Harley Street Ambulance Service Limited

Harley Street 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

Harley Street Ambulance Service provides patient transport services and urgent and emergency care to their National Health Service (NHS) contracted partners and the private sector. Urgent and emergency care services include high dependency transfers between hospitals. The service, which was established in 1982 and has one location in North West London, operates as a subcontractor to main contractors (identified as commissioners in this report).The main contractors who commission services from Harley Street Ambulance Service liaise directly with NHS providers.

Harley Street Ambulance Service transports patients across the whole of the United Kingdom and works across different boroughs and populations.

We inspected this service on 7 July 2016 as part of our comprehensive programme of inspections. We inspected the service again on 30 November 2016 following our quality assurance process. We obtained further information and followed up on some concerns arising from the July inspection. There were improvements within the service when we inspected in November 2016 compared to when we initially inspected in July 2016. The findings of both inspections are set out in this report. We do not currently have a legal duty to rate independent ambulance services but we do highlight good practice and issues that service providers need to improve and as a result we have not rated this service.

On our initial inspection on 7 July 2016, and following a consideration of evidence submitted to us prior to the inspection, we found the following areas of poor practice:

- Staff were not trained in children safeguarding and the service had low rates of completion of the adults safeguarding training.
- Staff left patient identifiable information on vehicles overnight posing data protection concerns.
- Mandatory training completion rates were low overall.
- We were not assured that the service was dealing with the level of risk within the service or had effective governance structures in place to identify risks within the service.
- No incidents were reported between 30 April 2015 and 30 April 2016. No incidents had been reported between April 2016 and the time of our inspection in July 2016.
- There was a high rate of staff turnover with the provider reporting 73% staff turnover between 30 April 2015 and 30 April 2016.
- We found poor infection control practices on the vehicles and on the premises.
- Some staff reported insufficient stock in their cars.

However, there were some areas of good practice:

- Those staff we spoke with on the inspection were happy to work for the service and felt supported and valued.
- Staff treated patients with respect, compassion and dignity.
- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment.
- The service was well coordinated with its commissioners to meet patients' needs.
- The service responded to and investigated complaints in a timely manner.

Findings of the follow up inspection on 30 November 2016 were:

- The service had introduced children safeguarding training and the completion rate was 75% as of 30 November 2016. However, this training was set at level one and this was not in line with national guidance.

Summary of findings

- Some incidents had been reported between July 2016 and November 2016.
- We found improvements in infection control practices in the vehicles and on the premises.
- We found that ambulances were appropriately stocked.
- There were improvements in training completion rates overall.

However:

- We found patient identifiable information in one of the vehicles we inspected.
- The administration of the medicine salbutamol, a medicine used for the lungs, by paramedics and emergency ambulance crews was in breach of regulations.
- A disclosure and barring service (DBS) certificate had not been applied for a member of staff we spoke to on the day of the follow up inspection.
- One risk had been recorded by the service. However, not all within the service had been identified and recorded.

Information on action we have asked the provider to take are listed at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We do not currently have a legal duty to rate independent ambulance services but we do highlight good practice and issues that service providers need to improve. Overall, we found the following areas of poor practice when we inspected on 7 July 2016 : • Staff had not been trained in children safeguarding even though the service transported children. • The service had low training completion rates overall, including safeguarding adults training. • The service reported staff turnover of 73 % between 30 April 2015 and 30 April 2016. • Patient identifiable information in the form of patient report forms and booking forms had been left on ambulances posing data protection concerns. • We found expired consumables in one of the three vehicles we inspected. • We found that there were no incidents reported by the service between 30 April 2015 and 30 April 2016. Although we do not have any documentary evidence it is unusual to find no incidents reported. We were not assured that staff reported incidents or that there were systems and processes for incident reporting in place. • There was poor infection control within the service including clinical waste that should have been disposed of but which had instead been left in an ambulance for days. There were dirty surfaces and glove compartments and unclear protocols for the deep cleaning of ambulances by staff. • During interviews, some staff reported insufficient stock in their vehicles. The areas of good practice were: • Staff we spoke with were happy to work for the service and felt supported and valued.

Summary of findings

- Staff treated patients with respect, compassion and dignity.
- Patient feedback forms seen during the inspection described the service as excellent or good.
- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment.
- There was good coordination between the service and its commissioners to meet patient's needs.
- We found the service responded to and investigated complaints in a timely manner.

Findings of the follow up inspection on 30 November 2016 were:

- The service had introduced children safeguarding training and the completion rate was 75% as of 30 November 2016.
- We found improvements in training completion rates overall.
- We found improvements in infection control practices. All three vehicles checked were clean and there were clearer protocols about the cleaning vehicles by staff at this location.
- We found ambulances were appropriately stocked.

However:

- We still found patient identifiable information in one of the vehicles we inspected.
- A disclosure and barring service (DBS) certificate had not been applied for one member of staff who had been with the service for two weeks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.
- Following the inspection in November 2016, we requested further information about the administration of medicines by paramedics and emergency ambulance crews. The administration of the medicine salbutamol, a medicine used for the lungs, by paramedics and emergency ambulance crews (EACs) was in breach of regulations.

Harley Street Ambulance Service

Detailed findings

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

Detailed findings

Contents

Background to Harley Street Ambulance Service

Harley Street Ambulance Service is an independent ambulance service providing patient transport services and emergency and urgent care services as a subcontractor to two main contractors (identified as commissioners in this report). They also provide patient transport services, including urgent care to the private sector. Emergency and urgent care services provided for commissioners include high dependency transfers between hospitals. The main contractors who commission services from Harley Street Ambulance Service liaise directly with NHS providers.

Harley Street Ambulance Service operates two services namely patient transport services and urgent and emergency care services using the same vehicles on an inter-changeable basis. As the information pertaining to these two services is substantially similar or the same we have reported on both services in the same report.

The service was established in 1982 and has one location in North West London. They transport patients across the United Kingdom working across numerous boroughs and populations.

The service has five ambulances used for both patient transport services and emergency and urgent care. The service is registered for transport services, triage and medical advice provided remotely and treatment of disease, disorder and injury.

We inspected the ambulance premises and the ambulances used by this service. We spoke with ambulance crews and patients and we also spoke with staff from some of the locations where the service transports patients to. As part of the inspection of the service we rode on ambulances and observed patient care throughout the patient journeys.

This was an announced comprehensive inspection. The initial inspection was carried out on 7 July 2016. A follow up inspection took place on 30 November 2016 following our quality assurance process. The registered manager for this location has been in post since July 2011.

Our inspection team

Our inspection team for the inspection in July 2016 comprised of two inspectors and three specialist advisors. On the follow up inspection, the team comprised of two inspectors.

Detailed findings

How we carried out this inspection

We visited Harley Street Ambulance Service for one day on 7 July 2016 as part of a comprehensive announced inspection. We decided to conduct a follow up inspection of the service in order to follow up on concerns arising from the inspection on 7 July 2016. We conducted the follow up inspection on 30 November 2016.

During the initial inspection on 7 July 2016, we spoke with ten members of staff including the director of the service, emergency ambulance crew (EACs), a paramedic and two administration staff. We inspected three of the service's five ambulances. We rode on ambulances and joined the ambulance crews on four patient transport journeys. We spoke with patients, relatives, and a transport manager from a hospital Harley Street Ambulance Service transported patients to.

We looked at data received from the service prior to the inspection. We also considered data provided during and after the inspection.

On 30 November 2016 we inspected three ambulances, spoke with five members of staff and reviewed a range of documents including daily vehicle checklists used by staff and documents relating to safeguarding and other mandatory training.

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Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Harley Street Ambulance Service is an independent ambulance service providing patient transport services and emergency and urgent care services as a subcontractor to main contractors (identified as commissioners in this report). They also provide patient transport services and urgent and emergency care to the private sector. The main contractors who commission services from Harley Street Ambulance Service liaise directly with NHS providers.

Harley Street Ambulance Service operates two services namely patient transport services and urgent and emergency care services using the same vehicles on an inter-changeable basis. As the information pertaining to these two services is substantially similar or the same we have reported on both services in the same report.

Harley Street Ambulance Service provides services across the United Kingdom working across numerous boroughs and localities. The service has five ambulances used for both patient transport services and urgent and emergency care services. The service is registered for transport services, triage and medical advice provided remotely and treatment of disease, disorder and injury. Urgent and emergency services include high dependency transfers between hospitals.

Patient transport services make up the bigger proportion of the work undertaken by Harley Street Ambulance Service. The service carried out 2,996 patient transport journeys and 885 urgent and emergency transfer journeys between 1 April 2015 and 30 April 2016.

We inspected this service as part of our comprehensive programme of inspections. The initial inspection took place on 7 July 2016. We had a follow up inspection on 30 November 2016.

The registered manager for this service has been in post since July 2011.

Patient transport services (PTS)

Summary of findings

We do not currently have a legal duty to rate independent ambulance services but we do highlight good practice and issues that service providers need to improve.

Overall, we found the following areas of poor practice when we inspected on 7 July 2016 :

- Staff had not been trained in children safeguarding even though the service transported children.
- The service had low training completion rates overall, including safeguarding adults training.
- The service reported staff turnover of 73 % between 30 April 2015 and 30 April 2016.
- Patient identifiable information in the form of patient report forms and booking forms had been left on ambulances posing data protection concerns.
- We found expired consumables in one of the three vehicles we inspected.
- We found that there were no incidents reported by the service between 30 April 2015 and 30 April 2016. Although we do not have any documentary evidence it is unusual to find no incidents reported. We were not assured that staff reported incidents or that there were systems and processes for incident reporting in place.
- There was poor infection control within the service including clinical waste that should have been disposed of but which had instead been left in an ambulance for days. There were dirty surfaces and glove compartments and unclear protocols for the deep cleaning of ambulances by staff.
- During interviews, some staff reported insufficient stock in their vehicles.

The areas of good practice were:

- Staff we spoke with were happy to work for the service and felt supported and valued.
- Staff treated patients with respect, compassion and dignity.
- Patient feedback forms seen during the inspection described the service as excellent or good.
- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment.
- There was good coordination between the service and its commissioners to meet patient's needs.
- We found the service responded to and investigated complaints in a timely manner.

Findings of the follow up inspection on 30 November 2016 were:

- The service had introduced children safeguarding training and the completion rate was 75% as of 30 November 2016.
- We found improvements in training completion rates overall.
- We found improvements in infection control practices. All three vehicles checked were clean and there were clearer protocols about the cleaning vehicles by staff at this location.
- We found ambulances were appropriately stocked.

However:

- We still found patient identifiable information in one of the vehicles we inspected.
- A disclosure and barring service (DBS) certificate had not been applied for one member of staff who had been with the service for two weeks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.
- Following the inspection in November 2016, we requested further information about the administration of medicines by paramedics and emergency ambulance crews. The administration of the medicine salbutamol, a medicine used for the lungs, by paramedics and emergency ambulance crews (EACs) was in breach of regulations.

Patient transport services (PTS)

Are patient transport services safe?

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

When we inspected the service in July 2016, staff had not received children safeguarding training even though the service transported children as part of both patient transport and urgent and emergency care services.

- On the follow up inspection in November 2016 staff had been trained in children safeguarding at level one. This was not in line with national guidance which states that the level of training must be at level two for all ambulance staff and at level four for the safeguarding lead.
- The service had low training completion rates overall, including safeguarding adults training.
- Data received from the provider prior to the inspection revealed that there was staff turnover of 73 % between 30 April 2015 and 30 April 2016.
- On 7 July 2016 we found that patient identifiable information had been left on ambulances overnight posing data protection concerns. On the follow up inspection in November 2016 we found one patient's identifiable information had been left on the ambulance, again, posing data protection concerns.
- We found that there was a lack of incident reporting with no incidents reported by the service between 30 April 2015 and 30 April 2016.
- The administration of the medicine salbutamol, a medicine used for the lungs, by paramedics and emergency ambulance crews (EACs) was in breach of regulations.
- Infection control issues were apparent within the service including clinical waste that should have been disposed of but had been left in the ambulance for days, dirty surfaces and glove compartments and unclear protocols for the deep cleaning of ambulances by staff.
- During interviews, some staff reported insufficient stock in their vehicles.

However:

- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment.
- On our follow on inspection in November 2016 we found there had been improvements in relation to safety. For example, the service had introduced children safeguarding training and the completion rate was 75% as of 30 November 2016.
- We also found improvements in training completion rates overall.
- We found improvements in infection control practices. All three vehicles checked were clean and there were clearer systems and processes for the deep cleaning of vehicles at this location.
- We also found ambulances were appropriately stocked.

Incidents

- The service did not report any incidents between April 2015 and April 2016. We asked the managing director about this and we were informed no incidents or near misses had occurred in that period. The service reported 2996 patient transport journeys and 885 urgent and emergency care journeys between April 2015 and April 2016 and out of these journeys no incidents had been reported. We were not assured that the organisation was reporting incidents or near misses. We were unable to assess how the provider used incidents to improve processes or how staff learnt from incidents because none had been reported. This also meant that the provider had no way of monitoring safety performance over time. We were not assured staff understood their responsibilities to raise concerns and report incidents and near misses.
- The service had an incident reporting policy and staff told us they were aware of this policy. We asked staff if they knew what the incident reporting protocol was. Staff told us when an incident occurred they telephoned the office to inform control staff. Staff subsequently attended the office to complete an incident reporting form which they handed over to the duty operations manager who logged the incidents onto an electronic system. There was no evidence of any incidents having been reported on the electronic system during the inspection in July 2016. Staff we spoke with did not

know they should be reporting near misses or no harm incidents. On 7 July 2016 we found that incident reporting was not embedded in the culture of the service.

- On our follow up inspection on 30 November 2016 we found the service had invested in an electronic system which they used as an information resource for staff as well as an incident reporting system. The service reported six incidents dated between 6 July 2016 and 28 November 2016. Incidents reported included near misses. There was evidence of learning from incidents and evidence of staff receiving feedback on incidents. There was evidence that the service had put systems and processes in place for the reporting of incidents.
- Staff reported untoward incidents such as aggression or violence by contacting their control room to report such incidents. Where staff were subjected to untoward incidents they would terminate the journey and contact control staff who made alternative arrangements for the journey to be carried out. This usually meant control contacting the commissioner to advise of the incident or getting a different crew to complete the journey. Staff reported they had not been subject to any untoward incidents between 30 April 2015 and April 2016 and were therefore unable to give us any examples of when they had reported such or of anything that had changed as a result of an untoward incident being reported to the service.
- From April 2015, NHS providers were required to comply with the duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Data received from the service prior to the initial inspection indicated staff had received training on duty of candour. However, we found that the service did not have a policy on duty of candour and staff we spoke with had a limited understanding of this duty and in some cases did not know what this duty was. We did not see any evidence of duty of candour being completed for patients and staff told us this was because there had been no incidents to trigger this duty. We were not assured that staff were responding to this regulation.

Mandatory training

- All staff completed mandatory training as part of their induction. Mandatory training included manual handling, fire safety, information governance, adults safeguarding, Mental Capacity Act, equality and diversity, and resuscitation training. Staff also received basic life support training and emergency ambulance driver training. Basic and intermediate life support training was provided by an external training company. Paediatric life support training was part of staff mandatory training. At the time of our inspection in July 2016, the training completion rate for basic life support was 30%.
- During the inspection on 7 July 2016 we found low completion rates for mandatory training, for example, 27% for information governance, 20% for Mental Capacity Act, 50% for adults safeguarding, and 59% for manual handling. Completion rates were higher in infection control (80%), equality and diversity (86%) and fire safety (68%). Harley Street Ambulance Service's target for training was 100% which meant that the target was not met in any of the training that was being offered by them.
- On our follow up inspection on 30 November 2016, we found an increase in training completion rates overall. The completion rates were 53% for basic life support, 50% for information governance, 35% for Mental Capacity Act, 90% for adults safeguarding level one, 82 % for adults safeguarding level two, 70% for manual handling, 94% for infection control, 95% for equality and diversity and 95% for fire safety.
- An external company provided driver training to staff. Topics covered included ambulance driving and the Highway Code, speed and safety and motorway driving. Drivers' licences were checked when staff commenced employment and annually.
- The service had a clinical governance manager whose role included training development and staff education and training. They were also responsible for monitoring staff compliance with training.

Patient transport services (PTS)

Safeguarding

- When we inspected in July 2016 staff at Harley Street Ambulance Service had not been trained in safeguarding children even though they transported children. We raised this with the managing director and the clinical governance manager and we were informed a training pack was being developed with plans to have all staff trained by 30 September 2016.
- On our follow up inspection on 30 November 2016 we found the service had introduced an online learning package in September 2016 for children safeguarding. This had been adapted from an external company resource which had been set at level one. Since this was introduced 75% staff had completed the training. The safeguarding lead was also trained to level one safeguarding children. Guidance from the Intercollegiate Document for Healthcare Staff (2014) is that all ambulance staff including communication staff should be trained to level two. This applies to all clinical and non-clinical staff that have contact with children/young people and parents/carers. That guidance also states that the safeguarding lead must be trained up to level four. The training provision for safeguarding at Harley Street Ambulance Service was therefore not in line with national guidance.
- Data received from Harley Street Ambulance Service prior to the inspection in July 2016 showed that 50% of staff had received training in safeguarding children. This was not consistent with evidence we found during the inspection, that is, staff had not had training in safeguarding children. We raised this with the clinical governance manager following the inspection. We were informed that the service had not actually trained staff in children safeguarding and that the figure had been placed on the document in error.
- Staff had received training in the safeguarding of adults at level two at the time of our inspection in July 2016. Staff we spoke with knew how to report safeguarding concerns and where to seek additional advice when necessary. We viewed two safeguarding referrals between December 2015 and January 2016. Referrals had been appropriately documented. We saw a total of six safeguarding referrals dated between January 2015 and July 2016. Four of these referrals were to do with conditions at patients' homes on discharge and the other two related to carers' conduct.
- Safeguarding adults training was part of mandatory training. At the time of our initial inspection 55% of staff had completed safeguarding adults level one training and 40% had completed safeguarding adults level two training. On our follow up inspection in November 2016 completion rates for safeguarding training were 90% for safeguarding adults level one and 82% for safeguarding adults level two.
- The service had a designated safeguarding lead who had been trained to level two for safeguarding adults. As they were responsible for putting the training materials together, they had been trained externally. Staff knew who the safeguarding lead for the service was. However, the safeguarding lead was not trained to the appropriate level in relation to adult safeguarding. A safeguarding lead would normally have a level of knowledge relating to safeguarding which exceeds the level required for operational staff, enabling the provision of advice and access to support across a safeguarding network in the event of difficult cases.
- The service had a safeguarding policy and staff told us they were aware of this policy and knew how to access it. On our follow up inspection we found the safeguarding policy (and other policies) were accessible to staff via the intranet which had recently been made available to staff.
- Harley Street Ambulance Service carried out enhanced disclosure and barring service (DBS) checks on staff. We saw evidence of the provider making checks to DBS and where appropriate getting copies of the DBS documents. Other employee checks included character references, driver and vehicle licensing agency (DVLA) driver checks, nursing and midwifery council (NMC) checks and health and care professions council (HCPC) checks. However, on our follow up inspection we spoke with one member of staff who had commenced work with the provider two weeks prior but had not had a DBS check done. We raised this with the managing director who assured us an application would be made that same day.

Cleanliness, infection control and hygiene

- On our first inspection in July 2016 we inspected three of the five ambulances used by the service and found issues with cleanliness and infection control in all three. For example, we found used cutlery in the front cab of

one of the vehicles and in another we found clinical waste which had not been disposed of and had been left in the vehicle. Staff told us this vehicle was not in use and had last been used two weeks prior. This meant that the clinical waste had been in that vehicle for two weeks.

- Clinical waste was disposed at the hospitals where staff transported patients to. Staff also collected clean laundry from the various hospitals they transported patients to and returned used linen there.
- On our follow up inspection in November 2016 we inspected three of the five ambulances used by the service. All were clean and clinical waste had been disposed of. The service had a new contract for a clinical waste bin to be provided at the premises. This meant that staff could dispose of clinical waste at the end of their shift if it did not finish at the hospital.
- Staff cleaned ambulances daily using materials provided by the provider. Antimicrobial wipes were used to keep vehicles clean during patient journeys. We found adequate cleaning material that killed most pathogens in the vehicles. There was a Control of Substances Hazardous to Health (COSHH) assessment book for all substances used by the service.
- An external company carried out the deep cleaning of vehicles every three months. We saw evidence of a deep clean by this external company in May 2016. On our follow up inspection in November 2016 we saw further evidence of a deep clean in August 2016. Some staff told us they took their vehicles to the car wash for deep cleaning. There was no recording of these deep cleans or what materials were used to clean the vehicles.
- We inspected the ground floor of the service on our first inspection in July 2016. We found an area used to store various equipment on one side and another area which had a sink and cleaning materials stored there. The mops and buckets were not colour coded and it was unclear what they were used for. We also saw equipment and ambulance kit stored in various areas in one of the rooms. We raised this with the managing director and the clinical governance manager and we were told the area was used to store equipment that was not in use and that none of the equipment stored there was used on the ambulances. When we asked about whether vehicles were cleaned in the downstairs area there were inconsistent answers. One senior member of staff told us that vehicles were cleaned there using the mops and buckets we had seen and another senior member of staff told us that no vehicles were cleaned in that area. We were not assured that staff were clear on the protocol for the cleaning of vehicles at the base or the credibility of information relating to whether vehicles were cleaned at the base or not or what materials were used.
- We found further infection control issues on the ground floor of the service during the same visit. Staff gave inconsistent statements about whether the sink located there was in use. The clinical governance manager told us the downstairs sink was not in use and staff washed their hands upstairs. This meant that if there was a need to wash hands, staff would have to open doors with unwashed hands until they went upstairs. This presented an increased infection control risk. Underneath the downstairs sink we found a clinical waste bag with dirty laundry in it. We raised this with the managing director and the clinical governance manager and the bag was removed.
- On our follow up inspection in November 2016 we saw that new arrangements were in place for the cleaning of ambulances at the service base. Barrels of cleaning chemicals were mixed with hot water through a pump system so that staff did not have to handle chemicals directly. Staff were able to show us how this system worked and showed us colour coded mops used for cleaning the ambulance interiors at the beginning of each day and when required during the shift. The sink located on the ground floor of the service had soap and towels available for staff to wash their hands prior to entering the rest of the station after carrying out cleaning tasks.
- Harley Street Ambulance Service had a member of staff allocated as the infection control lead within the service. Staff were aware of who this was. The service also had an arrangement with an NHS ambulance service that provided them with infection control advice if they needed it. 95% of staff had completed infection prevention and control training at the time of our inspection in July 2016.

Patient transport services (PTS)

- We observed good hand hygiene by staff when transporting patients. We observed staff wiping down the vehicles after each patient journey. Hand sanitising gels were available in all five ambulances.
- The service commissioners informed the service of any infection control alerts involving the patients they were contracted to transport. The information was recorded on the booking forms which were passed on to ambulance crews.

Environment and equipment

- On our first inspection there was no system in place to make sure that expired consumables were identified and removed from vehicles. We found out of date consumables in one of the three vehicles checked. These included gauze bandages, wound dressings and an icepack. We made the managing director aware of the out of date items we found and they removed them from the vehicles. Staff had access to consumables and personal protective equipment (PPE) stored in a cupboard in the office. We checked the cupboard and found that consumables were in date.
- On our follow up inspection in November 2016 we found that a new process of tagged equipment pouches had been introduced. The pouches all had a list of equipment so that it was clear what was inside and a tag showing the first expiry date of equipment inside. In addition each pouch was coded and a list in the office also showed the expiry date of the pouch. Staff were able to explain how they would take the pouch to the office when it reached the date and they could swap it for another if that date was passed. All of the pouches and equipment that we checked on the inspection were within their expiry dates.
- The service's five ambulances were owned and managed by an external company. Vehicles were leased by the Harley Street Ambulance Service and were serviced every six weeks. We saw evidence of vehicle servicing and planned maintenance and servicing. The leasing company notified the service a week before an MOT or servicing was due to arrange a date to have this completed.
- Ambulances were restocked by staff as part of the morning checks. Restocking of linen was done at the hospital locations throughout the day. Staff picked up clean linen from the hospital and dropped off the used linen.
- Some staff told us crews were sometimes sent out with the wrong equipment and that this was frustrating. On the day of our inspection a crew went out with an incubator when they should have gone with an infant pod to be used for an infant transfer. The service had to send another crew to deliver the correct equipment. Other staff reported that the way vehicles were stocked often meant that equipment was not standardised across all five vehicles with different equipment spread across all the vehicles. For example, staff told us that only two of the five vehicles had emergency paediatric kit on board. However, the managing director told us that the amount of paediatric journeys was low and therefore it was unlikely that they would all be required at the same time. We raised the issue of paediatric kit at the follow up inspection in November 2016 and we were assured that only the vehicles with paediatric kit would attend to paediatric bookings.
- We found that ambulances were well equipped for high dependency transfers. This included monitoring equipment, multiple sockets for hospital equipment and clamps for securing incubators to the ambulance if required.
- Some fire extinguishers in the vehicles did not have service dates on them. Staff told us these were checked as part of the vehicle lease agreements by an external company.
- An external company was responsible for the replacement of equipment such as the monitor and defibrillator. We looked at two monitors and found in date servicing stickers on them both.

Medicines

- No controlled drugs were kept on the premises or on the ambulances. Harley Street Ambulance Service staff who had undergone the drug administration training could administer oral paracetamol, aspirin, nebulised salbutamol (a medicine used for the lungs), oral dextrose gel (similar to glucose) and adrenaline. A total of 48% of staff had completed this training.

Patient transport services (PTS)

- The administration of the medicine salbutamol by paramedics and emergency ambulance crews (EACs) was in breach of regulations. Paramedics did not have the authority of a patient group direction to administer this medicine. Patient group directions (PGDs) allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. Also, paramedics did not have the legal authority to administer this medicine to patients in an emergency as it had not been prescribed for a particular patient. Salbutamol is a prescription only medicine which can be given by paramedics with the authority of a PGD or under a prescription. EACs did not have authority to administer this medicine. EACs would have been able to administer this medicine had it been prescribed for a particular patient and they had received the appropriate training to administer this medicine to that patient. Harley Street Ambulance Service did not have PGDs or individual patient prescriptions to allow for the administration of this medicine by paramedics and EACs and as such were not acting in accordance with the regulations.
- In the office, medicines were kept in a locked cabinet. Staff completed a signing in and signing out sheet as a means of managing medications and staff were signing the sheets appropriately.
- The service had a medicines management policy. Medical gases such as oxygen and Entonox were kept in a storage area which was locked. Medical gases were stored and secured safely on the ambulances. The service had an external medical advisor who was a medical doctor. He was responsible for prescribing medicines and signing off new stock for medicines.
- On vehicles, medicines were kept in sealed and secured bags with labels indicating what medicines where inside, quantity and expiry dates.

Records

- Staff received training in information governance. Completion rates at the time of the inspection in July 2016 were 27%. This was significantly below the 100% training target for the service. In November 2016 we found that 50% of staff had completed information governance training which was an increase from our first inspection.
- Harley Street Ambulance Service used booking forms (which they also referred to as running sheets) and patient report forms (PRFs) to record patient journey details and medical information. Ambulance crews and office staff informed us that all PRFs and booking forms were handed to the office at the end of each day. However, during our initial inspection in July 2016 we found booking forms and PRFs in two ambulances we inspected. The oldest document we found was from June 2015 and the latest was from 1 July 2016. Documents had been left in the glove box compartment and in a folder on the dashboard. Information contained within the documents included patient names, addresses, and contact telephone numbers and in some cases details of their medical conditions and medical history. This meant that sensitive and confidential patient information could have been seen or accessed by people who did not have the authority to do so.
- We raised this with the managing director who told us that leaving PRFs or booking forms in vehicles was against their policy. However the provider had no way of monitoring the return of PRFs or other documents which may contain patient information by ambulance crews. The documents we found were removed from the ambulances as soon as we raised the issue.
- On the day of our follow up inspection in November 2016 we found that there were new processes for paperwork submission. Staff had to put all the PRFs into an envelope which was then placed in a locked box in the office. These were checked off the main job sheet to make sure that they had all been submitted. However, we found one patient report form with patient details on it in one ambulance that was dated 10 days earlier. We raised this with the managing director on the day and the document was removed from the ambulance.
- The service had introduced a record audit process by the time of our follow up inspection in November 2016. Records were checked against a criteria and the results fed back to staff members. There were also prompt sheets for completion of paperwork within each vehicle.
- Staff did not always complete PRFs fully. For example we saw some PRFs with no dates or signatures on them. The managing director told us the audit of PRFs was an ongoing process. PRFs were stamped upon being returned to the office and any incomplete forms would be returned to staff for proper completion.

Patient transport services (PTS)

- Patient information including PRFs and booking forms were kept in locked cupboards in the office. The managing director told us that documents were kept for ten years. A confidential waste bin was kept in the office and documents placed there shredded on a regular basis.
- Harley Street Ambulance Service had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy. Staff we spoke with showed an understanding of the service's DNACPR protocol. Hospital staff and family members alerted the service if a patient they were transporting had a DNACPR order. Staff reported sometimes having difficulties in obtaining the original copies from hospitals. Details of DNACPR orders were appropriately recorded on the PRFs. Where staff had not been provided with the original DNACPR order, they requested to see it and telephoned their control room to inform them that they had seen an original copy of the order.
- Commissioners also informed the service of any DNACPR information when they despatched a job via telephone. This information was passed on to crews using the service's internal dispatch procedures. Where no information was provided to the service on dispatch of a job or on handover from a medical or nursing professional, or family it was assumed that, in the absence of a DNACPR order, resuscitation efforts were to be made in line with United Kingdom Resuscitation Council guidelines.

Assessing and responding to patient risk

- Health and safety management for the service as a business was carried out by an external provider who offered the service health and safety as well as risk advice.
- Staff assessed patients and monitored deterioration throughout patient journeys. For example, staff monitored blood pressure, heart rate, oxygen levels and blood sugar depending on the nature of the patient's condition. Observations were recorded on the patient report form (PRF). Staff told us that if the observations showed that the patient had deteriorated they took the patient to the nearest accident and emergency hospital.
- Commissioners informed the service if patients had any pre-existing conditions or risks. This was done at the time the job was dispatched to the service and any such information was included on the PRF or booking information. Staff told us that the commissioners did not always make them aware of patients' conditions or patient risks which meant that there were not always prepared for the patient or for safety risks. Staff informed us they carried on with the journey regardless.
- The service had an agreement with an NHS ambulance service for the provision of clinical advice over the phone. This arrangement allowed staff to contact the NHS ambulance service and receive clinical advice on deteriorating patients if staff felt it was needed. This was in addition to the systems they already had in place for continually assessing and responding to patient risk as a service. We found that this service was available but rarely used. Staff were aware of this service when we asked about it.
- Harley Street Ambulance service was not required to transport patients under section 136 of the Mental Health Act 1983 (MHA). The service did not transport patients detained under the MHA as their vehicles were not equipped for such transfers. The service transported patients with known mental health conditions (but not detained under the MHA) provided they had an escort with them.
- There was no policy for the management of disturbed or violent behaviour. Staff told us that the protocol was to contact control staff to inform them that a patient was showing disturbed behaviour. The patient journey would either be cancelled or staff would be advised on how to proceed. However, apart from staff telephoning the office there were no systems for the assessment and management of risks associated with transporting patients showing disturbed behaviour. We asked staff if dealing with patients with disturbed behaviour or violent patients was a common occurrence and staff informed us that this was rare. However, the risk remained for patients in this situation who may have needed the help of staff trained in the management of disturbed or violent behaviour.

Staffing

- Harley Street Ambulance Service employed 21 members of staff at the time of our inspection in July 2016. Staff included two paramedics, one registered nurse who was the managing director, a clinical governance manager,

and emergency ambulance crews. The above mentioned staff were a mix of permanent and bank staff. The service did not use agency staff. The managing director did not operate clinically.

- The skill mix was determined by the commissioners' requests. This was reviewed on a continuous basis and if there was need to change the composition of crew for a job this was done. The service only accepted transfers when they had sufficient staff and vehicles to carry them out. The service also used bank staff to align the rota to demand. Bank staff received the same training as permanent staff. Training completion rates already stated in the mandatory training section of this report include training for bank staff.
- Critical transfers had escorts such as intensive treatment unit (ITU) doctors and nurses accompanying the patient. The service also told us that as they received details for many jobs in advance they were able to allocate paramedics for transfers they assessed as higher risk.
- Staff worked nine hour shifts and had an hour's break. Staff told us that it was not always possible to get a break and that sometimes they had lunch whilst on patient journeys.
- Data received from the service prior to the inspection showed that Harley Street Ambulance Service had a staff turnover rate of 73% between 30 April 2015 and 30 April 2016. The high staff turnover was attributed to the fact that the majority of their staff were bank staff. The service had continued recruitment of bank staff. The service reported facing challenges with finding adequately qualified staff. To overcome this, new untrained staff had been sent on Institute of Health and Care Development (IHCD) courses and the service hoped that this would improve retention rates. There was also rolling recruitment of qualified staff for both permanent and bank staff positions.
- During our follow up inspection in November 2016, the managing director told us one member of staff had left between September and November 2016. Prior to that one member of staff left in May 2016 and another in June 2016.

Anticipated resource and capacity risks

- The service carried out a significant amount of ad hoc work and assessed resource requirements and capacity on an individual basis when requested. Demand fluctuated and the service only undertook work within their capacity. The service only accepted transfers when they had sufficient staff and vehicles to carry them out.
- There was ongoing communication between the service and its commissioners. This allowed for there to be a discussion about any resource and capacity risks. For example, where the service did not have the capacity to carry out a journey they would tell the commissioner that they were unable to carry out that job.

Response to major incidents

- There was no major incident training or planning. The managing director said due to the size of their service, there was no expectation that they would be involved in any major incident work.
- The business continuity plan for the service addressed what the action would be if there was a fire which meant that premises could not be occupied for more than 24 hours, if there was a fire leading to vehicle loss and if key employees were removed from the business with no notice.

Are patient transport services effective?

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- The service provided patient transport and urgent and emergency care in line with national guidance.
- The service coordinated well with commissioners in delivering effective care and treatment.
- Staff were able to appropriately plan for patient journeys using the information provided by their commissioners on booking.

However:

- There was no evidence of the provider monitoring patient outcomes for both contracted and private work.
- The provider did not have evidence on whether they met the key performance indicators as set out by their commissioners.

Evidence-based care and treatment

Patient transport services (PTS)

- Harley Street Ambulance Service's processes and policies were verified by their contract holders through due diligence audits. One of the two main commissioners carried out an audit of the service in June 2016. The service had not received feedback from that audit.
- Paramedics assessed patients using The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. Staff also referred to The National Institute for Health and Care Excellence (NICE) guidelines in providing emergency and urgent care. We saw a copy of JRCALC in the office but it was an out of date version.
- On our follow up inspection the service had updated their JRCALC to the 2016 full version. Pocket versions were also available on the ambulances.
- The resuscitation policy contained up to date resuscitation council guidelines and staff showed awareness of these guidelines.
- We saw three medicine management audits carried out in December 2015, March 2016 and June 2016. The audits showed that there were no issues or points requiring any action.
- There was no involvement in local or national audit activity and as such there was no benchmarking against other similar providers.

Assessment and planning of care

- Staff transported patients to destinations already identified on the booking forms received from their commissioners. Where the service was made aware of patient journeys in advance, they were able to appropriately plan delivery of care.
- Staff told us that an escort accompanied patients suffering from mental illness. They also told us that the commissioners indicated to them if a patient suffered from mental illness and this allowed them to plan staff numbers and skill mix for the journey beforehand.
- If a patient had a stroke or a heart attack en-route they were taken to the nearest appropriate hospital such as a stroke unit or an accident and emergency department.

Response times and patient outcomes

- Harley Street Ambulance Service did not monitor patient outcomes. This meant that we were unable to assess the effectiveness of the service in relation to people's outcomes.
- The managing director told us commissioners monitored the service's response times at various intervals. For example, one commissioner carried out spot checks on the service in order to ascertain that they were meeting the requirements of the contract and another carried out an audit on the service in June 2016. However, the service had not received feedback on the outcome of the audit or on the outcome of the spot checks. The service had also met with one of its commissioners on 15 October 2015 to discuss performance but no data or feedback had been given until a year later when a further meeting had been requested.
- There was no evidence Harley Street Ambulance Service monitored key performance indicators (KPIs) set by the commissioners. The managing director told us there was one target which was for staff to arrive at the pickup point on time and drop the patient at the destination at the time indicated on the booking form. The service believed they were meeting this target but there was no evidence of this.
- We saw three medicine management audits carried out in December 2015, March 2016 and June 2016. The audits showed that there were no issues or points requiring any action however the service did not carry out any other audits to look into the quality of the service they were providing. This meant that there were no action plans to improve quality or monitor improvements.
- Staff did not have to make decisions about the most appropriate hospital to take the patient to because this would already have been decided by the time they got details of the journey from commissioners or private patients. For example, all critical transfers were between hospitals.

Pain relief

- Staff trained in medicines administration could administer medicines such as oral paracetamol and

aspirin during patient journeys. Staff told us they monitored and assessed a patient's pain and if a patient was in pain that could not be managed during a journey they took them to the nearest accident and emergency.

- Entonox (a mixture of nitrous oxide and oxygen used for pain relief) was stored on the ambulances and could be given to patients to self-administer where appropriate.

Competent staff

- Informal supervision was carried out by the paramedics for the emergency ambulance crew, however this was not recorded.
- The service had an appraisal system where staff and their managers completed appraisal forms every twelve weeks before meeting to discuss staff performance and goals. 100% of emergency ambulance crews and paramedics had been appraised at the time of our inspection in July 2016. However only one of the two control room staff had received their appraisal.
- Harley Street Ambulance Service offered an induction programme during which new staff received ambulance familiarisation. Following the induction new staff would undergo mandatory training. Staff had a week of being supernumerary and during that time an experienced emergency ambulance crew member or a paramedic supervised them. There was evidence that staff at Harley Street Ambulance Service received supervision and appraisal as was necessary to enable them to carry out the duties they are employed to perform.

Coordination with other providers

- Ambulance staff spoke with members of hospital staff when they collected or dropped off patients. This enabled them to receive a handover about the patients as well as make sure that staff at the receiving centre were aware they had dropped off a patient into their care.
- Due to the fact that Harley Street Ambulance Service worked as a subcontractor, it was not always possible to directly coordinate care with other providers. Main commissioners dealt directly with staff at the hospitals and with patients or their families prior to contacting Harley Street Ambulance Service and giving them details of the journey to be carried out.
- For private patients the service dealt directly with those arranging or planning patient care and were able to coordinate arrangements for transfer.

Multidisciplinary working

- We observed ambulance crews entering the office to obtain details of journeys. We also observed telephone communication between staff and crews. Staff told us that they worked well with control staff and that if they had any problems whilst on the road they found the control staff effective in dealing with problems.
- We observed effective handovers between Harley Street Ambulance Service staff and staff at hospital locations during the initial inspection. We did not visit hospital sites on the follow up inspection.

Access to information

- Ambulance crews had access to patient information which was contained on booking forms provided by control staff. Any special notes were recorded on these sheets. For example if a patient was living with dementia, this would be flagged on the booking form. Staff reported that they were provided with the information needed to equip them to effectively provide care to patients.
- Staff reported they had access to policies and knew where to find them if they needed them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act was part of mandatory training and staff we spoke with showed a good understanding of mental capacity as well as about deprivation of liberty safeguards. However, the completion rate for Mental Capacity Act training at the time of our follow up inspection in November 2016 was 35%.
- We found that staff understood the need to have valid consent when supporting patients. For example, staff sought the patients' consent to be moved or placed on a stretcher or into a wheelchair.

Are patient transport services caring?

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Patient transport services (PTS)

Summary

We observed caring and compassionate care by staff during patient journeys and in their interactions with relatives.

- During the inspection staff from hospital locations and from organisations the provider worked with spoke of the caring nature of staff from Harley Street Ambulance Service.
- Patients we spoke with told us staff were caring and compassionate.
- Harley Street Ambulance Service involved people who used services and those close to them as partners in their care.

Compassionate care

- We rode on ambulances with crews and observed interactions between staff and patients. Staff treated patients with dignity and respect. Patients were covered with linen whilst on stretchers in order to maintain their dignity.
- Staff explained to patients what they were doing and gave assurance about where they were going and how long it would likely take.
- Family members and patients who had used the service described staff as "warm, humorous, patient and above all caring".
- Organisations that had used the services of Harley Street Ambulance Service had written references for the provider prior to the inspection giving feedback on what they thought about the services provided by Harley Street Ambulance Service. We saw various letters from organisations who used the service for their patients. One stated that "we always receive compliments from families on how professional, friendly and helpful the ambulance staff are". Another organisation said that "staff look presentable and treat patients with dignity and kindness".
- We spoke with a transport manager from a hospital where Harley Street Ambulance Service transported patients to who told us that Harley Street Ambulance Service staff were always caring and professional.

Understanding and involvement of patients and those close to them

- Harley Street Ambulance Service involved carers, family and others close to the patients in providing the service. However, due to the fact that Harley Street Ambulance Service worked as a subcontractor, they were not always involved in the planning stages of the booking of journeys.
- The service issued feedback questionnaires to all its private patients in order to gather the views of both patients and those close to them. We saw fifteen completed feedback forms and all fifteen of them stated the overall view of the service to be excellent or good.

Emotional support

- Patients who used services and those close to them received emotional support from Harley Street Ambulance Service staff. For example, we saw a feedback form where a family member stated that they "were really touched by [staff's] kindness and understanding of what a fraught time it was for us all." There were other similar examples seen in feedback forms.

Supporting people to manage their own health

- Ambulance crews told us that they encouraged patients to be as independent as possible and provided support where required. An assessment of whether this was appropriate was made by staff before encouraging independence.

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

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- Harley Street Ambulance Service responded to complaints swiftly.
- Services were planned to meet patients' needs.
- The service took into account the needs of different people.
- Vehicles had posters on how to make a complaint.

- Patients, relatives and carers had an opportunity to give feedback.

However:

- The service did not have aids to help staff communicate with patients with hearing or visual impairments.
- There was no training or aids to enable staff to better communicate with patients with a learning disability.

Service planning and delivery to meet the needs of local people

- Harley Street Ambulance Service provided services across the United Kingdom working across various boroughs and localities. The service planned its workload based on the work given to them by their commissioners as well as private work received. Planning was done in advance where possible.

Meeting people's individual needs

- Commissioners notified Harley Street Ambulance Service in the booking form details if a patient was living with dementia, had a learning disability, had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, or had a physical disability. The information was passed on to crews using the service's internal dispatch system.
- Data received from the service stated that its staff afforded people living with dementia, learning disability, physical disabilities and DNACPRs equal opportunity to access their services. It also stated that staff had undergone special training to enable them to be sensitive to these patient groups. However, while the majority of staff told us that they had received training on the Mental Capacity Act, they had not received any training specific to dementia, mental health or learning disability. This meant that staff did not always know how to communicate with patients suffering from these conditions.
- Staff had not had any conflict resolution training. However, staff told us even though they had not received any formal training to deal with violent or aggressive patients, they knew what the service's protocol was. Where staff were faced with violence or aggression they telephoned the control room to advise them of the situation. A decision would be made about whether the journey should continue.
- The service used an ambulance mental health triage assessment tool developed by an NHS ambulance service for patients they attended to as private urgent or emergency calls.
- Data received from Harley Street Ambulance Service stated that they had access to Language Line Translation Services, on an ad hoc pay as you go basis but had not yet used the service since its introduction in 2015. However, staff we spoke with were not aware of this service. They told us they used translation applications downloaded on their mobile phones to enable communication where there was a language barrier.
- Where the service was required to attend to patients as an emergency, arrangements for admission into hospital would already have been made therefore patients were conveyed without exception. Where patients were assessed as requiring lifesaving intervention by the ambulance crew they were conveyed to the nearest appropriate accident and emergency department or inpatient facility such as the heart attack centre or the hyper-acute stroke unit.
- The service had suitable equipment for bariatric transfers and an extra crew was provided where required.

Access and flow

- The majority of patient journeys were planned and booked by the provider's commissioners. Harley Street Ambulance Service took jobs they had capacity for. The service also took on private client bookings when they had the capacity for those journeys. Bookings were made for a time that suited patients.
- The service had not been provided with any information from their commissioners on whether they were meeting the targets set out for them. This meant that they had no way of knowing if they were meeting the response time targets. An assumption had been made that if the commissioners had not raised targets as an issue, they were more likely than not meeting them.
- The service met with one of their commissioners in October 2015 to discuss key performance indicators but they had not received feedback on how they were performing. Another commissioner carried out an audit in June 2016 and at the time of the inspection the

service were still awaiting feedback on that audit. There was no further evidence of whether Harley Street Ambulance Service were meeting targets on the follow up inspection on 30 November 2016.

Learning from complaints and concerns

- Harley Street Ambulance Service had posters in the back of ambulances informing users of the service how to make a complaint. There were two complaints between 1 April 2015 and 30 April 2016.These complaints related to subcontracted work and had been investigated jointly by Harley Street Ambulance Service and the commissioners involved. The complaints had been dealt with swiftly. Complaints were dealt with by control in the first instance and, if they needed escalating, the managing director investigated the complaints. Complaints arising from private work were investigated by the provider in accordance with the complaints policy.
- The service issued feedback questionnaires to its private patients and their relatives to complete. This allowed staff to quantify their successes and identify areas of improvement.
- Staff told us that with all private bookings, patients were advised at the time of booking, who they should contact should they experience any problems. Staff told us that where issues were identified during a journey, clinical staff would advise the patient to make contact with the service's control room staff who would try to resolve the problem informally in the first instance. After this patients could make a complaint in writing and this would be dealt with formally.
- The service aimed to resolve all complaints within five working days and this was reflected in their complaints policy. We found that Harley Street Ambulance Service dealt with or resolved complaints within the stated five working days in the complaints we viewed during the inspection.

Are patient transport services well-led?

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- There was no clear vision or strategy for the organisation.
- Staff did not know what the vision and strategy for the service was or their role in the strategy for the service.
- The service had a risk collection form but nothing had been recorded to indicate the risks within the service.
- There were no staff meetings involving all staff.
- We were not assured that the culture of the organisation promoted openness and transparency of the service in relation to children safeguarding training figures provided to us prior to the inspection.
- Risk management was outsourced to an external company. We were not assured the provider took ownership of the need to assess risk specific to the day to day running of the business and the provision of care to patients because the risk management company did not work with the service on a day to day basis.

However:

- There was a clear management structure within the service.
- Staff felt well supported and valued by their management.
- Staff reported that managers were visible and approachable.

Leadership of service

- Management was made up of the director of the service, a non - clinical operations manager, and a clinical governance manager. Clinical leadership was provided by the managing director who is a registered nurse.
- All staff we spoke with felt supported in the organisation and reported that the managing director and the clinical governance manager were visible and approachable. Operational road staff reported that they were able to see their managers whenever they came to the office.

Vision and strategy for this service

- The director of the service told us the vision for the organisation was to provide the best private ambulance company in London. However, there was no clear strategy for how this would be achieved. For example,

there were no set values setting out the organisation's vision or monitoring or reviewing of progress against delivering the strategy. It was therefore unclear how the vision would be achieved.

- Staff we spoke with did not know what the vision or values of the organisation were or understand their role in achieving the strategy for the organisation.

Governance, risk management and quality measurement

- The managing director of the service provided overall leadership of the organisation. The service also had a non-clinical operations manager and a clinical governance manager who both reported to the managing director. The non-clinical operations manager was responsible for managing the calls that came into the control room and communicating journeys to drivers. They worked with one other member of staff and the two were the service's control room team. The non-clinical operational manager was also responsible for arranging vehicle checks, the servicing of vehicles and equipment, and maintaining paperwork relating to vehicle checks and servicing. The clinical manager's role involved continually putting systems in place to improve clinical governance in the organisation as well as putting together training packages and monitoring of training data. They were also the safeguarding and infection control lead.
- The service did not routinely understand and record risks on the service. While it had a risk collection form nothing had been recorded. There were a number of risks we identified that were not on the register. For example, the service admitted to difficulties in recruiting qualified staff but this had not been recorded as a risk. Also, staff told us commissioners did not always make them aware of patients' conditions or patient risks which meant that they were not always prepared for the patient or for safety risks. This had not been recorded as a risk by the service. The lack of children safeguarding had not been recorded as a risk at the time of our initial inspection in July . For these reasons we were not assured that the service was dealing with the level of risk within the service or had effective governance structures in place to identify risks within the service.
- On our follow up inspection in November 2016 the service had recorded one risk related to tyre blowouts. The clinical governance manager told us that they were reviewing the register in order to identify any further risks.
- Risk management was outsourced to an external organisation who advised the service on risk and health and safety issues. This organisation was also responsible for reviewing the organisation's policies. However, we were not assured that the provider took ownership of the need to assess risks specific to the day to day running of the business and the provision of care to patients. For example, there was no evidence of drivers carrying out any risk assessments when they transported patients.
- Harley Street Ambulance Service was a member of Quality Management System (QMS), a system that documents processes, procedures, and responsibilities for achieving quality policies and objectives in an organisation. This system used ISO9001:2008 standards. Membership to QMS meant that the provider had guidance to ensure that their services consistently met customers' requirements, and that quality was consistently improved. The service used membership of QMS as a way of measuring the quality of the service they provided. QMS audited Harley Street Ambulance Service in January 2016. The audit covered 23 areas and Harley Street Ambulance Service passed in 22 out of these 23. They failed on lack of proper documentation for an audit they had undertaken of the QMS quality manual. Although the service was part of a quality measurement review process, this process had not been effective in identifying the risks within the service.
- The service held management review meetings every three months. The director of the service, the non-clinical operations manager and the clinical governance manager attended these. We saw minutes of two meetings held in September 2015 and March 2016. Agenda items included vehicles, staff training, office improvements and staff recruitment. Minutes of these minutes were not circulated to the rest of the staff.
- The service did not hold staff meetings (apart from the management review meetings mentioned above).Staff told us training days were the only opportunity they had to meet as a team and discuss any issues. The clinical

governance manager told us it was difficult to arrange staff meetings due to the fact that staff worked different shift patterns and were hardly at the office at the same time.

- The service's commissioners met with the service at varying intervals as part of quality measurement for the work they contracted to Harley Street Ambulance Service but there was no documentation of these meetings or their outcomes.

Culture within the service

- Staff reported that they were encouraged to be open and honest. However, no incidents had been reported in the 12 months prior to the inspection in July 2016 and we were not assured that incident reporting was embedded in the culture of the organisation.
- All staff we spoke with were happy to work for the service and reported that they liked the fact that Harley Street Ambulance Service was a small service which made them feel like it was a family to them.
- We found from speaking with staff that there was a strong culture of promoting the wellbeing of staff. Staff told us that the managing director and the clinical governance manager were always willing to listen to them if they had any concerns.

Public and staff engagement

- Private patients were given feedback questionnaires to allow the service to monitor the quality of their services. We saw 15 feedback forms for the period between 14 January 2016 and 10 May 2016. 14 of the forms stated that politeness of staff, general attitude of staff, condition of ambulances, behaviour and appearance of crew and overall view as either excellent or good. There were two negative comments seen in the feedback forms. In one form a relative said that the cost of the service was expensive and in another a relative said that the thickness of the mattress on the stretcher was too thin to absorb the bumps from the roads. The managing director told us the service took patient feedback into account in planning care going forwards.
- Harley Street Ambulance Service undertook a staff survey in June 2016. Ten staff responded. All staff surveyed said they would recommend the service as a place to work to a friend. For training, education and development, 60% of staff surveyed said that they were very satisfied, 30% were somewhat satisfied and 10% were neither satisfied nor dissatisfied. For the service's ambulances and equipment, 60% of staff were satisfied, and 40% of staff were somewhat satisfied. For shift patterns 30% of staff were satisfied, 50% somewhat satisfied and 20% neither satisfied nor dissatisfied.
- We found no evidence of leadership prioritising the participation and involvement of staff in improving and shaping the culture of the organisation. There were no formal staff meetings where the service could engage staff and obtain their views on the planning and delivery of services

Innovation, improvement and sustainability

- From April 2016 the organisation had appointed a member of staff as the clinical governance manager. Since then they had put systems and processes in place which focussed on improving clinical governance within the organisation. During the inspection we found that this work was still ongoing however there was evidence that there had been improvements between when this member of staff got into post and the time of the inspection in July 2016. For example they had put training packages together for staff, initiated and updated policies, and improved the recording and capturing of information such as training data. We found further evidence of improvements in governance systems overall on the follow up inspection in November 2016.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Safe care and Treatment** There was a breach of this regulation because : • The administration of the medicine salbutamol by paramedics and emergency ambulance crews (EACs) was in breach of regulations. Paramedics did not have the authority of a patient group direction (PGD) to administer this medicine. Paramedics did not have the legal authority to administer this medicine as it had not been prescribed for a specific person. EACs did not have authority to administer this medicine. • Regulation 12 (1) requires that care and treatment be provided in a safe way for service users and you were in breach of this regulation. • Regulation 12 (2) (g) requires that there be proper and safe management of medicines by the provider and you were in breach of this regulation. This was a breach of Regulation 12(1) and 12 (2) (g).

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Safeguarding** This regulation was not met because:

This section is primarily information for the provider

Requirement notices

- Staff must receive safeguarding training that is relevant, and at a suitable level for their role. Staff were not trained to the appropriate level of safeguarding training for children safeguarding. The level of children safeguarding training at Harley Street Ambulance Service was at level one including for the safeguarding lead.
- Guidance from the Intercollegiate Document for Healthcare Staff (2014) is that all ambulance staff including communication staff should be trained to level two. This applies to all clinical and non-clinical staff that have contact with children/young people and parents/carers. That guidance also states that the safeguarding lead must be trained up to level four.
- In relation to adult safeguarding, the safeguarding lead was not trained to the appropriate level. A safeguarding lead would normally have a level of knowledge relating to safeguarding which exceeds the level required for operational staff, enabling the provision of advice and access to support across a safeguarding network in the event of difficult cases. The highest level of adult safeguarding training was level two.

This was a breach of Regulation 13 (1) and 13 (2).

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Good governance** • This regulation was not being met because during the follow up inspection on 30 November 2016 we found patient identifiable information for one patient had been left on an ambulance. • We considered the fact that in July 2016 we found patient identifiable information for more than one patient in two of the ambulances inspected. We were

This section is primarily information for the provider

Requirement notices

not assured that Harley Street Ambulance Service had taken adequate or effective action to protect patients' data. Patient data must be maintained securely at all times.

- **Regulation 17 (2) (c)**requires providers to maintain service user records securely and as such there was a breach of this regulation.
- On the follow up inspection we found that one member of staff had not had a Disclosure and Barring Service check even though they had been working for Harley Street Ambulance Service for two weeks.**Regulation 17 (2) (d)**requires the provider to maintain records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity. The DBS document is a necessary document to be kept in relation to staff and you failed to do this.
- There was therefore a breach of Regulation 17 (2) (d).
- There were no effective systems and processes within the service to identify, record, and mitigate risks within the service. Even though the service had a risk form nothing had been recorded on it at the time of the initial inspection despite evidence of risks within the organisation which should have been recorded. For example, lack of children safeguarding.
- The provider must ensure there are systems and processes within the service to monitor performance against commissioner contracts.
- There were no governance structures in place for the monitoring of patient outcomes or response times. In addition, there were no systems in place for the monitoring of performance against commissioners' contracts.