetings.
- We identified risks that were not identified on the risk register. The risk register recorded one risk relating to infection prevention and control; but actions the service had taken to mitigate the risk were not recorded on the risk register.
- Due to issues with the directorship of the service, managers did not have access to computer systems and passwords at the time of the inspection, although managers could access patient and booking information.

However, we found the following areas of good practice:

- The service had high compliance rates for staff mandatory training and staff had met most of their targets.
- The service had clear processes and systems to help keep vehicles and equipment ready for use. This included yearly MOTs, regular servicing and maintenance.
- All staff had undertaken in-house induction and mandatory training in key areas to provide them with the knowledge and skills they needed to do their jobs.
- The service had up to date policies to support staff.
- Staff treated patients with compassion and empathy.
- The service acted to meet patients' individual needs.

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, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notice(s) that affected patient transport services. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	**Requires improvement** 	The main services provided were patient transport services. The main business of the service was the provision of patient transport services commissioned by two NHS hospital trusts. There had been issues with the leadership of the service. Managers acknowledged that this had an impact on the managerial oversight of services. We found medicines were not stored securely at all times. All staff did not have a valid 'disclosure and barring service' check prior to commencing work for the service. Although managers could describe how they monitored the service, there was limited formal governance oversight of the service. There were limited systems for monitoring patient outcomes. The service did not have regular systems for collating performance information. The service did not identify all potential risks to patients and manage them.

Summary of findings

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Summary of this inspection

Background to Wealden Ambulance Services

Wealden Ambulance Services is operated by Wealden Ambulance Services Limited. The service is an independent ambulance service which opened in 2017. The service provides patient transport services and event services. This inspection looked at the provision of patient transport services due to patient transport services being subject to regulation by the CQC.

To help people access healthcare in their respective areas the service mainly provides services for two local NHS trusts. The provider offers transport services for people attending outpatient appointments as well as admissions or discharges from hospitals and inter-hospital transfers. The service transports adults and children of any age, providing they do not need an incubator to travel.

Wealden Ambulance Services has four patient transport service vehicles and one emergency and urgent care vehicle. The vehicles operate from a depot at Vantage Point, North Trade Road, Battle, TN33 9LJ. The provider employs nine patient transport services staff.

The service is registered as an individual.

We previously inspected this service in October 2017, when the service operated from a different address, which was 19 Green Way, Eastbourne, BN21 9LG.

Our inspection team

The team that inspected the service comprised a CQC inspection manager; four CQC inspectors, and a specialist advisor with experience in patient transport services.

The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection (South East).

Information about Wealden Ambulance Services

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

During the inspection we visited 10 Vantage Point, Battle, East Sussex, TN33 9LJ. We spoke with eight staff including; patient transport services crew and management. We spoke with one patient and one relative. During our inspection, we reviewed 20 sets of patients booking records.

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 has been inspected once, and the most recent inspection took place in October 2017, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity from November 2018 to November 2019

There were 2,800 patient transport journeys undertaken.

One registered paramedic and nine patient transport crew worked at the service, which also had a bank of temporary staff that it could use. The accountable officer for controlled drugs (CDs) was the patient transport services manager.

Track record on safety

- No Never events, clinical incidents or serious injuries
- No complaints

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement

Requires improvement

Patient transport services

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Inadequate

Information about the service

The only service provided by this ambulance service are patient transport services.

The service is registered with the CQC to provide the regulated activity of transport services, triage and medical advice provided remotely.

The service had six vehicles at the time of this inspection, this was a mix of cars and ambulances that were either adapted for patient transport or designed for this purpose.

In the reporting period from November 2018 to November 2019 there were 2,800 patient transport journeys undertaken.

There were nine patient transport crew employed by the service. There was also a bank of temporary staff that could be used.

The service is organised locally from an office location in Battle, East Sussex.

Are patient transport services safe?

Requires improvement

We have not previously rated safe. We rated it as **requires improvement.**

Mandatory training

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

Mandatory training was completed on employment and then annually. The mandatory training programme was delivered by the service's former operational manager.

Mandatory training consisted of a one-day training course which included: safeguarding, health and safety, fire safety, equality and diversity, information governance, infection prevention and control, equality and diversity, manual handling, and Mental Capacity Act 2006 and the Deprivation of Liberty Safeguards and dementia awareness.

The service did not have a centralised mandatory training record. However, we saw certificates of completion of mandatory training in two of three staff files we viewed for mandatory training. Following our visit, the service sent us confirmation that 100% of staff had completed mandatory training and most staff mandatory training was due to be refreshed in June 2020.

Records of temporary staff mandatory were not kept. The service told us they sometimes used some temporary staff that worked for an NHS ambulance service. The service said they accepted evidence of mandatory training completed by these staff whilst working for the NHS ambulance service. The service said they did not find it necessary for these staff to repeat the service's mandatory training, as temporary staff were experienced technicians and registered paramedics. The service told us they asked to see evidence of temporary staff mandatory training completion upon employment. For example, when we asked to see a temporary staff member's mandatory training the service said they would have to ask the temporary staff member to provide this.

Safeguarding

Requires improvement

Patient transport services

Although most staff understood how to protect patients from abuse and staff had training on how to recognise and report abuse. We had concerns that all staff did receive timely disclosure and barring service (DBS) checks.

We reviewed seven sets of staff pre-employment check records. These contained documents which were provided as part of the recruitment process such as the application form, drivers licence and disclosure and barring service (DBS) check. However, we found not all staff had received timely DBS checks prior to commencing work. For example, we spoke with two staff members who told us they had worked for the service for six months. We saw a record of these staff completing mandatory training on 14 June 2019. We viewed the service's DBS spreadsheet this recorded that a company director had submitted one of the staff member's DBS applications on 2 October 2019. The service told us the other staff member's DBS was shown as processed in 2019, but not completed. The service told us they had applied for an enhanced DBS check on 21 January 2020 for this staff member. However, the service could not be assured that all staff had a timely DBS check prior to commencing work. The service told us the electronic account for DBS checks was registered to a director that was no longer with the service and other managers had been unable to access this until January 2020. The service told us the patient transport services manager had taken over the management of DBS checks in January 2020.

The service had identified leaders to support effective safeguarding. The patient transport services manager was a registered paramedic and trained to level 3 safeguarding for adults and children. The registered individual was trained to level 3 in adults and children's safeguarding. All operational crew were trained to level two in both adult and children's safeguarding. All staff had completed this training in the previous 12 months.

Safeguarding training was provided as part of the service's mandatory training programme.

The service did not have a contract or service level agreement for the provision of level 4 safeguarding advice. Hence, the service could not be assured about when level 4 safeguarding advice would be available. Staff and managers told us the service had an external provider for level 4 safeguarding advice. However, there was no contract or service level agreement for the provision of these services. Managers told us the arrangements were ad hoc, but, that the provider of level 4 advice always responded to communications in a timely way.

The service had policies for safeguarding children and adults. This covered areas such as descriptions of the type of abuse and the role of the safeguarding lead. During our visit on 12 December 2019 we noted that the policies did not have version controls. However, during our visit on the 14 January 2020 we found this had been addressed and version controls were in place.

The service informed us that they had not had any safeguarding alerts in the previous 12 months. Should there be any safeguarding concerns staff were required to raise them by completing a form. Safeguarding forms were available to staff in the office. Staff we spoke with told us if they had a safeguarding concern they would refer this to the management team without delay. The management team were responsible for reviewing safeguarding information and contacting the hospital or the local authority social services safeguarding team should they have a safeguarding concern.

Cleanliness, infection control and hygiene

Although staff kept themselves, and vehicle equipment visibly clean, infection risks were not always controlled. Staff did always not use satisfactory control measures to prevent the spread of infection.

Staff did not always record when vehicles were cleaned. Ambulance crews were responsible for cleaning the vehicles prior to and after their shifts and between patients when the vehicles were in use. Deep cleans were scheduled to be undertaken by staff on a weekly basis, this was recorded on a log sheet in the office. However, we found a few gaps in vehicle cleaning records dating from 24 November 2019 to 3 December 2019. Managers assured us that cleaning had taken place. Vehicles we saw were visibly clean.

The service was not following their own policy regarding records of vehicle cleaning. The service's memorandum WAS/UPDATE 09/10 stated records of vehicle cleaning should be held on both the vehicle and in the office. We did not see any records of vehicle cleaning on any vehicles. However, following our inspection the service submitted an

infection prevention and control monthly update document dated January 2020. This demonstrated that the service had introduced a system of audit to monitor vehicle cleaning and records of vehicle cleaning in January 2020. However, at the time of inspection the audit was not embedded in practice.

Each vehicle had its own colour coded mop to ensure that mops were not used on more than one vehicle. At the time of our visit on the 12 December 2019 we saw a green mop and yellow broom that had been used to clean an ambulance emptied and rinsed. However, the mop and head were left on a drainer on a draining board where coffee and tea cups were also washed and drained. This posed a risk of cross infection from the mops to any items on the drainer.

If, during a shift, a vehicle became contaminated to the point that the standard clean between patients would not be enough, the vehicle would be returned to the base to be cleaned and a replacement vehicle could be collected. All the patient transport vehicles we inspected and the equipment such as stretchers and mattress covers were visibly clean. There was clean linen, hand cleansing gel, and decontamination wipes available.

Staff told us they had not been informed that a patient had active flu when they were allocated a patient to pick-up. Staff had access to personal protective equipment (PPE) on vehicles, such as gloves and aprons. However, on the 23 December 2019 we saw a patient transport services crew that had received patient information over the telephone. When staff arrived to collect the patient, the crew were informed that the patient had active flu. Although staff had access to gloves, staff did not have face masks available on the vehicle. This meant there was a risk of staff contracting an airborne flu virus.

Due to staff being mobile and out of the office it was difficult for the service to monitor hand cleaning. As a result, the service did not undertake formal hand hygiene audits. The service told us staff were reminded of their responsibilities regarding hand hygiene in their induction and annual mandatory training. We saw two patient transport services staff assisting a patient manually and not wearing gloves. However, the provider's infection control policy was that staff were not required to wear gloves if there was no identified infection control risk. Staff were required to clean hands following any patient contact using gels and hand washing.

We saw mops were stored in the staff area. Staff told us there was no infection prevention and control cupboard in the office. Following our inspection, the service told us there was a designated Control of Substances Hazard to Health (COSHH) cupboard in the staff area that was locked. The cupboard contained all COSHH substances together with the information sheets relating to them. We did not view the COSHH cupboard during our inspection. However, we did not see any hazardous chemicals in the staff or office area. We also saw COSHH record sheets in the office.

Operational crew we saw during the inspection were dressed in clean and appropriate uniform for their roles. All staff had access to spare uniform which was kept at the base, should their uniform become contaminated during a shift. We saw spare uniforms were stored in a clean and dry environment.

Patient transport services (PTS)

Environment and equipment

Although the service had suitable equipment and tested them in accordance with manufacturers specifications, vehicles were not always secure, and some items of equipment had exceeded expiry dates. The service had suitable premises and looked after them well.

The service had offices located on an industrial park in Battle. The offices consisted of a small office and a staff/ meeting room. The level of security to get in the building was effective. There was closed circuit television which monitored the services car park area, entrance and offices.

During the inspection visits to the service there was variation in the number of vehicles parked in the car park. For example, on the 23 December 2019 there was three patient transport ambulances and one patient transport car parked in the car park. On 9 January 2019, we found a patient transport service vehicle with the engine running, keys in the ignition, and back doors unlocked in the car park. The vehicle did not have any staff on-board. We raised this with staff we met in the entrance hallway to the office. They told us they were aware the vehicle's engine was running and said they were on their way to a job. However, there was a risk that an unauthorised person could have taken the vehicle whilst staff were in the office.

Most equipment we looked at such as vehicle stretchers and chairs, had stickers attached to indicate that they had

been tested and serviced in line with manufacturers' specifications. For example, we checked defibrillators on vehicles and found these had been serviced. During our visit on 12 December 2019 we also viewed records confirming weekly defibrillator checks had taken place between 20 May 2019 and 8 December 2019. During a visit on 14 January 2020 we found dressings and equipment that had exceeded its expiry date. This included a tub of petroleum jelly with an expiry date of 2018 and a range of dressings and equipment that did not have dates of expiry recorded. These included: three conforming bandages, five triangular bandages, face wipes, and two emergency heat blankets.

We discussed out of date equipment and dressings with the registered individual. They said vehicles were audited annually prior to the events season and the annual audit was not due to be completed at the time of inspection. However, as some items were more than 12 months out of date, this indicated that vehicle audits were not fully effective in identifying all dressings and equipment that had expired or were due to expire during the events season. Out of date equipment and dressings were stored with in date equipment and dressings, this meant staff could have inadvertently used out of date equipment and dressings to treat patients.

The offices were equipped with closed circuit television which monitored a small corridor at the front entrance, the office, the staff/meeting room and the allocated parking for Wealden Ambulance Services vehicles, parked in the industrial estate car park. This was monitored by Wealden Ambulance Services staff working in the office or could be monitored remotely by managers on mobile devices, such as smart phones.

The office was clean, tidy and everything stored there was well ordered. There were

files containing records of memorandums, vehicle cleaning records, and a staff signing on and off shift form.

The service had informal agreements with local garages to provide maintenance for the service's vehicles. We were told that any issues would be dealt with on the same day where possible. Any faulty medical equipment would be reported to the supplier or manufacturer. Any defects were fixed as soon as possible.

The service kept a file on each vehicle at the office. We saw that these contained records of each vehicles MOT certificate. We saw servicing records for vehicles, which recorded when vehicles had been serviced and when their next service was due. We saw evidence that all vehicles were taxed and insured. The service had records of vehicle tail lift checks which were up to date.

The outside of the vehicles were in a good state of repair and all access doors were in full working order. Staff could access vehicle defect reporting forms and stock replacement request forms from the office.

Assessing and responding to patient risk

The service completed risk assessments for each patient, but staff were not always made aware of all risks. Staff identified and acted quickly upon when patients were at risk of deterioration although there was no formal policy for this.

The service did a risk assessment on the telephone for each patient. Risks were recorded on a booking form at the time of booking, and patient transport services crew completed the form when they attended the patient. We viewed 20 patient booking forms on the 12 December 2019 and found these had the necessary patient detail and were legible.

The service had measures to alert patient transport vehicle crews to patient risks. Staff told us they asked at the point of booking about patients mobility and medical history. Staff also told us that if patient needed a relative or carer to travel with them due to a medical condition this was recorded on the booking form.

We found risks were recorded on the patient booking forms. We had mixed responses from patient transport services crews regarding how information about patients' risks was passed to the crews responsible for collecting the patient. For example, some staff told us they were not always given basic patient information. On the 23 December 2019 we saw a patient transport services crew that had received patient information over the telephone, which included the pick-up point and destination; but the crew had not been provided with the name of the patient.

If a patient transport services crew required any clinical advice regarding a deteriorating patient, they were able to contact the patient transport services manager, who was a registered paramedic. The patient transport services

manager was on annual leave on 12 December 2019. Staff had a contact telephone number for the patient transport services manager. We saw staff contacting the manager for advice during our visit.

The service informed us they did not have a policy for management of a deteriorating patient. The service informed us that they would only convey patients that were fit to travel or patients at end of life with the relevant 'do not attempt cardiopulmonary resuscitation' (DNACPR) form or RESPECT paperwork.

One hundred per cent of the service's staff had completed first aid training. This training covered defibrillator training.

The service did not have a documented policy for the management of a deteriorating patient. The service's procedures were not formalised and there was a risk of staff not being aware of the procedures. Managers informed us all staff were aware that if a patient became unwell whilst being conveyed, staff should follow the DNACPR flowchart which was kept on the vehicle. If a patient appeared to bedeteriorating during a journey staff would provide first aid and either call 999 for clinical assistance, or if the vehicle was close to the hospital staff would immediately convey the patient to the nearest Accident and Emergency (A&E) department.

Patients with mental health conditions were regularly transported by the service. Some of these patients' conditions meant there was a risk that a patient could exhibit challenging behaviour or become violent. Ordinarily the patients travelled with an approved mental health professional (AMHP). If a patient had a mental health condition and was not travelling with an AMHP, the service assessed the patient's risk based on the type of condition they had. The risk assessment would be carried out by the patient transport services manager.

Senior management meeting minutes dated 1 November 2019 noted that the service was being asked to do more routine journeys with patients that required monitoring. However, the minutes did not identify how the outcomes of patients care, both physical and mental, was monitored on journeys to demonstrate that the intended outcomes for patients were being met. The service informed us that they would never convey a patient, using a patient transport services crew, that required monitoring unless the patient had an escort and their own monitoring equipment; alternatively a registered paramedic would convey the patient, following a full handover from the transferring nurse or hospital manager. The service did not routinely convey patients that required monitoring or patients with a high risk of deteriorating.

Staffing

The service had enough staff. Staff had the right skills and training to provide the right care and treatment.

At the time of the inspection the service was fully staffed with nine patient transport services staff. The service informed us that apart from the management team, this included the team leader and technical officer, all patient transport service crew members had worked for the service for less than 12 months.

The service operated an average of two vehicles with two-person crews per day. The crews would be allocated work dependent the needs of the service. During our inspection on the 14 January 2020 we were told the service rarely used temporary staff. Temporary staff were registered paramedics used for events.

Staff signed a sheet in the office at the beginning of a shift and end of a shift. We viewed signing in and out information during our visit on 12 December 2019. We found records dated from 27 November 2019 to 12 December 2019 indicated that two staff had been allocated to all journeys in the period and these records were up to date. We also saw a reminder on the office wall to prompt staff to complete the sign in and sign out record.

In the event of patient transport journeys booked at the weekend, staff were able to carry these out; or, if substantive staff were not available, the journey would be carried out by the registered individual or bank staff. The service had cover arrangements for sickness and staff leave as bank staff could be called in to cover shifts. However, staff told us the service had not used bank staff for patient transport services in the previous 12 months. Substantive staff or the registered individual had covered unfilled shifts in this period.

Records

Staff kept records of patients' care and treatment. Records we viewed were clear and up-to-date. However, records were not available to all staff providing care at all times.

Patient transport services

A record of each patient journey was made and retained. The booking form acted as a patient assessment form. We reviewed 20 booking forms and found these contained details of the booking and had a free text space for the crew to provide any details about the journey. Paper-based booking records were stored securely at the service's office, in a lockable cupboard. The checking process for booking forms was not formalised or recorded. The service informed us a manager reviewed booking forms on a weekly basis to ensure best practice was being followed.

Managers told us if patients were being transferred from hospital, and there were specific requirements for them, these were added to the notes that were given to the crew prior to the journey. A member of staff we spoke with told us that patient information was put in a safe in the office and all staff could access this. However, other staff we spoke with told us they did not have access to patient information in printed format for all journeys. This meant there was a risk of all staff not being aware of the procedure for accessing patient information.

If a patient was a social services transfer, the service would be sent a copy of their care plan which would travel with the patient. This would mean that staff were aware of any special notes regarding the patient.

The service had a process, at the time of booking, to identify and record patients that had a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) order. Patient transport services staff felt confident in their understanding of this process. Crews were alerted to patients with a DNACPR when work was allocated to them. The crews would then ensure patients had a valid DNACPR order for their journey.

Medicines

The service did not always follow best practice when storing medicines.

During our visit on 14 January 2020 we saw that the service had a controlled drugs licence displayed in the office, this had an expiry date of December 2019. The patient transport services manager was the accountable officer. We asked the service if they had renewed their controlled drugs licence and requested a copy of their new licence document. We received an email on 20 January 2020 saying that a former director of the service had not applied for a renewal of the licence. The service informed us by email on 25 January 2020, that their controlled drugs licence had expired in October 2019. The service said the Home Office had advised the service to complete an online renewal.

During our visit on 12 December 2019 we found a red bag on a vehicle which contained a range of medicines, which included two controlled drugs. Although the vehicle was locked, the medicines were not secured in the vehicle.The vehicle was parked in a car park that was shared with other companies that used the offices. This meant the service could not be assured that medicines were always secure. However, during our visit on 14 January 2020 we found the red bag and its contents had been removed and there were no medicines stored on vehicles at this time. Following our visit the service emailed us on 20 January 2020 and said, "The drug bag would ordinarily be placed back in the store room although it is very secure in the vehicle with keys locked in the safe and the site secured, this bag also did not contain any controlled drugs. But (the service) will make sure that the staff that use this vehicle, which are the event staff and not patient transport services staff, are aware that it should be returned to the store-room."

We reviewed the office medicines storage arrangements on 14 January 2020 and found controlled drugs were stored securely. Staff told us registered paramedics did events or jobs where a registered paramedic had been requested and medicines would not be required on a day to day basis. Managers told us controlled drugs were only used for the event work that the service carried out which was not part of the regulated activity. The service had a contract in place to dispose of any out of date drugs. We also saw that drug stocks in the office were checked for expiry dates and balances counted.

We reviewed booking forms and saw that patient's medicines information was included on the form at booking. However, we did not have the opportunity to see how patients' medicines were managed by patient transport services staff during our visit.

The service stored medical gases safely. The service did not hold any medical gasses apart from oxygen. Cylinders on vehicles we viewed had fill gauges indicating that they were full or nearly full. Cylinders and regulators appeared to be clean (dust and oil free) and immediately usable. Spare and empty oxygen cylinders were stored appropriately.

Requires improvement

Patient transport services

The service informed us that patient transport services staff only conveyed patients with cardiopulmonary disease with their own oxygen if the referrer confirmed the patient was well enough to travel and the service were informed of their prescribed litres of oxygen. Patient transport services crew ensured the patients oxygen was secured for the journey.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise incidents and report them.

The service had an incident policy. We reviewed the policy on 12 December 2019. The policy identified that the managing director was responsible for the review and monitoring of incidents on a tri-annual basis and compiling a report.Staff were required to record incidents in accordance with the services incident reporting and investigation manual. We reviewed the manual and found this did not provide clear directions as to how staff should report incidents.

Incidents were reported using a standard reporting form. Stocks of paper-based incident reporting forms were available to staff in the office. Reported incidents were investigated by managers to determine if there was any learning to be taken from them. The service reported in November 2019, in response to a provider information request prior to our inspection, that the service had not had any incidents in the previous 12 months.

During our inspection on 12 December 2019 we saw an incident report dated February 2019. We found the incident report had been reviewed and actions the service had taken in response to the incident were recorded. We were told learning from the incident had been shared with staff by telephone. However, staff told us about a further incident, involving a patient sectioned under Section 2 of the Mental Health Act 1983. Staff had not identified these events as an incident and had not completed an incident report in response. The service could not be assured that all staff could identify an incident and that all staff understood the incident reporting procedure.

During our visit on 12 December 2019 we saw two incidents involving minor collisions with vehicles in 2019. These had been recorded on accident forms and “repaired” had been recorded on the accident sheet. The service assured us there were no patients on the vehicles at the time of these collisions.

The service informed us there had been no need to apply the duty of candour to any incidents, but, there was a policy available to all staff. Duty of candour was included in mandatory training. We also saw the duty of candour policy available to staff on a vehicle.

The service had never experienced a never event. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

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

Requires improvement

We have not previously rated effective. We rated it as **requires improvement.**

Evidence-based care and treatment

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

The service had policies and guidance documents to support staff in providing evidence-based care. We reviewed a range of policies including; Data protection, safeguarding, health and safety, infection prevention and control and conveyance of patients. We found all policies were in date. However, during our visit on 12 December 2019 we found some policies did not have version controls. We found this had been amended during our visit on 14 January 2020 and version controls were in place.

Policies and procedures used by the service reflected national guidance and best practice. For example, the infection prevention and control policy reflected Department of Health (DOH) and NICE guidelines.

We saw a folder of memorandums in the office. This contained summaries of a range of policies and procedures. Staff signed the memorandums to indicate they had read and understood the updates. The service informed us that staff were provided with email updates when policies and procedures were changed in response to changes in national policy.

The office had a notice board which contained guidance for staff including: vehicle daily checklist, vehicle equipment checklist, defibrillator checklist, fire safety map, guide for how to complete the 'patient booking form' and time sheets. The notice board had a copy of the services 'do not attempt cardio-pulmonary resuscitation' (DNACPR) algorithm, as well as an explanation of the hand brake rule (the hand brake rule related to the time the crew started and finished a patient transport journey).

Nutrition and hydration

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

The service took account of patients' nutrition and hydration status at the time of booking. This included being aware of conditions such as diabetes and patients who may be nil by mouth.

At the time of the inspection the type of work undertaken by the provider was mainly short journeys between departments on large hospital sites. Patients' were not on vehicles for long and were therefore not without food or hydration for extended lengths of time.

Pain relief

The service informed us that patient transport services staff did not manage pain during a patients' journey as they were not clinical staff. All staff were instructed to ask for a patient handover when picking a patient up. If there were any concerns surrounding a patient's condition this would be managed by the hospital, before the patient was conveyed by a patient transport services crew. The patient transport services manager would be available to staff if the crew had any concerns about a patients' condition. Patient transport services crew would liaise with the person in charge of the patients care before the patient was conveyed. Occasionally patient transport services crew conveyed a pre-booked patient that required their own "gas and air" pain relief during transit. The service informed us that 100% of staff had received "gas and air" training as this was integrated into the service's first aid training.

Response times / Patient outcomes

The service had limited systems for monitoring the effectiveness of care. This meant there was a limit on audit and survey findings to learn from or improve services.

The service undertook a limited number of audits. Local audits included vehicle cleanliness and transport logs. However, managers told us because of the size of the team the processes were informal rather than formally documented. We had brought this to the attention of the provider during a visit in October 2017, when we received assurances from the provider that these processes would be formalised. However, during this inspection we did not see formal audit information. The registered individual acknowledged that the service could do more to undertake formal audits, but, said journeys and journey times could be monitored by managers in real time with the use of smart phone applications. We saw the technical officer monitoring a vehicle on their phone during our visit on 12 December 2019.

Patient transport journeys were recorded on a job sheet. The service had a 'handbrake time', this recorded the time on scene and would be measured from the time the crew put the handbrake on, to the time the crew took the handbrake off. All job sheets were retained, filed and stored at the office. The service told us they audited the handbrake time sheets annually. We requested audits on patient journeys and waiting times from the service. We did not receive an audit document. However, in response the service informed us that the waits for same day bookings were between zero and two hours. The service added that on average the service were able to pick up patients within one hour. Pre-booked journeys were picked up on time or within 30 minutes of the scheduled pick-up time.

We were unable to assess patient outcomes. This was due to a lack of measurable outcomes because of the short journey type of work undertaken. However, the service also provided nationwide transfers. For example, we saw a patient being transferred from East Sussex to London on 23 December 2019. Information on patient outcomes for longer journeys was not collated.

Competent staff

The service made sure substantive staff were competent for their roles.

Staff had access to an induction to ensure they were able to undertake their roles and meet peoples individual care needs. The service informed us that 100% of staff had completed an induction. This included staff completing mandatory training, shadowing opportunities, and staff receiving a staff handbook. We viewed three staff training

and saw induction records that confirmed staff had received inductions. However, there was no induction checklist to enable staff and managers in monitoring staff inductions. At the time of inspection all substantive staff, with the exception of managers, were on a 12 month probation period.

We spoke with a new member of staff on 9 January 2020 who told us they were a technician. The new staff member told us the registered individual had told them that they were trying to employ more technicians and experienced staff. We saw senior management meeting minutes dated 1 November 2019 which confirmed that the service were advertising jobs for technician staff due to an increase in the number of patients requiring monitoring.

Records showed staff had undertaken the required level of training. The training courses included, but were not limited to, ambulance driving competence. However, we had concerns about a member of staff's driving awareness. For example, on 12 December 2019 we saw a patient transport services crew member reverse a vehicle onto a main road, whilst a patient was on-board. There was room for the vehicle to have been turned around in the road outside the pick-up point without the risk of reversing onto a busy main road. We also saw the same staff member parking a vehicle, with the front of the vehicle facing the destinations doors and weather porch, rather than reversing the ambulance up to the doors to make transfer of the patient more comfortable for the patient. It was raining at the time of the patients transfer. The staff member told us they were an experienced driver and had completed a driving assessment with the patient transport services manager when they were first employed. However, this did not demonstrate that the driver's approach was patient centred.

At the time of the inspection there was a lack of formal evidence to suggest formal supervision was being undertaken by the service. Staff we spoke with told us supervision was informal, but, the team leader and patient transport services manager would provide this on request. This meant the service could not demonstrate how staff were actively involved in a formal supervision process.

At the time of the inspection managers told us there had not been the opportunity for the service to complete formal annual appraisals. We were told this was due to all patient transport services crew, except for the team leader, having worked for the company for less than 12 months. However, there was no formal interim monitoring during the 12 month period for managers to assure themselves of staff professional development. We saw evidence that the team leader had received an appraisal in the previous 12 months.

During busy times the service used temporary staff from a NHS ambulance service. The service told us they maintained oversight of their skills, competency and learning needs by asking the temporary staff to provide evidence from the NHS ambulance provider. We asked the service to provide an example of these and were told the service did not keep copies of them. However, a new member of staff confirmed that the registered individual had asked them to show evidence of mandatory training prior to being employed.

Patient transport services crew had not received training in mental health awareness. There was a risk to both staff and patients, due to staff lacking awareness of patients' mental health needs and not being trained in de-escalation. For example, staff told us of an incident involving a patient, sectioned under section 2 Mental Health Act 1983, where the patient's behaviour had become challenging and an AMHP was not present. The police were called, and the patient was accompanied by the police in the patient transport services vehicle.

The patient services manager had 17 years' experience as a registered paramedic. The manager was able to maintain their registered paramedic skills through the work they carried out on the events side of the service's business. The patient services manager also worked for a NHS ambulance service and completed a minimum of 598 clinical practice hours with them to meet their registration requirements. The manager also completed continuous professional development (CPD) courses with the NHS provider.

Multidisciplinary working

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

Patient transport services crews supported each other to provide care and communicated effectively with staff from external care providers and local NHS trusts. Managers were involved in assessing patients care needs upon referral from external providers. Staff worked with referrers

to plan patients' journeys, for example, over the telephone at the time of booking and when they picked patients up. We saw staff discussing a patient's needs when working with staff from a NHS trust.

Staff worked with external providers at the booking stage to establish whether the patient had any relevant information that needed to be carried on journeys; such as special notes, 'do not attempt cardiopulmonary resuscitation' (DNACPR) and advanced care plans.

Health promotion

Health promotion information was not readily available on vehicles. However, patients had access to information and leaflets at hospitals.

Staff empowered patients to be independent. This included encouraging patients to use their own mobility aids, manage their blood sugar levels, and use their inhalers as they would in the community. Staff told us they supported patients with this as required.

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 and used agreed personalised measures that limit patients' liberty. However, staff had not received awareness training in responding to patients experiencing mental ill health.

Booking forms demonstrated that the service took account of patient's mental capacity at the booking stage; confirming the patient's consent had been gained and stating how this had been given. We saw two ambulance crews asking patients consent prior to providing care.

Mental Capacity Act training was incorporated into the induction process. Staff we asked understood capacity and their role in identifying and reporting any capacity concerns.

During our previous inspection visit on 17 October 2017 the service informed us that an algorithm for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was in development. However, at the time of this inspection this had not been introduced. The service informed us on 28 January 2020 that following our inspection an assessment tool was being developed and would be introduced in January 2020.

We viewed a memorandum, this was a summary of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, dated 1 November 2016. Between 16 February 2019 and 20 August 2019, 10 staff had signed the memorandum to confirm they had read and understood the contents.

Staff told us there was an increase in the number of patients with mental health needs using the service. However, staff had not received training in mental health awareness. This meant there was a risk of staff not being able to provide effective care to patients with mental health needs.

Are patient transport services caring?

Good

We have not previously rated caring. We rated it as **good.**

Compassionate care

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

During our inspection, we observed two patient transfers and saw on both occasions that staff treated patients with dignity and respect. Staff interacted well with patients in a friendly way and with good humour. We noted that staff were courteous and professional when interacting with both patients and one carer. However, we did see a patient that was not driven to the door of their destination due to the vehicle driver not reversing the vehicle to park, which would have made the patients access more convenient for the patient.

We saw limited feedback from patients, families and carers. However, the feedback we saw was positive. We saw a positive patient feedback form in the office. We also saw positive feedback on the service's website. For example, an undated comment on the service's website said, "Great service, quick, responsive and clear. Would recommend them to anyone."

Requires improvement

Patient transport services

During our visit on the 12 December 2019 we asked the service to provide us with telephone numbers of patients that had consented to be contacted for feedback, but this was not provided.

We saw that patients' privacy was always respected and crew members addressed patients in the way they preferred to be addressed.

Emotional support

Staff provided emotional support to patients to minimize their distress.

We saw staff being sensitive towards patients and treating them with empathy. Staff were considerate and reassuring. We saw staff taking the time to talk to patients to identify their preferences and concerns.

Patients personal, cultural, social and religious needs, and how these may relate to their care needs, was requested at the time of booking. However, some crew told us they did not always receive detailed information on patients needs.

We saw a patient's carer accompanying a patient. Staff were considerate of the carer's needs as well as the patients, providing them with reassurance. We also saw a crew member sharing a joke with the patient and carer to break the ice and alleviate any anxiety they may have been experiencing.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff told us patients and relatives were given clear information at the time of booking over the telephone. Patients and relatives were informed by the office or the patient transport services crew, about times they would be picked up prior to and following their appointments. Staff and managers told us patients could discuss any concerns or raise objections at any time.

Patient transport services crew communicated with patients and their relatives in a way they understood. Patients were given enough time to ask questions and staff took time to explain how they were going to be transported and cared for in a calm, friendly and respectful manner. Patients could attend appointments with a carer or relative and could be accommodated safely.

Staff reminded patients to check they had everything they needed, such as appointment letters and mobile phones, prior to departing on their journey.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

We have not previously rated responsive. 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 had two contracts at the time of inspection. One contract was with an acute hospital NHS trust; and another contrat was with a clinical commissioning group (CCG). The contract with the hospital meant a vehicle was onsite at a hospital from 9am to 5pm, Monday to Friday. The contract required the crew to convey patients as requested by the hospital. The service also had a contract with a CCG. This involved a vehicle being based at another hospital from 12 noon until 12 midnight. The vehicle was on-call for the hospital's site managers to assist with any journeys requested. The work for the CCG was unplanned work.

The service supported NHS trusts and other organisations to deliver timely care to patients and to manage patient flow. The patient transport journeys carried out on behalf of the local NHS acute trust were contained to one site. It was known in advance if repeat journeys were required. All other work for the NHS acute trust was done on an ad hoc basis. Most of the work undertaken as part of the agreement with the acute NHS trust was limited to journeys of five miles or less. There was a similar arrangement with the CCG with staff providing journeys across a hospital site.

Requires improvement

Patient transport services

There were occasional longer distance journeys made to specialist hospitals, which were booked in advance. The service provided a wait and return service for some longer journeys.

The service provided a service for local authorities on an ad hoc basis. This involved transporting patients from their homes to attend hospital appointments. These journeys were ad hoc and by direct request from the local authority.

Managers worked with commissioners of services regarding service provision and established how the needs of the commissioning organisation could be met.

Meeting people's individual needs

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

Staff completed equality and diversity training and dementia awareness training as part of their annual mandatory training. However, staff told us the demography of the patients they served meant that staff understood most patients' cultural, social, and religious needs as these were similar to the staff group.

Patients with specific spiritual, cultural and religious needs were discussed before commencement of their journey. Patient transport service crew told us they respected and made always attempted to meet patients' preferences.

The patient's condition and individual needs were identified at the booking stage. This identified patients with complex needs such as people living with dementia, learning disability and those with a physical disability. The service told us they made reasonable adjustments to accommodate and

transport patients, such as providing wheelchairs.

Patient transport services crew were made aware of patients with complex needs including those living with dementia, learning disability and mobility difficulties via the booking form. However, some staff told us patients' needs were not always identified.

All the vehicles we inspected were wheelchair accessible with ramps. There were carry chairs and stretchers available to help patients who had mobility problems or walking difficulties.

The service did not provide transport for bariatric patients weighing over 300kgs. This was due to the stretchers having weight limits and the service ensuring the vehicles could accommodate patients associated body mass.

Patients that did not speak English did not have access to interpreters. Patients were encouraged to bring a friend or relative who could act as an interpreter for basic communication. However, this did not ensure patients confidentiality was fully protected.

The service ensured that children and young people were always transported by at least two members of crew staff. Children were always escorted by a carer or a parent.

Patients with a 'do not attempt cardiopulmonary resuscitation' (DNACPR) were identified. Crews were responsible for ensuring DNACPR documentation travelled with the patient. We did not see any patients with DNACPR, but saw this was recorded on booking forms we reviewed.

Most patient transport services crew ensured patients wore adequate clothing, vehicle heating was turned on and patients were offered blankets when they felt cold during transfers. We saw a crew asking a patient how they were feeling. We also saw the crew asking the patient if they were comfortable and whether they required any further blankets. However, we saw one patient being transferred in the rain without being offered a hood or poncho to protect them from the elements.

Access and flow

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

Patient transport services journeys could be booked 24 hours a day 365 days of the year. From November 2018 to November 2019 the service informed us that they had completed 2,800 patient transport service journeys.

The service informed us that they were unable to provide data on the number of same day bookings as this information was not collated. The service said the number of same day bookings changed from day to day.

Crews that carried out patient transport journeys at the local acute NHS hospital reported for duty and collected the ambulance at 10am. They then travelled to the acute hospital to collect the day's initial job sheet and started transporting patients across the site. Following our

Patient transport services

inspection, the NHS commissioner of services informed us the service provision from Wealden Ambulance Service was timely and said patients did not wait for extended periods of time for patient transport services.

The crews that transported patients from local authority care homes would plan their days around the times when transport had been booked. They may have also been used if a same day request was received.

Managers could track vehicles by use of a smartphone application which identified where crews were. Contact would be maintained with managers by mobile phone and text messages through the course of the day. We saw staff using mobile phones and texting to contact managers during our visits.

Learning from complaints and concerns

The service had an up to date complaints policy. The service had not received any complaints in the previous 12 months.

Complaints information was not routinely available on all vehicles. However, the service's website provided an email address for patients wishing to raise concerns or complaints. Staff told us vehicles had business cards which patients could be given which contained the managers contact details if a patient raised an issue which staff could not resolve on the spot.

In the previous 12 months the service informed us that they had not received any complaints from patients. At the time of the inspection there had been no complaints that had to be investigated jointly with any organisation that commissioned their services.

The service had an up to date complaints policy this detailed the time frames for responding to formal complaints. For example, informal complaints would be responded to within three days, formal complaints would be investigated within 25 working days.

Are patient transport services well-led?

Inadequate

We have not previously rated well-led. We rated it as **inadequate.**

Leadership

Internal issues at the service had resulted in a reduction in managerial effectiveness. The service could not be assured that managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care.

The registered individual was a company director and the strategic lead for the service. Staff told us the patient transport services manager had replaced the operations manager in 2018. As a result, the patient transport services manager was the service lead on quality improvement and compliance. The service's operations manager had left the service in 2018, but still provided staff training on an ad hoc basis.

We were informed at the time of our visits on 23 December 2019, and on the 9 January 2020, that the patient transport services manager was on extended leave. During our visit on the 14 January 2020, the service informed us that the patient transport services manager had extended their period of leave. At the time of inspection, the registered individual had taken over the quality improvement and compliance role, whilst receiving external support from the patient transport services manager.

Managers acknowledged that there had been a reduction in the effectiveness of leadership and administration of the company. Managers thought these issues were being resolved and managers could more forwards and focus on improving services.

The patient transport services manager and registered individual were responsible for the running of day to day operations. They were supported by a technical officer and team leader, that were responsible for managing the patient transport services crew. The patient transport services manager was a qualified registered paramedic and would provide clinical advice in the event of crews requiring this.

Staff told us leaders were generally visible. The registered individual acknowledged that in recent months they had not been fully available to staff at all times. Most staff told us they felt supported by the patient transport services manager and team leader.

The management structure was not clear to all staff. There was confusion about the role of the technical officer. The service submitted a management structure flowchart as part of a provider information return prior to our inspection. This identified the technical officer role as

equivalent to a team leader. However, during our visit on 23 December 2019 the technical officer was responsible for answering the telephone and allocating work, as the registered individual was on a job in Worcestershire and the patient transport services manager was on leave. We asked patient transport services crew about the seniority of the technical officer, staff said they thought the technical officer was "crew."

Vision and strategy

The service had a vision for what it wanted to achieve. However, plans to turn the vision into action had not been developed with involvement from staff.

At the time of our previous inspection in October 2017 the service did not have a written vision for the service. However, during this inspection we found the service had developed a 'mission, values and vision' document. The service's vision was "To be committed to delivering high quality care to patients while developing ways of working to ensure patients receive the best care in a timely manner." The service's mission was, "To provide a caring, positive, and safe experience for all our patients." The service had a set of values, these were, 'Respect and dignity; Compassion; Working together for patients; Everyone counts."

We saw the vision, values and mission statement document displayed on the noticeboard at the service's office. However, staff we spoke with including managers were unable to explain the service's vision, values and mission, although they were aware that the service had them. in a

Culture

Although managers across the service told us the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Some staff reported not feeling they could talk openly to the provider.

Managers at the service told us there was a culture of team working in the service and most staff worked co-operatively with managers and each other. However, some members of staff told us they did not always feel supported by the provider and did not feel they could talk openly to them.

Staff told us that they felt well supported by the patient transport services manager. They reported seeing the manager regularly. However, at the time of inspection the patient transport services manager was taking a break from working for the service on a full-time basis. We saw the patient transport services manager supporting staff remotely during a visit on 12 December 2019.

Staff were passionate about their roles. Managers told us the intentions of the service were to provide excellent care to patients.

Governance

The service did not have clear governance processes overseen by the directors. The service was not using a systematic approach to continually improve the quality of its services.

The registered individual and patient transport services manager were responsible for maintaining and managing improvements to the service. At the time of the inspection the registered individual was responsible for patient transport services and was receiving at a distance support from the patient transport services manager.

A lack of oversight of the service's governance meant the service could not be assured that there was regular review the service's governance and risk management processes. For example, prior to our inspection the service provided one set of governance meeting minutes dated 1 November 2019. We requested further governance meeting minutes following our visit. The service informed us the management team held regular meetings, but, these meetings were not recorded. In response the service sent us an agenda and minute taking template for management meetings which the service intended to introduce from January 2020.

Management of risks, issues and performance

The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service had a risk register which identified one risk relating to infection prevention and control. The risk register did not have a date when the risk was added to the risk register or date for review. The risk register was incomplete and did not identify the likelihood of the risk, potential consequences, actions to mitigate risks, or identify the person responsible for managing the risk. We

were unable to review the risk register or discuss this with the registered individual during our inspection on the 14 January 2020. The registered individual told us this was due to the risk register being managed by the patient transport services manager and the registered individual being unable to locate it on the system.

The service had not identified all risks to patients and staff or identified actions to mitigate these risks. However, during our visits we identified risks relating to: the management of mental health patients by crews, risk to vehicles parked in the car park, and issues with medicines storage during the inspection.

Resilience was built into service provision as the service had access to spare vehicles at the office in the event of a vehicle breakdown. The business continuity plan had been reviewed in March 2019 by the patient transport services manager. However, the plan was generic and not detailed about what actions would be taken regarding specific events, for example, loss of electrical supply in the office or vehicle accidents. Although managers could articulate what would happen in these events, they were not identified and specified in the plan.

Information management

The service did not formally collect, analyse, manage or use information to support all its activities. However, the services electronic systems had security safeguards.

The service had computer-based business management systems to support the business and its operations. These systems were set-up with individual password protection for each person, this allowed staff access to the parts of the system they needed to fulfil their role. This enabled the service to restrict access to systems people did not need. The provider also had an information security system to protect all private and confidential data.

The service used a secure system to store patient information. However, staff told us sometimes information about patients would be passed on to them by telephone and this information was not always detailed. For example, during a visit to the service staff told us they had been asked to attend a call without being given the name of the patient.

The service did not adequately collate information or use information technology systems to monitor and improve the quality of care. Whilst the provider understood the services performance and could explain this, the service did not have clear and robust performance measures which were reported on monthly or at regular intervals. For example, staffing data including sickness was not formally monitored. Journey time and patient waits information was not regularly collated or readily available. The service had a system of remote monitoring to monitor the movements of their vehicles. However, this information was not collated to enable the service to audit performance or identify areas to improve efficiency. The provider told us the service was a relatively small service and managers knew this data, but it was not formalised or recorded. Managers told us the service were working on ways to improve performance measures.

The service could not be assured that all managers had the skills to access information. The registered individual and technical officer were unable to locate information during our visits to the office on 12 December 2019 and 14 January 2020. Furthermore, prior to the inspection the service provided information in response to a CQC request for information using a system that was not compatible with CQC systems. The service informed us that they did not know how to convert data to make it accessible to a different operating system. However, the patient transport services manager provided converted information following our visit on the 14 January 2020.

Following our inspection the service informed us that staff had access to a company account which had uploads of: policies and procedures, training files and other information.

Public and staff engagement

Although the service collaborated with partner organisations to help improve service delivery for patients. There was limited engagement with patients and staff, the public and local organisations to plan and manage services.

The service did not carry out any formal patient engagement. The service had patient feedback cards. We did not see these offered to patients during the two journeys we saw, but we were provided with an example of a completed card in the service's office. There was also a facility on the service's website for patients or carers to leave feedback.

Requires improvement

Patient transport services

There was no regular formal engagement with commissioners of services, except for taking referrals from commissioners. There were no regular planning meetings with commissioners.

There was no structured process for staff meetings or other engagement. Following our visit, the service informed us that this was something they would like to implement. However, there was no date for the implementation. The service informed us that staff were communicated with via email. There was also a system of notes in the office where staff could leave messages for the registered provider or patient transport services manager. The office had a noticeboard which was also used to convey information to staff.

The service did not seek information from staff to improve patient and staff experiences. The service did not have a staff survey and acknowledged this was an area for improvement.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must take action to address significant concerns identified during the inspection in relation to medicines security and ensure the service has a valid and up to date controlled drugs licence. Regulation 19 (2) (1a)
- The provider must take action to address significant concerns identified during the inspection in relation to disclosure and barring services (DBS) checks for all staff including temporary staff and ensure all staff have a check before commencing employment. Regulation 12 (2) (g)
- The provider must take action to address significant concerns identified during the inspection in relation to the management of the service. There were limited formal systems to monitor and improve quality and safety. Regulation (17) (2) (d) (ii)

Action the provider SHOULD take to improve

- The provider should take action to address staff identification and recording of incidents.
- The provider should ensure there is a contract or service level agreement in place for the provision of level 4 safeguarding advice.
- The provider should ensure cleaning of vehicles is recorded in accordance with the service's policy.
- The provider should ensure there is a formalised policy and procedure for the care of a deteriorating patient.
- The provider should ensure staff receive adequate information in regard to patients' identities and needs at all times.
- The provider should ensure all staff are aware of the service's management structure and managers roles and responsibilities.
- The provider should ensure there are effective governance processes in place.
- The provider should ensure all potential risks to patients are identified on the risk register and the risk register is complete with actions taken to mitigate risks recorded.
- The provider should ensure there is an effective system of vehicle equipment audits.
- The provider should ensure there is an effective system of monitoring patient outcomes.
- The provider should ensure staff have the skills and knowledge to support patients with mental health needs.
- The provider should ensure staff have access to effective supervision and team meetings.
- The provider should ensure there is a formal system for collating performance information.
- The provider should ensure patients that do not speak English have access to independent translation or interpreting information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2) (g) the proper and safe management of medicines We found medicines being stored in a red bag on an ambulance, these were not secure or tagged. The ambulance was locked, but parked in a car park that was shared with other offices in the building. There was direct public pedestrian and vehicular access to the car park as this was not locked.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) 2014 Good governance (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— d) maintain securely such other records as are necessary to be kept in relation to-- (ii) the management of the regulated activity; We found limited formal management systems to monitor and improve quality and safety.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Requirement notices

Regulation 19 HSCA (RA) 2014 Fit and proper persons employed

(2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in--

(a) paragraph (1)

(1) Persons employed for the purposes of carrying on a regulated activity must—(a) be of good character.

The service did not ensure all staff including substantive and temporary staff had a valid 'disclosure and barring service' (DBS) check in place prior to working with patients.