Harley Street Ambulance Service Limited

Harley Street Ambulance Service

Quality Report

London Group Business Park
715 North Circular Rd
London
NW2 7AQ
Tel: 020 8208 4440
Website:
http://www.harleystreetambulanceservice.co.uk/

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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.

Ratings

Overall rating for this ambulance location	Good
Emergency and urgent care services	Good
Patient transport services (PTS)	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Harley Street Ambulance Service is operated by Harley Street Ambulance Service Limited. The service was registered with the Care Quality Commission (CQC) on 13 May 2011. The service provides patient transport services (PTS) and emergency and urgent care (EUC) services. EUC patient transfers are between hospitals. The provider is registered for the regulated activities: transport services, triage and medical advice provided remotely and treatment of disease, disorder and injury.

Harley Street Ambulance Service (HSAS) operates as a subcontractor to main contractors (identified as commissioners in this report). The main contractors who commission services from HSAS liaise directly with NHS providers. A small part of its work is private and for this work HSAS liaises directly with the private hospitals or private organisations.

HSAS transports patients (adults and children) across the whole of the United Kingdom and works across different boroughs and populations.

The service has six ambulances equipped for and used for both PTS and EUC.

We carried out an unannounced inspection of both the PTS and EUC core services using our comprehensive inspection methodology on 29 and 30 January 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.

The main service provided by HSAS was PTS. Where our findings on EUC – for example, management arrangements – also apply to PTS, we do not repeat the information but cross-refer to the PTS core service.

We last inspected this service in July and November 2016 but at the time we did not have the legal duty to rate independent ambulance services. However, following this inspection we rated the service good for both core services.

We rated this service good overall because:

- Staff treated patients and relatives with compassion, kindness, dignity and respect.
- The provider had systems, processes, and practices to keep people safe and safeguard them from abuse. Staff were aware of and knowledgeable about these processes.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff reported a positive working culture within the service.
- The service kept patient data safe and secure and this was an improvement from the previous inspection in 2016.
- The service had enough staff, with the right qualifications and skills, training and experience to deliver effective care, support and treatment.
- We observed effective multidisciplinary working between HSAS staff and staff at the various hospitals they worked with.
- Staff understood the relevant consent and decision-making requirements of guidance and legislation including the Mental Capacity Act 2005.
- There were effective recruitment and training processes to ensure staff were appropriately qualified and trained to deliver good quality care.

Summary of findings

- Policies and procedures were in date and reviewed in line with set review dates.

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

- Only 50% of staff had received an appraisal at the time of our inspection.
- The provider did not have access to translation services which meant they relied on staff or relatives who spoke the same language to communicate with patients.
- There were no regular staff meetings as part of the service's governance arrangements.
- The provider did not have systems and processes to ensure that ambulance staff declared working arrangements outside of the service and monitor this to make sure staff were not working excessive hours that may adversely impact on the care being provided.
- There was limited formal engagement with staff and not all staff were aware of the service's vision, strategy or values.
- Commissioners did not always make the service aware of patients' pre-existing conditions or risks and the provider did not have a policy or system to manage this.

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.

Nigel Acheson
Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Good	Emergency and Urgent Care (EUC) services were a small proportion of activity by the provider making up 20% of the work they carried out. EUC services included high dependency transfers between hospitals. Arrangements for patient transport services (PTS) and EUC were mostly the same. Therefore, we have reported most of our findings in relation to this core service in the relevant sections of the PTS report. We rated the EUC service good overall for the same reasons set out in the PTS summary of findings below.
Patient transport services (PTS)	Good	The main service was patient transport services (PTS) which made up 80% of the provider's work. The provider had six ambulances used for both PTS and emergency and urgent care (EUC). The arrangements for PTS and EUC were the same. Therefore, we have reported most of our findings for EUC in the relevant PTS sections of the report. We rated PTS as good overall because staff treated patients and relatives with compassion, kindness, dignity and respect, there were systems processes, and practices to keep people safe and safeguard them from abuse, there was 100% compliance with mandatory training, policies and procedures were in date and reviewed in line with set review dates, staff reported a positive working culture, and we observed effective multidisciplinary working between HSAS staff and staff at the various hospitals they worked with.

Harley Street Ambulance Service

Detailed findings

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

Detailed findings

Contents

Background to Harley Street Ambulance Service

Harley Street Ambulance Service (HSAS) is an independent ambulance service operated by Harley Street Ambulance Service Limited. The service which opened in 1982 is based in North West London and transports patients across the whole of the United Kingdom working across different boroughs and populations.

The service has six vehicles used for both patient transport services (PTS) and emergency and urgent care (EUC) services. EUC patient transfers are between hospitals. The majority of HSAS's work is PTS (80%) with EUC making up a small part of the service (20%). Arrangements for the provision of PTS and EUC were mostly the same and because of this we reported most of our findings for EUC in the PTS report.

HSAS registered with the Care Quality Commission on 13 May 2011. The registered manager has been in post since July 2011.

When we inspected the service in July and November 2016 we did not have the statutory power to rate it. However, in 2016 we told the service that it must make improvements in relation to the safe management of medicines, keeping patients' information safe, and risk management within the service. We issued requirement notices in relation to those three areas of concern. Following the 2016 inspection the provider made improvements and provided an action plan to address our concerns.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and two specialist advisors with expertise in working in private and NHS ambulance services. The inspection team was overseen by Terri Salt, interim Head of Hospital Inspection.

How we carried out this inspection

We carried out an unannounced inspection of both the Emergency and Urgent Care (EUC) service and Patient Transport (PTS) core services using our comprehensive inspection methodology on 29 and 30 January 2019.

During the inspection, we visited the service's base in North West London. We spoke with 14 staff including registered paramedics, emergency ambulance crews, management and office staff. We spoke with four patients

Detailed findings

and four relatives. We also spoke with six staff working at the hospital locations where Harley Street Ambulance Service provided PTS and EUC services. We also reviewed patient feedback forms which patients had completed after using the service and reviewed data sent to us by the provider prior to the inspection.

Facts and data about Harley Street Ambulance Service

The service is registered to provide the following regulated activities:

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

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 in the past and the most recent inspection took place in September 2016.

Activity (February 2018 to January 2019)

- There were 3,908 patient transport service (PTS) journeys undertaken.
- There were 572 emergency and urgent care (EUC) journeys undertaken.

Staff

- Two registered paramedics and eight emergency ambulance crew staff worked at the service. The service also had a bank of temporary staff that it could use.

Track record on safety (February 2018 to January 2019)

- There were no Never Events.
- Five clinical incidents.
- No serious injuries.
- Two complaints.

Our ratings for this service

Our ratings for this service are:

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

Emergency and urgent care services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Good

Information about the service

The main service provided by this ambulance service is patient transport services (PTS) making up 80% of the work the service undertakes. Emergency and urgent care (EUC) services is a small part (20%) of the work the service undertakes.

Moat of our findings for EUC including some arrangements for safety, effectiveness, responsiveness, caring and well led also apply to PTS and because of this we do not repeat the information but cross-refer to the PTS section below.

Summary of findings

We found the following areas of good practice:

- Staff treated patients and relatives with compassion, kindness, dignity and respect.
- The provider had systems, processes, and practices to keep people safe and safeguard them from abuse. Staff were aware of and knowledgeable about these processes.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff reported a positive working culture within the service.
- The service kept patient data safe and secure and this was an improvement from the previous inspection in 2016.
- The service had enough staff, with the right qualifications and skills, training and experience to deliver effective care, support and treatment.
- We observed effective multidisciplinary working between HSAS staff and staff at the various hospitals they worked with.
- Staff understood the relevant consent and decision-making requirements of guidance and legislation including the Mental Capacity Act 2005.

Emergency and urgent care services

- There were effective recruitment and training processes to ensure staff were appropriately qualified and trained to deliver good quality care.
- Policies and procedures were in date and reviewed in line with set review dates.

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

- Only 50% of staff had received an appraisal at the time of our inspection.
- The provider did not have access to translation services which meant they relied on staff or relatives who spoke the same language to communicate with patients.
- There were no regular staff meetings as part of the service's governance arrangements.
- The provider did not have systems and processes to ensure that ambulance staff declared working arrangements outside of the service and monitor this to make sure staff were not working excessive hours that may adversely impact on the care being provided.
- There was limited formal engagement with staff and not all staff were aware of the services vision, strategy or values.
- Commissioners did not always make the service aware of patients' pre-existing conditions or risks and the provider did not have a policy or system to manage this.

Are emergency and urgent care services safe?

Good

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff received training in safety systems, processes, and practices. This was delivered as part of the service's mandatory training of staff. There were processes to monitor training compliance by staff.
- Training was delivered as a mixture of face to face training and online completion by staff.
- Training modules included infection prevention and control, manual handling, fire safety, information governance, health and safety and awareness of mental health, dementia, equality and diversity, and learning disability training.
- Staff working in emergency and urgent care (EUC) services had additional training such as blue light driver training, tracheostomy care, use of suction units, and medical gas training. Only staff who had had training in emergency and urgent care were allocated EUC patient journeys.
- At the time of the inspection, all staff were up to date with the service's mandatory training modules.

Safeguarding

- See the patient transport service (PTS) section for main findings.

Cleanliness, infection control and hygiene

- See PTS section for main findings.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well. However, arrangements for the storage of oxygen need to be reviewed.**

- All six vehicles used were leased from an external company. The vehicles had current MOT, service and insurance and we saw evidence of this during the inspection.

  Vehicles were appropriately equipped for the transfer of EUC patients. Equipment was available for various patient groups. For example, the service had child seats, bariatric equipment (equipment to support the transport of obese patients) and other equipment used in the transportation of high dependency patients.

- During our inspection, we observed staff carrying out daily vehicle checks prior to commencing patient journeys. Staff reported faults to the operations manager and the managing director who arranged repairs with an external company as required.
- Drivers had the correct licence category for the type and weight of vehicles used within the service.
- Staff had access to satellite navigation systems and work phones where information on patient journeys was sent to by control staff.
- The ambulance station environment was designed such that there was space to store ambulances overnight.
- Equipment was stored appropriately on the vehicles and in the office and available for use.
- The service kept records for the servicing of vehicles and equipment. Servicing was carried out by an external company. Staff reported faulty equipment to the external company and arrangements were made to facilitate repairs. For example, on the first day of inspection one of the six vehicles was off the road and due to be taken for repairs.
- Portable appliances in the office and on the vehicles had been safety tested which meant that the provider had some assurance it was safe to be used.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.**
- Patients transported under the UEC service were accompanied by clinical staff from the hospitals the service worked with. This meant that most tomes, HSAS staff did not have to assess and or respond to patient risk.
- However, we spoke with staff about how they assessed and responded to deteriorating patients when there was no clinician on the patient journey and found that they knew how to respond to a deteriorating patient and escalate their concerns. Staff were able to describe the actions they would take including monitoring blood pressure, heart rate, and blood sugar depending on the nature of the patient's condition. Observations were recorded on the patient report form. Staff responded to deteriorating patients by providing first aid, calling for the emergency services or diverting to the nearest accident and emergency unit.
- Commissioners informed the service if patients had any pre-existing conditions or risks. This was done at the time the job was dispatched to the service. However, staff reported that commissioners did not always inform them of patient risks.
- Staff had access to clinical advice from an NHS ambulance service over the phone. This allowed staff to contact the NHS ambulance service and receive clinical advice on deteriorating patients if staff felt it was needed. The managing director had a clinical background and was an additional source of information if staff required clinical advice.
- HSAS did not transport patients detained under the Mental Health Act 1983. Patients experiencing a mental health crisis were accompanied by a member of staff from the transferring hospital. However, HSAS had received training in mental health awareness and dealing with patients presenting with challenging behaviour.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment**.
- The service employed ten permanent staff made up of two paramedics and eight emergency ambulance crew staff. Additionally, they had bank staff which they used as and when required. Office staff included the managing director, an operations manager and one control staff and one finance staff.

Emergency and urgent care services

- Staff reported that they generally managed to get a break during work hours but this was not always possible during busy periods.
- HSAS had control of the work they accepted from commissioners and only accepted jobs they had capacity for. This meant that they avoided having to deal with unfilled shifts.
- Only staff trained in EUC covered high dependency transfer journeys. These jobs were received in advance (at least a day before) which meant the service had time to allocate the right skill mix of staff to the journey. HSAS only accepted work if they had capacity to undertake it and this meant they only accepted high dependency transfer work when they had the trained available.
- The managing director had responsibility for creating the staff rota. She told us she did this by using staff timesheets and this enabled her to plan the rotas in such a way that staff would not have to work excessive hours that may adversely impact on the care and treatment being provided.

Records

- See PTS section for main findings.

Medicines

- **The service followed best practice when giving and recording oxygen to patients.**
- The service did not use controlled drugs and therefore none were stored on the premises or on the vehicles. Only oxygen was stored on the vehicles and on the premises.
- During the last inspection, we were concerned about the administration of medicines by staff at HSAS. We found that the medicine salbutamol, a medicine used for the lungs, was being administered by paramedics and emergency ambulance crews without the necessary authorisation required by law. However, on this inspection we found that staff no longer administered any medicines except oxygen. Training records showed that all had staff completed medical gas training as part of their mandatory training.
- Clinical staff from the transferring hospitals travelling with EUC patients administered any prescribed controlled medicines to patients.
- Oxygen cylinders were appropriately secured on the vehicles. However, the provider stored oxygen inside the building in an area which was not well ventilated. Although there was appropriate signage on the door to the storage area, we were not assured the provider had carried out the appropriate risk assessments in relation to storing oxygen inside the building. Following the inspection, the provider informed us they had reviewed their oxygen storage arrangements and new storage would be installed onsite but in a different location.

Incidents

- See patient transport service (PTS) section for main findings.

Are emergency and urgent care services effective?

Good

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.**
- We reviewed the provider's policies and found them to be comprehensive, clear and in date. Policies referenced guidance from the National Institute for Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- Policies included the cardiac arrest policy, blue lights driving policy, safeguarding, patient transfer policy, risk management policy, duty of candour policy, end of life care pathway policy, and guidance for ambulance service personnel when supporting patients with learning disabilities.
- Staff provided care in line with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). A copy of JRCALC was available in the staff room where staff could easily access it.
- Staff told us if a patient had a stroke or heart attack, they would be diverted to the nearest accident and emergency department.

Pain relief

- See PTS section for main findings.

Emergency and urgent care services

Response times

- **The service monitored response times but we found no evidence of action plans by the provider to address poor performance against response times.**
- The operational manager told us staff kept records of the time they were alerted to a patient requiring transportation, their time of arrival at the transferring hospital and time of arrival at the destination hospital. Information was recorded on patient report forms (PRFs). We reviewed some PRFs during the inspection and found that they had mostly been fully completed.
- Using information from PRFs the provider monitored whether patients were being seen within the required response times and without undue delay. Operational road staff reported any delays to the control staff who in turn made commissioners and the hospitals aware of any delays.
- Commissioners also kept records of response times and shared these with the provider monthly.

Patient outcomes

- **The service's commissioners monitored key performance indicators (KPIs) but we found no evidence of action plans by the provider to address poor performance against KPIs.**
- Between February 2018 and January 2019, HSAS undertook 572 EUC journeys.
- The only outcomes measured by the provider related to response times starting with the time they were notified of a patient journey by a commissioner. Office and ambulance staff recorded journey start and finish times and this enabled them to monitor their own response times.
- Commissioners kept records of the services performance in relation to key performance indicators such as the total time a patient waited before HSAS picked them up (this had to be within 45 minutes after they advised HSAS of a patient journey), the maximum time a patient spent on the vehicle (no more than 60 minutes for journeys up to ten miles). We found evidence of commissioners sharing this data with HSAS monthly and this enabled the service to gauge how they were performing in relation to response times.
- During the inspection we found that the provider's compliance with commissioners' KPIs ranged from 72% and 100%. However, we did not see any action plans to address poor performance against the KPIs.

Competent staff

- **The service made sure staff were competent for their roles.**
- New employees had a period of supervision where they shadowed more experienced staff for up to two weeks depending on confidence levels. This allowed the provider to assess staff competence of delivering patient care.
- The service asked new or prospective staff to provide evidence of qualifications, for example, in first response emergency care (FREC), which is part of the training for people working in emergency or ambulance services. We reviewed staff files and saw evidence of staff qualifications in the form of various certificates.
- Paramedics had to be registered with the Health and Care Professions Council (HCPC), the statutory regulator of health and care professions in the United Kingdom, including paramedics. This was checked prior to staff commencing employment and evidence noted on the staff file.
- Although the provider had a system for the appraisal of staff, only 50% of permanent staff had received an appraisal. When we asked the managing director about this they told us they were in the process of arranging appraisals for the rest of the staff.
- Outside of the induction process, the provider did not produce any evidence of a system to identify poor or variable staff performance and how this would be managed for staff to improve.
- The service did not routinely transport patients detained under the Mental Health Act or patients experiencing a mental health crisis. However, staff told us if they had to transport a patient experiencing a mental health crisis, a member of staff from the hospital would accompany that patient in the ambulance.
- HSAS training records showed that staff received mental health training as part of their mandatory training.

Multi-disciplinary working

Emergency and urgent care services

- See PTS section for main findings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care**.
- HSAS offered staff training in mental capacity and deprivation of liberty as part of the mandatory training for staff. At the time of our inspection all staff had completed this training.
- We also viewed the service's Mental Capacity Act and DoLS policy which was comprehensive and in date.
- Although HSAS staff did not routinely transport patients detained under the Mental Health Act 1983 they had received training in mental health awareness and conflict resolution. Patients experiencing a mental health episode were accompanied by staff from the transferring hospital during transfers with HSAS.
- We spoke with staff about mental capacity and they were clear about their responsibilities in relation to obtaining patient consent. For example, staff gave examples of the need to obtain patients consent before performing a blood glucose measurement test or giving oxygen.
- We asked staff working in EUC how they would make decisions about consent when patients were unconscious or confused and they told us they would act in the patient's best interest. However, for all EUC journeys a nurse or a doctor or sometimes both would be on the ambulance with the patient and HSAS would not have to make any clinical or consent related decisions for the patient.

Are emergency and urgent care services caring?

Good

Compassionate care

- See patient transport service (PTS) section for main findings.

Emotional support

- See PTS section for main findings.

Understanding and involvement of patients and those close to them

- See PTS section for main findings.

Are emergency and urgent care services responsive to people's needs?

Good

Service delivery to meet the needs of local people

- **The service planned and provided services in as a subcontractor for different commissioners who commissioned services from the NHS.**
- Harley Street Ambulance Services (HSAS) transported patients across the whole of the United Kingdom which meant that they did not serve only the local population.
- The main service was a patient transport service (PTS) which provided non-emergency transport for patients. EUC was a smaller part of the service. EUC transport journeys were between hospitals. Journeys were mostly pre-planned but could also be requested by commissioners or private organisations on the day.
- The service had six ambulances in total and only accepted work where it had capacity to carry out those patient transfers.
- The service had six ambulances in total and only accepted work where it had capacity to carry out those patient transfers.
- The service planned and provided services in partnership with its commissioners through formal contractual arrangements. HSAS also took direct bookings from private hospitals, private organisations and individuals.

Meeting people's individual needs

- See PTS section for main findings.

Access and flow

- **People could access the service when they needed it.**

Emergency and urgent care services

- The service only accepted work from their commissioners if they had enough staff and ambulances to provide EUC services.
- The operations manager and other control staff allocated patient journeys to staff considering the type of journey required and staff skills. They also made sure staff were where they needed to be at the required time.
- There was communication between ambulance staff and office staff in relation to any delays. Control staff kept the commissioners updated on any delays in the service.
- Response, on scene and turnaround times were monitored by reviewing patient record forms where this information was recorded.

Learning from complaints and concerns

- See PTS section for main findings.

Are emergency and urgent care services well-led?

Requires improvement

Leadership of service

- See patient transport service (PTS) section for main findings.

Vision and strategy for this service

- See PTS section for main findings.

Culture within the service

- See PTS section for main findings.

Governance

- See PTS section for main findings.

Management of risk, issues and performance

- See PTS section for main findings.

Information Management

- See PTS section for main findings.

Public and staff engagement

- See PTS section for main findings.

Innovation, improvement and sustainability

- See PTS section for main findings.

Patient transport services (PTS)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Good

Information about the service

The main service provided by this ambulance service is patient transport services (PTS). Where our findings on PTS – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the PTS section.

Summary of findings

We found the following areas of good practice:

- Staff treated patients and relatives with compassion, kindness, dignity and respect.
- The provider had systems, processes, and practices to keep people safe and safeguard them from abuse. Staff were aware of and knowledgeable about these processes.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff reported a positive working culture within the service.
- The service kept patient data safe and secure and this was an improvement from the previous inspection in 2016.
- The service had enough staff, with the right qualifications and skills, training and experience to deliver effective care, support and treatment.
- We observed effective multidisciplinary working between HSAS staff and staff at the various hospitals they worked with.
- Staff understood the relevant consent and decision-making requirements of guidance and legislation including the Mental Capacity Act 2005.

Patient transport services (PTS)

- There were effective recruitment and training processes to ensure staff were appropriately qualified and trained to deliver good quality care.
- Policies and procedures were in date and reviewed in line with set review dates.

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

- Only 50% of staff had received an appraisal at the time of our inspection.
- The provider did not have access to translation services which meant they relied on staff or relatives who spoke the same language to communicate with patients.
- There were no regular staff meetings as part of the service's governance arrangements.
- The provider did not have systems and processes to ensure that ambulance staff declared working arrangements outside of the service and monitor this to make sure staff were not working excessive hours that may adversely impact on the care being provided.
- There was limited formal engagement with staff and not all staff were aware of the services vision, strategy or values.
- Commissioners did not always make the service aware of patients' pre-existing conditions or risks and the provider did not have a policy or system to manage this.

Are patient transport services safe?

Good

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff received training in safety systems, processes, and practices. This was delivered as part of the service's mandatory training of staff. There were processes to monitor training compliance by staff.
- Training was delivered as a mixture of face to face training and online completion by staff.
- Training modules included infection prevention and control, manual handling, fire safety, information governance, health and safety, awareness of mental health, dementia, equality and diversity, and learning disability training.
- At the time of the inspection, all staff were up to date with the service's mandatory training modules.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, there was a discrepancy between the services written safeguarding procedure and what staff did in practice.**
- The service had systems, processes and practices to keep people safe from abuse and improper treatment. This included safeguarding policies for children and adults safeguarding which we viewed and found to be in date during the inspection.
- Staff, including the safeguarding lead had been trained in safeguarding adults and children to the appropriate levels. Training records viewed at the time of the inspection showed that all staff has completed safeguarding training.
- The service's safeguarding procedure set out what actions staff had to follow on identifying a safeguarding concern. Staff were to contact the police where a person

was at risk of immediate threat or danger or liaise with the control room in all other instances. According to the procedure crews would then need to complete a safeguarding referral to the relevant local authority. However, in practice ambulance crews contacted the control room and it was staff in the office who would complete the safeguarding referrals. There was therefore a discrepancy between the services written safeguarding procedure and what staff did in practice.

- Staff we spoke with understood what safeguarding was and were able to give examples of what might constitute a safeguarding concern.

Cleanliness, infection control and hygiene

- **The service did not control infection risk consistently well.**
- We inspected four of the provider's six vehicles and found they were visibly clean and tidy. Cleaning schedules for vehicles were adhered to. There were reminders for staff to complete a weekly cleaning record sheet on the service's staff notice board and this prompted staff to complete these sheets as per HSAS policy. There was also an audit of the cleaning of vehicles which showed good compliance.
- Personal protective equipment (PPE) was available on vehicles and we saw staff appropriately using PPE during transport journeys.
- Sterile consumables were in date and stored appropriately on the vehicles and in the office.
- We saw evidence staff at HSAS had completed training in infection prevention and control as part of their mandatory training. Staff told us they had access to an external infection prevention and control advisor who they could contact for any infection control related advice.
- An external company was responsible for the deep cleaning of all HSAS ambulances. Deep cleaning took place every six weeks or sooner if required. Records for all deep cleaning and the deep cleaning scores before and after a clean were kept in the vehicle files.
- Staff were able to explain their policy on handling serious contamination of the vehicles following a patient journey. For example, for bodily fluids they used granules on top of the spillage then used gloves and spatulas to put the waste in a chemical waste pack which was then sealed. They would also clean the area using the appropriate cleaning chemicals and equipment. The vehicle was then booked in for deep-clean by an external contractor following spillage.
- Although we found the infection control practices at HSAS mostly in line with good practice, the service needed to improve its waste management. Staff could either dispose of clinical waste at the various hospitals locations or dispose of it on the HSAS site to be collected by an external contractor. However, we found that staff did not always place tags around the clinical waste bags. Tags are used to tieclinical waste bagsand provide an effective audit trail, so thebagcan be traced back to the hospitalor service if need be.
- Furthermore, on two ambulances clinical waste bags were not secured which meant there was a risk of clinical waste contaminating the clean environment in the ambulance.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- All six vehicles used were leased from an external company. The vehicles had current MOT, service and insurance and we saw evidence of this during the inspection.
- During our inspection, we observed staff carrying out daily vehicle checks prior to commencing patient journeys. Staff reported faults to the operations manager and the managing director who arranged repairs with an external company as required.
- Drivers had the correct licence category for the type and weight of vehicles used within the service.
- Staff had access to satellite navigation systems and work phones where information on patient journeys was sent to by control staff if required.
- The ambulance station environment was designed such that there was space to store ambulances overnight.
- Equipment was stored appropriately on the vehicles and in the office and available for use.
- The service kept records for the servicing of vehicles and equipment. Servicing was carried out by an external

company. Staff reported faulty equipment to this external company and arrangements were made to facilitate repairs. For example, on the first day of inspection one of the six vehicles was off the road and due to be taken for repairs.

- Portable appliances in the office and on the vehicles had been safety tested which meant that the provider had some assurance it was safe to be used.
- Equipment was available for various patient groups. For example, the service had child seats, bariatric equipment (equipment to support the transport of obese patients) and other equipment used in the transportation of high dependency patients.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.**
- We spoke with staff about how they assessed and responded to deteriorating patients and found that they knew how to respond to a deteriorating patient and escalate their concerns. Staff were able to describe the actions they would take including providing first aid, calling for the emergency services or diverting to the nearest accident and emergency department.
- HSAS told us commissioners were supposed to inform the service if patients had any pre-existing conditions or risks at the time a job (patient journey) was dispatched to the service. However, staff reported that commissioners did not always inform them of patient risks. There were no service level agreements between HSAS and its commissioners on the requirement for commissioners to inform the service of any risks prior to a patient journey and the service did not have a policy detailing what procedure staff should take if not informed of patient risks prior to arriving to pick up a patient.
- The service had an agreement with an NHS ambulance service for the provision of clinical advice over the phone. This arrangement allowed staff to contact the NHS ambulance service and receive clinical advice on deteriorating patients if staff felt it was needed.
- The managing director had a clinical background and was an additional source of information if staff required clinical advice.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment**.
- The service employed ten permanent staff made up of two paramedics and eight emergency ambulance crew staff. Additionally, they had bank staff which they used as and when required. Office staff included the managing director, an operations manager and one control staff and one finance staff.
- Staff reported that they generally managed to get a break during work hours but this was not always possible during busy periods.
- HSAS had control of the work they accepted from commissioners and only accepted jobs they had capacity for. This meant that they avoided having to deal with unfilled shifts.
- The managing director had responsibility for creating the staff rota. She told us she did this by using staff timesheets and this enabled her to plan the rotas in such a way that staff would not have to work excessive hours that may adversely impact on the care and treatment being provided.

Records

- **Staff kept records of patients' care and treatment.**
- At the previous inspection in 2016, we found instances where the provider had not kept patient information safe. However, during this inspection, we found the provider had established effective systems and processes to keep patient data safe.
- Staff ensured patient information such as the patient record form (PRF) and discharge summaries were transported securely and covered up so that personal details were not on show.
- Control staff recorded information pertaining to patient journeys electronically. The information was only shared with the drivers allocated the journey.
- At the end of each shift, staff returned completed PRFs to the ambulance station. If the office was closed they

placed the PRFs in a post box which was locked and only accessible to office staff. This meant that PRFs were not left out in the open where they could be accessed by unauthorised persons.

- The operations manager carried out random audits on the completion of PRFs and there was evidence of improvements in the completion of PRFs.
- Control staff obtained details of any "special notes" for individual patients when they took details of the patient journey from the commissioners. This was then passed on to the ambulance staff carrying out the journey.
- The service had a policy on the creation, storage and destruction of patient information. All patient information which was no longer required was placed in a confidential waste bin.
- During the inspection some staff expressed concerns about their payslips being left on a table in the office. This meant that staff addresses were exposed, and other colleagues could see this information. We raised this during the inspection and the manager removed the payslips placing them in a secure place.

Medicines

- **The service followed best practice when giving and recording oxygen to patients. However, arrangements for the storage of oxygen needed to be reviewed.**
- The service did not use controlled drugs and therefore none were stored on the premises or on the vehicles. Only oxygen was stored on the vehicles and on the premises.
- Staff administered oxygen as prescribed for the patient by their clinician or administered it in emergencies as required.
- Training records showed that all had staff completed basic medical gas training as part of their mandatory training.
- Oxygen cylinders were appropriately secured on the vehicles. However, the provider stored oxygen inside the building in an area which was not well ventilated. Although there was appropriate signage on the door to the storage area, we were not assured the provider had carried out the appropriate risk assessments in relation to storing oxygen inside the building. Following the inspection, the provider informed us they had reviewed their oxygen storage arrangements and new storage would be installed onsite but in a different location.

Incidents

- **The service managed patient safety incidents well.**
- HSAS had systems and processes for the reporting of incidents within the service. The service's incident reporting policy was comprehensive and in date. Staff also reported they were encouraged to report incidents by the management of the service.
- The provider reported no never events or serious incidents between February 2018 and January 2019. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Staff we spoke with knew what constituted an incident and were aware of the service's policy on incident reporting. Staff also said they felt confident in reporting an incident.
- Duty of candour (DoC) 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. HSAS had a DoC policy and DoC was part of the mandatory training for staff. Staff were clear on their responsibilities in relation DoC.

Are patient transport services effective?

Good

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.**
- We reviewed the provider's policies and found them to be comprehensive, clear and in date. Policies included safeguarding (adults and children), patient transfer

policy, risk management policy, duty of candour policy, end of life care pathway policy, and guidance for ambulance service personnel when supporting patients with learning disabilities.

- Policies made reference to the National Institute for Health and Care Excellence (NICE).
- There were suitable policies and protocols in relation to children.

  Policies and procedures were kept in the office in an area accessible to all staff and staff knew how to access them.

Nutrition and hydration

- **Staff gave patients opportunities to obtain food and drink during patient journeys.**
- Staff sometimes undertook long distance journeys, for example transporting a patient to Wales. They told us they asked the hospital to prepare a packed lunch for the patients and let patients know they could make as many stops as they needed to obtain food or drink.
- On shorter journeys patients were also given the option to stop for food or drink if required.

Response times / Patient outcomes

- **The service monitored response times but we found no evidence of action plans to address poor performance in relation to response times.**
- Between February 2018 and January 2019, HSAS undertook 3,908 PTS journeys.
- The only outcomes measured by the provider related to response times starting with the time they were notified of a patient journey by a commissioner. Office and ambulance staff recorded journey start and finish times and this enabled them to monitor their own response times.
- Commissioners kept records of the services performance in relation to key performance indicators such as the total time a patient waited before HSAS picked them up (this had to be within 45 minutes after they advised HSAS of a patient journey), the maximum time a patient spent on the vehicle (no more than 60 minutes for journeys up to ten miles). We found evidence of commissioners sharing this data with HSAS monthly and this enabled the service to gauge how they were performing in relation to response times.
- Performance data provided by a commissioner for two NHS Trusts showed that in the reporting period, the provider mostly met the commissioner's set targets. However, we did not see evidence of action plans to address poor performance in relation to required response times.

Competent staff

- **The service made sure staff were competent for their roles.**
  New employees had a period of supervision where they shadowed more experienced staff for up to two weeks depending on confidence levels.
- The service asked new or prospective staff to provide evidence of qualifications. We reviewed staff files and found evidence of staff competencies and qualifications in the form of various training certificates.
- As a part of the staff induction process, staff completed training in dementia, learning disabilities and mental health. At the time of our inspection all staff had completed this training.
- Although the provider had a system for the appraisal of staff, only 50% of permanent staff had received an appraisal. When we asked the managing director about this they told us they were in the process of arranging appraisals for the rest of the staff. Following the inspection, we received evidence showing that as of April 2019, 70% of staff had been appraised.
- The service did not routinely transport patients detained under the Mental Health Act 1983 or patients experiencing a mental health crisis. However, staff told us if they had to transport a patient experiencing a mental health crisis, a member of staff from the hospital would accompany that patient in the ambulance.
- HSAS training records showed that staff received awareness of mental health training as part of their mandatory training.

Are patient transport services caring?

Patient transport services (PTS)

Good

Compassionate care

Staff cared for patients with compassion.

- Staff cared for patients with compassion, kindness dignity and respect. We spoke with four patients and four relatives who all spoke positively about the staff. They told us staff treated them well and with kindness.
- We travelled with staff on some of the ambulances and observed patient transfers during the inspection. Staff maintained the privacy and dignity of patients including using blankets to protect patients from the cold. They also drew curtains when transferring patients from beds to trolleys.
- Ambulance staff spoke with patients and relatives in a caring and polite manner throughout the journeys.
- We spoke with staff at four different hospitals (discharging and receiving patients) and they were complimentary about staff at HSAS. They said the crews were friendly, approachable, professional and kind.
- The service had its own patient feedback questionnaire which asked patients or carers about the quality of the service and additional comments they would like to make. Comments from 2018 and 2019 were consistently positive and included statements such as: "received a high standard of care…", "friendly, flexible and always kind", and "ambulance crew were polite and friendly".

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- We observed staff talking reassuringly to patients who were anxious about their transfers.
- Staff showed a genuine interest in the welfare of patients they were transporting. Staff would intermittently talk to patients to check how they were doing during the transfer.
- Staff said they had not had a patient die in while being transported but were able to articulate the service's procedure for dealing with such a scenario.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment**.
- We observed crews respecting that a patient was able to independently mobilise. They ensured that the patient was empowered and supported to move independently and transfer from their bed to the trolley.
- Staff showed respect to relatives, welcomed them to join the patient on the ambulance and treated them as important partners in the delivery of the patient's care.
- We observed one ambulance journey where a relative wanted a copy of their mother's discharge form and the ambulance crew ensured that the nurse at the receiving hospital was aware of this and would arrange this upon that patient's discharge.

Are patient transport services responsive to people's needs?

Good

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of the various locations they served.**
- Harley Street Ambulance Services (HSAS) transported patients across the whole of the United Kingdom which meant that they did not serve only the local population.
- The main service was a patient transport service (PTS) which provided non-emergency transport for patients. EUC was a smaller part of the service. EUC transport journeys were between hospitals.
- The service had six ambulances in total and only accepted work where it had capacity to carry out those patient transfers.
- The service planned and provided services in partnership with its commissioners through formal contractual arrangements. HSAS also took direct PTS bookings from private hospitals, private organisations and individuals.

Patient transport services (PTS)

Meeting people's individual needs

- **The service did not always take account of patients' individual needs**.
- HSAS had no access to translation services which meant they relied on staff or relatives who spoke the same language to communicate with the patient.
- Equipment in ambulances was suitable for the transportation of bariatric patients. Staff also told us that where bariatric patients were to be transferred they used a four-person crew instead of the standard two-person crew.
- Although the service did not routinely transport patients experiencing a mental health episode, they had a member of staff from the hospital in the ambulance with them in the few instances where they have had to transport such patients.
- Staff had been trained in conflict resolution as a way of equipping them to deal with violent or aggressive patients.
- Senior staff told us that if their commissioners informed them that a patient requiring transport had a learning disability, spoke a language other than English, had physical disabilities, had a hearing or visual impairment, they informed their commissioners whether they were able to transport the patient considering equipment and resources they had within the service.
- The service allocated the same crews to its regular patients where possible to maintain a degree of continuity of care.

Access and flow

- **People could access the service when they needed it.**
- The service only accepted work from their commissioners if they had enough staff and ambulances to provide PTS services.
- The operations manager and other control staff allocated patient journeys to staff considering the type of journey required and staff skills. They also made sure staff were where they needed to be at the required time.
- There was communication between ambulance staff and office staff in relation to any delays. Control staff kept the commissioners updated on any delays in the service.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously and investigated them but there was no evidence of learning from complaints.**
- The service had an up to date complaints policy. There was a clear process between HSAS and its commissioners on handling complaints. Complaints received directly by the commissioner were sent to HSAS for investigation and comment. These were then sent back to the commissioners for completion and conclusions.
- Staff involved with the complaint were required to provide a statement which was then communicated to the commissioners via the management at HSAS.
- We reviewed two complaints which had been sent to HSAS by their commissioners and found they had been acknowledged and responded to on the same day. However, although the complaints were responded to within a timely manner, we did not see the external communications record form which was part of the service's complaints policy being used. This meant that the service was not compliant with its own complaints policy which required them to complete an external communication form where they had been such communication with the commissioners.
- We did not see any evidence of learning from complaints which had been investigated.
- We asked to see complaints that came directly to the provider but the managing director told us there had been no complaints made in relation to HSAS's private patients outside of commissioning work.

Are patient transport services well-led?

Requires improvement

Leadership of service

Patient transport services (PTS)

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- A managing director (also the registered manager for the service) led the organisation with the help of an operations manager. The managing director was responsible for strategic planning, management reviews, managing contracts with commissioners and reviewing policies.
- The operations manager was responsible for coordinating the day to day running and delivery of the service including managing staff. They were also responsible for the service's audit and quality processes.
- Staff were able to identify to us who the leadership of the organisation were and their responsibilities within the organisation.
- Staff reported that both the managing director and the operations manager were visible and approachable.
- Operational road staff reported they were always able to meet with management when they came to the ambulance base.

Vision and strategy for this service

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action but this had not always been developed with staff input.**
- The managing director was able to articulate the vision and strategy for the service. The provider had no plans to expand but had a vision to provide the best quality service (PTS and EUC).We saw evidence of current policies and a strategy document which stated that the vision would be achieved by ensuring staff worked in accordance with the values of the organisation and in compliance with the service's policies and procedures.
- The service's values were better safety, better knowledge, better teamwork and better outcomes. However, although the leadership were clear on the vision, strategy and values for the service not all staff were aware of the service's vision, strategy or values. We found no evidence of the leadership engaging staff in the vision or strategy for the service.
- We found no evidence of how management measured that operational staff were delivering a service aligned to the service's vision and values.
- The service worked with commissioners to plan for future demand but only undertook work they had capacity for taking into account the number of vehicles and staff they had.

Culture within the service

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff described a positive working culture where they were valued and supported. Staff also consistently spoke positively about the flexibility the work allowed them and how proud they were to work for the service.
- There was evidence that management took action to address behaviour and performance that that was inconsistent with the vision and values of the organisation.
- Duty of candour (DoC) was part of the service's mandatory training for staff. Furthermore, the service had a DoC policy and staff were aware of their responsibility to be open and honest with those who used the services.
- Staff spoke of a culture where they were encouraged to report incidents. They also said they could raise concerns without fear of retribution.
- Staff could access confidential support via an employee assistance programme (EAP). EAP was an online and telephone employee benefit designed to help staff deal with personnel and professional problems that could be affecting their home life, health and general wellbeing. This included assistance with legal, counselling, consumer, family, financial, medical, work, and stress.

Governance

- **The service did not always systematically improve service quality or safeguard high standards of care by creating an environment for excellent clinical care to flourish**.
- The managing director who was also the registered manager for the service had overall responsibility for

governance and quality monitoring. This included investigating incidents and responding to patient complaints. The registered manager was supported by the operations manager.

- The service had some systems to monitor the quality and safety of the service. For example, they used audits of daily vehicle and equipment checks, infection control, and record completion to improve quality. They also had regular reviews of policies to ensure that staff delivered a service that was safe and effective.
- HSAS did not coordinate care directly with the NHS. Coordination arrangements between HSAS and its commissioners were set out in the contacts agreements between the service and the commissioners. One off private transfer journeys were coordinated by control staff in line with the service's policies.
- There were effective recruitment and training processes to ensure staff were appropriately qualified and trained to deliver good quality care.
- The service did not have regular staff meetings with ambulance staff as part of its governance arrangements. Although some meetings took place with ambulance staff these were not regular. This limited the provider's ability to use these meetings to improve service quality or safeguard high standards of care.
- The management of HSAS held meetings every four to five months. Agenda items were set and these included staff training, vehicles, vehicle checks, equipment needs, and completion of paperwork. Meeting minutes were recorded and available to the rest of the staff and visible on the staff notice board.
- Although the provider routinely collected patient feedback there was no evidence that this feedback was reviewed and acted upon to improve the service.
- The provider did not have systems or processes to ensure that ambulance staff declared working arrangements outside of the service and monitor this to make sure staff are not working excessive hours that may adversely impact on the care being provided.

Management of risk, issues and performance

- **The service did not always have good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- HSAS outsourced risk management to an external organisation which produced the service's risk management documents and advised the service in relation to risk within the service.
- A risk management committee met quarterly to discuss key agenda items such as risk register monitoring, professional education and development, clinical effectiveness, evidence-based practice and incidents. The risk management committee actively reviewed risk occurrence and ensured that where appropriate risks were adequately reported and recorded.
- The service recorded risks in a risk register. Risks were rated according to likelihood and severity with mitigation factors stated. At the time of the inspection risks had last been reviewed two months prior.
- However, we identified a risk related to the provider not having systems or processes to ensure that ambulance staff declared working arrangements outside of the service and this had not been identified by the provider or placed on the risk register.
- Although the risk management for the service was outsourced to an external organisation who advised the service on risk and health and safety issues, we found that the provider took ownership of the need to assess risks specific to the day to day running of the service and the provision of care to patients. This was an improvement from the previous inspection in 2016.
- The service had no statutory role in major incident response and would not be expected to respond in the event of one.
- We reviewed the service's business resilience policy which set out how the service could be relocated to a different location in the case of an emergency. It also set out how vehicles could be replaced.
- Although there was some monitoring of key performance indicators (KPIs), we did not see evidence of action plans to address poor performance against the KPIs.

Information Management

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**

Patient transport services (PTS)

- The service ensured the accuracy of data by keeping complete and accurate records of patients record forms (PRFs). It ensured further accuracy by auditing staff completion of the PRFs. We saw reminders of staff being asked to complete PRFs fully following an audit.
- We also found evidence of engagement between the service and its commissioners where performance against targets was discussed.
- Staff had work mobile phones where they received information on the journeys to be undertaken. Phones were kept at the ambulance location overnight. Details of jobs sent to the work phones were deleted at the end of each shift. Staff were aware of this policy and were able to consistently tell us how they managed information received on the work telephone.
- The service carried out Disclosure and Barring Service (DBS) checks as part of its recruitment process. However, not all DBS certificates had been processed in line with data protection legislation. We found that the provider had retained two DBS certificates which should have been returned to staff following the necessary recruitment checks.

Public and staff engagement

- **While the service engaged well with patients, there was limited engagement with staff.**
- HSAS had no formal process for staff engagement. However, staff we spoke with said the management tried to speak to them about any proposed changes in order to obtain their views. They told us this was made easy by the fact that staff returned to the ambulance location after every shift and this was an opportunity for them to speak to management.
- We found management engaged well with its commissioners and HSAS staff engaged well with staff at the various hospital locations they served.
- The service used patient feedback forms which asked patients or carers about the quality of the service and any additional comments they would like to make. We reviewed eight forms which were all complimentary and positive about the quality of the service. However, it was not clear how HSAS used information from the patient feedback forms HSAS to assess the quality of its service.

Innovation, improvement and sustainability

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- We found that the managing director was committed to continuous learning and improvement. There was evidence of the management continually exploring and considering new ways of working. For example, by engaging various external organisations to advise on risk management, staff training, and infection control processes.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve
Action the provider SHOULD take to improve:

- The provider should appraise all staff working within the service.
- The provider should have systems and processes to ensure that clinical ambulance staff declare working arrangements outside of the service and monitor this to make sure staff are not working excessive hours that may adversely impact on the care being provided.
- Staff should tag clinical waste prior to disposal and secure clinical waste bags on the vehicles.
- The provider should have systems and process to enable learning from complaints.
- The provider should review current arrangements for the storage of oxygen inside the building.
- The provider should review its safeguarding procedure document so that it reflects what the procedure is in practice.
- The service should follow its complaints policy in relation to completing an external communication form where there has been such communication.
- The provider should engage and involve staff so they are aware of the services vision, strategy and values.
- The provider should have systems and processes to measure how operational staff deliver a service aligned to the service's vision and values.
- The provider should review arrangements for translation services and not rely on staff or relatives to translate for patients.
- The provider should monitor key performance indicators (KPIs) and have action plans to address poor performance against the KPIs set by commissioners.
- The provider should continue to review its recruitment processes to ensure that in relation to Disclosure and Barring Service (DBS) checks the service is compliant with data protection legislation.
- The provider should have regular staff meetings as part of its governance arrangements.
- The provider should review patient feedback and act on it to improve the service.
- The provider should have a system to identify and manage poor or variable staff performance.