Care Quality Commission

ION Ambulance Care Ltd

ION Pinewood

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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 to people's needs?	**Good** 🟢
Are services well-led?	**Requires Improvement** 🟠

Summary of findings

Overall summary

Our rating of this location went down. We rated it as requires improvement because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment and assessed patients' food and drink requirements. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service took account of patients' individual needs and made it easy for people to give feedback. People accessed the service when they needed it and did not have to wait too long for treatment.
- It was easy for people to give feedback and raise concerns about care received.

However:

- The service did not always use systems and processes to safely administer and store medicines.
- The service did not always manage the risk of infection well. There was no processes to screen patients for some infectious diseases and staff did not always have access to or training on the correct level of personal protective equipment.
- Leaders did not operate effective governance processes, throughout the service.
- Systems for monitoring the effectiveness of care and treatment were not fully embedded.
- The service had a mission statement for what it wanted to achieve but no coordinated strategy or vision.
- Managers did not review competency of staff.
- Leaders and teams did not always use systems to manage performance effectively or identify and escalate relevant risks and issues to reduce their impact.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up to date or detailed enough to ensure good care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good 🟢	Urgent and emergency care is a small proportion of service activity. The main service was patient transport services (PTS). Where arrangements were the same, we have reported findings in the appropriate sections of the report. Our rating of this service stayed the same. We rated it as good. See overall summary for more information. **Areas for improvement** Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services. **Action the service MUST take to improve**: • The service must ensure staff who may be exposed to aerosol generating procedures at any time during their work must have the correct level of personal protective equipment and are trained to use it in line with Department of Health guidelines (Regulation 12(1)). • The service must develop an overarching governance strategy for managing risk, performance and driving improvement (Regulation 17 – Good Governance). **Action the service SHOULD take to improve:** • The service should ensure it formally records medicines audits into a central register (Regulation 12). • The service should ensure it continues to develop its staff personnel records process (Regulation 17). • The service should ensure it carries out its own safety and quality checks and assurances via its own governance framework for any NHS ambulance trust bookings provided (Regulation 17).

Summary of findings

- The service should ensure the infection status of all patients is recorded (Regulation 12).
- The service should ensure records are maintained for all patients including essential information such as pain score and clinical observations (Regulation 12).
- The service should ensure there are systems to review staff competency (Regulation 17).
- The service should ensure all records and action plans are accurate and available for safe patient transfers; such as booking forms and risk assessments to support safe transfer (Regulation 12).
- The service should ensure fire extinguishers are not cable tied to the vehicles (Regulation 12).
- The service should ensure that the consumables room does not contain any out-of-date items and ensure staff do not have access to out of date supplies (Regulation 12).
- The service should ensure it reviews the quality of what was recorded by the crew completing the transfers and the handovers from the hospital staff (Regulation 12).
- The service should ensure it holds the equipment to carry out randomised alcohol tests in line with the staff handbook (Regulation 17).
- The service should ensure it documents on the forms the patients' preferences regarding the gender of the crew carrying out the transport for dignity, privacy or sexual safety (Regulation 12).
- The service should consider including the details of visual observations completed during transfers in the patient record forms.
- The service should consider reviewing the booking form and patient record forms to ensure they meet the needs of patients receiving high dependency transfers.
- The service should consider drafting and implementing a patient search policy for mental health secure transfers.
- The service should consider carrying out regular safety and maintenance checks of the rigid handcuffs kept on board the mental health secure transfer vehicle.

Summary of findings

- The service should consider providing restraint procedure training to all staff carrying out mental health secure transfers once these resume.
- The service should consider appointing a controlled drugs officer to oversee transport and administration of controlled drugs during transfers.

Emergency and urgent care	Requires Improvement ⬤	**Areas for improvement** Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services. **Action the service MUST take to improve:** **Urgent and Emergency Care** - The service must ensure systems and processes are embedded to identify and manage risk throughout the service (Regulation 17 (1)). - The service must ensure staff who may be exposed to aerosol generating procedures at any time during their work must have the correct level of personal protective equipment and are trained to use it in line with Department of Health guidelines (Regulation 12(1)). **Action the service SHOULD take to improve:** **Urgent and Emergency Care** - The service should ensure the infection status of all patients is recorded (Regulation 12 (1)). - The service should ensure it formally records medicines audits into a central register (Regulation 12 (1)). - The service should ensure records are maintained for all patients including essential information such as pain score and clinical observations (Regulation 12 (1)). - The service should consider reviewing the booking form and patient record form to ensure they meet the needs of patients receiving high dependency transfers (Regulation 12 (1)). - The service should ensure there are systems to review staff competency (Regulation 17 (1)).

Summary of findings

Our rating of this service went down. We rated it as requires improvement because:

- Although we found the service largely performed well, it did not meet legal requirements relating to infection control and governance, meaning we could not give it a rating higher than requires improvement.
- The service did not always manage the risk of infection well. There was no processes to screen patients for some infectious diseases and staff did not always have access to or training on the correct level of personal protective equipment.
- Leaders did not operate effective governance processes, throughout the service.
- Leaders and teams did not always use systems to manage performance effectively or identify and escalate relevant risks and issues to reduce their impact.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up to date or detailed enough to ensure safe care.
- Systems for monitoring the effectiveness of care and treatment were not fully embedded.
- Managers did not review competency of staff.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. The service managed incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment. The service met agreed response times. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Summary of findings

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received.

Urgent and emergency care is a small proportion of this service's activity. The main service was patient transport services. Where arrangements were the same, we have reported findings in the patient transport section.
We rated this service as requires improvement because safety and leadership require improvement, although the service was effective, caring and responsive.

Summary of findings

Contents

Summary of this inspection

Background to ION Pinewood

iON Pinewood is operated by iON Ambulance Care Limited. It is an independent ambulance service based in Slough, Berkshire. iON Pinewood provides patient transport services (PTS) across the Southeast of England region and urgent and emergency care services under contract with a local NHS Ambulance Trust. iON Pinewood also provides ambulances and staff to support the local NHS ambulance services with their patients' transfer needs. It is registered with the Care Quality Commission (CQC) for the regulated activities of transport services, triage and medical advice provided remotely and the treatment of disease, disorder or injury.

The main service operated by the provider is patient transport. iON Pinewood includes a fleet of 18 ambulances, with four high dependency (HDU) vehicles and one bariatric support vehicle. The service employs 60 permanent staff members to support patients who require transport to attend hospital appointments. They also provide a service for patients who are discharged from hospital to alternative living accommodation such as care homes, nursing homes or other hospital accommodation. In addition, the service provides ambulances to assist patients who require minimal medical intervention or support during their transfers. These are staffed by ambulance technicians and ambulance care assistants. For patients who may require medical support during their journey, iON Pinewood provides a high dependency service with qualified paramedics and ambulance technicians. They also provide mental health secure transfers using a special vehicle.

The registered manager has been in post since 2017 and covers several sites.

We last inspected iON Pinewood on 14 and 29 August 2019 as part of our routine comprehensive inspection schedule. We rated the service as good for safe, effective, caring and responsive, and requires improvement for well led. On 13 October 2021, we carried out an unannounced comprehensive inspection as part of our new approach inspection methodology, followed by an announced visit focused on mental health secure transfers on 24 November 2021.

How we carried out this inspection

The team that inspected the ambulance service comprised four lead inspectors, and a specialist advisor with expertise in paramedic services.

We looked at all of the key questions: safe, effective, caring, responsive and well-led.

Whilst on site we reviewed eight vehicles, medicines, staff records including training and competencies and the environment of the base. Off-site we reviewed policies and procedures, patient report forms, audits, 30 patient and carer feedback forms and contract information. We looked at 20 patient report forms and we observed four high dependency (HDU) vehicles, one bariatric support vehicle and three patient transport (PTS) vehicles, including one vehicle used for secure mental health transfers, containing a caged area at the back.

At the base we spoke with the registered manager, the base operations manager, the fleet manager, the lead planner, the administration assistant, and the area operations base manager.

We carried out remote interviews with managers and carers. We were not able to speak to any ambulance crew members, on site or remotely.

Summary of this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure staff who may be exposed to aerosol generating procedures at any time during their work must have the correct level of personal protective equipment and are trained to use it in line with Department of Health guidelines (Regulation 12(1)).
- The service must develop an overarching governance strategy for managing risk, performance and driving improvement. (Regulation 17 – Good Governance).

Action the service SHOULD take to improve:

- The service should ensure it formally records medicines audits into a central register. (Regulation 12).
- The service should ensure it has a standard operating procedure to support staff working in the patient transport service (PTS) to administer medical gases. (Regulation 12).
- The service should ensure it continues to develop its staff personnel records process. (Regulation 17).
- The service should ensure it carries out regular audits of its response times, in line with national guidance. (Regulation 17).
- The service should ensure it carries out its own safety and quality checks and assurances via its own governance framework for any NHS ambulance trust bookings provided. (Regulation 17).
- The service should ensure the infection status of all patients is recorded (Regulation 12).
- The service should ensure it formally records medicines audits into a central register (Regulation 12).
- The service should ensure records are maintained for all patients including essential information such as pain score and clinical observations (Regulation 12).
- The service should ensure there are systems to review staff competency (Regulation 17).
- The service should ensure all records and action plans are accurate and available for safe patient transfers; such as booking forms and risk assessments. to support safe transfer. (Regulation 12).
- The service should ensure fire extinguishers are not cable tied to the vehicles. (Regulation 12).
- The service should ensure that the consumables room does not contain any out-of-date items and ensure staff do not have access to out of date supplies. (Regulation 12).
- The service should ensure it reviews the quality of what was recorded by the crew completing the transfers and the handovers from the hospital staff. (Regulation 12).
- The service should ensure it holds the equipment to carry out randomised alcohol tests in line with the staff handbook (Regulation 17).
- The service should ensure it documents on the forms the patients' preferences regarding the gender of the crew carrying out the transport for dignity, privacy or sexual safety. (Regulation 12).
- The service should consider including the details of visual observations completed during transfers in the patient record forms.
- The service should consider reviewing the booking form and patient record forms to ensure they meet the needs of patients receiving high dependency transfers.

Summary of this inspection

- The service should consider drafting and implementing a patient search policy for mental health secure transfers.
- The service should consider carrying out regular safety and maintenance checks of the rigid handcuffs kept on board the mental health secure transfer vehicle.
- The service should consider providing restraint procedure training to all staff carrying out mental health secure transfers once these resume.
- The service should consider appointing a controlled drugs officer to oversee transport and administration of controlled drugs during transfers.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	Good	Good	Requires Improvement	Good
Emergency and urgent care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Patient transport services

Good 🟢

Safe	**Good**	🟢
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Requires Improvement**	🟠

Are Patient transport services safe?

Good 🟢

Our rating of safe stayed the same. We rated it as good.

Mandatory training

Most staff completed mandatory training. The service use a system called skills for health, and the target for mandatory training completion is 100%. At the time of our inspection, 94% of staff had completed their mandatory training.

The service provided mandatory training in key skills to all staff and made sure everyone completed it. We reviewed staff files and the training module on site. The compliance and governance team had oversight of mandatory training rates on an electronic system which alerted the team when staff's training was due for renewal. Staff were contacted the month before their training dates expired so that they could complete their training. The service also provide monthly updates with compliance figures to their clients and contracting trust.

Staff who have not completed their mandatory training are not assigned on shifts.

The mandatory training included 16 different modules, depending on job role and included Mental Capacity Act (MCA) training and training for Deprivation of Liberty Safeguards (DoLs).

Safeguarding

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

The registered manager was the safeguarding lead for the service and had completed level three safeguarding training for adults, children and young people. Data provided by the service following our inspection showed that 80% of staff had completed level 2 safeguarding adults training. The service had up to date policies for safeguarding which reflected with national requirements outlined in *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Fourth edition: January 2019*

Patient transport services

We reviewed five recruitment files showing that the service had processes for checking all staff were fit to work with adults and children and essential checks had been carried out.

Clinical staff also followed the safeguarding polices of the trust they were contracted to work for and completed any safeguarding referral paperwork, which was submitted to the contracting trust.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

During our inspection we reviewed seven vehicles including four emergency and urgent care and three patient transport service (PTS) vehicles. All of these vehicles were visibly clean. We also reviewed infection and prevention control audits for the previous seven months, and hand hygiene audits from January to May 2021 and found them to be compliant.

The service used check lists for vehicle cleanliness which were signed off by managers or team leaders to indicate the vehicles met the required standards.

Staff used personal protective equipment (PPE) for example disposable aprons, face masks and gloves. Hand sanitizer, clinical wipes and PPE were available on all the vehicles we reviewed.

Environment and equipment

The maintenance of equipment generally kept people safe.

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment. We reviewed the checklists for the seven vehicles we inspected and found no gaps.

The service had suitable facilities to meet the needs of patients' families. The vehicles we inspected had enough room to accommodate carers, friends and family members. The vehicles used for mental health secure transfers are equipped with CCTV to ensure patient safety.

The service had enough suitable equipment to help them to safely care for patients. All the vehicles we reviewed were visibly clean and contained the required equipment according to national guidelines.

Staff disposed of clinical waste safely. The base included facilities which were labelled correctly, and all the sharps bins we observed were labelled correctly and kept clean and tidy.

However, during our inspection we found fire extinguishers were cable tied on the vehicles. This is a risk because they cannot be removed quickly in the event of an emergency. We raised this with the provider on the day of our inspection and obtained reassurance that this would be addressed as a matter of urgency. We received photographic evidence that this had been done. During our second visit, we saw the extinguishers fastened in a way which removed the risk.

Patient transport services

Additionally, the consumables room located on site contained items which were out of date, and the labelling on the shelves was not correct, as it indicated different expiry dates. We raised this with the provider on the day and they informed us that the room was no longer in use. We also saw the provider kept the room locked and stored the key in the registered manager's office. However, there was no signage to inform staff and crew members to not use any items stored in the room. Following the inspection, the provider implemented signage and warning posters, both on the door and in the staff room, and added it to the risk register.

The service ensured all equipment on its vehicles displayed up to date service dates.

The service had processes in place to track vehicle servicing, documentation we reviewed during our inspection showed all vehicles were compliant with road tax, MoT inspections and insurance cover. Vehicles are checked, equipped and prepared for daily jobs at a different location.

Assessing and responding to patient risk

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

Staff followed risk assessments completed by hospital and care home staff for each patient and carried out dynamic risk assessments prior to each patient journey to reduce risks. Staff completed life support training appropriate to their roles. According to the patient record forms, staff identified and quickly acted upon patients at risk of deterioration.

Mental health secure bookings were received via telephone. Staff completed a booking form and a paper handover form when collecting the patient. However, these forms had no information pre-recorded to guide staff to enquire about current and historical risks, triggers, support plans and risk mitigation. For example, we saw a booking form for a patient where it was recorded they were alcohol dependent. No other information was recorded such as level of dependency, when they last had a drink, current or historical risk of seizures related to their substance abuse or other support needs during the transfer journey.

Staffing

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

The service did not use agency or bank staff and had effective systems to plan staffing levels based on demands within the service.

Managers regularly reviewed and adjusted staffing levels and skill mix. Managers made sure all staff had a full induction and understood the service before starting their shift. Managers checked staff had the appropriate training when allocating them to journeys. The service used a scheduling system, to which staff have access from their phones or through the laptop available in the staff room. In case of unexpected absence, the service used the ad-hoc shift tool included in the scheduling system to notify all staff members to sign up to cover the required shift, if they wanted to. Additionally, the service used a WhatsApp group to communicate any last-minute cover arrangements or requirements.

Patient transport services

Staff had access to managers through a 24-hour call line if they had any issues regarding resources or staffing for journeys. They were also able to contact the clinical lead via the on-call number or their work mobile directly. Staff also had access to clinical advice through the client dispatch line when working for the contracting trust.

Records

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

Ambulance crew had access to limited patient information on the personal digital assistant (PDA) tablets provided by the contracting trust. This mainly consisted in the patients' name, pick up address and drop off address, plus mobility issues. Once staff completed the dynamic risk assessment, they called through to the contracting trust dispatch in relation to any changes in patients' details. The crews on shift returned the patient record forms (PRF) to the base daily and stored them in a locked confidential box in the crew room until senior staff were able to remove them. We reviewed 20 patient transport service booking forms.

Staff we spoke with knew how to support patients who had a do not attempt cardiopulmonary resuscitation (DNACPR) decision in place. Staff told us the DNACPR process was part of the risk assessment with hospital or care home staff. Patient record forms we reviewed referred to patients transported with a DNACPR decision in place and staff told us they would always carry out risk assessments with hospital staff to ensure the patient was well enough for the journey.

Patient booking information included the pick-up and drop off address, mobility needs and any additional information such as whether the patient was living with dementia.

However, the forms were not always complete. Of the 20 forms we reviewed, two were missing information about when the patient was handed over, five were missing details about the person who had booked the transfer, five were missing escort information, such as if that was not applicable. Similarly, the structure of patient record forms we reviewed did not make it clear if controlled drugs (CD-s) were applicable or not. This did not represent best practice, but it did not put patients at immediate risk of harm.

Medicines

The service did not always use systems and processes to safely administer and store medicines.

There was a medicines management policy which detailed the management of medicines including how the service managed patient group directions (PGD).

The service did not store any controlled drugs (CD-s) on site.

Staff completed an eLearning module on medical gases and signed off a hard copy of oxygen procedures when joining the company. PTS staff followed the contracting trust standard operating procedure (SoP) for the administration of oxygen. The SoP was updated regularly, and any changes were cascaded out to staff via the message service or the internal human resources system.

Emergency care assistants (ECA-s), technicians and paramedics also completed a Level 3 Certificate in First Response Emergency Care (FREC) with an external training provider.

Patient transport services

Additional findings about medicines management and administration are detailed in the Emergency and Urgent Care report.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.

We reviewed ten incidents from the past 12 months and found that the service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Managers debriefed and supported staff after any serious incident. Managers encouraged staff to reflect on practice following any incident. We looked at one serious incident from the past six months and saw that it had been notified to the relevant organisations and communicated to staff as a learning point.

Managers investigated incidents and patients, external providers and patients, and families were involved in these investigations.

Staff received feedback following the investigation of incidents, both internal and external to the service.

Are Patient transport services effective?

Good ●

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service generally provided care and treatment based on national guidance.

Service policies and procedures were in date, version controlled and accessible to staff via an application they accessed from their work phones.

Emergency and urgent care staff had access to **_The Joint Royal Colleges Ambulance Liaison Committee (JRCALC, 2019)_ guidelines to provide additional guidance when managing emergency patients. Patients' needs are assessed at booking point and entered on the booking system and the associated patient record form. The patient record forms (PRF) we reviewed contained some information about specific needs the patients had. However, details such as physical health monitoring and mental health needs were not recorded.**

Nutrition and hydration

Patient transport services

Staff assessed patients' food and drink requirements to meet their needs during a journey. The service made adjustments for patients' religious, cultural and other needs.

Due to the nature of the service food was not prepared for patients. When travelling long distances, the location from where patients were collected were asked to provide food based on the needs of the patient, or refreshment stops were added to the journey. If a patient was hungry or the journey was extended due to traffic or other circumstances, staff told us they would stop and get the patient something to eat.

Pain relief

Staff provided pain relief where appropriate and based on their competency and skills level.

Staff on patient transport services (PTS) did not provide any pain relief for patients. There were clear processes in place for staff to follow regarding patient's own medicines.

Staff providing patient transport services (PTS) services did not carry controlled drugs. The service liaised with the local NHS Ambulance trust to ensure staff were deployed on these vehicles with the correct competencies and skill level. Should staff arrive at the scene and require additional pain relief for patients they would call for additional support from the NHS Ambulance trust and request a qualified paramedic or additional staff.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. Staff told us they had clinical support either from the contracting trust, the hospital or the base. Staff gave us examples of raising issues with the contracting trust and agreeing on improvement actions. For example, the service refused a request to transfer a patient using the secure caged vehicle because the patient was voluntary and elderly, suffering from dementia. The service raised it with the contracting trust. As a result, they provided the transfer timely but used a PTS vehicle to ensure the patient was comfortable and safe, rather than the mental health secure vehicle.

Patient outcomes

Systems for monitoring the effectiveness of care and treatment were not fully embedded.

The service recorded journey times for Patient Transport Services (PTS) services for discrepancies when invoicing the contracting trust. The contracting trust held bimonthly meetings where key performance indicators (KPI-s) were discussed and monitored. Messages were sent to staff and recorded in the dedicated human resources system to flag any required improvements, such as updating the PDA on arrival.

Competent staff

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

The registered manager told us all staff had received appraisals in the 12 months prior to our inspection. We reviewed the dedicated system used to log and flag appraisals and saw that no staff were due their appraisals.

Patient transport services

Good 🟢

The operational staff rota was overseen by the management team. They identified staff with the right skill mix and allocated staff shifts based on patient needs and demands within the service. For urgent and emergency care journeys, the service always deployed an emergency care assistant and an emergency care technician. For mental health secure transfers, the service ensured both a trained emergency care assistant and a trained technician were present.

All staff completed a full induction to the service, which was documented in the staff files we reviewed on site.

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.

Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The provider had an up to date mental capacity act (MCA) policy and guidelines for staff to follow.

Staff received patient information in advance of each journey, including if the patient required additional support due to living with dementia, or if they lacked capacity. This enabled them to carry out risk assessments with hospital or care staff to manage the patient's safety during any patient transport journey.

Training on the Mental Capacity Act and on consent are part of the mandatory training modules. Staff we spoke with gave examples of informed and implied consent and how they supported patients who may lack capacity. For example, patients who may have a temporary loss of capacity due to injury in an emergency or those patients living with dementia or cognitive impairment.

Are Patient transport services caring?

Good 🟢

Our rating of caring stayed the same. 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.

Due to the ad hoc nature of the service, we were unable to observe any interaction between patients and staff. The service did however seek feedback from patients, families and service commissioners.

Staff told us they would give the patient a feedback form at the end of a journey, with the contact details for the office, to provide feedback. The feedback forms were also available at the reception desk of the main building for visitors to the service. Patients and carers were also able to give feedback on the provider's website. We reviewed 30 patient and carer feedback forms.

Good ●

Patient transport services

Staff explained sometimes they only met a patient or family once and first impressions counted. It was important they made the patients feel at ease and placed them at the centre of the journey, making sure they listened to their needs and always respected their dignity.

Examples of patient feedback included, "I wanted to thank you and the crew of the transport for such a wonderful job". Another family member said, "I wanted to thank you for being so helpful in getting the booking sorted assuring all of my concerns".

The three carers we spoke with told us the support their relatives and themselves received from crew members had been excellent. They told us staff took time to explain the processes and the expectations regarding care and treatment and were also very accommodating towards any anxiety and mental health struggles the carers and their relatives experienced. The carers also told us this had been the best ambulance service they had used for years, and that they would often request iON crews over other providers.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff we spoke with told us they enjoyed working with patients and recognised some patients may be living alone.

Staff told us they had some patients they regularly transferred. These patients needed regular dialysis, orthopaedic or oncology appointments. They told us they built good relationships with the patients and some patients specifically asked for certain staff when they booked in for journeys.

Staff explained sometimes patients would get upset during the journey, and they would listen to the patients and provide reassurance. If staff felt a patient was vulnerable or needed more support, they would report this to their manager for escalation back to the service commissioners.

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.

Managers and staff kept patients and their families informed about transport pick up and drop off times.

Staff told us the journeys were pre-planned and the patient's information was handed over to them in advance by hospital or care home staff. They spent extra time, particularly if the patient was living with dementia, to explain the journey to the patient and keep them informed of any unexpected delays, their expected time of arrival, either at their home or the location of their appointment.

Staff we spoke with said when they handed a patient over at a care home, they would pass all the paperwork to the carers. If staff dropped the patient at their home, they would run through what the patient had eaten, or if they have had any medicines before leaving to ensure the patient was safe.

Are Patient transport services responsive?

Patient transport services

Good ●

Good ●

Our rating of responsive stayed the same. 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.

The registered manager had regular meetings with commissioners of the service to discuss demand and flow in the local area. The service provides Patient Transport Services (PTS) and Urgent and Emergency Care (U&EC) through NHS contracts to relieve pressure on those services as well as providing specialised services such as bariatric care.

The registered manager told us they were in the process of planning to move their location as they recognised the service was outgrowing its current location.

Meeting people's individual needs

The service was inclusive to take account of patients' individual needs and preferences.

The service relied heavily on the service commissioners to provide information in relation to the patient journeys and staff used patient care records that included specific details in relation to the patient care. For example, if a patient needed a wheelchair, a trolley or additional care support on the journey. The staff would then liaise with the services leaders to ensure they had the right vehicle and equipment to meet the patient's needs.

We reviewed the bariatric support vehicle on site and found it to be new, visibly clean and fully equipped to meet the needs of bariatric patients. It also included guidance for staff on how to use the equipment present on the vehicle.

Staff we spoke with explained how they supported patients living with dementia and how they liaise with hospital and care home staff and family to ensure they understood the patient's needs. Dementia training was also included in the mandatory training module for all staff members. Patient record forms flagged patients with additional needs to ensure staff were aware of any additional support required. We reviewed detailed aide materials available to staff in the crew room, as well as an up to date infographic about dementia.

Staff we spoke with told us the service had communication aids to support people, and they could access translation services. One member of staff explained English was their second language and they had interpreted for patients where English wasn't their first language to help hospital staff understand their needs. Staff used mobile phone apps and pictorial cards inside the vehicles, and one member of staff told us they had used pen and paper sometimes to draw pictures or hand gestures to encourage interaction with patients.

Access and flow

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

Patient transport services

Good ●

Staff were allocated to journeys by NHS site management teams and deployed based on demand. Journeys included transporting patients to and from hospital appointments, hospital discharges as well as providing urgent and emergency care support as part of front-line resilience for a local NHS ambulance trust.

Most patient record forms we reviewed indicated journey times in line with national standards. However, two of the 20 forms we reviewed were missing handover times.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

All vehicles carried patient feedback forms and gave the opportunity for relatives and patients to give feedback on their experience of care. Further, the service had moved to electronic feedback from patients and family members with QR codes being published on posters within the vehicles.

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

We reviewed records of complaints and compliments within the service which showed information was shared with staff. The service maintained a spread sheet of complaints, including actions taken to minimise any further similar complaints. However, the service as unable to establish how this feedback fed into wider improvements in the service as the service had no quality improvement plans or governance framework.

Staff we spoke with knew the service had a complaints process and said managers gave feedback when things had not gone right. Managers praised staff when they did well, and we reviewed feedback from families and commissioners showing where staff had made the patient journey enjoyable and patients felt well cared for and safe.

Are Patient transport services well-led?

Requires Improvement ●

Our rating of well-led stayed the same. We rated it as requires improvement.

Leaders were mostly visible in the service for staff and patients.

The service was led by the registered manager, supported by a governance and compliance lead, an operations base manager and a fleet manager.

Staff we spoke with described the leadership team as visible within the service, willing to support them and available if they had any concerns.

However, the leaders had focused on the growth of the business and not considered the wider risk this created, for example ensuring governance and risk management, mainly regarding medicines and risk assessments.

Vision and Strategy

Patient transport services

The service had no coordinated strategy or vision.

The service vision was to become the best private ambulance provider for local hospitals and maintain and grow their training provision. The vision was displayed on the providers website. Leaders had plans to develop a mental health division within the service, as well as an in-house training department. However, the service did not have a coordinated strategy to implement their vision.

Staff we spoke with during our inspection were unaware of the vision for the service. The registered manager and director told us they were in the process of updating this at the time of our inspection.

There were no systems for putting the mission into a strategy to improve the service or a vision for the service in the future.

Culture

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

Staff we spoke with during our inspection told us they liked working for the service and enjoyed the work they did. The provider had an up-to-date grievance policy, and disciplinary processes involving an independent third-party organisation for transparency. We also reviewed the whistleblowing and allegations policies, which were detailed and up to date.

Staff explained the importance of providing the right care for patients and ensuring they were given good care and the journeys were enjoyable.

Staff told us leaders were generally approachable and available to discuss any concerns. However, during our inspection visits we witnessed instances where senior leaders addressed staff members rudely, abruptly or shouting.

Governance

Leaders did not always operate effective governance processes, throughout the service.

The service had some systems for auditing the quality of the service, such as hand hygiene audits, Covid-19 passport audits, ambulance spot check audits, uniform and appearance audits, patient feedback reviews. However, there was no overarching governance process to drive quality, or draw learning from incidents or complaints to make improvements within the service. We reviewed four sets of minutes for quarterly clinical governance meetings and eight sets of minutes for the monthly management meetings and saw that they did not detail the discussions regarding incidents or any sharing of learning from incidents.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively, identify and escalate relevant risks and issues to reduce their impact.

Patient transport services

At the time of our inspection the provider had implemented a risk register following recommendations from the previous inspection. However, it mainly contained generic risks related to the day-to-day operations within the service, for example, fire risks, office risks and medicines risks amongst others. There was limited evidence the provider had a process to capture risks as they emerged within the service for example the lack of governance, audits and safety monitoring over time.

The service did capture some key performance indicators for example urgent and emergency care journey times, the cleaning of vehicles, and servicing of equipment. However, leaders were unable to demonstrate how they coordinated this information to improve performance or safety over time.

The service provided the up to date records of management or staff meetings with a significant delay. The registered manager told us during the COVID-19 pandemic this had been difficult to manage, and they were reintroducing these back into day-to-day business.

The service had plans to cope with unexpected events and an up to date business continuity plan.

Information Management

The service collected some data and analysed it.

The service collected some key performance indicators in relation to its journey times and collected these on individual spread sheets. The service did not have embedded quality and improvement processes to join information together and drive improvements.

The information systems were integrated and secure. Staff used mobile phones and an IT portal and desk-based computers to access information in relation to the service, these were password protected.

Engagement

Leaders had a limited engagement strategy for staff, patients or other stakeholders.

Leaders and staff had limited engagement with patients, staff, equality groups, the public and local organisations to plan and manage services.

The registered manager told us they had not held staff meetings in the twelve months prior to our inspection, they had tried remote meetings using IT systems, but these had proved unsuccessful.

The staff did see the registered manager, director or team leaders on a day-to-day basis when they signed on for duty, and they shared feedback and information during this time. The leadership team shared updates by email and staff had access to an IT portal where they accessed policies, shift rotas and information on the service.

We reviewed evidence of positive patient feedback shared with the service by its Commissioners.

Learning, continuous improvement and innovation

Patient transport services

Some staff we spoke with were not aware of quality improvement initiatives within the service. However, senior leaders told us they make staff aware of initiatives to improve the business through the audits conducted by team leaders and managers, suggestion boxes on site for staff to suggest ways of improving the business and a group mailbox about "bright ideas" where staff can send their suggestions. Further, leaders told us there were incentives for staff performance, such as employees of the month.

The registered manager told us they were in the process of planning to move their location as they recognised the service was outgrowing its current location. They had increased the number of vehicles within the fleet, increased the number of staff employed within the service and felt the premises were no longer suitable for their needs.

Emergency and urgent care

Requires Improvement 🟠

Safe	**Requires Improvement** 🟠	
Effective	**Requires Improvement** 🟠	
Caring	**Good** 🟢	
Responsive	**Good** 🟢	
Well-led	**Requires Improvement** 🟠	

Are Emergency and urgent care safe?

Requires Improvement 🟠

Our rating of safe went down. We rated it as requires improvement.

Mandatory Training

All staff completed mandatory training.

Mandatory training was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Safeguarding

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

Safeguarding was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Cleanliness, infection control and hygiene

Staff did not consistently manage patient's infection risk. Staff did not always have access to advanced personal protective equipment to reduce the risk of staff contracting COVID-19 when undertaking some procedures. However, vehicles and equipment were visibly clean.

Staff did not consistently use documentation to show how the service or staff had assessed the risk of COVID-19 either on booking the patient or during a patient journey. We reviewed 10 patient record forms and only four of these documented the patient's COVID-19 status. On one form, staff had documented the patient had returned from a high-risk country two days previously and COVID-19 status was unknown, there was no information detailing any precautions staff took for this patient. There was a section on the booking form to record if the patient had other infectious diseases, but this had not been updated to include covid-19.

Emergency and urgent care

There was a risk that staff did not have access to the correct personal protective equipment and were not always trained to use it effectively. On one of the vehicles used for high dependency transfers, we found two tight fitting respirator masks. The Health and Safety Executive (HSE) recommend staff have a FIT test prior to using them as the masks rely on having a good seal against the face. The registered manager did not have any evidence that staff had a FIT test but told us that the service did not carry out aerosol generating procedures and staff had brought these into the service from another provider they worked for. However, equipment bags did contain emergency equipment for aerosol generating procedures such as intubation kit and manual ventilation equipment.

The four urgent and emergency care vehicles we reviewed during our inspection were visibly clean.

The management of other infection control practices, vehicle and equipment cleaning and provision of basic personal protective equipment (PPE) was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Environment and Equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Ambulances used to transfer patient with high dependency needs had additional equipment such as suction units and cardiac monitors. They were also fitted with blue lights for emergency transfers. We inspected four high dependency ambulances and found the equipment was well maintained and visibly clean. However, there was a risk that new staff may stock the vehicles with appropriate equipment for high dependency transfers as there was no standard equipment list. We raised this with the registered manager who told us the service was working to implement one.

All other arrangement for environment and equipment were the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Assessing and responding to patient risk

There was no process for assessing and responding to risk for high dependency patients. Staff had access to clinical advice if a patient deteriorated.

Bookings forms and discussions with staff did not provide evidence that patients were triaged for high dependency transfers. The service had three ways of booking a transfer, by email with a booking form, by telephone or by electronic message. Staff told us once the control operator had basic information about a patient, they would text the location to the crew and phone with any additional information. One booking form submitted by the service for a high dependency transfer did not detail the patient's condition. However, the service told us that they always discussed the patient's condition with nursing staff who accompanied the patient and all high dependency transfers were led by a qualified technician. Therefore, the impact on patient safety was reduced.

Patient record forms were not tailored to meet the needs of high dependency transfers and did not prompt staff to assess patient needs, such as clinical condition, monitoring or the speed of transfer required. Out of the forms we reviewed, only two included details of the patient's past medical history. These were written on a blank space within the form as there was no area dedicated for staff to document the patient's past medical history.

Emergency and urgent care

There was a risk that patient record forms did not provide enough detail about the patient's care and treatment during high dependency transfers. The provider told us that a registered nurse was on board for all high dependency transfers. Six out of 11 patient record forms we reviewed showed patients had cardiac conditions and required constant monitoring. Journey times ranged from 10 minutes to one hour and 20 minutes. All the patient record forms provided a brief summary of the patient's journey and any medical gases that had been administered.

Staff had remote access to clinical advice if the patient deteriorated. From 6am to 10pm, staff had access to a clinical lead who was a paramedic. Outside of these hours, the operations manager who was a qualified technician provided clinical support. Staff could also contact the hospital where the patient was travelling to or from for advice. We asked the provider to submit a copy of their protocol for accessing clinical advice if a patient deteriorated on a journey, but this has not been received.

There was an application that was downloaded onto phones from the Joint Royal Colleges Ambulance Liaison Committee that allowed individual ambulance services to combine the national guidelines with their regional information. This gave ambulance crews access to up-to-date clinical guidelines at all times.

Staffing

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

Staffing was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Records

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

The arrangements for storage and accessibility of records was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Medicines

Staff did not always follow systems and processes to ensure safe storage of medicines.

The service did not always safely monitor medicines. The batch number and expiry date of medicines were recorded with a running total of the amount medicines available. A sign in and a sign out register was kept ensuring each medicine bag could be tracked. However, the service did not carry out routine medicines storage audits and we were not assured the service had arrangements in place to safely monitor medicines within the service.

Additionally, we found a technician bag containing expired medicines, as well as an expired glucose monitoring kit. These were kept in a room with restricted access via a code lock, but not accounted for in the associated register. We raised this with the provider on the day and they removed both items. The provider also informed us that all medicines had been moved to a different site.

Emergency and urgent care

Further, the technician bags storage cupboard lock was not fully efficient, as the doors could be pulled half open and there was a risk of reaching out to contents of the technician bags. However, the provider told us that vehicles would arrive on site equipped from the Oxford location, including any technician or paramedic bags, as required.

The service had up to date patient group directions (PGD) for technicians. A PGD is legally required if the medicine is administered from the service's own stock to a patient. A PGD allows healthcare professionals to supply and administer medicines to a pre-defined group of patients without a prescription ensuring patients receive medicine quickly if needed. Staff also had access to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines which provided further guidelines on how to administer medicines.

There was an up to date medicines management policy which outlined the roles and responsibilities of ordering, storage and administration of medicine. Arrangements for medicine management were also included in staff induction.

The service stored medical gases safely.

The service did not store any controlled drugs on site. These were stored at another location.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.

The arrangements for managing incidents was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Are Emergency and urgent care effective?

Requires Improvement 🟠

Our rating of effective went down. We rated it as requires improvement.

Evidence based care and treatment

The service generally provided care and treatment based on national guidance.

The arrangements for evidence base practice was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Pain relief

Staff did not always document patients' pain. The service did provide suitable tools to assess pain for those unable to communicate.

Emergency and urgent care

Patients' pain assessment was not always documented. There was no clear prompt for staff to record the patient's pain assessment on the patient record form. Out of the 10 records we reviewed, pain scores were recorded for three patients in the comments section of the form.

The service provided different tools for staff to assess patients' pain, these included a verbal 0-10 pain scale and a visual pain scoring system.

Response times

The service monitored response times but there was no system for monitoring the effectiveness of the service.

The service reviewed its response times for providing urgent and emergency care services. Staff recorded pick up times, arrival times and site departure times on patient record forms. We reviewed 10 patient record forms and all had journey times recorded. However, the service did not have an embedded system to review these or make improvements. Further, the service did not carry out audits of response times and driver assessments.

The service did not carry out an emergency (999) work, so was not required to monitor the performance against the national targets.

Patient outcomes

Systems for monitoring the effectiveness of care and treatment were not fully embedded.

Patient outcomes were the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Competent staff

The service made sure staff were qualified for their roles when they joined the service. However, the service took assurance from their qualifications and did not carry out their own competency checks.

There was no evidence staff received ongoing competency checks. The provider told us all staff received and completed a theory and practical test before starting and qualified staff received skills testing from the clinical lead. However, we reviewed five staff files and did not see evidence of these tests. The service had recently moved to an electronic system for managing staff recruitment and training files. We asked a senior member of staff to show us the electronic system, but they had difficulty accessing the system. We did see one staff member's electronic file, but it did not contain any additional information. All staff with a professional qualification had this checked prior to joining the service. However, there was no process to check the competence of staff either upon joining or throughout their employment. The registered manager told us that team leaders would observe staff practices on shift, but we did not find any evidence of this in the staff files we reviewed.

Staff who carried emergency driving for their role held additional qualifications for this. We reviewed five staff recruitment files and found none of these had driving assessments within the last year. Two members of staff did have a driving assessment, but these were dated September 2020 and March 2017.

Emergency and urgent care

All other arrangements for competent staff were the same for both urgent and emergency care and patient transport services. We have used this evidence to inform our rating.

Multidisciplinary working

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

Multidisciplinary working was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Consent, mental capacity act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Consent and the mental capacity act were the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Are Emergency and urgent care caring?

Good ●

Our rating of caring stayed the same. 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.

The three carers we spoke with told us the support their relatives and themselves received from crew members had been excellent. They told us staff took time to explain the processes and the expectations regarding care and treatment and were also very accommodating towards any anxiety and mental health struggles the carers and their relatives experienced. The carers also told us this had been the best ambulance service they had used for years, and that they would often request iON crews over other providers.

Compassionate care was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Emotional support was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Emergency and urgent care

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.

Understanding and involvement of patients and those close to them was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Are Emergency and urgent care responsive?

Good 🟢

Our rating of responsive stayed the same. 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.

Service delivery to meet the needs of local people was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Meeting people's individual needs

The service was inclusive to take account of patients' individual needs and preferences.

Meeting people's individual needs was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Can people access care in a timely way

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

Access was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Learning from complaints and concerns was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Are Emergency and urgent care well-led?

Emergency and urgent care

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders were mostly visible in the service for staff and patients.

Leadership of the service was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Vision and strategy for this service

The service had no coordinated strategy or vision.

Vision and strategy were the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Culture within the service

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

Culture within the service was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Governance

Leaders did not always operate effective governance processes throughout the service.

Governance systems were not always effective. Whilst there were some processes, we found several areas where these were not effective, particularly in medicines management.

The pharmacy that supplied the service with medicines was not licensed to provide wholesale medicines. We reviewed medicine orders that had been signed by the medical director and registered manager, meaning they were both aware of the pharmacy used to supply medicines. Whilst this is unlikely to cause a patient safety issue, it demonstrates the service do not have oversight or assurance of their medicine supply.

All other governance arrangements were the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Management of risk, issues and performance

Emergency and urgent care

Leaders and teams did not always use systems to manage performance effectively, identify and escalate relevant risks and issues to reduce their impact.

Management of risk, issues and performance was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Information management

The service collected some data and analysed it.

Information management was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Public and staff engagement

Leaders had a limited engagement strategy for staff, patients or other stakeholders.

Public and staff engagement was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

Learning, continuous improvement and innovation

Innovation, improvement and sustainability was the same for both the urgent and emergency care service and patient transport service and we have used this evidence to inform our rating.

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
Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose The service did not ensure staff who may be exposed to aerosol generating procedures at any time during their work had the correct level of personal protective equipment and were trained to use it in line with Department of Health guidelines. There was evidence that staff could perform aerosol generating procedures, but masks with the appropriate level of protection were not provided or fit tested.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983 The service did not have systems or processes to operate effective governance. For instance, there was not sufficient oversight of medicines, staff competencies and patient risk to ensure patient safety. We saw medicines were not audited, ongoing competencies were not documented in appraisals or elsewhere, and there were no processes to drive improvement. The service did not have effective audits, did not have governance meetings, and there was no clear structure for management or oversight.