Centralized Ambulance Transport Services Ltd

Centralized Ambulance Transport Services

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

This is the first time we have rated this service. We rated it as requires improvement because:

- Leaders did not operate effective governance processes. Systems were not in place to manage performance effectively. Managers did not identify and escalate relevant risks and issues, and identify actions to reduce their impact. The service did not always collect reliable data and analyse it.
- There were no formal audits in place at the time of our inspection. Whilst leaders carried out ad-hoc checks, these were not documented. This meant that leaders had not always identified the concerns that were raised during our inspection.
- Staff had not always ensured that cleaning, vehicle and equipment checks had been carried out and documented as required. Staff did not always recognise incidents and near misses and report them appropriately. Managers did not always share lessons learned with staff.
- There was no formalised process for policy sign-off by the senior leadership team. The service did not always follow the processes set out in provider policy documents. Managers did not check to make sure staff followed guidance.
- The service did not document staff competencies. Managers had not yet begun to appraise staff's work performance.
- Managers did not make sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Managers did not routinely monitor performance data to make sure patients could access services when needed.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse.
- Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Requires Improvement 	This is the first time we have rated this service. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Centralized Ambulance Transport Services

Centralized Ambulance Transport Services is operated by Centralized Ambulance Transport Services Ltd. The service began operating in December 2021. It is an independent ambulance service based in Peterborough, providing patient transport services for the public sector. The service transports patients from hospital to home or other care providers. The service also transports patients from home to outpatient appointments.

The service does not provide transport to children or to patients detained under the Mental Health Act 1983.

The service is registered to provide the following regulated activity:

Transport services, triage and medical advice provided remotely.

The service employs 13 members of staff. The fleet consisted of 3 vehicles. The service carried out 750 patient journeys in 2022.

The registered manager for this service had been in post since December 2021.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 7 February 2023. The registered manager was unavailable on the day of our inspection so we returned on 17 February 2023. We have not previously carried out an inspection of this service. We spoke with 5 members of staff, reviewed patient transport booking records, personnel files for 5 members of staff, feedback received by the service, and policies and procedures for the service. Following our inspection, we spoke with 3 service users via telephone to gather feedback about the service.

The team that inspected the service comprised a CQC lead inspector and another CQC inspector. The inspection team was overseen by Antoinette Smith, Interim Deputy Director.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that it has effective processes for governance, information management, and management of risk, issues and performance. This includes ensuring that all risks which arise from the carrying on of the regulated activity are assessed, monitored and mitigated. (Regulation 17)

Summary of this inspection

- The service must ensure that it has effective systems and processes to maintain cleanliness and control infection. (Regulation 12(2)(h))
- The service must ensure that it has effective systems and processes to ensure that equipment is properly maintained. (Regulation 12(2)(e)).
- The service must ensure that there is an effective incident reporting and learning system within the organisation. (Regulation 12(2)(b)).
- The service must ensure that an effective process is in place for policy sign-off by the senior leadership team. The service must ensure that policies accurately reflect the service provided. (Regulation 17(1)(2)(d))
- The service must assess, monitor and improve the quality and safety of the services provided, through the implementation of regular audits. (Regulation 17(2)(a)).
- The service must ensure that staff appraisals and competencies are completed and documented. (Regulation 18(2)(a)).

Action the service SHOULD take to improve:

- The service should ensure that staff have completed training on recognising and responding to patients with learning disabilities or autism, at a level appropriate to their role. (Regulation 18)
- The service should ensure that leaders are aware of and up to date with all the requirements placed upon the service by regulations. (Regulation 7)
- The service should develop and monitor progress against a documented strategy for achieving the service's vision. (Regulation 17(2))
- The service should consider making safeguarding referral information accessible to staff whilst transporting patients.
- The service should consider introducing additional ways to communicate with patients who do not speak English, or have other communication needs.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Patient transport services

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

This is the first time we have rated this service. We rated safe as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. At the time of our inspection, 100% of staff had completed their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. Staff completed mandatory training on a range of topics, including basic life support, customer care, moving and handling, and medical gases. Training was provided by an external company through face-to-face sessions.

All staff completed training on recognising and responding to patients with dementia. Staff did not complete training on recognising and responding to patients with mental health needs, learning disabilities, or autism. From 1 July 2022, all health and social care providers registered with the CQC were required to ensure that their staff received training in how to interact appropriately with people who have a learning disability and autistic people, at a level appropriate to their role. We raised this concern with managers during our inspection, who said that they would review staff mandatory training courses.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff mostly 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 specific for their role on how to recognise and report abuse. The registered manager, who was the safeguarding lead, was trained to level 3 in both adult and children's safeguarding. All other staff were trained to level 2 in adult and children's safeguarding.

Staff had informal access to someone who was trained to level 4 for additional support and advice. The registered manager stated that they received support from the safeguarding team at the local NHS trust.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff did not have access to safeguarding referral information on vehicles when transporting patients. Instead, a process was in place for staff to contact their manager by telephone to raise any safeguarding concerns. The service ensured that at least one manager was on duty at all times to ensure that staff were supported with safeguarding concerns.

There had been no safeguarding concerns reported in the 12 months prior to our inspection.

The service had an up to date safeguarding policy in place. The policy provided staff with relevant information including the safeguarding procedure and relevant contact details.

The service could not provide assurance that full fit and proper persons checks or recruitment processes had been followed. We reviewed 5 staff files during our inspection. Whilst Disclosure and Barring Service (DBS) and reference checks had been completed in the files that we reviewed, they did not have a written explanation of any gaps in employment. Following our inspection, the service undertook a review of all staff files and held conversations with any staff where gaps were identified. The outcomes of discussions were stored in personnel files. The service also introduced new recruitment checklists to ensure that all relevant information was gathered.

Cleanliness, infection control and hygiene

Staff did not always ensure that cleaning was documented and there were no audits to monitor cleanliness. However, the service took action to address these concerns shortly after our inspection.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. This was confirmed through a review of the service's vehicles, equipment and the ambulance base during our inspection.

The service's base location provided staff with access to suitable vehicle and equipment cleaning facilities, including running water.

Cleaning of the vehicle and equipment was carried out by ambulance crew members. Vehicles were cleaned daily and after every patient transfer. Deep cleans of the vehicles were carried out monthly. They were carried out more frequently if required.

We identified gaps in the completion of cleaning records. We reviewed the cleaning checklists for all 3 vehicles as part of our inspection. Staff told us that these checklists were required to be completed on each day that the vehicle was used to transport patients. We found that there had been a total of 7 occasions between 22 December 2022 and 23 January 2023 where cleaning had not been documented as required. There was no evidence that action had been taken regarding the gaps in documentation.

The service did not keep records of the cleaning of the ambulance base premises, which was undertaken by staff. Following our inspection, the service stated that they were liaising with a local cleaning company to set up a contract for weekly cleaning of the premises, which would be documented on a cleaning template.

Staff showed an awareness of infection control principles including the use of personal protective equipment (PPE). There were appropriate hand washing facilities and sanitising hand gel was available. Personal protective equipment was readily available for staff to use at the service. Clean linen and decontamination wipes were on board the vehicles.

Staff said that they cleaned equipment after patient contact. All of the equipment reviewed during our inspection was visibly clean.

Staff labelled some equipment to show when it was last cleaned. We observed 'I am clean' stickers in use on 1 of the service's vehicles. Stickers were not consistently used throughout the service. However, information about when equipment had last been cleaned was available separately on cleaning and vehicle check documentation.

The service did not carry out formal audits to monitor cleanliness. The service managers said that they carried out ad-hoc checks of vehicle cleanliness. The results of the checks had not been documented but had been discussed at team meetings. Minutes from meetings showed that actions had been taken in response to any concerns that were identified. Following our inspection, the service introduced twice monthly audits of vehicle cleanliness and environment cleanliness. The service provided evidence to show that audit results would be documented and monitored at monthly meetings.

Environment and equipment

Staff did not always complete daily safety checks of equipment and vehicles as required. The service had not completed environmental risk assessments. The service did not document staff equipment competencies. The service did not have a vehicle or equipment fault log. However, the service took action to address these concerns shortly after our inspection.

We identified gaps in the completion of daily safety checks of equipment and vehicles. We reviewed the vehicle safety checklists for all 3 vehicles as part of our inspection. Staff told us that these checklists were required to be completed on each day that the vehicle was used to transport patients. We found that there had been a total of 7 occasions between 22 December 2022 and 23 January 2023 where vehicle checks had not been documented as required. There was no evidence that action had been taken regarding the gaps in documentation. Managers did not monitor the completion of vehicle checks through a documented audit, although managers stated that ad-hoc checks were carried out. Following our inspection, the service introduced a twice monthly audit of vehicle safety, which would be discussed at monthly meetings.

The service did not have equipment or vehicle fault logs to allow managers to monitor any faults identified and actions taken in response. Following our inspection, the service provided evidence to show that a vehicle and equipment fault log had been introduced.

Requires Improvement

Patient transport services

Staff had not carried out specific risk assessments for fire, Legionella, or substances which met the 'Control of Substances Hazardous to Health' (COSHH) regulations. This meant that staff had not gone through a process of identifying all potential risks to health, and of identifying and implementing appropriate control measures. Following our inspection, the service provided evidence to demonstrate that these risk assessments had been completed. The service also introduced a Legionella checklist and a twice monthly audit. During our second visit on 17 February 2023, we observed that additional COSHH control measures had been put in place, including a locked storage cupboard with a sign to alert others that substances which met the COSHH regulations were kept inside.

The registered manager stated that staff received training on the use of equipment as part of their induction process. However, this had not been documented. Following our inspection, the service introduced competency frameworks to document the training that staff received during their induction.

Processes were in place to check consumables dates and stock levels by one of the nurse managers. The checks were not documented. However, a monthly documented audit of equipment stock was introduced following our inspection.

The service had enough suitable equipment to help them to safely care for patients. The service used an external company to check all electrical equipment and ambulance equipment. Vehicles contained equipment such as a defibrillator, blood pressure monitor, stretcher and carry chair. Equipment that we checked during the inspection was clean and within date for testing. All consumable supplies checked during the inspection were within their expiry date.

The service had 3 vehicles which were kept at the registered address for the service. We carried out visual checks of all 3 vehicles and found them to be clean, fit for purpose, and in a good state of repair. The vehicles had up-to-date MOT certificates, service and tax records.

Staff carried out monthly checks of first aid kits and weekly checks of 'red bags' with emergency equipment. The checklists that we reviewed during our inspection demonstrated that these checks had been carried out as required.

Staff disposed of clinical waste safely. The service stored clinical waste correctly and an external company collected it regularly. However, 1 of the vehicles that we reviewed during our inspection did not contain a sharps bin. We raised this with staff, who immediately located a sharps bin and placed this in one of the vehicle compartments.

Assessing and responding to patient risk

The service did not have formalised inclusion and exclusion criteria. However, the service took action to address these concerns shortly after our inspection. Staff knew how to respond promptly to any sudden deterioration in a patient's health.

Staff knew how to respond promptly to any sudden deterioration in a patient's health. A policy was in place which provided guidance for staff on how to respond to deteriorating patients. This set out that in an emergency, staff should call 999 for support and follow their advice. Staff said that they had not had to put this into practice since the service registered in December 2021.

Staff had access to support from nurse managers if they had any concerns about a patient's condition.

Staff knew about and dealt with any specific risk issues. The service carried out risk assessments ahead of patient journeys. This included any potential risk factors such as if a patient had additional needs or used specialist equipment. Ambulance crews were made aware of all relevant information before collecting a patient. Crews would also obtain a handover from hospital staff. However, the patient record forms did not have sufficient space to allow staff to record relevant information relating to patient risks. This has been reported on further under the records heading.

The service did not have formalised inclusion and exclusion criteria to ensure that the service only conveyed patients whose needs could be met by the service. The service did have an introductory leaflet which set out exclusion criteria for mental health patients. Staff said that the leaflet was shared with local NHS providers. However, the leaflet did not include inclusion and exclusion criteria for other types of patients. However, during our inspection all staff demonstrated an understanding of the type of patients that the service would accept. All staff said that if there was any uncertainty about whether a patient was appropriate for their service, then this would be escalated to a nurse manager. Staff would also go to assess patients in person, if necessary, before a final decision was made. We observed this in practice during our inspection. Staff were also able to provide a range of examples of occasions where they had found that a patient did not meet the criteria to be transported by their service and they had refused to carry out the transport as a result. Following our inspection, the service introduced a formalised inclusion and exclusion criteria.

The service provided by this location was patient transport services delivered by ambulance care assistants for patients who were not acutely unwell. Staff therefore did not undertake routine observations of vital signs for standard patient transport journeys.

Staffing

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

The service had enough staff to keep patients safe. The service employed 13 members of staff. This included 3 nurse managers and 10 ambulance crew members. Most staff were employed either on a part-time basis or on a zero-hour contract and were also employed by other healthcare providers on a part-time basis.

Managers accurately calculated and reviewed the number and grade of staff needed for each shift. Managers scheduled at least 2 ambulance crew members to be on-call for each day. There was always 1 manager scheduled to be available either on-call or on-site.

The manager could adjust staffing levels daily according to the demands of the service. The service employed 7 members of staff on zero-hour contracts, who could support with unfilled shifts.

The service did not monitor vacancy, turnover or sickness rates. We requested this information as part of our inspection and this was not provided.

The service had not used agency staff since the company began operating in December 2021.

Managers had not formally assessed the risks associated with lone working. The registered manager provided examples of long-distance transfers that had been undertaken by lone workers since the service registered in December 2021. The registered manager described several informal measures that had been put in place to mitigate risk for lone workers.

For example, staff were encouraged to take regular breaks and overnight accommodation could be arranged if required. However, the service had not gone through a process of formally reviewing all potential risks and identifying all appropriate control measures. Following our inspection, the service completed a formal lone worker risk assessment document and a lone worker policy was introduced.

Records

The service did not maintain an accurate, complete and contemporaneous record in respect of each service user. The service was not undertaking any documentation audits. However, the service took action to address these concerns shortly after our inspection.

The service did not maintain an accurate, complete and contemporaneous record in respect of each service user. We reviewed 7 patient record forms during our inspection and we found that the patient record template was not fit for purpose due to a lack of space on the document to record relevant information relating to patient risks. This meant we were not assured that staff transporting patients had the required information to mitigate individual patient risks. In addition, we found that in 2 out of 7 records reviewed, staff had not completed pick-up or drop-off times.

Following our inspection, the service made changes to their patient record form to ensure that there was enough space for staff to record all relevant information.

The service identified people with do not attempt cardiopulmonary resuscitation (DNACPR) forms in place either at the point of booking or when staff received handovers prior to transporting patients. This information was recorded on the patient record forms.

Records were stored securely. Patient record forms were completed by hand and kept in a folder in the cab of the vehicle. On return to the service's registered address, the forms were kept in a locked cupboard.

At the time of our inspection, the service was not undertaking any documentation audits. This limited leaders' ability to identify and address any areas of concern. Following our inspection, the service implemented a monthly documentation audit.

Medicines

The service did not always follow best practice when storing oxygen cylinders. However, the service took action to address these concerns shortly after our inspection.

Staff did not prescribe or administer any medicines. Patients own medicines were transported with the patient in sealed, named bags. The ambulance crew did not take any responsibility for controlled drugs (CDs) carried by patients.

The service stored oxygen cylinders at their base and in their vehicles, to supply to patients who could self-administer this during their transport. We identified concerns during our inspection regarding the storage of oxygen cylinders. The oxygen cylinders in 1 vehicle were stored in the footwell and were not secured to prevent them from moving during transport. This meant there was a risk of injury to patients or staff. We escalated this during our inspection and staff took action to remove the cylinders. Following our inspection, the service stated that oxygen cylinder holders had been fitted into the relevant vehicle. In the ambulance base, whilst oxygen cylinders were stored inside a cage, they were not

chained or clamped to prevent them from falling over. In addition, empty and full oxygen cylinders were stored together. This was not in line with national guidance and also meant that there was a risk of injury to staff. We escalated this during our inspection and staff took action to separate the cylinders and locate chains and clamps for the cylinders inside the cage.

There was a policy in place to provide guidance for the safe storage and transportation of medical gases. Staff completed medical gases training as part of their mandatory training.

Incidents

Staff did not always recognise incidents and near misses and report them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service.

Incidents that affected the health, safety and welfare of people using services were not always reported internally in line with policy. Staff provided examples of concerns which had arisen, such as vehicle breakdown, or staff not being able to access the property on arrival and having to take the patient back to hospital, which they had not reported as incidents. The registered manager said that they had recognised that staff were not always reporting near-miss incidents. The registered manager was planning to discuss this with staff during the next team meeting. Following our inspection, the incident reporting standard operating procedure document was updated to include information about near-miss incidents.

Incident reporting forms were available on the vehicle and staff knew where to find them.

There was no formalised process for learning from incidents. Staff were not aware that any incidents had been reported since the service registered in December 2021. Whilst the registered manager was able to provide information about incidents that had been reported, this demonstrated that information about incidents had not always been effectively communicated with staff. Minutes from the last 3 team meetings did not include incident learning. Following our inspection, the service updated their governance meeting templates to ensure that incidents were discussed at each meeting. We requested the service's incident log as part of our inspection and this was not provided. This meant that we were not able to review the total number and the type of incidents that had been reported in the 12 months prior to our inspection.

The service had an incident policy which provided information about the type of incidents that should be reported, how to report an incident and information about how incidents would be investigated.

The service's incident policy did not include reference to the requirement to notify external bodies of some incidents. However, the registered manager was aware of these requirements.

Staff understood the duty of candour. They were focused on being open and transparent, and giving patients and families a full explanation if and when things went wrong.

There was evidence that changes had been made as a result of incidents. For example, one of the vehicles had sustained a flat tire after the crew had completed a patient transport journey. Following this incident, staff had reviewed their policies to ensure that a clear process was in place for the actions that should be taken if a vehicle broke down with a patient on-board.

Requires Improvement

Patient transport services

The registered manager was responsible for conducting investigations into all incidents. We reviewed the last 3 incident investigation reports as part of our inspection. The reports that we reviewed identified lessons learnt but included minimal information about what action had been taken to investigate the incident. For example, it was not clear whether patient records had been reviewed, or whether the staff involved had been spoken with. However, all 3 incidents were no-harm and they would therefore undergo a less detailed investigation process compared to an incident where harm had been sustained. The registered manager had completed incident investigation and human factors training, and had experience of undertaking incident investigations, as part of their role in the NHS.

Is the service effective?

Requires Improvement

This is the first time we have rated this service. We rated effective as requires improvement.

Evidence-based care and treatment

There was no formalised process for policy sign-off by the senior leadership team. The service did not always follow the processes set out in provider policy documents. Managers did not check to make sure staff followed guidance. However, the service took action to address these concerns shortly after our inspection.

There was no formalised process for policy sign-off by the senior leadership team. We identified 11 policies which did not have version control, sign-off dates, and review dates.

Policies did not always contain referencing to national guidance. This meant it was not always clear what guidance had been referred to when writing the policy.

Following our inspection, the service provided evidence to show that they had begun the process of reviewing all their policies. The service introduced a formalised process for policy sign-off by the senior leadership team through monthly meetings.

Staff had access to policies and guidelines through a folder at the ambulance base. Staff signed an induction checklist to confirm that they had been provided with information about the service's policies.

The service did not always follow the processes set out in provider policy documents. For example, the infection prevention and control policy stated that monthly and quarterly audits would be carried out to provide assurance of infection and control standards. No official audits were in place at the time of our inspection. The service also had a policy in place for the Control of Substances Hazardous to Health (COSHH). The policy stated that the service would identify, record and risk assess all substances normally used by the service, and that staff would take steps to minimise identified risks and implement control measures. These actions were not being completed by staff at the time of our inspection.

We identified some examples of processes in place at the service which were not in line with best practice and national guidance. For example, oxygen cylinders were not stored in line with national guidance. The service had not risk assessed and put control measures in place for substances which came under COSHH regulations, in line with national guidance. The service took action to address these concerns as soon as they were raised during our inspection.

Requires Improvement

Patient transport services

At the time of our inspection, care was not routinely monitored to ensure it was delivered in line with evidence-based guidance. Whilst leaders carried out ad-hoc checks, these were not documented and there were no formal audits in place at the time of our inspection. Following our inspection, the service introduced an audit schedule with 9 audits, covering topics ranging from patient feedback to equipment, vehicles, cleaning, records and response times. Audits were scheduled to take place on at least a monthly basis. Audit outcomes were added as a standing agenda item at monthly meetings.

Nutrition and hydration

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

Due to the nature of the service provided, food was not routinely offered to patients. Bottled water was available on vehicles.

Response times

The service did not routinely monitor response times so that they could facilitate good outcomes for patients. However, the service took action to address these concerns shortly after our inspection.

The service had carried out 750 patient journeys in 2022. The service carried out an average of 62.5 patient journeys per month in 2022. The service had an average of 87.3% same day bookings in 2022.

The service did not have agreed response times as commissioners had not set any key performance indicators for the patient transport service.

The service had set some internal targets for response times for patient discharge journeys. The service aimed for a 30-minute response time if a crew was at the ambulance base when a booking was received, and a 45-minute response time when crews were on-call. Whilst the service had begun compiling response times data for 1 of their stakeholders in January 2023, the service did not routinely monitor compliance with internal performance targets.

We requested response times data for 2022 as part of our inspection. The service was not able to provide this data. However, the service was able to provide response times data for January 2023. This demonstrated an average response time of 25.7 minutes for the local NHS trust. This therefore demonstrated that the service was exceeding the internal response times target.

The service also provided transport for another NHS trust which was based 1 hour away from the provider's premises. The average response times for this provider were 109.5 minutes in January 2023. However, this number had been impacted by the NHS trust's request to delay response times on several occasions.

The service did not provide data for the number or percentage of patient journeys that arrived by the agreed time of arrival for outpatient appointments.

Staff used a messaging service to share key times with managers, including the time they left base, the time they arrived at the destination to collect the patient, the time they left to transport the patient to their destination and the time of arrival at the destination. This allowed the managers to keep track of any delays.

The registered manager said that they regularly liaised with stakeholders regarding the service's performance.

Requires Improvement

Patient transport services

Competent staff

The service did not keep staff competency records and managers had not appraised staff performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Almost all staff had experience of working in patient-facing roles. Mandatory training was in-date for all members of staff.

The service did not document checks to ensure that staff had appropriate and current registration with a professional regulator. Following our inspection, the service provided evidence to show that they had begun to document registration checks.

Managers gave all new staff a full induction tailored to their role before they started work. This included working on a supernumerary basis with the registered manager. The service did not have documented evidence that staff had completed competencies at the start of their employment. This included documentation relating to driver competency assessments and other competencies relating to the role. Following our inspection, the service introduced competency frameworks for staff.

Managers had not yet begun to support staff to develop through yearly, constructive appraisals of their work. However, at the time of our inspection, there were only 2 members of staff who had been employed by the service for over a year. The registered manager stated that plans were in place to begin carrying out appraisals in February 2023.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Supervision was carried out by nurse managers every 6 to 8 weeks. This provided an opportunity for managers to identify any areas of poor performance or to identify any training needs their staff had.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There had been 3 team meetings in the 6 months prior to our inspection.

Managers mostly made sure staff received any specialist training for their role. However, staff did not complete training on recognising and responding to patients with mental health needs, learning disabilities, or autism.

Staff did not receive training in restraint as the service did not accept patients who had a history of violence or aggression.

Multidisciplinary working

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

Staff worked well together and communicated effectively. We observed positive interactions between team members during our inspection and staff provided positive feedback about team working.

Staff held regular and effective multidisciplinary meetings to discuss and improve their care. This was confirmed through a review of meeting minutes following our inspection.

Requires Improvement

Patient transport services

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked well with other agencies to establish all the relevant information they needed to accept a booking. Staff said that they handed over any information relevant to that patient to ensure they continued to receive the appropriate care.

Managers had positive relationships with stakeholders and were in regular contact with them.

The service had received positive feedback from stakeholders about the way that staff worked with other agencies. For example, staff were described as "very professional", "very helpful and friendly", with a "can-do attitude".

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and the Mental Capacity Act 2005 and they knew who to contact for advice. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to explain the actions that they would take if they had concerns about a patient's capacity to make decisions about their care.

Staff described how they gained consent from patients for transport in line with legislation and guidance. When patients could not give consent, staff said that they made decisions in their best interest.

Staff did not record consent in patients' records. Staff obtained verbal consent to transport patients.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were 100% compliant with this training at the time of our inspection.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff had access to the policy in a folder at the ambulance base.

Managers did not formally monitor how well the service followed the Mental Capacity Act.

Is the service caring?

Good

This is the first time we have rated this service. We rated caring as good.

Compassionate care

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

Requires Improvement

Patient transport services

Patients said staff treated them well and with kindness. Feedback received from patients and relatives during our inspection was continually positive about the way staff treated people. Patients and relatives told us staff were “polite and helpful”, “brilliant”, “friendly” and “caring”.

Staff described how they were discreet and responsive when caring for patients. Staff said they took time to interact with patients and those close to them in a respectful and considerate way. For example, staff spoke about regularly checking that patients were comfortable. Staff said that they ensured that they were always polite to patients.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff described how they were focused on providing the “same dignified treatment” to all patients.

The service had received positive feedback from stakeholders about the care provided by crew members. For example, stakeholder feedback described crew members as “very friendly and kind”, “helpful” and “professional”. Stakeholders stated that “we received only positive feedback from our patients regarding the whole journey”, and that the crew members “always go the extra mile. Nothing is too much trouble”. None of the stakeholders who provided feedback had ever had any concerns about crew behaviour or attitude.

Staff followed policy to keep patient care and treatment confidential. Staff ensured that patient record forms were stored securely.

Emotional support

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

Staff said that they gave patients and those close to them help, emotional support and advice when they needed it. Staff said that they would spend time speaking with and getting to know patients during transport. This provided staff with an opportunity to provide patients with support and advice.

Patients provided positive feedback about the support provided by staff and said that they felt able to discuss any concerns or worries with staff. For example, one patient described how staff always made conversation with them during the journey, which “helps a lot”. Staff were described as “supportive” and “understanding”.

Staff supported patients who became distressed, and helped them maintain their privacy and dignity. For example, staff said that they would use the blinds in the vehicle to create a more calming atmosphere.

All stakeholder feedback confirmed that they had never had any concerns about the way that staff supported patients.

Understanding and involvement of patients and those close to them

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

Requires Improvement

Patient transport services

Staff made sure patients and those close to them understood their care and treatment.Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients and relatives said that they felt listened to by staff and that staff kept them updated. Staff told us about a time that they had used a whiteboard to communicate with a patient who was unable to speak after having a stroke.

Patients and their families could give feedback on the service and their treatment. Feedback could be provided through the service's website and by email. Staff had identified that these feedback methods would not be accessible for all patients. As a result, staff had introduced paper feedback forms with stamped envelopes, which were kept on the vehicles.

Patients gave positive feedback about the service. The service had only received feedback from 1 patient since December 2021. We reviewed the feedback provided as part of our inspection. The feedback stated that the patient "could not have wished for anything better", "everything was first class" and "could not think of anything that could have been improved".

Is the service responsive?

Good

This is the first time we have rated this service. 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.

Managers planned and organised services so they met the changing needs of the local population. The service supported local NHS trusts by providing conveyance for patients that other contracted services were unable to complete. The service provided non-emergency transfers between a range of locations, including hospitals and care homes. The registered manager said that they held regular discussions with stakeholders to review the service being provided.

The service had capacity to cope with differing levels and nature of demand. The service had recruited additional members of staff and had increased the number of vehicles in their fleet so that they could cope with increased demand.

The service had received feedback from stakeholders which stated that the service was "efficient, flexible and responsive". Other stakeholder feedback stated that "not once but many times they have helped us with transportation on very short notice" and "Management are responsive to our needs, they get back to us quickly to confirm if they can provide a crew or cover a job."

The service accepted bookings over the telephone. The service normally operated between 10am and 5pm, Monday to Friday. However, the service had flexibility to complete journeys in the evenings and at weekends, if required.

Meeting people's individual needs

Requires Improvement

Patient transport services

The service was mostly inclusive and took account of patients' individual needs and preferences. However, staff did not have access to interpreters or signers when needed.

Staff were aware of and responsive to the individual needs of patients living with mental health problems, autism and learning disabilities. Staff gathered information about any individual needs as part of the booking process. Staff said that they would then work to accommodate these on a case by case basis.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. For example, relatives or carers could accompany a patient during transport to provide additional support. Staff could use blinds on vehicle windows to create a more calming environment for patients.

Vehicles were wheelchair accessible. Patients could be transported securely in their own wheelchair. Stretchers were available in 2 of the service's vehicles. The service had suitable equipment to transfer bariatric patients.

Managers did not make sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.Managers told us that the staff employed by the service could speak a range of languages and they would therefore assist with translation where possible. Staff told us that they would use relatives to translate or they would use the translation tool on an online search engine. This was not in line with best practice. The service did not have information leaflets available in languages other than English.

Staff had access to some communication aids to help patients become partners in their care and treatment. Staff had access to whiteboards to aid communication with patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Information about patients' communication needs was gathered during the booking process and the patient record template prompted staff to record information about communication needs.

Access and flow

Managers did not routinely monitor performance data to make sure patients could access services when needed. However, the service took action to address these concerns shortly after our inspection.

Managers did not routinely monitor performance data to make sure patients could access services when needed. The service had begun to collate response times data in January 2023 for 1 of the NHS trusts that they worked with, after the trust had requested this as part of the invoicing process. The service did not monitor response times for other providers. The service was not able to provide evidence that response times were discussed and monitored at management or team meetings. Following our inspection, the service introduced a monthly response times audit, began monitoring performance data for all work undertaken, and added performance data as a standing agenda item at meetings.

Managers did not monitor the number of cancelled journeys. We requested information about the number of cancelled journeys as part of our inspection and this was not provided. Staff said that journeys would normally only be cancelled if a crew arrived to collect a patient and found that they did not meet the service's eligibility criteria.

Transport was normally booked on the same day that it was provided. This meant that the service would only accept the booking if they had the staff and vehicles available to undertake the transport. Stakeholders could either book a whole shift or an individual journey.

Requires Improvement

Patient transport services

Feedback from stakeholders stated that the service was organised and met the timeframes set for transfers. Feedback also stated that the service responded appropriately and in a timely way to the jobs allocated to them.

Staff recorded key times during a journey and shared these with managers through a messaging service. This allowed the managers to keep track of any delays.

Learning from complaints and concerns

Processes were in place to allow people to raise concerns, and for staff to investigate them and share lessons learned with all staff.

The service clearly displayed information about how to raise a concern in patient areas. Information about how to complain was kept on board the vehicles. The service's website also provided information on how to contact the service via email, telephone or letter.

Staff understood the policy on complaints and knew how to handle them. The service had an up to date complaints policy in place, which outlined the processes of acknowledging complaints, investigating them and the timeline for a response.

Processes were in place for managers to investigate complaints and for patients to receive feedback after the investigation. The service had not received any complaints since they registered in December 2021. This meant that we were not able to review the quality and timeliness of any complaint investigations.

Stakeholder feedback indicated that they had received no complaints or concerns regarding the service.

The service had arrangements in place for the independent external review of complaints, through the Independent Services Complaint Advisory Services (ISCAS).

Is the service well-led?

Requires Improvement

This is the first time we have rated this service. We rated well-led as requires improvement.

Leadership

Leaders did not always understand and manage the priorities and issues the service faced.However, they were visible and approachable in the service for patients and staff.

There was a clear management structure with defined lines of responsibility and accountability. The service had a registered manager who held overall responsibility for the leadership of the service. The registered manager worked at the service on a part-time basis and had another role at an NHS trust. The service had 2 other nurse managers, who also worked at the service on a part-time basis. The hours worked by all of the managers amount to 1 whole time equivalent. The directors of the company also worked in the service as ambulance crew members.

Requires Improvement

Patient transport services

The registered manager was a registered nurse who had worked in a management role in the NHS for nearly a decade. However, none of the leaders of the service had previous experience in patient transport services.

Leaders understood some of the challenges to quality and sustainability, and could identify the actions needed to address them. However, the lack of a formal audit programme and performance monitoring meant that leaders had not always identified the concerns that were raised during our inspection. For example, leaders had not identified gaps in the completion of cleaning and vehicle checklists, or the concerns we identified regarding the completion of patient record forms.

The registered manager was not always able to demonstrate that they had appropriate knowledge of applicable legislation and regulations. For example, risk assessments had not been carried out in line with the 'Control of Substances Hazardous to Health' (COSHH) regulations. In addition, the registered manager was unaware of new requirements which had come into force in July 2022 which meant that all staff were required to receive training in how to interact appropriately with people who had a learning disability and autistic people.

Staff told us that leaders were well respected, visible, and approachable. Staff felt confident to discuss any concerns with managers.

Leaders were highly responsive to concerns identified during our inspection and took significant actions to address the concerns raised.

Vision and Strategy

The service had a vision for what it wanted to achieve, although no documented strategy was in place to turn this into action.

Staff were not able to provide a documented strategy for the service. However, the registered manager was able to discuss plans which initially focused on establishing a high-quality service and then on expanding service provision. Staff were aware of the service's future plans.

The service had developed a mission statement which was focused on becoming a leading private ambulance service and to exceed customers' expectations. During our inspection, staff demonstrated a commitment to working in line with the service's mission.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt supported, respected and valued. Staff felt positive and proud to work in the organisation.

The culture was centred on the needs and experience of people who used services. The registered manager asked staff to focus on providing the same level of care that they would to their own relatives. Staff demonstrated a commitment to providing dignified treatment to all patients.

There were cooperative, supportive and appreciative relationships among staff. We observed positive working relationships between staff throughout our inspection. Staff spoke positively about the working relationships with their colleagues.

The culture encouraged openness and honesty. The provider had processes and procedures in place to ensure they met the duty of candour, although this had not needed to be put into practice in the 12 months prior to our inspection.

The service had processes in place to take action to address behaviour and performance that was inconsistent with the vison and values. However, this had not needed to be implemented since the service began operating.

The service had mechanisms to provide staff with the development they needed. The service had not yet begun to undertake appraisals. However, only 2 members of staff were due for an appraisal at the time of our inspection and the registered manager planned to begin undertaking appraisals in February 2023. In addition, the service held regular supervision meetings with staff which provided an opportunity to identify any training or development.

There was a strong emphasis on the safety and well-being of staff. Managers were on-call to provide support to staff. Staff were encouraged to raise concerns with managers. Staff were presented with gift vouchers and a meal at a restaurant at the end of 2022 as a thank you for their hard work throughout the year.

Governance

Leaders did not operate effective governance processes. However, the service took action to address these concerns shortly after our inspection.

The service did not have effective governance processes in place. Management meetings were not minuted. This meant that we could not gain assurance about the content of meetings, the attendance at meetings or the frequency of meetings. The lack of meeting minutes also meant that the service did not have an audit trail of discussions held and actions identified to address any areas of concern. We raised concerns during the inspection process about the lack of governance systems and processes for the service. Following our inspection, leaders took action to design and implement assurance processes, such as a programme of audit, health and safety risk assessments and records of managers meetings. The service introduced a monthly quality and safety group meeting for managers. The service created terms of reference for the group, as well as a standing agenda for meeting minutes. This ensured that key topics such as performance data, audit outcomes, risks, incidents and feedback would be covered at each meeting.

Managers held regular team meetings for all staff, which were minuted. There had been 3 meetings in the 6 months before our inspection. We reviewed the minutes from meetings during our inspection. This showed that staff were provided with updates about any changes within the service, and were given an opportunity to discuss and raise questions about the policies and procedures that were in place. Staff were also provided with feedback from any ad-hoc quality checks that had been carried out. There was evidence that staff had the opportunity to escalate any concerns during team meetings. However, the meetings did not include discussion of incidents, risks or performance data. Following our inspection, the service introduced a monthly governance and operational meeting for all staff. The service introduced a standing agenda for meeting minutes. This ensured that key topics such as performance data, audit outcomes, risks, incidents and feedback would be covered at each meeting.

The registered manager regularly liaised with stakeholders on an informal basis to discuss the service being provided. The service did not hold minuted meetings with stakeholders. There was no formal contract or service level agreement in place for patient transport.

Staff were clear about their roles and they understood what they were responsible for, and to whom. Responsibilities were set out in provider policy documents.

The registered manager monitored working arrangements outside of the service to ensure that staff were not working excessive hours.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. The service did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. However, the service took action to address these concerns shortly after our inspection.

The service did not have effective processes in place to manage performance. Managers did not routinely assess and monitor response times data unless this data was requested by the relevant external provider. The service was not able to provide evidence that performance data was discussed and monitored at management or team meetings. Following our inspection, the service introduced a monthly response times audit, began monitoring performance data for all work undertaken, and added performance data as a standing agenda item at meetings.

The service did not have a systematic programme of clinical and internal audit to monitor quality, operational and financial processes. Whilst leaders carried out ad-hoc checks, these were not documented and there were no formal audits in place at the time of our inspection. Following our inspection, the service introduced an audit schedule with 9 audits, covering topics ranging from patient feedback to equipment, vehicles, cleaning, records and response times. Audits were scheduled to take place on at least a monthly basis. Audit outcomes were added as a standing agenda item at monthly meetings.

The service did not have effective arrangements for identifying, recording and managing risks. The service had not assessed, monitored and mitigated all risks which arose from the carrying on of the regulated activity. There were gaps in risk assessments, for example for Control of Substances Hazardous to Health (COSHH), Legionella, and lone workers. The risk register did not identify the date risks had been identified, the date the risk was due to be reviewed by, and there were no updates to mitigations. There was no evidence through meeting minutes that risks were regularly reviewed or discussed. Following our inspection, the service provided evidence to show that risk assessments had been completed for fire, Legionella and COSHH. The service also revised their risk register template, and added a discussion about risks as a standing agenda item at monthly meetings.

The service had an up to date business continuity plan. This demonstrated that the service understood and managed foreseeable risks, including loss of facilities or infrastructure and disruption to staffing levels.

Information Management

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, the service took action to address these concerns shortly after our inspection.

Leaders did not formally monitor all data relevant to the quality and performance of the service. For example, the service did not have any formal audits in place at the time of our inspection and this meant that there was limited information available about the quality of the service.Managers did not routinely assess and monitor response times data unless this data was requested by the relevant external provider. Managers did not monitor data about cancelled

journeys or the percentage of journeys that arrived by the agreed time of arrival for outpatient appointments. Manager did not formally monitor staffing data such as sickness, turnover or vacancy levels. However, following our inspection the service introduced an audit schedule and had begun to monitor relevant performance data through monthly meetings.

The service did not always have effective arrangements in place to ensure the availability of all relevant information. The service did not always formally document all relevant information. This meant that staff were not always able to provide evidence to confirm that they had completed actions as they had described. For example, the service did not have documentation relating to competency assessments or for ad-hoc checks of cleaning and equipment undertaken by managers. The service did not record minutes for management meetings. This meant that the service did not have an audit trail of discussions held and actions identified to address any areas of concern. Following our inspection, the service introduced a range of actions to ensure that all relevant information was formally documented.

Staff did not always have sufficient access to information. For example, information about incidents and performance data was not shared in team meetings. Staff did not have access to safeguarding information in vehicle folders to ensure that referrals could be made whilst transporting patients. However, the service took action to address these concerns following our inspection.

There was limited use of information technology systems to monitor and improve the quality of care. However, the registered manager had plans to increase the use of information technology and was in discussions with an external organisation about the creation of an app.

Arrangements were not always in place to ensure that data or notifications were submitted to external bodies as required. For example, the service's incident policy did not refer to the requirement to notify external bodies such as CQC or the Health and Safety Executive of certain incidents. However, the registered manager was able to demonstrate an awareness of these requirements.

Staff understood information governance and the importance of securely storing patient information.

Engagement

Leaders and staff engaged with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service was attempting to gather people's views and experiences to shape and improve the services and culture. Feedback could be provided through the service's website and by email. Staff had identified that these feedback methods would not be accessible for all patients. As a result, staff had introduced paper feedback forms with stamped envelopes, which were kept on the vehicles.

Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. Managers regularly held team meetings and these provided an opportunity for staff engagement.

There were positive and collaborative relationships with external partners. The service had carried out a survey in 2022 with stakeholders to gather feedback. All of the feedback received through the survey had been positive and no areas of concern had been identified.

Requires Improvement

Patient transport services

There was transparency and openness with stakeholders about performance. The service provided monthly response times data to 1 of their commissioners, based on their request for this information.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Mangers were responsive to any concerns raised and sought to learn from them and improve services. Staff took time together in team meetings to review the service being provided. There was evidence that this had led to improvements and innovation. For example, staff had discussed the lack of feedback being received from service users and they had introduced a new feedback method in response.

The service sought feedback from patients and stakeholders to improve services. The feedback that the service had received was all positive and no areas for improvement had been identified as a result.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service had not ensured that staff appraisals and competencies were completed and documented.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service had not ensured that effective processes were in place for governance, information management, and management of risk, issues and performance. This included not ensuring that all risks which arose from the carrying on of the regulated activity had been assessed, monitored and mitigated. The service did not have a formalised process for policy sign-off by the senior leadership team. The service had not ensured that policies accurately reflected the service provided. The service was not assessing, monitoring and improving the quality and safety of the services provided through the implementation of regular audits.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service had not ensured that systems and processes to maintain cleanliness and control infection were consistently implemented and documented.

This section is primarily information for the provider

Requirement notices

The service had not ensured that systems and processes in place to ensure that equipment was properly maintained were consistently implemented and documented.

The service had not ensured that incident reporting and learning was embedded within the organisation.