Hearts First Ambulance Service Limited

Quality Report

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Date of inspection visit: 3 December 2019
Date of publication: 12/02/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Good**
Are services safe?	Good
Are services effective?	Good
Are services caring?	Not sufficient evidence to rate
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

Hearts First Ambulance Service Limited is operated by Hearts First Ambulance Service Limited. The service provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 3 December 2019.

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.

We rated this service as **Good** overall.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them.
- Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and locum staff a full induction.
- Records were clear, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff assessed patients' food and drink requirements to meet their needs during a journey.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools.
- The service had started to monitor response times so that they could facilitate good outcomes for patients.
- The service made sure staff were competent for their roles. Managers were on target to appraise staff's work performance and provided support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Summary of findings

- The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- At the time of our inspection, a staff survey was being undertaken.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

However:

- The service provided mandatory training in key skills to all staff but there was no target and not all staff completed it.
- Staff did not always complete and update risk assessments for each patient.
- Staff did not always keep detailed records of patients' care and treatment.
- Leaders and staff did not actively engage with patients, equality groups, the public and local organisations to plan and manage services. This was due to the type of service being ran, which was a one-off transport, for which the service did not keep patient contact details.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Heidi Smoult

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good	Hearts First Ambulance Service is a medium sized independent ambulance provider. It runs from the town of Radlett, in Hertfordshire. The service had 13 ambulances and four cars. The service employed 131 members of staff. We rated safe, effective, responsive and well-led as good. There was insufficient evidence to rate caring. We came to these ratings as the service controlled infection risk well and the facilities, premises, vehicles and equipment kept people safe. The service made sure staff were competent for their roles. The service planned and provided care in a way that met the needs of local people and the communities served. The service was inclusive and took account of patients' individual needs and preferences. Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.

Summary of findings

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Summary of this inspection

Background to Hearts First Ambulance Service Limited

Hearts First Ambulance Service Limited is operated by Hearts First Ambulance Service Limited. The service opened in January 2008. It is an independent ambulance service in Radlett, Hertfordshire. The service primarily repatriated patients from European countries back to the UK, under travel insurance. These included both adults and children. This is not in scope for CQC regulation. A smaller proportion of work was private and NHS funded patients who need to be repatriated back to their home address or a receiving hospital. The service did not provide an emergency response service.

We last inspected the service in July 2017. At that time, we did not rate independent ambulance services. Following this inspection, we served five requirement notices on the service. These included breaches of:

- Regulation 14 CQC (Registration) Regulations 2009 for not informing CQC the previous registered manager had been absent for more than 28 days.
- Regulation 17 Health and Social Care Act (HSCA) (Regulated Activities) (RA) 2014 for not having an incident management policy, no risk assessments or risk register, inadequate information in staff files, no participation in audits and lack of policies.
- Regulation 15 HSCA (RA) for not having appropriate child safety harnesses.
- Regulation 19 HSCA (RA) for not having adequate personnel files.
- Regulation 12 HSCA (RA) for not having safe storage, management and temperature control of medicines.

Following the inspection, the service provided an action plan demonstrating improvement made to the service to ensure compliance with the regulations. All of these had been resolved prior to the December 2019 inspection.

At the time of the inspection, a new registered manager had recently been appointed and was registered with the CQC in November 2019.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,and one other CQC inspector.The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Hearts First Ambulance Service Limited

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder and injury

During the inspection we visited the ambulance base. We spoke with four staff including; the registered manager, a governance consultant, an operational manager and a 'make ready' worker.

During our inspection, we reviewed five sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in July 2017.

Activity (November 2018 to October 2019)

- Less than 5% of the service's activity was regulated patient transport journeys.

50 registered paramedics and 81 technicians or emergency care assistants worked at the service, which also had a bank of temporary staff that it could use.

Track record on safety

Summary of this inspection

- Zero never events
- Zero clinical incidents
- Zero serious injuries
- Zero complaints

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	Not rated	Good	Good	Good
Overall	Good	Good	Not rated	Good	Good	Good

Good

Patient transport services

Safe	Good
Effective	Good
Caring	Not sufficient evidence to rate
Responsive	Good
Well-led	Good

Summary of findings

We found the following areas of good practice:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them.
- Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and locum staff a full induction.
- Records were clear, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff assessed patients' food and drink requirements to meet their needs during a journey.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools.
- The service had started to monitor response times so that they could facilitate good outcomes for patients.
- The service made sure staff were competent for their roles. Managers were on target to appraise staff's work performance and provided support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Good

Patient transport services

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- At the time of our inspection, a staff survey was being undertaken.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

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

- The service provided mandatory training in key skills to all staff but there was no target and not all staff completed it.
- Staff did not always complete and update risk assessments for each patient.
- Staff did not always keep detailed records of patients' care and treatment.
- Leaders and staff did not actively engage with patients, equality groups, the public and local organisations to plan and manage services. This was due to the type of service being ran, which was a one-off transport, for which the service did not keep patient contact details.

Good

Patient transport services

Are patient transport services safe?

Good

We rated safe as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff but there was no target and not all staff completed it.

Mandatory training topics included infection prevention and control (92% staff completion), basic life support (83%), and safeguarding adults and children (87%). The service did not have a set target for mandatory training completion. Additional training was given in other areas including information governance (66%) and moving and handling (71%). A training manager was in post who was reviewing training compliance with plans to increase compliance in 2020. Staff were suitably trained and assessed to carry out driving duties safely. Driving assessments were conducted yearly by qualified driving assessors.

Training was provided both online and by classroom teaching. The service had an automated system which sent weekly training reports to the registered manager, so they knew which staff members needed which training.

The service had developed on site a training centre which was accredited with the Resus Council UK, which allowed all staff to have appropriate life support training.

Some staff employed were also employed by NHS organisations. In these instances, the service obtained copies of their training certificates from their substantive employer.

Safeguarding

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

Staff received training in safeguarding adults and children level 2, with 87% of staff up to date with the training. Some staff were also trained in safeguarding adults and children level 3; 47% of staff had received this training. We saw evidence that the service transported very few children, usually less than five per year. As all transport journeys were pre-booked, if the booking involved a child, the service ensured that the staff members in the ambulance had safeguarding children level 3 training.

Staff had an awareness of how to protect patients from abuse and what to do if they suspected a patient was being abused. The service had sent one safeguarding referral to the local authority following an allegation of neglect. As the allegation involved a member of staff, the service referred them to their professional body and terminated their employment.

A safeguarding policy was in place and in date. A hard copy was available in the crew room. The safeguarding policy also had information on female genital mutilation and human trafficking and included details on how to report these concerns to the relevant statutory bodies. Each vehicle also had information on how to escalate a safeguarding concern, if concerns arose whilst the ambulance was on a transfer.

Safeguarding was a standard agenda item on the monthly management meetings. All staff had a safeguarding mobile application 'app' on their phone which meant they could find out the contact details of the local safeguarding board, regardless of where they were in the country.

The external governance consultant employed by the service was in the process of getting a level 4 safeguarding certification for both adults and children. This was due to be completed in March 2020.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.

Reliable systems were in place to prevent and protect people from a healthcare-associated infection. All vehicles we looked at were clean and well kept. Personal protective equipment (PPE) was available in every vehicle. Hand sanitising gel were available in all vehicles.

During the course of a journey antibacterial wipes were available for staff to clean any areas needed. A thorough process was in place to clean each vehicle after each patient transport journey. Once a vehicle returned to base a sign was placed in the front indicating it was out of service and the crew wiped down the vehicle. Following this a

'make ready' employee then cleaned the vehicle so that it was ready for use. We saw daily cleaning checklists which evidenced this process as well as observing the process during the inspection.

As all journeys were pre-booked, staff were made aware in advance of any infections that the patient they were transporting had. This meant that they could take protective measures in advance, to prevent the infection from spreading. We saw the booking sheet prompted staff to check if the patient had MRSA or clostridium difficile (c. diff) (types of infections).

Each vehicle was deep cleaned every two weeks, or after transporting an infectious patient or if a spillage occurred. This was completed by the service's internal 'make ready' team.

Environment and equipment

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

All equipment we looked at were serviced and electronically safety tested where required. Emergency equipment including a defibrillator were present on all vehicles and checked daily. During the 'make ready' process, staff checked all equipment, including disposable equipment, to make sure there were adequate stock levels for the next journey.

All vehicles were in good condition and were serviced every 15,000 miles by a registered dealer. This was more frequent than the manufacturer's guidance of every 25,000 miles. All had appropriate MOT and tax. We reviewed the doFcumentation that supported this. All vehicles also had a spare wheel and tyre repair kits in case of punctures at the road side. Ambulances were also equipped with spare light bulbs and spare windscreen wiper blades in case either needed repairing on a long distance transport journey.

There were two vehicles with bariatric beds and a bariatric chair and hoist available. We were assured that only staff who had the appropriate training in this equipment were sent out with these vehicles.

At our last inspection we found that the service did not have appropriate equipment for transporting children. At this inspection we saw that child and baby car seats were available, and these were appropriately safety marked. A process was in place for hiring a baby pod if required.

The base stored a back up of equipment, so if a piece of equipment broke it could be replaced and avoid the ambulance being taken off the road for a long period of time. All equipment was standardised across all the ambulances and kept in the same place in all ambulances. This meant in case of an emergency, staff immediately knew where to access the correct equipment. Vehicles had satellite navigation systems with the nearest hospital function programmed in. This was in line with the National Patient Safety alert in 2015.

A crew bunk house was based on site which allowed up to five members of staff to stay and sleep before or after a shift if needed. As the service was open 24 hours a day and some transport journeys were long distance, crew were given the opportunity to stay before or after their shift, to ensure they were not driving to or from work overly tired.

A process was in place for managing clinical waste. Each vehicle had clinical waste bags for use during transport journeys. However, once opened there was no place to keep the clinical waste bag within the vehicle and we were told they were put in a corner of the vehicle. We raised concerns about the safety of this as these bags could contain used vomit bowls, for example. The management team were unsure of where they could place the used bag but told us they would try to think of a better place for them to be put. Following our inspection, we saw that each ambulance had been fitted with bins to hold clinical waste whilst the vehicle was in transit.

Sharps bins were in use in each vehicle and the service had a contract with an external company to remove used sharps bins and clinical waste.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration.

At the time of our inspection, there was not a robust risk assessment process in place. There was no criteria set for what type of patients or conditions the service would accept for transport journeys, although we were told by the

registered manager some conditions, such as being under a Deprivation of Liberty Safeguard (DOLS) or patients living with severe dementia, would make them ineligible for transport. However, despite the lack of a formalised criteria we saw examples of where the service refused to provide services due to the level of clinical risk to the patient and staff. This included their refusal to undertake a tarmac transfer of an intubated patient, despite losing a valuable contract as a result. This was due to the risks to the patient for this type of transfer. Managers also provided an example of where they refused to take a booking for a patient with Ebola, due to the risks to their staff. We raised the lack of an admission criteria to the registered manager. Following this, they made a criteria, outlining the types of patients they would and would not accept for transfer bookings, which they provided to us.

Each patient transport journey had a booking sheet. This listed certain risks for staff to consider during the transport, for example, whether they required bariatric equipment. A tick box was in place for staff to confirm that they had completed the risk assessment. Out of the five records we reviewed, two of them had blank risk assessment boxes. This meant we were unsure if the patients' needs had been risk assessed.

Observations were not undertaken routinely during patient transfers as the service did not primarily provide treatment. However, National Early Warning Scores (NEWS) guidance was in every vehicle to help staff identify if a patient was deteriorating. A process was in place that if a patient deteriorated during a transfer, staff would divert the ambulance to the nearest hospital.

Staffing

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

The service employed a mixture of paramedics, technicians and emergency care assistants. Rotas were planned in advance, with most full-time staff working a 'four on, four off' pattern, with four days working and four days off. The service also had its own bank staff, with approximately 55 staff on bank. All staff had worked substantively in NHS posts for a minimum of three years prior to being taken on at the service and new starters came from word of mouth recommendations as the service did not publicly advertise for staff.

Skill mix was planned in advance, as all journeys were pre-booked. Due to the types of patients often transported, for example, patients serving custodial sentences, escorts from the service booking the journey, for example, the prison, often accompanied them.

All crews were made of two staff. These could be one paramedic and one technician, two technicians or two paramedics. The skill mix would depend on the clinical picture of the patient they were transporting. All technicians were Institute of Health and Care Development (IHCD) level 4 qualified. This meant that they had undertaken an 18 week course and a minimum of three years post qualifying experience.

Staff received appropriate breaks during long transport journeys. Policy stated that they must have a break every four hours as a minimum. All breaks were paid for.

A designated clinical manager was on site at all times, to take bookings and provide advice to crews who were undertaking journeys.

We looked at the personnel records of new members of staff and saw that they had evidence of an induction.We looked at five personnel records and saw that all had evidence of their qualifications and skills as needed for their post.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care.

Records were stored securely in a locked cupboard in the main office. We reviewed five sets of records and saw that there were some gaps in recording. We found that two records did not have evidence of consent, two did not have evidence of a risk assessment and two did not have evidence of staff checking for allergies. These were tick boxes which had not been completed.

The managers were aware of this and had began auditing the completion of records in August 2019. We saw from the audits from November 2019 that this had been improving,

with the most recent audit outcome showing that risk assessments had been completed in 67%, and consent in 78%. We saw actions were in place to remind staff of completing documentation and that individual staff members who had failed to complete the records correctly had been identified and spoken with.

When patients were being transported to a hospital, a separate record was completed. One copy of this was given to the admitting hospital, and the other was kept securely at the base.

Medicines

The service used systems and processes to safely, administer, record and store medicines.

Medicines were stored securely. Medicines were stored in locked cupboards in the ambulances, with extra medicines stored securely at the base. We reviewed medications both in ambulances and in the stock room and found that they were all in date.

Emergency medicines including adrenaline were present in all ambulances. Ambient vehicle temperature monitoring was undertaken and recorded daily. We saw that on occasions the temperature fell below freezing. We raised concerns about whether this could affect the efficacy of the medications, as they could have been partially freezing, thawing and then freezing each night. Following this the service amended their medication policy. A new process was put in place whereby drugs were removed from vehicles overnight if low temperatures were expected and returned in the morning before the ambulances were dispatched. The policy also stated that if the temperature fell below freezing with liquid medications on the ambulances, they would be replaced.

All medications that were administered were recorded appropriately on the patient records.

We found that ambulance technicians were making the decision to treat patients with non-parenteral prescription only medicines. Whilst this practice is not supported by current legislation, an appropriate governance process was in place to assess and manage ongoing risk. Staff had undertaken appropriate training and were assessed as competent. This ensured people had timely access to safe treatment.

The service held a schedule 4 controlled drug; rectal diazepam 5mg. However, there is no legal requirement to treat schedule 4 controlled drugs as a controlled drug. Therefore, they did not need a controlled drug accountable officer or any additional safety measures surrounding the medication.

Whilst on inspection we found three oxygen cylinders on ambulances which were out of date. We raised this as a concern with the registered manager who assured us they had only recently been bought from a supplier. As such, the service was raising the concern with their supplier, regarding the inappropriate delivery. Once we made the service aware of this they immediately removed them from the ambulances and replaced them with in date oxygen cylinders. The service had spare cylinders stored appropriately in the store room.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service had an electronic incident management system in place. Since June 2019 there had been 50 incidents reported. These included vehicle problems such as a flat tyre, to a patient deteriorating during a transfer and being diverted to the nearest hospital. However, these also included incidents that had occurred during the carrying out of work that was not regulated by CQC. Learning from incidents was shared through a monthly newsletter.

There had been no serious incidents and no never events. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

Good

Patient transport services

An incident reporting policy was in place, which was an improvement from the last inspection. An incident reporting form was available in each vehicle for staff to complete if an incident occurred. Staff we spoke with were aware of how to raise concerns and report incidents.

There had been no incidents resulting in patient harm, therefore, there was no need for the duty of candour to be discharged. However, staff we spoke with were aware of the duty of candour and what to do if a patient suffered harm.

Managers were informed of patient safety alerts and made changes as required. An example of this was a recall of a defibrillator by the Medicines and Healthcare products Regulatory Agency (MHRA). As a result of the recall the managers promptly changed all the defibrillators in the ambulances.

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

Good

We rated effective as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff had access to guidelines and policies for the safe transfer of patients and any relevant activity. For example, there were policies on manual handling and infection control. Policies were available in hard copy format in the crew room and changes to policies were both reflected in paper copy and emailed to staff. Plans were in place to move all policies onto an electronic system that would capture data on how long staff had the policy attachments open, to get better insight into how long staff spent reading them.

Policies were written in a consistent format and there was an effective process for managing and reviewing policies along with any associated written control documents. This ensured that documentation remained legally compliant and actions were undertaken in a safe and efficient manner. We reviewed a sample of the policies and found they referred to national guidance and legislation.

An audit schedule was in its infancy at the time of our inspection. Local audits had started in August 2019, following the hiring of an external governance consultant. We saw audits were beginning to be undertaken on completion of records, medicines management and infection control.

Nutrition and hydration

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

A meeting nutritional needs policy was in place and in date. All vehicles had water and high calorie drinks onboard. When patients were being transported a long distance, the crew scheduled in regular breaks at service stations so that patients could buy food and drink.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools.

We were told staff asked patients if they were in pain during transport. However, at the time of our inspection the patient records were not designed so as to remind staff to check this, nor was there a designated place for this to be recorded. We raised this as a concern and a pain score section was added to the patient records. A section on pain management was added to the clinical observation policy.

We also noted that the cohort of patients that the service transported were generally 'well' patients who required transport from primary to secondary care, or from primary care to their home location. As such, most of these patients did not require pain relief.

At the time of our inspection the service did not have alternative communication aids to assist patients who were unable to verbalise communication. We raised this as a concern and during our inspection period the service printed out a sheet of Makaton sign language to help communicate with these patients. These were added to the vehicles at the time of inspection.

Good

Patient transport services

Response times

The service had started to monitor response times so that they could facilitate good outcomes for patients.

As the service was pre-booked all journeys were pre-planned and therefore, there were no response times. However, leaders had begun auditing the times the ambulances were booked for and what time they arrived, to assess whether they were arriving on time. There had not been any outcomes from this as of the time of the inspection.

Competent staff

The service made sure staff were competent for their roles. Managers were on target to appraise staff's work performance and provided support and development.

Staff had appropriate training to meet their learning needs to cover the scope of their work. Staff completed additional competencies. These were a mixture of clinical competencies, for example, handling syringe drivers and measuring end-tidal carbon monoxide levels (ETC02 – the amount of carbon dioxide in exhaled air) and operational, for example, applying snow chains to the tyres in case of bad weather and using the trolley winch.

All paramedics had been trained in advanced life support (ALS) and paediatric advanced life support (PALS). All technicians were trained in basic life support (BLS).

At the time of our inspection 25% of staff had completed an appraisal. The process was newly begun, and the service was on target with its trajectory to complete all staff appraisals by August 2020. Part of the quality strategy for 2020 was to improve the level of clinical supervision staff received.

Arrangements were in place to ensure that if there were performance issues with a staff member, that any other place of employment they had was also notified. Arrangements were also in place to notify staff members' professional regulatory bodies, if required.

All technicians employed by the company were in the process of registering with the Health Practice Associates Council (HPA). At the time of our inspection 30% of technicians had completed this, with the rest ongoing. It was also a requirement for any new technicians being employed to be registered with the HPA. The HPA is a voluntary organisation which provides a registry for clinical staff who are not eligible to be registered with another professional body.

Multidisciplinary working

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

Crews worked well together and were made up of a mixture of paramedics, technicians and emergency care assistants. The management team had built solid relationships with its main contracted organisations and provided a joined-up transfer process for them.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

On long patient transport journeys rest stops were scheduled and mobile patients were encouraged and supported to walk around and get some exercise.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff were aware of the process of getting patients' informed consent and had an understanding of the Mental Capacity Act 2005. We were told by the registered manager that the service did not transfer patients who were subject to the Deprivation of Liberty Safeguard (DOLS) or those that lacked mental capacity.

The training figures for Mental Capacity Act training at the time of our inspection was 65% compliance. However, this was not treated as a mandatory training topic for the service, as they did not often proactively treat patients and therefore, rarely had to assess mental capacity. Furthermore, as above, they did not transfer patients who were known to lack mental capacity.

Are patient transport services caring?

Good

Patient transport services

Not sufficient evidence to rate

There was insufficient evidence to rate caring.

Compassionate care

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

We saw evidence of testimonials displayed on the service's website, and physical copies were stored in the office. These were all extremely positive.

We were unable to observe any patient transfers during the inspection and so were unable to speak to patients. We were also unable to get patient details to contact, as the service had contracts with other organisations, not the patients themselves, and as such were unable to provide contact details due to legal implications.

Staff we spoke with explained how they would treat patients with compassion and kindness. They were able to provide examples of how and when they respected patients' dignity and privacy.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff supported both patients and their families during transport journeys. One of the testimonials we saw stated that excellent care was given to both a patient and their relative during a journey.

Staff were aware of different cultural and religious needs and provided examples of ways in which they accommodated them.

Understanding and involvement of patients and those close to them

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

We were unable to assess this due to the lack of patient observations. However, staff described explaining to patients clearly why they were being transported and where to, so that they understood the reason for the transfer.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service met the needs of their population by being available for bookings 24 hours a day, seven days a week. This meant that they would transport patients at whatever time was convenient for them. They also planned for dealing with bad weather during transport journeys. All ambulances were equipped with winter tyres, snow shovels and salt spray for the colder months. This meant that transfers were not cancelled due to snow and ice.

The service worked well within the wider system and had formed strong working relationships with specific NHS trusts and local prisons whilst transporting patients.

The facilities and premises were appropriate for the services that were delivered. A bunk house was located on the base that allowed for five members of staff to rest and sleep in if they had a long drive for a patient transport journey.

Meeting people's individual needs

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

The ambulances provided by the service met all of the patients' needs. Alongside the required medical equipment, the ambulances also contained DVD players,

Good

Patient transport services

USB sockets for patients to charge their mobile phones, a flip over table, a cup holder placed next to the trolley and seats for relatives to accompany them. Tea and coffee making facilities were also available in the ambulances. They also contained wheelchair clamps so that patients could be transported securely in their wheelchair if they preferred that option.

There were two bariatric ambulances available, alongside a hoist and bariatric chair, that could be brought along on a transport journey. This meant that patients with a high body mass index (BMI) could be transported safely and comfortably. As all journeys were pre-booked the service was able to send the correct type of ambulance and equipment.

When transporting patients back to their home address, staff always ensured that a plan was in place for their arrival. This meant they checked they had food in, that their heating was working, and their pipes had not burst in cold weather. This process was documented on every job sheet to remind staff. A policy was in place that if the home address was not suitable or safe, they would return the patient to the nearest hospital until further arrangements could be made.

Each ambulance had a translation book, to help communicate with patients who did not speak English. However, at the time of our inspection, there was no communication aids to assist people who were unable to verbalise. We raised this as a concern and as a result, the service immediately downloaded Makaton signs and placed copies in each ambulance.

We were told that the service would not accept a booking for a patient living with severe dementia, as they were unable to provide the appropriate care for them.

Access and flow

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

As all journeys were pre-booked there were no key performance indicators (KPIs) on response times. However, on each job sheet there were boxes to document the time the transport was booked for and the time the ambulance arrived. We were told on inspection that plans were in place to start auditing this to confirm the timeliness of arrivals. In the absence of these audits we were unable to tell whether ambulances arrived on time, however, we noted that there had been zero complaints about delays or late arrivals.

Same day bookings were accepted, so long as they the service had adequate crew members and vehicles available.

All vehicles were fitted with a tracking device which meant they could be tracked wherever they were. The operations manager could review this and check that they were on time. If there were concerns they were running late, they would inform the patient in advance.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service had processes in place to treat concerns and complaints seriously, investigate them and share lessons learned with all staff, including those in partner organisations.

A 'how to complain' card was available on all ambulances. Information on how to complain was included on their website.

The service had zero complaints in the 12 months prior to our inspection.

The management team held a monthly meeting which included complaints as a standard agenda item, to discuss if any arose.

The service was a member of the Independent Sector Complaints Adjudication Service (ISCAS). This is an independent adjudication service which assists if complaints are unable to be resolved locally.

Are patient transport services well-led?

Good

We rated well-led as **good.**

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and

issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and knowledge that they needed to run the service. The service had a new registered manager in post at the time of our inspection. The registered manager had been the service's director for many years but had only recently become the registered manager.

We reviewed the registered manager's personnel file and saw that all required documentation was present. This was in line with Health and Social Care Act 2008 (regulated Activities) Regulation 5, Fit and proper persons: directors.

The registered manager had a long career in the ambulance field and had grown the business from a small enterprise. The nominated individual was a newly appointed external governance consultant, with a long career in governance and regulation.

Leaders understood the challenges to quality and were quick to respond to any concerns that we raised during the inspection. They were aware of upcoming political change and the effects that could have on their business. This related specifically to maintaining adequate supplies of medications which were imported from abroad. Plans had been put in place to ensure adequate stock levels were maintained.

The registered manager was very visible. They had an office in the main base from which they were clearly visible at all times. The registered manager was aware of when additional needs arose which were outside of their knowledge or remit and hired in external consultants to fill the gap.

Leaders supported staff to develop their skills and hosted a variety of additional competencies for staff to complete. They had trained cleaning staff to take on more roles and had now become 'make ready' staff for all the ambulances.

The service had a newly appointed medical director who was available for advice and assistance with medications.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision in place at the service. This was to 'provide the very best level of clinical care together with the most cost-effective transport service to all patients from, or wherever they need to be transferred to, whatever their medical requirements may be, via the most appropriate transfer method available.'

Staff we spoke with were aware of the vision and knew where to go to find out more information about it.

A quality strategy was in place to assist the service in delivering their vision. This had been created in June 2019. There were six targets for 2019, including establishing a governance structure, developing assurance reporting, and ensuring policies were fit for purpose, among others. At the time of our inspection; early December 2019 five of the targets had been met, with the sixth target due to be completed by the end of the month.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was an open and friendly culture at the service. Staff we spoke with gave positive feedback about working for the service and that the culture was supportive.

The culture was centred on the needs of patients and there were no examples of times when patient care had been affected by financial constraints.

Any performance management issues were outsourced to an external human resources (HR) company, who managed all the service's HR concerns.

Staff were aware of how to raise concerns and a whistleblowing policy was in place. The service's governance consultant acted as their freedom to speak up guardian. The service was also signed up to an electronic whistleblowing system. This meant if staff had concerns they did not want to share with the registered manager or governance consultant, they could raise them with a completely independent body.

Good

Patient transport services

Staff's driving times were monitored, and safeguards were in place to ensure staff did not drive excessive hours. Two ambulance cars were kept on base and used to deliver relief staff, if a patient transport journey went above the allowed hours of driving.

A new appraisal system was in place, whereby all staff were receiving a new type of appraisal. At the time of our inspection, 25% had completed a new appraisal, and the service was on target with its trajectory plans.

There was a strong emphasis on the safety and wellbeing of staff. Staff were provided with a bunk house so that they did not drive whilst sleep deprived. The service also provided all staff with a group accident policy, so if they had an accident either on duty or off, and had to miss work, they would still get paid.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

An internal governance team were in place. The service had recently recruited an external governance consultant, who worked alongside a compliance manager and a compliance coordinator.

Monthly management meetings occurred which had a standard agenda, which included reviewing incidents, audits and the risk register. We reviewed the minutes from three months of these meetings to confirm this. Learning from incidents was shared through a monthly newsletter. We saw copies of newsletters kept in a folder in the crew room.

All staff had clearly defined roles and responsibilities for their jobs. We saw lists which included all the responsibilities each staff member was expected to undertake.

An audit strategy had been created. On a monthly basis audits were conducted on records completion. Monthly assurance reports were also produced on medicines management and infection prevention and control.

All policies had creation and review dates, so that staff could make sure they were reading the most up to date version. Any changes in policy were sent by email to staff, and the hard copies kept in the crew room were updated.

Clinical ambulance staff were told to declare working arrangements outside of the service and leaders monitored this to make sure staff were not working excessive hours that could adversely impact on the care and treatment being provided.

Formal whole team meetings occurred twice a year. These were recorded and the minutes were sent to all staff.

Management of risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. A risk register was in place, which identified the risk, the impact it could have, mitigating actions and additional risk reduction measures. All risks had an assigned owner who was responsible for reviewing them. All risks were reviewed monthly in the monthly management meetings. Examples of risks on the risk register were patients requiring specialist medical treatment during transfer, patients being uncomfortable during transfer and ambulance break downs. Mitigating actions were in place, to reduce the likelihood of these risks occurring.

The service had identified two areas of weakness; their new appraisal system being rolled out and a new audit schedule which was in its infancy. These were both reflected on the risk register and were being dealt with as a priority.

Plans were in place to cope with unexpected events. For example, if an ambulance broke down, a comprehensive breakdown policy was in place with a priority call out service. If a recovery vehicle did not arrive quickly, then staff sent a relief ambulance to them.

Good

Patient transport services

There were no examples of when financial pressures had compromised patient care. All vehicles were replaced once they were 18 months old and serviced every 15,000 miles, to ensure that patient transport journeys were optimised.

A business continuity plan was in place which accounted for seasonal demand fluctuations and any major incident.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

All information was stored securely, both paper records and electronic records. Electronic systems were automatically backed up to an internet 'cloud' based system five times a day.

Staff had easy access to policies and laminated sheets on important topics such as safeguarding and incident reporting were stored in the ambulances. This meant they had access to this information even if they were away from their base.

The service had cyber-attack ransom insurance. This meant that if their electronic records were held to ransom during a cyber-attack, the ransom would be paid immediately, to reduce the impact on patient care.

Notifications which were required to be submitted to external organisations were done so. This was evidenced by submissions to CQC and the Health Care Professionals Council (HCPC).

Public and staff engagement

Leaders and staff did not actively engage with patients, equality groups, the public and local organisations to plan and manage services. This was due to the type of service being ran, which was a one-off transport, for which the service did not keep patient contact details. At the time of our inspection, a staff survey was being undertaken.

As the regulated patient transport work was via ad hoc contracts with organisations, such as NHS trusts or local prisons, the service did not have contracts with the patients they transported. This meant that after the transfer had finished, they were unable to get in touch with them.

Plans were in place and recorded in the strategy document, that all patients would be given a feedback card for them to complete during their transfer. This was started in October 2019.

At the time of our inspection, a staff survey was being undertaken.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Leaders were clearly committed to continually improving the services they provided. This was evidenced through their proactive response to any concerns raised during the inspection and how they maintained and updated their fleet of ambulances. The service had also developed on site a training centre which was accredited with the Resus Council UK, which allowed all staff to have appropriate life support training. This training was also offered to others in the local community.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that a training target is set and that all staff complete mandatory training.
- The provider should ensure that staff roles have been checked against national guidance in relation to child safeguarding requirements.
- The provider should ensure that all records are completed.