

First Care Ambulance Limited

16/17 Kestrel Business Park

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 known to CQC and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

First Care Ambulance is operated by First Care Ambulance Limited and provides patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 17 and 18 April 2018.

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

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

The main service provided by this service was patient transport.

Services we do not rate

We regulate independent ambulance services but at the time of the inspection we did not have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There were strong, comprehensive and embedded systems, processes and procedures to keep people safe.
- The environment was secure and suitable for safe storage of ambulances and equipment.
- Patient care was at the centre of everything the organisation and staff did.
- Patient's individual needs and preferences were central to the planning and delivery of the service.
- There was a commitment from frontline staff and senior managers to provide a high-quality service for patients with a continual drive to improve the delivery of care.
- The organisation had a flexible and responsive approach and had developed a positive partnership with commissioners.
- The registered manager and the management team were committed to the patients who used the service, as well as to staff.

However, we also found the following issues that the service provider needs to improve:

- The named professional responsible for safeguarding was not trained to level four for safeguarding in line with the recommendations in the intercollegiate document. 'Safeguarding children and young people: roles and competencies for health care staff' (2014).
- Medicines were not administered and supplied with the correct legal authorisation of a patient group direction. Paramedics required a patient group direction to administer any prescription only medicine that was not on the exemption list.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices that affected the service. Details are at the end of the report.

Amanda Stanford

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

Summary of findings

Our judgements about each of the main services

Service

Patient transport services (PTS)

Rating

Why have we given this rating?

First Care Ambulance provided a patient transport service.

We found First Care Ambulance provided a safe and quality service under the regulated activities.

At the time of this inspection we did not rate the service.

16/17 Kestrel Business Park

Detailed findings

Services we looked at

Patient transport services (PTS);

Detailed findings

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Background to 16/17 Kestrel Business Park

First Care Ambulance is operated by First Care Ambulance Limited. It is an independent ambulance service with the main headquarters based in Exeter with base stations in Barnstaple and Plymouth. The organisation primarily serves the communities of Devon.

The team consists of a managing director, John Fraser who is the registered manager, a medical director, a lead

paramedic, a training and compliance manager, a senior operations manager, operations managers, team leaders, controllers, hospital liaison assistants, administrators, paramedics, ambulance care assistants (ACAs) and technicians.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and an assistant inspector. The inspection was overseen by Daniel Thorogood, Inspection Manager, and Mary Cridge, Head of Hospital Inspection.

Facts and data about 16/17 Kestrel Business Park

First Care Ambulance is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once, and the most recent inspection took place in January 2014, which found that the service was meeting all standards of quality and safety it was inspected against.

During the inspection we visited the headquarters in Exeter and the base in Plymouth. We spoke with 18 members of staff including the senior management team, operations managers, team leaders, controllers, hospital liaison assistant, administrator, paramedics, ambulance care assistants (ACAs) and technicians. We reviewed 15 sets of patient records and five staff files. We checked five ambulances and a vehicle for transporting mental health patients at the Exeter base and four ambulances at the Plymouth base.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

First Care Ambulance was established over 20 years ago and has many years' experience in the industry offering patient transport solutions and event medical support across the UK.

Originally First Care Ambulance provided an ad hoc patient transport service and specialist transfer service to the local community, local clinical commissioning groups, mental health services, NHS hospitals and private individuals.

First Care Ambulance was acquired by its current owners in 2013. It holds two NHS contracts and continues to provide ad hoc services to the community, NHS trusts, NHS commissioners and private individuals.

Summary of findings

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- Patient's individual needs and preferences were central to the planning and delivery of the service.
- There was a commitment from frontline staff and senior managers to provide a high-quality service for patients with a continual drive to improve the delivery of care.
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Patient transport services (PTS)

- Not all medicines were administered and supplied with the correct legal authorisation of a patient group direction. Paramedics required a patient group direction to administer any prescription only medicine that was not on the exemption list.

Are patient transport services safe?

Incidents

- There was an incident reporting policy which set out the processes for reporting and managing incidents. All adverse incidents were reported using paper incident reporting forms that were available on vehicles and recorded on a spreadsheet on the shared IT system.
- Information was captured in monthly quality reports with the details, the investigation and actions taken.
- Prior to the inspection the organisation provided details of the incidents in the period from February 2017 to February 2018. We saw details of the investigations, outcomes, actions taken and lessons learned. Details related to delayed discharge, lack of heating on vehicle, deteriorating patient, abusive patients and relatives, patient leaving the vehicle, no response at home address, late arrival for appointment, lateness of pickup, vehicle breakdown, crew behaviour, equipment failure and falls.
- Staff told us they had a good understanding of incidents and felt confident to report them. They all understood their responsibility to raise concerns, report incidents and near misses. Incidents would initially be reported to the controller who would in turn inform the team leaders or and/or /operations managers. Once back in the office staff would complete the incident report form.
- We attended a management meeting and saw minutes of previous meetings that showed the organisation had a standing agenda item for incidents and lessons learnt. Incidents and learning were shared with staff through presentations on a loop on TV screens in the staff room. Most staff said they received feedback; however, staff in the Plymouth base told us they did not always receive feedback.
- The organisation recognised its responsibilities under the provisions of duty of candour. 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'.
- The organisation was committed to ensuring openness and honesty with patients when things went wrong and they were provided with reasonable support, truthful

Patient transport services (PTS)

information and a written apology. The organisation included duty of candour in the induction training and within the induction booklet. There was 100% compliance for this training.

Mandatory training

- Systems were in place to ensure effective delivery of training.
- There was a programme of training in safety systems, processes and practices. Mandatory training was delivered by combination of face- to-face training and e-learning. Training included; health and safety, information governance, manual handling, equality and diversity, fire training, mental capacity act, oxygen therapy, prevent and safeguarding adults and children. Ambulance care assistants completed the first aid training which included adult and child resuscitation. Paramedics completed an annual update training which technicians could attend.
- Staff were up-to-date with their mandatory training and compliance against requirements was well monitored by the management team. All staff had a personal training record which was recorded on an electronic HR system. A monthly report was presented to the monthly management meetings. The most recent report identified the majority of staff had completed training. Exceptions were recorded for any staff who had not completed training or staff were flagged as requiring training. The team leaders discussed any outstanding training on weekly operational calls.
- The organisation was a registered training provider which meant internal training could be provided by trained staff.
- All staff irrespective of role were provided with an Induction course, which incorporated a two-day theory and practical based training, with two further days as a third man with an experienced crew and a one-day emergency first aid course which was externally certificated. The staff role also determined what practical induction training was provided. For example, office-based staff would not receive specific vehicle and equipment training.
- There were allocated revalidation periods for training disciplines as below:
- Annual training: manual handling, basic life support including AED usage for core service staff
- Biennial training: Safeguarding adults level 2, safeguarding children and young people level 2,

Prevent, Health Education England learning packages (including mental health, data security, fire safety, health, safety and welfare and equality, diversity and human rights)

- Tri-ennial training - first aid, control and restraint.

Safeguarding

- There were policies, systems and processes for safeguarding children, young people and adults.
- Staff were clear that safeguarding was everybody's responsibility. They could demonstrate what constituted abuse and exactly what they needed to do should they have safeguarding concerns about people in their care, other members of the public or their colleagues.
- All staff said they knew how to report a safeguarding both in and out of hours. In hours they would phone the training and compliance manager who would advise crews on next steps and asked them to write a statement. Out of hours they would phone the local authority.
- Staff were appropriately trained in safeguarding for both children and adults, All staff received level two safeguarding training in line with the recommendations for ambulance staff in the intercollegiate document 'Safeguarding children and young people: roles and competencies for health care staff' (2014). Compliance for safeguarding training was 91% or above for each base team.
- The training and compliance manager, the safeguarding lead, and the medical director, were all level three trained and were available to advise and support staff. Any concerns raised ahead of transportation were considered as part of the booking and planning process.
- However, there was nobody in the organisation trained at level four safeguarding. A named professional is required to be identified and level four trained in line with the recommendations in the intercollegiate document.

Cleanliness, infection control and hygiene

- There were reliable systems in place to monitor and maintain standards of cleanliness and hygiene.
- There was an infection prevention and control policy which included handwashing, personal protective equipment, spillage management, clinical waste management, safe handling and disposal of sharps, linen management, cleaning and disinfection.

Patient transport services (PTS)

- Before commencing operational duties, all members of clinical staff completed appropriate infection control induction training. Induction training programmes for new staff incorporated the principles and practice of infection prevention and control, awareness of policy and guidance documents, hand hygiene, safe handling and disposal of sharps, management of inoculation incidents, feedback of audit results, examples of good practice and action needed to correct deficiencies. It also covered cleaning of equipment and vehicles, types of cleaning and NHS approved codes of practice for colour coded cleaning equipment. Linen care and changing protocols were also covered. At the time of the inspection compliance was at 100%.
- All new members of staff were required to fulfil the pre-employment health checks including appropriate immunisations.
- We inspected five ambulances and a vehicle for transporting mental health patients at the Exeter base and four ambulances at the Plymouth base. The vehicles were chosen randomly by the inspection team.
- The vehicles were visibly clean and tidy with appropriate materials for cleanliness, infection control and hygiene. Surface wipes were available on all vehicles and there was a good supply of personal protective equipment, such as gloves and masks.
- Re-usable equipment, for example, splints and blood pressure cuffs were visibly clean. Surfaces, including seat and trolley covers were mostly intact and easy to wipe clean. However, two vehicles at the Plymouth base were found to have torn seat covers which presented an infection control risk. The operations manager confirmed these were in the process of being re-upholstered.
- An inspector accompanied staff on two patient transfer journeys and witnessed them decontaminate their hands immediately before and after direct contact and care with the patient. The seat in the ambulance used by the patient was also cleaned after use.
- Staff were responsible for frequent and routine cleaning activities. A vehicle file contained all copies of the relevant documentation surrounding vehicle and equipment cleaning. It was expected that the following tasks were to be undertaken at least once per shift: saloon floor to be mopped with low level detergent; all visible surfaces to be wiped over with low level detergent; vehicle cab floor to be mopped with low level detergent; particular attention to be paid to door handles, horizontal surfaces, control levers, switches and the steering wheel.
- Staff were aware of the procedures to follow if they were transporting an infectious patient. Deep cleaning was carried out following the transportation of a patient who had been unwell (vomiting / diarrhoea) or bleeding excessively whilst in the vehicle. Staff were required to undertake a number of tasks immediately following the occurrence. These included notifying control and informing them of return to base for deep clean; removing all equipment from the vehicle; wearing gloves, aprons and masks; having a supply of orange clinical waste bags ready; absorbing any remaining body fluid; cleaning of all flat surfaces using a low-level detergent, followed using disinfectant or clinical wipes and allowed to air dry.; mopping of salon floor with low level detergent followed by disinfectant and allowed to air dry.
- Deep cleaning was carried out every six weeks. This involved the vehicle being taken off the road, all equipment removed from the vehicle including the contents of the cupboards and the whole of the interior of the vehicle being cleaned using steam and disinfectant, in addition all equipment was cleaned adhering to the same protocols.
- Colour coded buckets and mops were provided for use in specific areas and "I am clean" stickers were seen on equipment.
- There was a clinical waste disposal policy which described the procedure for disposal. Waste was segregated and clinical waste was held in orange bags on vehicles and collected by team leaders at the end of each shift and placed in secure marked bins and collected fortnightly by an external contractor.
- We observed a good supply of clean linen. Staff said soiled linen was swapped for clean at the hospitals.
- The operations managers were responsible for implementing a monthly audit of staff compliance with the requirements of the infection control policy. This information was collated and any risks or issues were raised at operations meetings. We saw details of the standard and cleaning frequency and records of the managers' checks and ad hoc inspections.

Patient transport services (PTS)

- The training and compliance manager would randomly select a number of completed vehicle check sheets and deep clean sheets for auditing purposes and recorded the findings of these audits on the risk register.
- Staff were issued with a uniform, which they laundered themselves. Should they become heavily soiled beyond domestic cleaning, they were disposed of and replaced. The staff we met had clean and tidy uniforms. Staff were expected to wear black safety shoes/boots.
- All staff maintained a high standard of cleanliness at all times. All staff adopted the bare below the elbow dress code whenever they were engaged in a direct patient care. Those with long hair (shoulder length or longer) had it tied up and jewellery was kept to a minimum with a plain wedding band and stud earrings.

Environment and equipment

- The organisation operated from bases in Exeter, Plymouth and Barnstaple. We visited the bases in Exeter and Barnstaple. Both were of an appropriate design to meet the needs of the service. The environment was secure and suitable for safe storage of ambulances and equipment.
- The units consisted of a combination of a vehicle depot area, offices and storage. There was wheelchair access and a disabled toilet for use by staff and any business visitors. Refreshment facilities were provided to staff including a staff rest room and kitchen area.
- Staff confirmed that regular fire drills had taken place at the Exeter base.
- We checked five ambulances and a vehicle for transporting mental health patients at the Exeter base and four ambulances at the Plymouth base. The vehicles were chosen randomly by the inspection team. They were equipped with up-to-date satellite navigation systems.
- There were two specialist vehicles for transporting mental health patients. There were specific seating arrangements with rear compartment bench seats which were assessed as the most suitable platform for transporting mental health patients. Extra seat belts including shoulder and chest belts were available if required in transit and soft cuffs were available but rarely used. Staff said they had only been only used once in ten years.
- All the vehicles had working doors and there were no visible signs of damage to the exteriors. All vehicles had

emergency equipment, including a defibrillator, oxygen and suction machines. We checked four pieces of equipment and all were in service date. Most gases on board were at a required level and were in date.

However, on one ambulance at the Plymouth base we saw a portable oxygen cylinder that was empty and a larger cylinder that had expired in July 2017.

- All vehicles underwent daily vehicle checks which were recorded on the personal digital assistant devices (PDA), this included under-bonnet fluid checks, tyre checks, screen, wipers, mirrors lights, bodywork and damage records. Most checks were completed accurately.
- Vehicles were serviced by manufacturer guidelines and the next service due mileage was recorded in the team leaders' office(s) either on a white board or in a folder. MOTs were recorded in the same way and were booked in to local garages. .
- Where repairs or servicing were required the vehicle was taken off the road and booked in to a local garage usually within 24 to 48 hours and was then back on the road.
- A local tyre fitter was used within close proximity to the base to minimise downtime, who usually kept a minimum of two tyres in stock.
- There were records kept of vehicle maintenance and these were up to date. Post inspection we carried out MOT and tax checks on a randomly chosen sample of 12 of the organisation's vehicles using www.gov.uk/check-mot-status. All had a valid MOT and tax certificate.
- All staff recorded and reported any defects to the team leaders. Staff were also required to report any near misses, minor collision or similar incident using a vehicle reporting template.
- In the event of a vehicle breakdown whilst in operation there was a process in place to report the incident to control without delay who would arrange for vehicle breakdown services and a replacement vehicle. If a replacement resource could not be found within First Care Ambulance resources, a third-party provider (pre-approved) was sought to back fill.
- The incident was also escalated to the manager on duty or on call, to ensure adequate support was available for control and staff. If there was a two-person crew, one crew member would remain with the patient at all times whilst the other remained with the vehicle. All breakdowns and the subsequent actions had to be recorded as an incident using the reporting procedure.

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- Most staff told us that their vehicles and equipment were well maintained and fit for purpose. However, staff in Plymouth said vehicles and equipment needed a revamp and were particularly concerned about the effectiveness of the brakes on some wheelchairs.
- We saw child seats that could be used on the ambulances and one of the four vehicles inspected at the Plymouth base had a trolley suitable for bariatric patients. The ramps on all vehicles were manual, as were the carry chairs.,
- The vehicles we inspected were well stocked with supplies and included basic and advanced airway devices, suction equipment, defibrillation and cardiac monitoring, piped oxygen supplies, Entonox, spinal care equipment including scoop stretchers and spinal collars, patient diagnostic equipment and a full range of first aid consumables. Items such as needles, syringes, gauze and dressings were all in date and had not reached their expiry date. The serviceability of all manual handling equipment and electrical equipment was in date.
- All equipment had been tested under portable appliance testing (PAT) in house by accredited staff. All equipment was inside the safety testing period.
- We saw that pat slides were stored between the side of the stretcher and the wall of the ambulance in three vehicles. We were informed that some vehicles had storage clips. However, there were no clips on the three vehicles and the slides remained loose, and were not secured safely.
- completed for medicines and controlled drugs to confirm stock balance, any discrepancies would be investigated. A random selection of medicines was checked and found to be within range of their expiration date.
- Medicines were made available to paramedics to include a stock in paramedic bags, general sales list medicines and controlled drugs. Medicines were signed out and back in to base with appropriate records kept. If medicines were administered to patients this was recorded on the medical administration record and on the patient report form.
- The organisation held a valid home office licence. This enabled the provider to order, possess and supply controlled drugs.
- One patient group direction (PGD) was dated, signed and authorised, however there was not a PGD for all prescription only medicines. Prescription only medicines administered by paramedics that are not on the exemption list must be either be prescribed or administered under a PGD. For example, salbutamol nebulas, cyclizine lactate and ipratropium nebulas. These medicines are not listed in the schedule 17, part 3 of The Human Medicines regulations or Schedule 19 of The Human Medicines regulations: medicinal products for parenteral administration in an emergency. The organisation had a PGD for tranexamic acid, which was good practice. We saw the PGD had been signed as read by the paramedics.
- There were approved medication lists for paramedics, technicians and ambulance care assistants (ACAs). These groups were allowed to administer medication or continue care of a patient provided they had received and successfully completed medication training relevant to their role. Medications could only be administered in line with the specific skill sets for each role. All personnel who were not prescribers in their own right completed an annual revalidation update for medications as an additional module. This was evidenced in their annual revalidation sessions.
- There were procedures for managing patients' own medication and for patients travelling with controlled drugs. During transportation medication was stored in sealed bags for the destination ward staff or for the patients to self-administer at home.
- There was a procedure for disposing of controlled and all other medication. All controlled drugs (CDs),

Medicines

- Arrangements for managing medicines and medical gases kept people safe. Medicines and medical gases were ordered, stored, recorded and disposed of safely.
- The organisation had a medicines management policy. There were processes to record medicine movement and administration.
- All medications were stored in the designated, approved storage areas within the buildings. Access to the areas was limited only to authorised staff. The areas were secure and medicines were kept in locked cupboards.
- Stock levels of medicines were well understood and appropriate amounts of stock were held in the Exeter base. We reviewed the processes to record stock levels and movements. Stock levels were checked daily and this was recorded on the daily site check sheet and located in the site folder. Monthly audits were

Patient transport services (PTS)

prescription only medications (POMs) and general sales list (GSL) medications were disposed of by the lead paramedic and placed into the clinical waste after the designated time. All medication for disposal was logged and recorded on the order-returns form and in the controlled drug register and a witness signature was required. However, there was no waste exemption certificate from the environment agency for the destruction of controlled drugs. This certificate is required to comply with the requirements of the Misuse of Drugs Regulations 2001 by denaturing controlled drugs.

- Medical gases were stored safely and securely at bases and on vehicles. Storage was compliant with guidance from the British Compressed Gases Association. Empty and full cylinders were stored in signed, locked, secured cages away from sources of ignition, flammable materials, in a well ventilated, dry, clean areas away from oils, greases, and from extremes of temperature. Cylinders for replenishment were transferred to the designated exchange points. Whilst on the vehicle, cylinders were securely fastened in the provided storage facilities.
- Staff were only permitted to administer oxygen under the instruction of the professional healthcare employee responsible for the safe handover of the patient and using the equipment provided to support this administration (e.g. oxygen mask or nasal cannula).

Records

- People's individual records were written and managed in a way that kept people safe.
- There was a policy for managing patients' records and confidentiality which included standards in the keeping of clinical records and maintaining and developing the programme of audits of patients' records.
- Staff we spoke with understood the importance of accurate record keeping. We looked at 15 patient records. They had been completed fully and provided a clear account of the patient's presenting condition and special notes, and details of the journey including pick-up and drop-off, stops en-route and nutrition given. Details of the patient's property were also recorded. Medicine charts and papers relating to the sectioning of patients under the Mental Health Act were placed in a secure envelope for transit.
- Key personal information was obtained from the initial booking. Information included date of birth, height and

weight, capacity to consent, risk assessment, mobility, allergies, illness and disabilities and the type of service required. However, there was reliance that information provided from the hospitals and patients was accurate. Some staff said the information was not always accurate.

- Information was available on personal digital assistant devices (PDAs) and was uploaded to the IT system to record an audit trail of the effectiveness of the handover system.
- Records were audited to ensure they were fully and properly completed. The training and compliance manager would randomly select a number of patient record forms for auditing purposes and recorded the findings of these audits on the risk register.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for people who used the service.
- Staff undertook a risk assessment before completing all patient handling tasks and they could describe this process. If after undertaking the assessment, it was believed that it was not safe to proceed without additional support from within the organisation or external agencies such as the police, this decision and the information used to inform that decision were documented on the booking. Staff told us about situations where they had to make a decision to ensure patient safety, for example, if a patient's home was not suitable for them to be left, or if different equipment was required to safely move a patient.
- There were processes in place to attend to disturbed or violent patients. Staff had received training in non-pain conflict break away management. This training looked at techniques to use which would not cause pain to a patient. Two thirds of the staff group required to undertake this training had completed it, with the final third due to complete their training in the near future.
- Staff were aware that if patients deteriorated during conveyance, emergency services (using 999) would be called without delay and the journey suspended until their arrival. The care of the patient transferred to the emergency service upon their arrival and the crew followed any reasonable instruction given. If this occurred whilst still on the grounds or in the premises of a healthcare organisation such as a hospital or care home, the crew obtained the assistance of the nearest medical team.

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- Whilst waiting for support to assist, it was the responsibility of the crew to administer basic first aid and address the patient's needs to the best of their ability. Staff were trained in basic life support as part of their first aid training. The crew informed the controller to ensure further support and assistance could be provided. Consideration was given to any other patients who were travelling on the same vehicle and the controller obtained additional resources to manage the onward journey of these patients without delay.
- If staff encountered a non-related incident such as a road traffic accident, they were expected to stop and find out if assistance was required until emergency services arrived at the scene. During these events the crew informed the controller to ensure that the effects to other patients could be managed effectively.

Staffing

- Staffing levels and skill mix were planned to meet the needs of the patients requiring transport. Team leaders were responsible for organising rotas in advance and aligning the rota and shift patterns to meet the demand. Shifts were filled by permanent and bank staff.
- At the time of our inspection there were 195 staff, the majority of staff were ambulance care assistants, there were also technicians, five paramedics, controllers, three hospital liaison officers and six team leaders. There were five teams, this included; three contract teams in Plymouth, Exeter and Barnstaple, and two ad hoc teams in Plymouth and Exeter. The contract teams completed work for the patient transport contract. The ad hoc team completed additional transport work, for example repatriations, neonatal transfers, coroner transfers and event cover. Each team had a team leader. A controller was located at each base and a hospital liaison assistant at each of the main hospitals served.
- Staffing was regularly discussed and managed amongst the management team. A weekly operational meeting was held with the operations managers and team leaders, this included discussion on staffing, sickness and annual leave. A daily operational call was held, chaired by the operations manager and attended by team leaders and controllers, any changes to staffing were discussed and the bases could support each other with patient transfers as required.
- The organisation had systems to assure itself of the competency and suitability of staff on recruitment.

There was an employment policy which combined all elements of recruitment, retention, relocation, retirement, resignation and redundancy. The recruitment element outlined the processes for advertising, shortlisting, interviewing, vetting and screening potential employees.

- Staff would be selected in accordance with their experience and qualifications and appropriate checks were completed at recruitment. This included; obtaining two references, identification checks, disclosure and barring service (DBS) check and driving licence checks. This information was uploaded to the electronic HR system. We reviewed five staff members on the system and confirmed all checks had been completed. This meant that the organisation was assured about the applicant's previous conduct.
- Candidates were shortlisted by team leaders and invited to attend a competency based interview, during which they were required to complete a driving theory test and a driving assessment in the vehicles that were to be used for the purpose of the position.
- A number of staff and a manager had recently joined the organisation from another provider who had ceased operating. They provided services for mental health patients. They had transferred under the transfer of undertakings protection of employment (TUPE) regulations. For these staff a risk assessment was completed if full recruitment and training documentation was not yet received. All staff had a driving licence and DBS check completed and a reference from the previous provider.
- Disclosure and Barring Service (DBS) enhanced checks were completed for all employed staff every five years to ensure they were safe to work with patients. This information was recorded on the electronic HR system and reported on monthly basis to the management team. All DBS checks were complete for the five teams and the management team. Risk assessments were completed if a concern was identified on a DBS check. We saw an example of this and the actions taken.
- Driving licence checks were carried out every six months to confirm staff were still safe to work. Checks and classification codes were recorded on the HR system. All staff had a check on recruitment. Across the teams 89% or more staff had received their six-monthly driving licence check.

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- Part of the driving policy required staff to notify the organisation of any endorsements accrued since the last licence check. There was a six-point maximum tolerance on licences.
- Registration checks were completed every two years for paramedics, in line with the health care professional council's renewal. We saw evidence of these checks on the electronic HR system and in date registration for paramedics.
- The provider had completed a due diligence check on a third-party provider, this was a contingency should they require additional capacity. They had not used the third-party provider. We saw evidence of the completed due diligence check which had involved a visit to the provider and review of their systems and processes for ensuring staff were safe to work.
- All staff were required to read all HR policies and this was an HR system task upon commencement of employment. All policies were available both in hard copy at the bases and electronically on the HR system for anyone to access.
- Sickness was recorded on the HR system under specific headings such as general sickness, diarrhoea and sickness, influenza like illness and upper respiratory tract infections by the staff member's line manager. Sickness rates were reported to commissioners on a monthly basis.

Anticipated resource and capacity risks

- Anticipated risks were considered prior to delivery of patient transport services. Risk assessments were completed based on information provided.
- Staffing levels and skill mix were calculated in liaison with commissioners of patient transport services.

Response to major incidents

- There was a process to cope with the effects of a major incident or emergency.
- The organisation had a business continuity plan which outlined the decisions and actions to be taken to respond to, and recover from, a range of adverse incidents causing disruption to services. These included loss of electricity, gas or water supply, adverse weather, IT failure or localised incidents.
- Where major incidents occurred at any of the hospitals serviced as a result of a bed crisis, electrical failure or extreme weather, support was provided to clear as many beds as possible and to transport hospital staff to

and from the hospital during extreme weather. Staff told us about the part they played during the recent snow when parts of the county were cut off and managers told us about the learning from the events where early and regular communication with the hospitals was paramount.

Are patient transport services effective?

Evidence-based care and treatment

- Policies and procedures were based on relevant and current evidence-based guidance, standards, best practice and legislation. This included the National Institute for Health and Care Excellence (NICE) guidance and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), national patient's safety alerts and any other guidelines applicable to the service.
- Policies for staff were available on the shared intranet, through personal digital assistant (PDAs) devices and in hard copy at all bases. Staff we spoke with said they were aware of the policies and procedures and could access them.
- Clinical updates and guidelines were reviewed and disseminated to staff. Staff confirmed they were aware of the updates and had read and understood the information.
- Performance was constantly monitored through monthly performance reports to ensure effectiveness and to highlight areas where there was room for improvement against key performance indicators relating to response times and patient time on vehicles. The data was used to compare the differences between the two main contracts in terms of performance and to inform an investigation of the reasons.
- There was a programme of clinical audit which demonstrated the effectiveness of the service. For example, the information recorded in patient records was used to evidence good patient care and rapid, high quality continuation of care for receiving clinicians. Reports were generated to identify themes and highlight training needs.

Assessment and planning of care

- People's needs were assessed and their care planned in accordance with Joint Royal Colleges Ambulance

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Liaison Committee (JRCALC) guidelines. Staff were made aware of patients' conditions including mental health issues prior to transportation so that they could plan transport accordingly.

- Information was dependent on that available from patient transport service booking, which in turn was reliant on information from patients and hospitals. The information related to illness, allergies, travel requirements and specialist crew selection, admission and transfer. It was recorded on the personal digital assistant (PDAs) devices for on the road staff and on the IT system for the controller to see and consider when booking.
- There was a standard operating procedure for the transport of mental health patients including capacity to consent, risk assessment relating to the patient's resistance to travel, potential for violence or aggression, self-harm or risk of absconding.

Response times and patient outcomes

- The organisation monitored the effectiveness of their service. This meant data was readily available to address any shortcomings and to make changes to improve the service.
- Key performance indicators (KPIs) were used to measure performance of patient transport journeys. This included response times and patient time on vehicles. KPIs were agreed with commissioners and measurable targets were set.
- Monthly KPI reports were submitted to the commissioners and discussed at quarterly meetings. The reports contained a summary of activity, mileage, performance, quality themes including compliments and concerns, trends and actions. New service development improvement plans were also recorded with details of operational and cost savings.
- Any shortfalls were reviewed in real time by the operation managers, team leaders or controllers as they would flag on the system if they were out of the KPI.
- These included arrivals for admissions, day case and outpatient appointments; collections for day case and outpatient appointments; collection from ward or department, discharges and transfers; time specific appointment, home visit and time on vehicle.
- The organisation was performing well against their measured KPIs. There were three measured KPIs: the patient arriving for their appointment on time or not more than 45 minutes early; the patient being collected

from their appointment at the agreed time or no more than 45 minutes after and a discharged patient being collected from the hospital at their agreed discharge/ready time or no more than 60 minutes after. Data from August 2017 to January 2018 showed the organisation was meeting the targets set by the commissioners of the service.

- There were two further captured KPIs. These were captured but not used as measured KPIs by the commissioners. The first captured KPI reviewed the patient's time on the vehicle, the organisation was performing well against this KPI. The second captured KPI required improvement as the information showed the organisation was underperforming. This KPI was in relation to patient home visits, whereby patients would be delivered home or to an agreed destination within 15 minutes of a specified time, and would return to collect the patient and staff within two hours from the start of the agreed appointment time. We discussed this KPI and the underperformance with the organisation who said this was mostly due to hospitals incorrectly booking a home visit rather than a discharge/transfer. They had discussed their concerns with the commissioner who was satisfied with the reason behind the underperformance. The organisation, via their hospital liaison assistants, was trying to educate hospitals about the booking process to reduce the incorrect bookings.
- Information on the percentage of journeys booked on the day of travel was recorded on the monthly reports. In Exeter and Barnstaple on average 25% of journeys were booked on the day of travel. In Plymouth this was 39% of journeys.
- System induced failure information was reported on regularly. This included the number of cancellations or aborts with less than one hours' notice, and the number of journeys with delay. The most common cancellation or abort reasons related to the patient not being ready, the hospital cancelling the transfer, or an incorrect booking.

Competent staff

- There was assurance that staff had the skills, knowledge and experience to deliver effective care. A training and development strategy was in place to ensure delivery of an annual training and development plan for all staff based on annual appraisal and personal development plans.

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- All new staff completed a five-day induction programme. This included; two days of classroom theory and practical, two days of third-manning with colleagues and a one day first aid course. A detailed induction book was completed by the staff member and signed off by an assessor. The content of the induction book included; personal development, role of ambulance care assistant, communication, equality, diversity and inclusion, implementing duty of candour, duty of care and complaints, safeguarding, patient centred care and equipment.
- New staff entered a probationary period and were assessed at six and 12 weeks to confirm they were appropriate for their role.
- On an annual basis staff were assessed as competent in their safety, effectiveness, care, responsiveness and well-led. This was completed as part of a 'ride along' quality audit where a staff member would be observed in their practice. We saw examples of completed quality audits to assess the staff member and provide feedback and areas for improvement.
- Staff received an annual appraisal. This enabled both the manager and staff member to feedback on their performance. Appraisals were completed electronically and a face-to-face meeting was held as required. Staff confirmed this to be the case and were happy with the process. The most recent report showed 81% of staff had a complete appraisal; the majority of manager assessments were complete and were awaiting the staff self-assessment. Staff were being reminded to complete their self-assessment to ensure 100% of staff had a complete appraisal.
- Poor or variable staff performance, when identified, would be reviewed by the manager and the staff member would be supported by means of an improvement plan.
- Staff we spoke with told us they felt well supported with training and there was a commitment to training and education within the organisation. They told us they were encouraged and supported with training and to take responsibility for their own continuing professional development.
- The organisation used a web-based system to monitor training and education of staff. It also contained details of driving assessments, driving licence checks, DBS checks and immunisations.
- There were processes in place to ensure staff maintained the appropriate and current registration with a professional body on an ongoing basis. All paramedics were registered with the Health and Care Professions Council.
- Staff were assessed to carry out driving duties safely. There was an external trainer who completed driving assessments at the time of recruitment. Annually each staff member received a 'ride along' quality audit where their driving ability was observed by a team leader. Further assessments could be completed as required, for example in response to any concerns with performance. Some staff completed blue light driving training if this was required for their job role. This was completed every three years.

Coordination with other providers

- The organisation aimed to deliver care in a coordinated way. The hospital liaison assistants provided a link between the organisation and the hospitals. Relationships were building with the hospitals to help improve timely discharge and transfer and therefore the patient experience.
- There were agreed care pathways with NHS providers for whom they were contracted to carry out patient transfers. The management met regularly with providers who commissioned their services.
- Information from the patient report forms was used to provide a comprehensive handover of the patient to hospital staff.

Multi-disciplinary working

- All necessary staff were involved in assessing, planning and delivering patient's care and treatment. Staff worked well together. However, friction sometimes occurred between office based staff and on the road staff. This was as a result of trying to meet the demand and operationally deliver against the key performance indicators, compared to giving the patient extra time and care as required. Managers were working with staff to resolve this conflict through open and honest communication.

Access to information

- The organisation was reliant on the information provided by the patient to enable them to effectively assess and manage their care. This was documented on the patient report form and this information was

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available on personal digital assistant (PDAs) devices. However, at the Plymouth base we saw that not all PDAs were fully functioning, which meant that some information was not always. We were told that the PDAs were in the process of being updated. In the meantime, phone contact was made with the staff to inform of them of any missing information.

- Ambulances were equipped with up-to-date satellite navigation systems.
- Staff said they avoided displaying patients' personal information while in transit, such as the patient's address, clinical destination or unnecessary information regarding the patient's condition. However, it was recognised that on occasions this information was required for maintaining and promoting patient safety.
- Confidential records and commercially sensitive information were safely and securely managed by an external contractor.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training and understood their roles and responsibilities for consent, Mental Health Act 1983 and the Mental Capacity Act 2005.
- The organisation used patient report forms which included tick boxes to record if the patient had capacity and whether consent was gained.
- The organisation provided transport services to individuals being detained under the Mental Health Act (2005). Staff had a good knowledge of mental health issues. As a result of learning from a previous incident where the paperwork was not completed correctly resulting in an aborted journey, staff always scrutinised papers relating to patients sectioned under the Act to ensure they were current.
- As the organisation was not the primary booking information taker for patient transport services they used the information taken by the patient transport booking service. The booking system had an option to select if the patient was to travel with a Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) form. There was also an option to add special notes relating to transport, or private notes relating to medical needs. There was also an option to select travelling alone. Crews were able to read the transport notes but would need to phone their controller for the private notes.

- It was not uncommon for the organisation to receive a call to transport a patient from hospital to hospital or to a home address, and the person making the request informed the controller that the patient was in possession of a DNACPR. Staff had a responsibility for the continuation of patient care and this included DNACPR decisions if they had been put in place by a hospital prior to discharge or transfer, or by a GP prior to the admission.
- All DNACPR patients were pre-booked and the DNACPR decision was recorded in the patient's medical records.

Are patient transport services caring?

Compassionate care

- Staff were passionate about how they cared for patients and said it was of paramount importance. We found staff displayed a genuine desire to help people in need and aimed to treat patients with respect, courtesy and compassion.
- Staff enjoyed caring for patients and everyone did their best. They would always ensure patients returning home had everything they needed such as a hot drink, a phone within easy reach, food in the fridge and the heating was heating on.
- During our inspection we observed two patient transfers where there was excellent interaction between staff and patients. We saw the patients were treated with the highest levels of compassion, dignity and respect. The staff were skilled in talking to and caring for patients in a calm and relaxed manner. Staff introduced themselves and were open, friendly and approachable but always remained professional. They were very kind and gentle with the patients.
- Dignity was ensured in public places and for those in vulnerable circumstances. When caring for patients in a vehicle staff said they used blinds at windows to provide privacy and dignity during certain tasks involving patient care.
- Wherever possible patients would be assisted to use the toilet during comfort breaks rather than using a bottle or bedpan. However, if this was not possible patients would be given as much privacy as possible.
- Staff said they would ensure patients were adequately dressed or covered prior to leaving home or a clinical area for any reason, so that their privacy was maintained and they were warm and comfortable.

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- When discussing a patient within hearing of another patient or visitors staff said they would speak in a manner so that they could not be overheard.
 - Feedback cards were available on all on vehicles and we saw the feedback received from patients. Comments included: "I was dreading the visit to hospital but the ambulance crew were absolutely wonderful. They couldn't have been more kind courteous and considerate." Crews were described by another as "angels in disguise ...very understanding and considerate." Other comments included "Excellent service, staff very caring to my husband who has dementia. He was being assured every step of the way." Another commented that the service was "outstanding in every way."
 - We also saw feedback from a manager about a local home closure who praised the team of staff "for the excellent job assisting us. I have had some really positive feedback from my staff. They explained how efficient and patient your drivers were – they were empathetic and treated all the clients with the utmost respect and dignity. Generally, a really helpful bunch and good to work with during a challenging time."
- Staff told us they were mindful of how important it was to quickly form a relationship with patients to build their trust. They also understood the impact the care, treatment or condition might have on a patient and to provide extra support when required.
 - We saw feedback from a patient who commented that the crew were "so jolly and caring, they comforted me when they saw I was getting a bit upset and made me laugh - they took such great care handling me."
 - When we asked staff to describe events or situations where they or their colleagues had provided emotional support, they said "it's just our job... we do the best we can for our patients."

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

Understanding and involvement of patients and those close to them

- Staff welcomed patients and let them know what to expect during their time with the service.
 - The aim was to give patients full attention and to try to answer all questions in an open and honest way. Staff said time was allowed for the patient to ask whatever questions they wanted to.
 - Staff said for those patients with limited knowledge and understanding they would have their care explained to them in a manner that they were able to understand and that did not demean them.
 - Staff told us that family members and friends were comforted, reassured and kept informed. If appropriate and safe, they were invited to travel in the ambulance with patients. However, staff explained that no relative, friend or escort could visit or accompany a patient without that patient's explicit agreement.
- People could access the service when they needed it.
 - There were contracts with local commissioning bodies and others were pending. The organisation ensured resources were where they were needed to be at the required time. Planning was informed by liaison with commissioners of patient transport services where operating requirement frameworks were in place.
 - Patient transport services were mainly provided in Devon but trips for repatriation took place across the country.
 - The management team had an understanding of the hospitals in their area, and the geography, in order for capacity to be planned to meet the needs of the people requiring patient transport. For example, as one hospital had later discharges more staff were put on the rota to cover this time period, and in the summer as hospitals had more repatriations longer distances were required to travel requiring additional work for the team.
 - For patients attending regular hospital appointments for renal services, the organisation plotted the patients' home addresses and grouped them together geographically to travel together to appointments. This promoted efficiency and reduced the travelling time for patients.

Emotional support

- Staff said they took the time to provide emotional support to patients, family members and friends who were distressed, anxious or confused.

Meeting people's individual needs

- Patient's individual needs and preferences were central to the planning and delivery of the service.

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- A patient conveyance policy was available and captured the patient journey from the point a resource arrived on scene to the point of discharge from ambulance care. Guidance included the patient mobility, escorts, respect and dignity, consent and the actions of the crew.
 - Staff spoke sensitively about being accessible to people of all ages and backgrounds. They showed an understanding of the different needs of people using the service, and told us how they adapted their style of communication to the individual needs of those requiring the service.
 - Staff were respectful of each patient's individual needs including religious and cultural beliefs. and took time to establish how each patient would like to be addressed. They did not assume that every patient would want to be called by his or her first name.
 - Escorts would be arranged by the external booking team or hospital if required to support a patient.
 - A pain assessment tool was available where pictorial images showing a scale of 0 to ten, with 0 being no pain and ten being the worst possible pain. Pictures of parts of the body and emoji symbols of happy and sad faces assisted assessment.
 - Policies and procedures were in place for the management of transporting mental health patients from receiving, transporting and handing over of patients. Staff would liaise with mental health teams to plan patient journeys and discuss the patient's cooperation to travel. They explained they would travel and park around the corner from the location, subdue the lighting on board the vehicle and play soft music.
 - Staff said they always looked at dietary requirements and would stop to buy patients a drink or food if needed and always had cold water on board if the patient was unable to stop.
 - First Care Ambulance was not the primary booking information taker for patient transport journeys and used the information taken by the external booking service. The internal electronic booking system had an option to select various medical conditions, whether the patient had any visual, hearing, speech impairments, whether an amputee, non-English speaker and many other options. There were also options for equipment required for the transport and specialist notes could be added specific to the patient or to the journey. Crews could read the transport notes and phoned the controller for the private notes.
 - Guidelines for patient communication and interaction were available for staff including access to interpretation for patients who were unable to hear fully or who could not communicate in English. Communication leaflets and communication picture cards were available on all vehicles and could be used to aid communication. In addition, staff for whom English was not their primary language were able to support patients. There was also access to interpreters. Language sheets were also available in English, French, German, Spanish, Hungarian, Czech, Polish, where a list of questions ranged from "are you in pain", "did you lose consciousness", "are you having difficulty breathing", "are you diabetic", "are you on medication".
 - Where appropriate staff ensured patients had the correct equipment to travel with and on arriving at the destination they ensured there was a package of care in place. If the package was not in place the patient would be returned to the pick-up location.
 - If a patient was expected to die within the next 48 hours arrangements were made to ensure the patient was booked as a single patient journey to ensure privacy and dignity.
 - As a result of the transfer of staff from another provider there was an intention to increase the number of patients with mental health needs transported from the community to inpatient settings.
- ## Access and flow
- Systems were in place to ensure resources were where they needed to be at the time required.
 - Patients could access patient transport services in a timely way. overall the organisation was achieving their key performance indicators for collecting patients. The patient transport service was available seven days a week from 6am to 1am. This ensured resources were available to meet the needs for patient transport.
 - The provider confirmed work at short notice could be undertaken if there were staff available with the specific skills and training needed. They told us the most difficult staffing problem was balancing demand with staff availability.
 - The controller was responsible for ensuring resources were where they need to be at the time required. Electronic systems enabled the controller to have an oversight of the booked work and allocate vehicles and

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staff to complete the patient transfers. The controller planned work the day before and reviewed regularly on the day to ensure the best fit and to add additional bookings as they arrived.

- The hospital liaison assistants helped with patient flow by ensuring the appropriate booking had been made and patients were ready to be collected by First Care Ambulance.
- Information on delays and cancellations was captured to enable trends and themes to be identified. Any delays or cancellations were communicated to patients.
- Staff collecting patients from their homes would text or phone before they collected the patient to check they were still expecting to go to an outpatient appointment.
- Bookings were managed externally between 7am and 6pm. Booking information would then be sent to the controller to allow them to dispatch vehicles and staff. Out of hours the team leaders or controller provided the booking service, receiving phone calls directly from the hospitals.
- Between August 2017 and March 2018 there were 40,596 patient transport journeys undertaken.

Learning from complaints and concerns

- There was a complaints management policy. Staff were aware of the policy and the complaints received and any learning that had resulted. The policy and procedure aimed to ensure that complaints were dealt with efficiently, openly, fairly and consistently.
- Prior to the inspection the organisation provided details of the comments received in the period from February 2017 to February 2018. There were very few complaints received from patients. We saw details of the investigations, outcomes, actions taken and lessons learned. Details related to lateness of pickup and late arrival for appointment and we saw the learning which related to improvement in planning and communication.
- Vehicles carried 'How to make a complaint' trifold leaflets which were readily available to all patients, in addition information about raising concerns and making complaints was available on the organisation's website.
- All concerns and complaints were initially presented to the training and compliance manager, who then passed

the initial investigation to the relevant line manager. Where relevant, statements were requested from staff or they were invited to an investigatory meeting with a clear set of questions to be asked.

- All concerns and complaints were recorded by the training and compliance manager and were stored on a spreadsheet on the intranet. Where complaints were linked to staff members all the investigatory documentation were securely stored electronically on the staff members' file. Where the complaints required actions to be taken these decisions were made and instigated by a member of the management team.
- A chronology of events was kept when dealing with any complaint and a written record of the investigation was produced by the investigating person/s including complaint received, investigation records, statements and any actions taken, by whom and a timeline of implementation
- An initial response was provided within one working day from receipt of the complaint, either by phone call, email or in writing. This target was in the main achieved. However, there were on occasions delays in receiving a complaint from a stakeholder or another service, where for example another stakeholder or service had conducted an internal investigation which was then passed to First Care Ambulance for further investigation.
- A response or an apology for a delay was provided within 20 days. All response letters provided details of the complaint raised, actions taken to investigate and any improvement actions.
- A 'Lessons Learnt' process was in place where on a monthly basis lessons were added to staff information boards and displayed as a presentation on TV screens in the staff rooms. Where relevant stakeholders were informed of the learning and any actions taken.
- We saw an example of learning where as a result of complaints from patients and staff about the heating in the vehicles, heater units had been replaced or repaired.

Are patient transport services well-led?

Vision and strategy for this this core service

- The organisation had a clear vision and strategy to deliver good quality care to patients.
- The vision stated the organisation would provide a caring, safe and reliable transport service for the whole

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community. A mission statement also stated that the service would put people at the heart of everything they did. All staff were aware of the agreed destination for the organisation and this was reflected in their actions.

- A quality strategy formed a key part of the organisation's journey in moving forward to be the best they could be. The aim of the quality strategy was to support the delivery of the mission and vision, and to incorporate the organisation's values in everything they did. The values were:

1. Compassion, treating everyone with courtesy and compassion.
 2. Integrity, being honest and open and having strong moral principles.
 3. Innovation, being able to transform ideas into good services which met the needs of the communities.
 4. Professionalism, having the competence, skills, courtesy, honesty and responsibility expected.
 5. Respect, treating everyone with respect and dignity and
 6. Working in partnership, to deliver and improve the services provided for the communities and stakeholders.
- The strategy was communicated to everyone across the organisation through meetings and engagement with staff. The main aims included:
 1. To continuously strive to be a highly effective business with effective leadership across all levels, robust governance measures, financial sustainability and to be a value for money provider.
 2. To continue to employ a skilled and engaged workforce, working to the best of their skill sets to provide high quality care and transport.
 3. To effectively manage the fluctuating demands on the service provision by using a unique flexible staffing model.
 4. To maintain strong partnerships with patients, staff, commissioners, hospitals and the public.

Governance, risk management and quality measurement

- Governance and risk management processes were fit for purpose and demonstrated a positive working relationship between all staff teams and the senior management team. The governance framework was focused on supporting the delivery of safe, quality care.

- There was a clear reporting structure from the staff to the senior management team and back down. A number of regular operational and business meetings fed into the quality governance assurance which ensured a comprehensive clinical and operational oversight.
- Regular operational meetings were held to ensure shared knowledge of operational pressures across the organisation. A daily operational call was chaired by one operations manager and attended by all team leaders and controllers from Plymouth, Exeter and Barnstaple. This call reviewed staffing, vehicles and capacity for the day. The two operations managers each held a weekly operational meeting with their team leaders. The weekly operational meeting discussed vehicles off road, recruitment, training, annual leave, and staff sickness, along with any other business. We observed these meetings and found there was good discussions held and support provided to each other.
- We also observed a monthly management meeting. There was a standing agenda where discussions centred around vehicle servicing, MOTs, cleanliness audits, rotas, recruitment, performance reviews, sickness, training compliance, incidents, complaints, finances and projects.
- There were clear lines of responsibility and accountability for the overall quality of clinical care. The medical director and a lead paramedic worked closely with the senior management team to maintain a programme of quality improvement and effective clinical governance. The clinical governance board met quarterly and was chaired by the managing director and included representatives from compliance, training and operations.
- A comprehensive set of policies was readily available on the intranet, personal digital assistant (PDAs) devices and as hard copies at each of the bases. This ensured staff could work according to best practice guidance.
- Audits measured the quality of the organisation. Outcomes were developed through clinical audits which demonstrated the effectiveness of the service. For example, the information recorded in patient records was used to evidence good patient care and rapid, high quality continuation of care for receiving clinicians. Reports were generated to identify themes and highlight training needs.
- Data of key performance indicators was accurately maintained. There had been considerable investment in

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IT business management systems and this ensured efficient collection of data. Systems were in place for dispatch, HR communications and finance and fleet tracking. Data was accessible to relevant managers through a shared IT point and reports were generated to inform business maintenance and planning. Reports were generated from the data collection.

- The organisation understood, recognised and reported their risks. The organisation had a risk register and this had been kept up-to-date. Risks were identified on the risk register and were categorised as financial, governance, health and safety, sites and resources, HR recruitment and staffing, business continuity, operational, environmental and reputational. The register highlighted the risk area, risk description, existing controls, score, lead, action required, residual risk, progress, due date and date completed.

Leadership of service

- The leadership of the service had the skills, knowledge and integrity required.
- The senior management team, who consisted of the managing director, the medical director, the training and compliance manager, the senior operations manager and the operations managers, were experienced and passionate about the organisation with a commitment to the patients who used the organisation, and also to staff. They were available to staff and accompanied staff on a “ride along” from time to time. We heard about good support for members of the team. Staff felt able to openly discuss issues and concerns with their team leaders and operations managers. They believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed.
- There was a clear management structure and the senior management team communicated with staff by email and face-to-face. We received consistently positive feedback from staff who had a high regard and respect for the management team. They were visible, approachable and supportive and one member of staff said they met the senior management team as part of their induction and they “would always listen and had time for staff.”
- Through the content of governance systems, we saw the leadership of the organisation reflected the requirement to deliver safe, effective, caring, responsive and well-led

services. Most staff were eager to share with us how much they enjoyed working for the organisation. They were very proud to work for the organisation and were passionate about the care they provided.

- The medical director worked remotely and visited the base every three months. He was available by phone or email to discuss any medical issues and worked closely with the lead paramedic and the senior management team. There were no current concerns about the arrangement; however, the situation was closely monitored to ensure the needs of the service and the team were being met.

Culture within the service

- The organisation considered its strengths to be those of delivering on promises, a great reputation, a flexible and responsive approach, partnership working and team spirit. The positive working relationship with the commissioners was also seen as an area of outstanding practice.
- Most staff we met said they felt valued and enjoyed being part of a team who worked together for the benefit of people who needed them. One member of staff said the organisation was “a really good place to work.” Staff felt supported by the registered manager and management team and their colleagues. One member of staff said “the managers have an open-door policy and are very visible. I’d have no problem raising a concern and know it would be taken seriously.”
- However, morale at the Plymouth base was not as positive. Some staff said they felt “like the poor relation.” This was recognised by the management team and staff alike and a recent change of management had been implemented to address this issue.
- Managers and staff told us how staff made great efforts to get to the bases during the recent snow because they knew colleagues would not be able to get there. Managers also told us about the sterling efforts of staff who were involved in an evacuation of 50 residents from a care home following a fire.
- There was a good culture to speak up. Staff were passionate about their work and told us they would readily speak up if they were not happy and were encouraged to raise concerns. There was a whistleblowing policy which outlined the process for

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raising concerns about the safety of patients or care standards. Once a concern had been raised the matter would be investigated confidentially and the outcome reported directly back to the member of staff.

- Staff were aware of the whistleblowing policy and the arrangements for reporting poor practice without fear of reprisal. They felt confident about using this process if required and that concerns would be taken seriously.
- Concerns could also be raised through the organisation's grievance procedures. Types of concerns included: operational failings that could result in patient safety being endangered i.e. broken equipment; poor staff training; poor quality of care; fraud or corruption; health and safety violations; employees being mistreated by other members of staff or service users; malpractice; acts of violence, discrimination or bullying towards patients; negligence; substance and alcohol misuse affecting ability to work. Where concerns were identified they were fully investigated and necessary action taken.
- Where concerns had not been resolved staff were advised that they could take the issue externally to the care Quality Commission (CQC). Guidance was provided in the leaflet 'Raising a Concern with the CQC' in the staff handbook.

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

- There were systems to engage with the public to gain feedback on services. This was used for learning and development. However, given the transient nature of this service public engagement was challenging. There was little opportunity for follow up with patients, nevertheless, the organisation strove to engage with patients.
- A patient involvement policy promoted the involvement of patients in the monitoring of service delivery through a range of feedback mechanisms. Patients' views on the whole patient experience were obtained by post, email, phone, the website and feedback cards on vehicles. However, the cards were not clearly displayed on some of the vehicles we inspected. This meant that some patients might not be aware they could provide their feedback.

- A communications strategy had been formulated to improve communications with patients, carers, referrers and others, including patients and carers who had difficulties in communicating due to language or cultural reasons or due to various impairments.
- A patient satisfaction survey was available and included five statements which patients were asked to agree or disagree with. They included: "the crew listened to me and explained any necessary movements to promote my well-being and experience during my transport", "my consent has been obtained before and throughout my transport and care", "my consent was obtained for personal information to be used between booking transport and the provider", "personal information was treated confidentially", "recommend service to family and friends" with a section for further comments. The survey was sent to 50 random patients each month. There was an average of 20 surveys returned each month. Information was gathered from the surveys and although the majority of feedback was good, any concerns and learning were investigated and an action plan was put in place.
- We saw comments received and of the 157 only three contained negative feedback about delays. Positive comments included "I've been using your service for about 2 years. The crew have always been incredibly helpful friendly and punctual. Being housebound having a bit of friendly banter makes my day!" and "I cannot say thank you enough to the ambulance crew who were so friendly and helpful in getting my wife home for Christmas, nothing was too much trouble. They are all a credit to your organisation. I would recommend your service. Thank you once again."
- There were also effective systems to engage with staff.
- Managers ensured all staff understood how to manage feedback and provided feedback information to the people involved and shared lessons learnt through notices on staff notice boards and on presentations on TV screens in the staff rooms. Staff confirmed they encouraged patients to give feedback.
- There was a mobile phone application group for communication between crews and controllers for example, about road closures and weather conditions.
- Staff could express their opinions and raise concerns directly with managers. A staff working group met quarterly with representatives from all roles across all bases in the organisation. Attendees canvassed their

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colleagues and presented their concerns and questions at the meetings. We saw minutes of the meetings where actions were recorded and followed through. The senior management team were aware of any issues and actions in place.

- Staff told us about a positive outcome from this meeting. The patient's weight was not visible on the personal digital assistant (PDA) device. This meant staff could not see the weight of the patient to enable them to plan appropriately for the transfer. As a result, the parameters had been changed to include the patient's weight and this information was now available. Another example related to concerns about the location of the light switch in the vehicle depot at the Exeter base. As a result, the switch was moved and timers installed.
- Following staff feedback, the organisation was looking at a programme to upskill ambulance care assistants in the ad hoc teams. This would enable them to better support the paramedics and technicians they were crewed with, for example taking simple measurements like blood pressure.
- The organisation used a yearly staff survey to gather feedback from staff and to consider improvement of health and well-being. Prior to annual appraisals a survey was also taken to obtain in a snapshot of time how valued staff were feeling. The results were plotted on a chart for trends and correlation with events happening in the organisation.
- Where positive feedback was received about an individual member of staff they were praised by means of a letter (posted or emailed) and this was also recorded on the staff member's HR file. If the feedback was generic then each base had an electronic notice board where anonymous messages could be uploaded for staff attention.
- Staff were recognised for good practice and service with awards in the form of monetary vouchers. Staff said there was a summer b-b-q and a Christmas party.
- Those staff working alone were encouraged to familiarise themselves with health and safety procedures which applied to them, particularly emergency procedures.

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

- The registered manager showed a desire to continually improve the organisation and saw our inspection as a

positive learning experience. There was a clear focus on improving the quality of care for patients and developing services to ensure sustainability of the service.

- Staff told us they were always keen to learn and develop the organisation. Innovation and improvement was encouraged with a positive approach to achieving best practice. It was apparent during our inspection that the management team and all the staff had the patient at the centre of everything they did. They were dedicated to their roles and approached their work with flexibility.
- A demand on service management process was in place where the organisation was able to offer limited flexible services incorporating all areas of the business to meet with fluctuating daily demands from the various acute hospitals within contracts.
- These variable demands were hard to predict. Discharges from hospitals were often at the last minute and the booking system would be bombarded. This proved challenging for staffing and resource capacity levels for specific times of day.
- The organisation had implemented a hospital liaison assistant role (HLA) at the acute hospital. The role had proven to be invaluable by supporting the crews, reducing aborted journeys and providing a communication line on the ground in the hospital. The role had also improved the process of getting the more vulnerable patients home as quickly as possible. The organisation considered the continued engagement with the hospital to be essential to ensure they could provide the service required.
- The management team embraced the value of the organisation's contribution to the wider healthcare system. They were also open to a changing footprint of the organisation and possibilities to improve the sector through further integration and development of services for the benefit of patients.
- The implementation of IT systems had enabled efficient reporting of niche information for commissioners and hospitals.
- The organisation was keen to further develop their working relationships with professional groups to look at the patients' requirements during discharge transfers. A group of occupational therapists had already visited to discuss the appropriateness of equipment needed during transfer such as the use of scoop stretchers or carry chairs. This had been very valuable for both groups and had informed future planning.

Outstanding practice and areas for improvement

Outstanding practice

- There was an example of outstanding care provided to patients. Feedback from another provider praised the efforts of staff who had gone above and beyond in exceptional circumstances during the transportation of patients, because of the closure of a local care home.

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure at least one person in the organisation, the named professional, is trained in safeguarding level four.
- Administer and supply medicines with the correct legal authorisation of a patient group direction. Paramedics require a patient group direction to administer any prescription only medicine that is not on the exemption list.

- Apply for a waste exemption certificate from the environment agency for the destruction of controlled drugs. This certificate is required to comply with the requirements of the Misuse of Drugs Regulations 2001 by denaturing controlled drugs.

Action the hospital **SHOULD** take to improve

- Provide seat covers that are in good repair and free from tears.
- Remind all staff to complete vehicle checks thoroughly, and replenish any out of date or empty medical gas cylinders.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>(1) Care and treatment must be provided in a safe way for service users</p> <p>(2) (g) the proper and safe management of medicines</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">Medicines were not administered and supplied with the correct legal authorisation of a patient group direction. Paramedics required a patient group direction to administer any prescription only medicine that was not on the exemption list.There was no waste exemption certificate from the environment agency for the destruction of controlled drugs to comply with the requirements of the Misuse of Drugs Regulations 2001 by denaturing controlled drugs.
Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	<p>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>(2) Systems and processes must be established and operated effectively to prevent abuse of service users</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">The named professional responsible for safeguarding was not trained to the appropriate level.