Abacus Ambulance Service

Abacus 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

Abacus Ambulance Service is operated by Abacus Ambulance Service. The service provides both patient transport services (PTS) and emergency transport for high dependency transfers.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of our inspection on 7 March 2017, along with unannounced visits to the base location on 20 March 2017 and 3 April 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.

The main service provided was patient transport services, with a small proportion of work carrying out urgent care and emergency transport services.

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 service had no formal incident reporting policy in place. There was no formal sharing of lessons learnt as a result of incidents. Staff had not received training in incident reporting.
- Staff were unaware of the duty of candour and had not received training in this at the time of our inspection.
- There was a lack of deep cleaning processes in place to prevent the spread of infection. The infection prevention and control policy, put in place after our announced inspection on 7 March 2017, lacked key information and guidance.
- The safeguarding adults and children lead had not received the appropriate level of safeguarding training as recommended in best practice guidelines.
- We found faulty equipment in vehicles, which posed a risk to staff and patients. Equipment was not securely stored during transportation.
- Patient report forms lacked pertinent patient information. A patient report form records all patient information relevant to medical conditions, for example, personal information and observations. We were not assured that patient report forms accurately reflected a patient's condition or any care that may have been given.
- We were unable to gain assurances that staff had received the necessary mandatory training to carry out their role safely and effectively.
- There was no inclusion or exclusion criteria in place. We were not assured that the booking process adequately assessed a patient and their clinical needs due to the limited amount of information taken at the point of booking.
- There was a lack of competency oversight for ambulance paramedic and technician staff when used for high dependency transfers.
- The service had weak governance systems and poor oversight of risk. Policies lacked reference to national guidelines. Monthly governance meetings lacked clear agendas and no discussion around risk took place.

Summary of findings

- There was a lack of regular and documented staff engagement. Staff did not have regular planned appraisals and one to one meetings were informal and not documented.

However, we found the following areas of good practice:

- Staff were able to clearly articulate what constituted an incident despite a lack of formal training.
- Staff were able to explain what constituted a safeguarding concern.
- Vehicles contained personal protective equipment for staff.
- All vehicles had received regular MOT and servicing. The service was meeting the nutritional and hydration needs of patients.
- Patient feedback was consistently positive.
- The service was planned and delivered to meet the needs of local people.
- Staff described management as approachable and supportive. They reported feeling valued in their role.

We highlighted our findings and concerns to the registered manager over the course of the announced inspection and two subsequent unannounced inspections.

We found the provider to be in breach of several regulations of the Health and Social Care Act 2008 Regulated Activities regulations (2014), inclusive of regulation 12 (safe care and treatment), regulation 13 (safeguarding service users from abuse and improper treatment), regulation 15 (premises and equipment) and regulation 17 (good governance).

Following our unannounced inspection on 20 March 2017, the service voluntarily suspended all high dependency transfers that required paramedic and ambulance technician skills. After our second unannounced inspection, on 3 April 2017, the service voluntarily suspended all patient transport services. On 2 May 2017, the service recommenced work for patient transport service journeys only. The ambulance fleet had reduced in number from eight vehicles, to four vehicles.

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. The provider was in breach of regulations and submitted a statutory notification after our unannounced inspections to suspend all patient transport services.

Professor Ted Baker

Deputy 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)		Overall we have not rated patient transport services (PTS) at Abacus Ambulance Service because we were not committed to rating independent providers of ambulance services at the time of this inspection. Patient transport services were the main activity of the service, with the service carrying out a small number of high dependency transfers. The service was in breach of several regulations of the Health and Social Care Act 2008 Registration regulations (2014), such as regulation 12 (safe care and treatment), regulation 13 (safeguarding service users from abuse and improper treatment), regulation 15 (premises and equipment) and regulation 17 (good governance). The service suspended their services after our unannounced inspections.

Abacus Ambulance Service

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Abacus Ambulance Service

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The main service provided was patient transport services, with a small proportion of work carrying out urgent care and emergency transport services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and a specialist advisor with experience as a registered paramedic. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

How we carried out this inspection

We carried out the announced part of our inspection on 7 March 2017, along with unannounced visits to the base location on 20 March 2017 and 3 April 2017. We spoke with 12 staff including; registered paramedics, patient transport drivers and management staff. We spoke with two patients and three relatives. During our inspection, we reviewed 10 sets of patient records (patient report forms) and inspected three ambulance vehicles.

Detailed findings

Facts and data about Abacus Ambulance Service

Abacus Ambulance Service provides patient transport services from its base in Southend-on-Sea, Essex. The service carries out patient transport services, emergency and critical care transfers to both public and private sector services including acute trusts, clinical commissioning groups (CCG's), private hospitals and social services.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Patient transport services were provided from one location, in Southend-on sea, Essex. There were eight ambulances based at the location, with 31 staff of various grades employed to provide patient transport services.

Summary of findings

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

- Staff had not received formal training in incident reporting or the duty of candour. There was no incident reporting policy in place. There were no processes in place to share leaning as a result of an incident.
- There were no robust processes in place to monitor vehicle cleanliness. We found dirty linen and equipment during vehicle checks.
- Vehicles contained damaged and faulty equipment.
- Patient report forms lacked pertinent information. There was no process in place to audit or monitor patient report forms.
- The safeguarding adults and children lead had not received the level of training as recommended in best practice guidelines.
- No mandatory training compliance data was provided and therefore we could not gain assurances that staff had received adequate training to safely and effectively carry out their role.
- There was no formal inclusion and exclusion criteria in place. Information taken at the point of booking did not sufficiently assess the patient's eligibility to ensure safe transport.
- Key policies lacked reference to national guidelines. The system used to access up to date policies was not embedded with staff.
- There was no formal monitoring of response and journey times.

Patient transport services (PTS)

- There was a lack of training records to demonstrate paramedic and technician staff competencies.
- Staff had not received training in the deprivation of liberty safeguards and the consent policy did not contain reference to relevant guidance or legislation.
- Staff had not received training in dementia awareness.
- Although patient feedback was positive, the level of patient feedback was low.
- The service's visions and values were not embedded. Staff were unaware of the vision and values statement in place.
- The risk register was in its infancy. It did not identify all relevant risks and lacked oversight and ownership.
- Governance meetings did not contain evidence of an effective governance framework.
- Communication from management with staff was ad hoc and not documented. No regular staff meetings took place.
- There was a lack of oversight relating to the maintenance and servicing of equipment.
- There was a lack of training oversight around paramedic and technician competencies.

However we also found the following areas of good practice:

- Despite a lack of formal incident training, staff were able to clearly articulate what constituted an incident and safeguarding concern.
- Vehicles contained personal protective equipment for staff to prevent and control the spread of infection.
- The service was meeting the nutritional and hydration needs of patients.
- Patient and relative feedback consistently stated that the service provided compassionate care.
- Feedback indicated that patients were treated with dignity and respect.
- The service was planned and delivered to meet the needs of local people. The service demonstrated flexibility and availability for booking, including out of hours bookings.
- The service had received only two complaints in the 12 months prior to our inspection.
- Staff described senior managers as approachable, open to suggestions and supportive.
- Staff reported feeling respected and valued in their role.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- The service had reported three incidents between April 2016 and March 2017. One incident related to a member of staff, two were patient related incidents.
- The incident reporting system was paper based. Staff had access to forms for either non-injury/damage/ dangerous occurrence or violence and abuse. The registered manager told us that all other incidents, such as patient injury, were documented on the bottom of a patient report form if necessary. We could not gain assurances that the incident reporting process for injury to staff or patients was robust.
- The service had no formal incident reporting policy in place however, staff could access a document to give guidance on the steps to take for the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR). This document lacked a review date, and made no reference the occurrence of injury to staff or patients.
- Staff had not received formal incident training; however, we spoke with six members of staff, who could clearly articulate what constituted an incident and the reporting process.
- We asked the registered manager and director to provide examples of where learning had been shared as a result of an incident. There was no formal sharing of lessons learnt as a result of incidents.
- We found an example of an incident relating to a faulty piece of equipment, which had been located on an ambulance 19 days prior to our visit. This had been recorded on daily vehicle check sheets however there was no incident report form completed. We were not assured that staff were identifying and reporting incidents.
- The service had produced a new staff guide to inform staff on how to report incidents. The document referenced enforcement officers; however, the service did not have staff employed in this role. We could not gain assurances that the document was fit for purpose or that it was relevant to the service provided.
- The service had no duty of candour policy in place at the time of our inspection. The duty of candour is a regulatory duty that relates to openness and transparency and requires the 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.
- A memo had been sent to staff in February 2017, which outlined the meaning of duty of candour. Information within the document included when the duty of candour should be implemented, for example, when a patient safety incident resulted in moderate harm, severe harm or death.
- We were told that the service was in the process of starting training in the duty of candour, however, we were not given an estimated date for completion.
- We spoke with six staff about their understanding of the duty of candour, four of which were not able to tell us what this term meant and where the duty should be used. We could not gain assurances that staff knew the meaning of the duty of candour and that appropriate action would be taken in the event of it's use being required.
- We asked a senior manager to give us an example of when the duty of candour had been used in practice. They were unable to provide any relevant example. We were given an example of an event that did not relate to the duty of candour and it's application.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service did not have any process or system in place to monitor the clinical quality and safety of the service. This meant we were not assured that the service was provided in a safe and effective way.

Cleanliness, infection control and hygiene

- The training manager told us that staff received training in infection control at their induction. We requested overall compliance with training for infection prevention and control however, we were not provided with this data.
- We inspected three vehicles during our unannounced inspections. On one vehicle, we found a bag of dirty

linen on the floor, unsealed clinical waste, and two visibly soiled high visibility jackets. A stretcher mattress had a visible tear meaning that this piece of equipment could not be effectively cleaned.

- On the second vehicle, we found a visibly dirty orthopaedic stretcher (scoop) and wheelchair, a visibly dirty equipment cupboard and a torn spinal head block. The provider could not assure us that the vehicle and equipment had been cleaned effectively to control and prevent the spread of infection.
- Both vehicles contained aprons, gloves, biohazard spill kits and decontamination wipes. In addition, hand gel was available for staff and patient use.
- There was no infection prevention and control policy in place. We escalated our concerns to the registered manager at the time of the announced inspection.
- The service implemented a new infection prevention and control policy prior to our unannounced inspection. This policy was not fit for purpose and lacked key guidance and information on bacteria such as MRSA and Clostridium difficile (C-difficille).
- The service had introduced a weekly vehicle cleanliness audit in January 2017. The audit looked back at cleaning activity, which took place on a daily basis after each episode of patient care. It was not clear however, who had ownership for the oversight of this audit.
- Daily cleaning processes were unclear. We saw cleaning check sheets, which indicated when a piece of equipment was cleaned after each patient use. However, there was no overall daily cleaning check sheet to ensure that all areas had been cleaned. This meant staff coming on to shift the following day would not have known if the vehicle had been effectively cleaned.
- A manager told us that vehicles were visually checked on a daily basis, prior to being used. However, this check was not recorded so we were unable to verify that this process was taking place.
- The service had previously used an external company's deep cleaning facilities. However, in the five weeks leading up to our inspection, this facility had not been available. We could not gain assurance that vehicles were cleaned to a safe standard given a lack of deep cleaning facilities.
- The registered manager told us that a new provider had been sought, and that they were in the process of implementing a new deep cleaning schedule. This was subsequently commenced during our unannounced inspection period and we saw evidence that three vehicles had been deep cleaned, with plans in place to deep clean the remainder of vehicles.
- The clinical waste bin was locked and there was clear signage in place indicating that this was for clinical waste only.
- There were no facilities to store sharps (needles) containers at the service's base. We escalated our concerns to the training manager, who told us that as they had never had any full sharps containers returned, they had not had the need to dispose of any. There was no policy in place for the management or disposal of sharps. During our unannounced inspection, we saw that a contract had been put in place for the safe storage and disposal of sharps.
- Cleaning products and equipment to clean ambulances were colour coded to ensure the correct equipment was used in the right area of the ambulance.
- The service had commenced a uniform audit in March 2017 which looked at staff's uniform, presence of hand sanitising gel, identification badges (ID) and footwear. The audit demonstrated that staff were 99% compliant overall. However, we were not assured that staff were adhering to best practice with arms bare below the elbow as this was not examined during the audit process. We were unable to look at previous audit results as the audit had been recently implemented.
- We spoke with six staff, three of which told us they were instructed to carry spare uniform in the event of contamination. There was no uniform policy in place to provide staff with guidance on how to wash and maintain uniform.
- At our initial inspection, we found that there was no system or process in place to decontaminate linen. Dirty linen was taken off site, to the home address of a member of staff for laundering. We raised our concerns regarding this process at the time of the inspection.
- At our unannounced inspection, we saw evidence that a contract had been put into place to ensure that contaminated linen was laundered appropriately.

Patient transport services (PTS)

Environment and equipment

- The vehicle and equipment storage area was secure, well lit, visibly clean and well maintained.
- Vehicle servicing and MOT testing was carried out by an external company. An MOT database was held onsite. We reviewed MOT and tax records which showed all vehicles held an up to date MOT and tax.
- The service held no central record of vehicle servicing dates and mileages to enable oversight of when servicing was required. We requested to see evidence that all vehicles had received a service in accordance with recommended service schedules. The control room manager contacted the garage and manually cross-referenced up to date vehicle mileages to ensure services had been carried out.
- We saw that vehicles had received a service within the manufacturer's recommendations however, we could not gain assurances that systems or processes were in place to maintain a reliable, contemporaneous and accessible record of vehicle servicing requirements.
- Vehicle keys were securely stored and accessible by staff at all hours.
- Consumable stocks, such as oxygen masks, were replenished as and when required. Staff had access to a stock room at the base station. Staff working at the base station oversaw stock levels and ordering of consumables.
- There were no paediatric and adult oxygen masks in the storeroom. We escalated our concerns to the registered manager. The registered manager told us that all vehicles had been fully stocked and that due to recent financial pressures, stock ordering and replenishment had been limited.
- There were no standardised vehicle equipment check sheets in use. This meant that staff could not reliably ensure that each vehicle contained the correct equipment and quantity of consumable items such as oxygen masks. However, at our unannounced inspection a standardised vehicle inspection checklist was in draft format, with an estimated implementation date of April 2017.
- During our unannounced visits, we inspected three ambulances used for both patient transport and high dependency transfer services.
- Equipment stored on vehicles, including carry chairs, a suction unit, piped oxygen lines and stretchers had been serviced within the recommended period with servicing stickers reflecting when the next service was due.
- However, a selection of carry chairs in the equipment storage area lacked visible service dates. The service told us these items were not in use. These items were not clearly marked as out of service and were accessible to staff. We were not assured that they would not be used if a piece of equipment on an ambulance required replacement.
- Ambulance stretchers had appropriate stretcher harnesses in place and vehicles contained clamping systems to enable the safe transportation of patients if travelling in a wheelchair.
- Fire extinguishers on both vehicles lacked service dates. We could not gain assurances that these pieces of equipment would be effective or safe to use if required. However, on our subsequent inspection, all fire extinguishers had been replaced and displayed service dates.
- A cardiac monitor had passed its recommended service date by two months. We escalated this to the registered manager immediately. The equipment was removed from service and replaced with an alternative monitor.
- We found a paediatric defibrillator battery was not working, which meant in the event of patient collapse or cardiac arrest, the equipment would not work. The registered manager told us that this piece of equipment was on order at that time and stated the vehicle was not being used to transport children whilst this piece of equipment was not available.
- A wheelchair was found to have a broken footplate leaving exposed metal and therefore posed a risk of injury to both staff and patients. Another wheelchair had a broken armrest and footplate, ripped rear cushion and tangled lap belt. Both chairs were visibly dirty. We escalated our concerns to the registered manager who immediately took both wheelchairs out of service and replaced them.

Patient transport services (PTS)

- Suction tubing and catheters were stored folded in cupboards, resulting in kinks to the tubing. This meant that the equipment might not have worked effectively if required.
- One suction unit was not secured when in use during transportation. The suction unit was stored on the floor as there was nowhere to secure this piece of equipment. This meant that it could move and potentially cause injury to a patient or staff member. After our first unannounced inspection, we were told that an electrician had been booked to install a specific bracket to ensure safe transportation of this piece of equipment, however a date was not provided for completion.
- We found a suction machine was not working despite being plugged in to the wall charging bracket, which meant this equipment would not have worked if required in an emergency situation. We spoke with four staff who stated all defective equipment was reported to the office for escalation to a manager, and then repaired or replaced as required. However, one member of staff stated that they had raised the issue of the suction machine not charging on a number of occasions, but “nothing was done”.
- The service did not carry out a formal equipment audits. A senior manager stated "if there is a faulty piece of equipment, I keep this in my head". We could not gain assurances that the service had effective oversight relating to the service and maintenance of equipment.
- Staff completed a vehicle check sheet on a daily basis. This included inspection of the engine, lights, external condition and internal condition of the vehicle. Vehicle daily check sheets were sent in to the office on a weekly basis for vehicles that were stored at staff members addresses. We reviewed the vehicle daily check sheets for one vehicle over the period of five working days in March 2017. All forms had identified five areas relating to: suction not working, wheelchair footplate missing, noisy vehicle brakes, vehicle creating excess smoke and a stretcher that could not hold at maximum height when elevated. We were advised that this particular vehicle’s brakes had been serviced in February 2017. However, the staff member had escalated that the issue had continued, and no further action had been taken.
- We requested to see monthly audit data from vehicle daily check sheets for the three months prior to our inspection. The service was unable to provide any data since August 2016 stating ‘things had got a bit behind’.
- The Control of Substances Hazardous to Health (COSHH) folder contained limited information. On our subsequent inspection, the COSHH folder had been updated, although review dates were not in place.
- The training manager told us that staff had received training in manual handling (including the use of moving and handling equipment),automated external defibrillation, and assisting and moving people upon induction. We requested training compliance data however, we were not provided with this information.

Medicines

- The service carried medical gases but did not carry medicines, as they were not required for patient transport services.
- We looked at two vehicles and the storage of medical gases.We found one oxygen cylinder was not stored in a safe manner, unsecured on the floor. Another vehicle contained a loose oxygen cylinder in a cupboard. After our first unannounced inspection, the registered manager advised that inspections were to be carried out to ensure compliance in the safe storage and transportation of medical gases; at our second unannounced inspection we did not find any evidence of this.
- There was no policy in place to provide guidance for the safe transportation of medical gases. A senior manager told us "that is something we need to put in place". However, on our unannounced inspection an oxygen policy had been put into place and detailed information on the safe transportation, storage and use of medical gases.
- Full and empty medical gas cylinders were stored at the base station in a cabinet. Crews could exchange cylinders when required. We inspected this area and found three large oxygen cylinders outside of the cabinet, secured in place with a strap.
- The training manager told us that staff had received training in medical gases as part of mandatory training. We requested training compliance rates, however the service did not provide this data.

- The service withdrew a medicines management policy in March 2017, as the service did not carry or administer medicines. The service did not have a process in place to manage and assess the risk of medicines that may be carried by a patient or during high dependency transfers where an escort was not present.
- One patient report forms showed that staff had transported a patient with an intravenous (IV) infusion running. An IV infusion administers fluids and other medications to a patient directly into a vein. The form did not state if a clinical escort accompanied the patient. The crew accompanying the patient were not trained in the administration, oversight or care of IV infusion. We immediately escalated our concerns to the registered manager.
- Due to our findings, relating to untrained staff monitoring patients with IV lines, the service immediately ceased all journeys that required oversight or maintenance of such medications.

Records

- We saw that archived medical records were securely held at the service's base location.
- We reviewed 10 completed patient report forms, randomly selected from the month of January 2017. All contained basic information such as pick up and drop off locations, mileage travelled and if oxygen had been administered. Records contained a specific section for completion if a patient had a do not attempt resuscitation order (DNAR) in place.
- Between January 2017 to March 2017, the service had carried out four blue light emergency transfers. We asked to review the patient report forms, of which three were available. The registered manager was unable to locate the fourth record. We requested this document again at our unannounced inspection, and were told that it was previously unavailable as it was in the invoicing department. All records demonstrated that a senior clinician had signed to indicate the need for blue light transfer of the patient.
- The patient report forms did not contain appropriate areas to record patient observations such as pulse, blood pressure and other pertinent information.
- However, at our unannounced inspection the patient report forms had been revised and included specific fields for date of birth, allergy status and patient observations. These were due to be rolled out to staff in April 2017.
- The service did not carry out any audits or checks of completed patient report forms. Therefore, we could not gain assurances that records were accurate, complete, legible and up to date.
- Staff did not provide a copy of the patient report form to the receiving hospital or clinic therefore we could not gain assurances that patient records were shared with other healthcare professionals if required.

Safeguarding

- The service had a safeguarding adults and a safeguarding children policy in place. Both policies lacked reference to national guidelines and best practice. There was a lack of clear instruction for staff on what process to follow in the event of identifying safeguarding concerns.
- The policies stated that all employees who have contact with adults and children would receive appropriate safeguarding training, however, the level of required training was not specified.
- The training manager told us that safeguarding children and adults level two was included as part of mandatory training. We requested overall training compliance figures, however this data was not provided.
- The service had a named safeguarding lead, who could articulate what constituted a safeguarding concern and gave a range of examples, including assessment of a patient's home environment and possible warning signs of neglect.
- One safeguarding referral had been made in January 2017.The referral had been completed appropriately and there was evidence that there was sharing of information between the service and other relevant bodies. However, this had not been shared with staff so we were not assured that learning had taken place.
- The safeguarding lead for the service told us they were trained to level two safeguarding children. The safeguarding lead had not undertaken additional

safeguarding training to provide experience and support to staff when reporting and escalating safeguarding concerns. This meant the service was not working in line with national guidelines on safeguarding.

- The safeguarding lead told us they were trained to level two safeguarding adults. The safeguarding lead for adults had not undertaken any additional training to provide support to staff when reporting and escalating safeguarding concerns. This meant the service was not working in line with national guidelines on adult safeguarding.
- In the two weeks following our announced inspection, the safeguarding lead was not available. This meant that there was no member of staff available to provide support and advice to staff if required.
- At our second unannounced inspection, the service stated they would forward evidence for planned safeguarding adults and children training to ensure compliance with recommended guidelines on safeguarding children and adults. We did not receive this evidence after our second unannounced inspection.
- We spoke with five members of staff who all reported they would report safeguarding concerns to a manager or to the control room. One member of staff was able to give a working example of a safeguarding referral however, they stated they had not received feedback or that any learning had been shared.

Mandatory training

- Mandatory training included, but was not limited to, first aid at work (including basic life support), defibrillator training, medical gases, manual handling and safeguarding awareness. These were delivered on pre-planned training days, or were delivered before or during shifts.
- We checked staff files for training compliance, however, data was not clear whether training had been completed or when refresher training was due. There was no system in place to monitor overall compliance with mandatory or role specific training. We requested overall compliance figures for mandatory training but the service did not provide us with this data.
- The service had planned a new rolling training programme for commencement in January 2017, with subjects including, but not limited to, mental health awareness, risk assessment, dementia awareness and duty of care. The rolling programme was written by an external company and addressed a different subject each month. At the time of our inspection, this training rollout had not started.
- Initial driving assessments were carried out at the start of employment. There was no formalised driving re-assessment during the course of employment and senior management told us that they would re-assess a member of staff if concerns relating to driving were identified.

Assessing and responding to patient risk

- The service had no formal inclusion or exclusion criteria in place, which meant the booking process did not thoroughly assess if the patient was eligible to safely use the service. During our unannounced inspection, we were shown a draft document for assessing eligibility criteria, however, this was in its infancy with no clear implementation date.
- The service reported that was patient eligibility was assessed verbally over the telephone at the point of booking. The booking forms in use lacked space to detail important information such as medical conditions, if the patient had an escort or what level of training the crew required. We lacked assurance that comprehensive information was taken about people prior to them using the service.
- At our unannounced inspection, we saw the service had implemented a revised booking form, which included information on but not limited to; a patient's level of mobility, equipment required, access to property details and infectious disease.
- The service did not have a policy in place relating to the management of a deteriorating patient. We spoke with four members of staff and asked what actions they would take if a patient's health deteriorated during transfer. All four members of staff reported they would contact the control room and if required divert to the nearest accident and emergency department. We were not assured that staff would request urgent back up from an emergency ambulance as no policy was in place to provide guidance.
- We escalated our concerns regarding the lack of policy in place for deteriorating patients. We were told that

staff training covered this topic and that additional training was due to be rolled out however we were not provided with a date for the start of this training. In addition, the service was in the process of developing a deteriorating patient policy, which was in a draft format when we completed our unannounced inspection. This was due for completion and subsequent rollout to staff by May 2017.

- Staff did not receive training in conflict resolution. We were told that training was due for rollout in the current year; however, the service was unable to provide us with a start date for this training. An incident in March 2016 had occurred where a member of staff experienced aggression from a patient. We were not assured that staff had sufficient knowledge or training to respond appropriately to peoples behaviours that may be violent or aggressive.
- The service transported patients detained under the Mental Health Act. All detained patients had a medical escort with them. The service did not carry out formalised risk assessments in relation to transportation of patient with mental health conditions. Information about medical history and risk of violence was obtained at the time of booking and passed to staff either electronically or verbally.
- The service undertook paediatric transfers at the time of our announced inspection. The registered manager told us that all paediatric transfers were escorted by either a registered nurse or medical team from the outgoing provider. We spoke with five members of staff who corroborated this.

Staffing

- The service employed 31 members of staff, comprising a mixture of full-time, part-time and bank staff. The staffing level was appropriate to meet the needs of patients and the registered manager informed us that bookings were never turned down due to lack of available staff.
- Full time staff worked fixed hours operating a four on, four off rota. Bank staff gave their availability one week in advance and the control room manager stated they were also available at short notice if required.
- Out of hours, staff were able to contact senior management for support if required.
- Disclosure and barring service (DBS) checks were carried out at the time of commencement of employment with the service. We randomly selected five staff personnel files, all of which contained a DBS check that had been carried out on the commencement of employment.
- Contracted staff worked shifts that varied in length and were a minimum of eight hours in duration. We spoke with three staff who all reported that they were encouraged to take regular breaks, and maintain a minimum of 11 hours between shifts to reduce the risk of fatigue.
- The service employed patient transport staff, paramedics, ambulance technicians and first person on scene (FPOS) basic (FPOSB), intermediate (FPOSI) and advanced (FPOSA) trained staff.
- Skill mix was determined by the acuity of patient being conveyed. Paramedics and technicians undertook high dependency transfers however, they did not administer medications, as vehicles did not carry medicines. Patient transport staff undertook clinic work such as outpatient journeys and discharge to home addresses.

Response to major incidents

- The service did not provide an emergency response and therefore there was no major incident plan or policy in place.
- The service implemented a business continuity policy in January 2017. This provided guidance in the event of evacuation from the service's location. The policy did not provide guidance should the service experience a reduction in fleet, shortage of staff or any other relevant risks the service may face.

Are patient transport services effective?

Evidence-based care and treatment

- There was no clear process for the implementation and review of polices, to ensure that practice was evidence based and in line with standards, best practice and legislation. Policies were poorly written, contained a number of typographical errors and did not contain pertinent references.
- The infection control policy contained little reference to national guidance and lacked key information for staff,

for example the management of transferring patients with infections such as MRSA and clostridium difficille (c-diff). The safeguarding adult's policy did not refer to best practice guidelines and therefore did not provide staff with clear actions to take in the event of identifying a safeguarding concern.

- The care of the dying patient policy contained inconsistencies and made reference to 'recognition of life extinct' (ROLE) forms which the service did not use. In addition, the policy provided guidance on action to take when attending the unexpected death of a child. We could not be assured that the policy was applicable to the service provided.
- The mental health conveyance policy was not applicable to the service provided. It referred to a health, safety and risk management committee, which did not exist within the service. It referenced responding to 999 emergency calls, which the service did not carry out.
- Staff could access the policies at the base location or remotely, via an electronic system. The electronic system was recently implemented.
- We asked five members of staff how they would access relevant policies. Four said that they were unaware of the electronic system in place to access policies and guidance remotely. All staff reported they had access to paper-based policies and procedures at the location or that copies of policies could be left out for staff on request.
- There were no formal processes in place to ensure that patients care was delivered in line with evidence based practice, standards or guidance including the National Institute for Health and Care Excellence (NICE), through the use of audits.

Assessment and planning of care

- The new patient booking form included sections to highlight additional or complex needs that a patient may have. This enabled the service to take into account a patient's individual needs.
- Control room staff received information about patients requiring transport whilst detained under the mental health act at the point of booking. This enabled the service to ensure that an escort would be with the patient for the duration of transport.
- On longer journeys, patients could bring their own refreshments. In addition, the service gave examples of where nutrition and hydration would be provided for patients should the need arise, especially if journey times were extended.
- We spoke with one patient who used the service on a regular basis. They stated that food and drink was provided during a long journey.

Response times and patient outcomes

- Data could be manually retrieved from the electronic system to monitor pick up times or delays. However, the service did not monitor these routinely, and did not have any systems in place to review or benchmark itself against other providers, nor identify where improvements could be made.
- We requested the total number of journeys and number of cancelled and delayed journeys for the period of March 2016 to February 2017. We did not receive this data. We were informed that this data had only started to be formally collated in March 2017; however, we were not provided with any evidence to support this.
- The service did not monitor the number of same day bookings received. Therefore, the service was unable to identify possible trends and adjust staffing levels in advance if required. No audit was in place to monitor the number of declined bookings.
- We spoke with five patients and relatives who all said vehicles always arrived in a timely manner. One relative stated that should there be any delay, the service communicated this through telephone or text message.

Competent staff

- We reviewed 21 staff files for evidence that regular appraisals had taken place. We saw that all staff had received an appraisal in 2016, the majority of which were due for annual review in the month of our inspection. At the time of our inspection, no repeat appraisals had been planned.
- Staff received an induction programme at the start of their employment which included training in; first aid at work (including basic life support), automated external defibrillator, medical gases, and manual handling.
- The service employed paramedics and ambulance technicians to provide care for patients during high

dependency transfers. The registered manager told us they were employed to make use of their enhanced monitoring skills, for example the use of blood pressure and electrocardiogram (ECG) monitoring. We requested to see evidence of paramedic and technician competency oversight. However, paramedic and technician competencies were not monitored by the service.

- Initial driving assessments were carried out on commencement of employment. There was no formalised driving re-assessment during the course of employment and senior management told us that they would re-assess a member of staff if concerns relating to driving were identified.
- Driving licences were checked on a yearly basis, via an online system. All staff licences had been checked in March 2016, and were in the process of being reviewed at the time of our inspection (March 2017).

Coordination with other providers and multi-disciplinary working

- We spoke with one patient who had travelled with the service. They said they felt their journey details were well communicated to them in advance of transport, and that they were informed if there was going to be a delay in transport.
- We spoke with six members of staff who told us additional patient information could be obtained at patient handover, from the provider who booked the transport. Additional information could include if the patient had dementia, learning difficulties, a do not attempt cardiopulmonary resuscitation (DNACPR) order or an infectious disease.
- We spoke with one member of staff who described coordination with another provider when returning a patient to hospital after identifying a safeguarding concern at the home address. Both services liaised to ensure the appropriate action was taken in the patient's best interests.

Access to information

- Patient transport staff received information about journeys via an electronic system based in the ambulance cab. Booking details were passed from the control room including the patient's name, pick up/drop of location and any other relevant information that had been taken at the point of booking.
- The electronic system conveyed patient information and was also used for satellite navigation purposes. Vehicle movements were overseen from the control room at the service's location.
- Staff completed a patient record form for transfers. We saw a specific box on this document to indicate whether or not the patient had a DNACPR order and that the crew had been given paperwork to reflect this order.
- Staff received a verbal handover at the point of patient pick up. This ensured that staff were made aware of any specific requirements a patient may have.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service did not provide training for staff in relation to the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLs), or the Mental Health Act (MHA). The training manger told us that this was to be included as part of the new rolling training programme for 2017, however there was no estimated date of implementation for this. This meant we could not be assured that staff understood the relevant consent and decision making requirements in line with legislation and guidance.
- We spoke with four members of staff about their knowledge of the MCA and MHA. Staff were unsure what these terms meant.
- One relative of a patient stated "staff always ask for consent".
- The patient treatment and consent policy did not contain reference to relevant guidance or legislation. In addition, it described a 'quality safety and effectiveness committee', which did not exist within the service. We could not be assured that the policy was fit for purpose.

Are patient transport services caring?

Compassionate care

- Senior management gave examples of how they would ensure the dignity of a patient during transport. They

told us how staff spoke with patients and their relatives on how dignity could be maintained before transportation took place. A senior manager explained how patient dignity would be taken in to account during transfer with the use of blankets.

- We spoke with five patients and relatives who described the service as "brilliant, caring and wonderful".
- We spoke with one relative who described how well staff interacted with their family member in a respectful and caring manner. They described the service as having a “human touch”.
- We spoke with one patient who said “they cater for my needs, stop the vehicle if I need to use facilities and treat me like part of the family. They treat me with respect, courtesy and provide the service I need”.
- Two patients stated that their dignity was maintained at all times, for example with the use of blankets. Another relative described how their family members privacy and dignity was maintained as staff always ensured doors on the vehicle were closed when treatment was being delivered.
- The service transported a number of patients on a regular basis. This meant that staff got to know patients and their families. Therefore, patients received continuity of care in a familiar environment.
- Relatives described that staff demonstrated a respectful and caring attitude to relatives and carers travelling with the patient.
- The service did not carry out any patient surveys.

Understanding and involvement of patients and those close to them

- We spoke with two relatives whose family members used the service. Both reported feeling involved in the care provided. One patient said “I always know what is happening”, another relative stated “staff always explain what they are doing”.

Emotional support

We spoke with five relatives and patients who had used the service. All stated that staff communicated well with patients and kept them informed during 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 service liaised with other providers such as hospitals and clinical commissioning groups (CCG’s) when planning journeys to ensure that appropriate vehicles were available. The majority of work was allocated one day in advance with occasional bookings taking place around pre-planned journeys.
- We spoke with five patients who had used the service within the 12 weeks prior to our inspection. All patients described the service as meeting their needs in terms of bookings, timeliness and information provided.
- The service was open to take bookings between the hours of 8.30am to 5.30pm Monday to Friday. Outside of these hours, senior managers were contactable by mobile phone to take bookings. These were entered remotely on to the booking system and then passed to crews via the electronic system.

Meeting people’s individual needs

- Patient transport staff had previously received training in dementia awareness. We were unable to verify when this had taken place as no training data was provided. We were told that specific dementia training was planned for roll out in November 2017 as part of the new training programme.
- There was no specific flagging in place to identify patients living with dementia or those with a learning disability. However, the control room manager stated that additional information passed during the booking process was appropriately shared with staff where available. This was corroborated by five members of staff who told us that either the hospital or control room staff informed them if a patient had complex or additional needs.
- Staff had access to translation services over the telephone. We spoke with five staff, of which only one was aware that this service was in place.

Patient transport services (PTS)

- Patient's individual needs were considered at the time of booking. For example, the service could provide an all-female or male crew if requested by the patient.
- The service provided the same crew to certain patients so that staff were familiar with a patients individual needs.

Access and flow

- Bookings were received on regular basis for clinic work, and on an occasional basis for other transfers and private transfers.
- The service took bookings in a variety of ways, dependent on the organisation or person requesting transport. Bookings were taken from hospital transport offices, clinical commissioning groups (CCG's) or directly from private patients. Bookings were received over the telephone, or by fax for pre-planned work.
- We spoke with five patients and relatives on how they accessed the service. A relative stated that booking staff were responsive when answering queries and making bookings. Another patient stated "I only have to make a phone call to book transport and they always respond in a timely manner".
- All relatives and patients we spoke with reported that the service ran on time.
- Information relating to journeys was sent to ambulance crews via an electronic system, direct to the ambulance cab. In addition, other relevant information regarding a patient was also communicated by telephone to ambulance crews if required. For example, this information might include additional information around mobility requirements or access to the property.
- The service did not formally monitor crew on scene and turnaround times. Journey times were informally monitored by the control room during a shift. However, delays were not documented or audited.

Learning from complaints and concerns

- Between March 2016 and February 2017, the service had received two complaints.
- The service had a complaints policy in place which outlined time frames for responding to complaints and who was responsible for investigations relating to complaints.
- The service carried comments cards on vehicles with posters displaying information on how to complain or forward comments to the service. On our unannounced inspections, we saw posters displayed on vehicles providing information for patients on how to make a complaint.
- We reviewed the comments cards for the year 2016, relating to private hire and clinical commissioning groups booked patients. Out of 800 journeys, there were 12 completed cards. This was a return of approximately 1.5% however as some work was subcontracted to the service; we were told that patient feedback could be directed to other providers.
- The service had no formal process in place to receive feedback from other providers to whom transport services were provided. A senior manager described an example of when the service had contacted a patient who had complained to a clinical commissioning group.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The service had two directors who were responsible for overseeing the work of ambulance and control room staff. The control room manager had overall responsibility to plan bookings on a daily and weekly basis.
- The clinical lead was new to post at the time of our inspection. It was planned for them to have overall responsibility for all clinical matters, the risk register and other key areas including the oversight of competencies for staff.
- There were no records of previously completed or planned one to one meetings with staff. Managers told us that staff could come to them for support if required. We were not assured that leaders were visible, in particular to remote workers who were out on shift all day without pre-planned and documented one to ones taking place.
- There was no formal process in place for regular communication with staff. We were told that managers planned to go out to speak with staff during their shift

over the coming months. We spoke with four members of staff, three of which said that staff meetings did not take place. The other staff member reported that meetings were on an ad hoc basis, when required.

- We spoke with three staff who described senior managers as approachable, open to suggestions and supportive.
- Staff described feeling respected and valued in their role. We spoke with two staff who confirmed that the control room made regular checks to ensure staff welfare whilst working remotely.

Vision and strategy for this core service

- The service provided us with their vision and values statement;
- To provide a service that supports client needs to achieve best practice in clinical care.
- To support staff in achieving full potential within their job role.
- To respect staff and to support new initiatives that improve the service delivery that's safe and effective and promote diversity within the company workforce and of the clients we serve.
- The vision and values statement provided did not correspond with a senior managers comments who said; "we treat people with respect and provide an outstanding service, but there is nothing in writing". We asked four members of staff if they were aware of the service's visions and values. None were able to tell us what the statement included. We were not assured that the service's vision and values were embedded with staff.
- The service had no strategy in place.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- There was not an effective governance framework in place to support the delivery of good quality care, or to ensure that the service ran efficiently or effectively.
- The service did not measure performance outcomes in terms of key performance indicators (KPIs) and how responsive the service was in regard to time from collection of patients to their arrival at required destination, the waiting time for return journeys, number of patients spending more than (locally defined) standard time on vehicles and same day booking rates.
- We reviewed the managers meeting minutes from October 2016 and November 2016. There was no evidence of standing agenda items, for example performance monitoring, compliance with mandatory training or risks to the service.
- The safeguarding adult's policy stated that safeguarding should be an agenda item at a senior level in operations meetings. We reviewed manager's meetings minutes from October 2016, November 2016 and December 2016. No reference was made in relation to safeguarding. Therefore, we were not assured that the policy and content was embedded with senior staff.
- There was no systematic programme of clinical and internal audit, used to monitor quality.
- The service lacked policies, which were required to enable staff to carry out their role safely and effectively. Absent policies included, but were not limited to; infection prevention and control, incident and patient deterioration.
- Vehicle cleanliness was not effectively overseen by senior management. Daily cleaning processes were unclear and checks were not documented or monitored.
- Incident themes were not being identified and reviewed to improve practice. There was no formal sharing of lessons learnt at the time of our announced and unannounced inspections.
- A risk register had been developed in January 2017. However, not all risks to the service had been identified for example a reduction in staffing, loss of vehicles or service interruption. The person accountable for each risk was not identifiable and there was no specific date that the risk was to be, or had been reviewed. Risks were not 'risk rated' to indicate the level of risk posed. We were not assured that appropriate arrangement were in place for the identifying, recording and managing of risks.
- Recommended practices in the health and safety handbook provided to staff, had not been carried out by senior management. For example, the handbook stated

that Control of Substances Hazardous to Health (COSHH) would be subject to regular review and risk assessments. We found that the COSHH folder was not up to date or regularly reviewed. This meant that management were not doing all that was possible to reduce the risk towards employees.

- There was an up-to-date lone working policy in place. However, four staff we spoke with confirmed that vehicles were rarely single crewed.In the event of lone working, two members of staff confirmed that the control room would regularly check on the welfare of staff by keeping in touch on a regular basis.
- We reviewed risk assessments for, manual handling tasks, the use of carry chairs and fire safety. We saw that these risk assessments were up to date.

Public and staff engagement (local and service level if this is the main core service)

- The service did not hold regular meetings with staff. In addition, there was no regular newsletter to provide staff with information
- Systems to engage with the public were limited to patient comment cards.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The service had implemented a system to enable staff to access policies remotely. However, this system was not embedded at the time of our inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The service must ensure that all relevant staff have received the appropriate level of safeguarding training to ensure compliance with national guidance on safeguarding training and competence.
- The service must ensure that there are robust processes in place to ensure the monitoring and oversight of vehicle checking and cleanliness.
- The service must ensure that equipment is clean, secure and properly maintained.
- The service must ensure that staff receive training in incident reporting, the duty of candour and infection prevention control.
- The service must ensure that staff have the necessary qualifications, skills and competence to carry out their role.
- The service must ensure that accurate and contemporaneous records are kept in the respect of each service user.
- The service must ensure that patient eligibility to use the service is assessed.
- The service must assess, monitor and improve the safety of service provided to identify and mitigate risk.
- The service must ensure that relevant risks are identified and overseen.
- The service must ensure that appropriate risk assessment are carried out for patients who use the service. For example; children and patients detained under the mental health act.
- The service must ensure that policies in place are relevant to the service and reference up-to-date national guidelines.
- The service must ensure that an effective governance framework is in place.
- The service must monitor and oversee vehicle cleanliness and have robust processes in place to ensure vehicles are maintained to manufacturer's recommendations and servicing schedules.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not assess the risks to the health and safety of service users. The service did not do all that was reasonably practicable to mitigate risk as there was a lack of risk assessments in place. The service did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. The service lacked key infection prevention and control training, policy and oversight. Regulation 12 (1), (2), (a), (b), (c) and (h).

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The named safeguarding lead had not received training to comply with national guidance on safeguarding training and competence. Regulation 13 (2) and (3)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

The provider did not ensure that all equipment used by the service was clean and properly maintained.

Regulation 15 (1) (a) and (e)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was not an effective governance framework in place. The service did not assess, monitor and improve the quality and safety of the services provided to identify and mitigate risk. The service did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. There was a lack of assessment for a patient's eligibility to safely use the service. The service did not maintain an accurate, complete and contemporaneous record in respect of each service user. The service did not monitor performance to determine how the service was delivering against its contracted work to continually evaluate and improve services. The service did not provide policies that reflected national guidelines or best practice. Policies were poorly worded with a number of typographical errors. 17 (1) and (2) (a), (b), (c) and (e)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour Staff did not know or understand their responsibilities under the Duty of Candour Regulation. 20 (1)