EMC Medical Services Limited

EMC Medical Services - Blewbury

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

EMC Medical Services Limited - Blewbury is part of EMC Medical Services Limited. It is an independent ambulance service provider based in Blewbury, Oxfordshire. The service provides patient transport, event medical services, first aid training and ambulance aid training. We inspected patient transport and event medical services. Services are staffed by trained paramedics, ambulance technicians and ambulance care assistants. The service has a contract with a local NHS hospital trust and provides services on request from a local NHS ambulance trust.

We carried out a scheduled comprehensive inspection on 15 September 2016 and an unannounced inspection on 27 September 2016. .

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

Our key findings were as follows:

- The service had a system in place for reporting and recording incidents. Staff knew how to keep patients safe through incident reporting, incidents were reported, investigated and learnt from.
- Services were planned and delivered in a way that met the needs of the local population. The service took into account the needs of different people, such as bariatric patients or people whose first language was not English, and journeys were planned based upon their requirements.
- The service had a system for handling, managing and monitoring complaints and concerns. Public engagement mechanisms were in place in the form of patient experience feedback forms. The service had a duty of candour policy. However, there was no duty of candour training for staff.
- Staff had a strong focus on providing a caring and compassionate service. We observed staff acting in professional and respectful ways when engaging with patients and their families.
- Staff felt valued by their peers and managers and reported high levels of support. The managers organised social events for the staff which helped with team bonding and cohesiveness. However, we found there were no structured meetings to share learning from incidents or changes to practices
- We observed good hand hygiene, clean and well maintained vehicles. However, we were not assured that the vehicles were being deep cleaned to a satisfactory standard.
- We found concerns regarding the governance and strategic risk management processes of the service.There were no effective governance arrangements in place to evaluate the quality of the service or to improve delivery.
- There was no formal risk register in place at the time of the inspection and therefore we had no assurance that risks were being tracked, managed or mitigated. However, since the inspection we have been provided with a risk register.
- A vision and strategy for the service had not been developed.
- The service had not had a CQC registered manager in post for over six months. They had submitted an application but remained unregistered.

However, there were also areas of poor practice where the location needs to make improvements.

Importantly, the location must:

- Implement robust systems to assess, monitor and improve the quality and safety of the services provided.
- Develop a vision and strategy for the service and ensure this is embedded across the organisation.
- Ensure systems and processes are in place to implement the statutory obligations of duty of candour.
- Ensure a manager for the regulated activity is registered with the Care Quality Commission.
- Store oxygen and medicines safely and securely, preventing a risk to others.
- Notify the Care Quality Commission of both safeguarding incidents and incidents if they occur which affects the running of the service as required by Health and Social Care Act.

Summary of findings

In addition the location should:

- Ensure hand held communication systems for staff are in a useable condition and available for use.
- Review its process for operational issues within a strategic overview or central risk register.
- Ensure all staff are trained and understand the duty of candour.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

EMC Medical Services - Blewbury

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Detailed findings

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Background to EMC Medical Services - Blewbury

EMC Medical Services - Blewbury, part of EMC Medical Services Limited, was registered on 15 May 2011. It is an independent ambulance service provider based in Blewbury, Oxfordshire. The service provides patient transport services, event medical services, first aid and ambulance aid training. Services are staffed by trained paramedics, ambulance technicians and ambulance care assistants.

The service was last inspected in December 2013 and was found to be compliant with the five outcomes inspected at that time.

The service provides cover seven days a week for its patient transport contract work with a local NHS hospital trust. EMC Medical Services – Blewbury has 17 whole time equivalent employed staff and approximately 49 self-employed staff.

We visited the ambulance station at Blewbury and accompanied staff on ambulance vehicles to observe care given to patients.

At the time of our inspection, there was no registered manager in post, two members of staff had submitted applications to undertake this role.

Our inspection team

Our inspection team comprised of an inspector, assistant inspector and a specialist advisor who had extensive experience and knowledge of emergency ambulance services and non-emergency patient transport services

How we carried out this inspection

We carried out an announced inspection on 15 September 2016 and an unannounced inspection on 27 September 2016. We visited the ambulance station at Blewbury and accompanied staff on ambulances to observe care given to patients. Before visiting EMC Medical Services Limited - Blewbury, we reviewed a range of information held about the location including information from other organisations.

During the inspection, we spoke with 15 staff members including ambulance care assistants, managers, the lead for education and training. We also spoke to three patients, one carer and observed care being provided to patients by accompanying crews on patient transport service (PTS) journeys. This observation included the interactions between the ambulance crew and hospital staff. We reviewed local and national policies, staff files

and servicing records. We conducted random spot checks on eight vehicles and inspected cleanliness, infection control practices and stock levels for equipment and supplies.

Facts and data about EMC Medical Services - Blewbury

EMC Medical Services - Blewbury is an independent ambulance service registered to provide diagnostic and screening procedures, transport services, remote triage, medical advice and treatment of disease, disorder and injury required by the patients who use their services.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

EMC Medical Services - Blewbury is an independent ambulance service, which provides patient transport services, event medical services, first aid and ambulance aid training.

The service holds a contract with a local NHS hospital trust and is commissioned by a local NHS ambulance trust. The patient transport service (PTS) service contract with the local NHS hospital trust is funded to provide transport for patients from three different departments.

From January to July 2016, the service undertook 4381 patient journeys. The service employs 17 full time staff and 49 self-employed staff.

There was no registered manager in post at the time of our inspection. The service had not had a CQC registered manager in post for over six months. Two members of staff had submitted applications to undertake this role.

Summary of findings

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

We found that:

- The service had a system in place for reporting and recording incidents. Learning and action points from incidents were disseminated to staff. Complaints and concerns were managed, monitored and handled effectively.
- Patient transport services were managed, in line with the current standards and legislation. Staff had the skills to carry out their roles effectively, and in line with best practice.
- Feedback was positive and ambulance crews were highly rated by patients and staff. Staff were aware of and responded to patients' needs whilst being transported.
- The needs of the local population were identified and taken into account when planning services. For example, ambulances had specialist equipment for bariatric patients.
- Staff felt valued and supported by their peers and the management team. They were given appropriate training and were mostly completing mandatory training.
- We observed very positive, compassionate and caring interactions between crews and patients and their relatives. Staff acted in a professional and courteous manner at all times.

Patient transport services (PTS)

- Systems and processes were not in place to implement the statutory obligations of duty of candour (DoC).
- A vision and strategy had not been developed and embedded across the organisation.
- There were no effective governance arrangements in place to evaluate the quality of the service and improve delivery. There was no formal risk register in place at the time of the inspection and quality assurance audits were not undertaken, therefore learning did not take place from review of procedures and practice.
- Whilst we observed suitable infection control practices, we had concerns regarding the standard of the deep cleaning of vehicles.
- The service had not had a CQC registered manager in post for over six months.

Are patient transport services safe?

By safe, we mean people are protected from abuse and avoidable harm.

- There were processes in place for reporting incidents and staff confirmed they received feedback and shared learning. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Vehicles were well maintained and checked on a daily basis. There was a system for reporting defects and staff had received appropriate training to use equipment safely.
- Staff understood their responsibilities in relation to patient notes and records. Medical notes were transported securely in red bags and staff applied the appropriate checks to DNACPR (do not attempt cardio pulmonary resuscitation) forms.
- There were reliable safeguarding systems, processes and practices in place to protect adults, children and young people from avoidable harm.

However,

- Although there was an external contract for the deep cleaning of ambulances, we found that this process was not being reviewed or completed to a high standard.
- There were no infection prevention control audits conducted to ensure high standards of cleanliness and daily cleaning sheet checks were not always completed.
- Oxygen canisters were not being stored in a safe and secure way. We found three loose oxygen canisters in vehicles.
- System and processes were not in place to implement the statutory obligations of duty of candour.

Incidents

- The service had a system in place for reporting and recording incidents. Staff reported incidents via an electronic or paper record. All incidents were graded taking into consideration the impact and likelihood of recurrence, to ensure investigations and actions were taken in a timely manner
- From July 2015 to July 2016, the service recorded eight incidents; five vehicle accidents, two clinical incidents and one equipment defect.

Patient transport services (PTS)

- Staff we spoke with were able to describe the procedures for reporting incidents. They stated they were confident to report any accidents, incidents or near misses. Staff were able to give examples of minor accidents, which managers had discussed with them. We saw forms were available in all vehicles to record the investigation of an incident.
- Learning from incidents and safety alerts were shared via the website portal, email or face to face. The website portal was accessible to employees from home and at work.
- The service had a Duty of Candour Policy (2016). The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff did not receive training in duty of candour and not all staff were familiar with the term. Despite their lack of training, staff told us they would be open and honest with people if things went wrong and would immediately seek support from their manager if a patient experienced avoidable harm.

Mandatory training

- Mandatory training consisted of patient handling, data protection, equality and diversity, infection control and personal safety.
- Mandatory training was delivered by a combination of e-learning and face to face training. All staff were required to complete and record their mandatory training. However, training records showed that not all staff had received their mandatory training. Data provided by the service showed 89% of staff had completed their mandatory training, at the time of the inspection. The service target was 100%.
- Senior management were able to review records to see the training staff had completed and training due for renewal.
- Staff completed the e-learning training as part of their induction process, upon beginning employment with the service.
- Self-employed staff were not expected to complete mandatory training. The service ensured that all self-employed staff had up to date training records from their primary employer.
- All PTS staff completed an in-house driving assessment on commencement of employment and would undertake a further assessment once they felt confident to transport patients.

Safeguarding

- There were reliable systems, processes and practices in place to protect adults, children and young people from avoidable harm and abuse.
- All staff we spoke with had a good understanding of safeguarding and when they would report a safeguarding concern. We saw a safeguarding referral completed in August 2016.
- The service had Safeguarding & Mental Capacity Policy 2015. There were safeguarding alert forms available for staff to complete to make a safeguarding referral to the statutory safeguarding team to protect vulnerable patients.
- The service had an appointed safeguarding lead for vulnerable adults and children trained at Level 3.
- There was a flow chart displayed on the notice board within the office detailing the actions to be taken and who to contact in the event of an adult safeguarding issue arising.
- Safeguarding vulnerable adults and child protection was part of mandatory training. All staff had completed safeguarding adult's level 2. Twelve out of 14 staff had completed safeguarding children training level 2.

Cleanliness, infection control and hygiene

- All the vehicles we looked at were uncluttered and visibly clean. The ambulance station was tidy and well organised. The floors were swept clean in the ambulance parking area and there was no excess equipment so the areas were not cluttered, making them easy to clean.
- Crews were required to ensure their vehicle was fit for purpose, before, during and after they had transported a patient. Decontamination cleaning wipes were available on all vehicles and we saw staff cleaning surfaces, seats and equipment after each patient.
- The crew assigned to the vehicle each day completed the day to day cleaning of vehicles. However, we found the daily cleaning sheet record on all vehicles had not been completed consistently and vehicle cleaning standards had not been audited.
- Cleaning materials and chemicals were available for staff use. Different coloured mops and buckets were

available for different areas; advice as to which mop should be used in which area was prominently displayed to prevent cross infection. The station room was divided into clean and dirty areas by colours on the walls.

- An external contractor managed the deep cleaning of ambulances every 12 weeks. The external contractor provided records to confirm ambulances were cleaned appropriately. However, the service managers were concerned with the standard of the deep cleaning and the vehicles we checked appeared to have ingrained dirt and not to have received a thorough deep clean.
- Staff followed infection control procedures, including washing their hands and using hand gel after patient contact. All staff wore visibly clean uniforms and were observed to be bare below the elbow.
- Hand washing facilities were available at the ambulance station. Although hand gel was not available on all vehicles we inspected, staff carried individual hand gel dispensers to combat this.
- We saw no evidence of infection, prevention and control audits or hand hygiene audits within the service. This meant the service could not be assured they were compliant.
- There were arrangements with the local hospitals for disposing of used linen and restocking with clean.
- The service followed operational procedures in relation to infection control. Staff told us that if a patient was known to be carrying an infection, they were not transported with another patient. The vehicle would be cleaned afterwards in accordance with infection control policy and procedures.
- Staff had access to personal protective equipment such as gloves and aprons to reduce the risk of the spread of infection between staff and patients. Crews carried a spills kit on their vehicle to manage any small spillages and reduce the infection and hygiene risk to other patients.
- Staff did not routinely have to manage clinical waste. However, clinical waste bags were carried on each ambulance. There were no containers for the disposal clinical waste bags in the ambulances and this could expose patients and staff to cross infection risks from their contents. Full bags were disposed at the hospital or at the ambulance station.
- The ambulance station had facilities for depositing and disposing of clinical waste through an external contractor.
- Staff were provided with sufficient uniform, which ensured they could change during a shift if necessary. Staff were responsible for cleaning their own uniform, unless it had been heavily contaminated when it was disposed of as clinical waste.
- The ambulances we inspected were fully equipped, with disposable single use equipment stored appropriately and in-date.

Environment and equipment

- The ambulance station provided ambulance vehicle parking facilities, an office base and facilities for managers and staff.
- The service operated 13 vehicles; six ambulances, three non-patient conveying cars, two training ambulances and two support vehicles. Two of the ambulance vehicles could be used as emergency ambulances. We inspected eight ambulance vehicles.
- There were systems in place to monitor servicing and Ministry of Transport (MOT) testing of the vehicles. There was a central log of vehicle MOT tests kept at the station and at a local garage. However, we found one vehicle with an expired MOT dated September 2016, we received assurance that the vehicle had not been used since the MOT had expired. This was raised with the management team and underwent a MOT immediately. Each vehicle displayed a sticker with MOT and tax dates clearly shown.
- We looked at the arrangements in place to service and maintain ambulance vehicles. Vehicle defect report forms were provided on each vehicle, which included a description of the fault or defect, action taken to resolve, and further action required. Staff informed us they reported any defects directly to managers; we saw when staff had completed these.
- A local garage opposite the ambulance station performed vehicle inspections every six weeks so garage staff were aware of any faults and action needed. We spoke with the mechanics from the garage who showed us the vehicle maintenance schedules. We saw they were up to date.
- Vehicles were taken off the road for repair and labelled to alert staff.
- Some of the vehicles had an on-board wheelchair available for patient use and this was secured with fasteners.

Patient transport services (PTS)

- An external contractor provided annual enhanced training and equipment checks. Safe use of patient restraints was covered in the staff induction.
- All keys for vehicles were stored within a locked cabinet to ensure staff within the service could only access them. All vehicles were locked when unattended.
- Equipment had been safety tested, stickers showed when the equipment was next due for testing and records were available to support their suitability for use. However, we saw three suction units stored in the clinical storeroom of which one did not have a label and was not listed. This was highlighted at the time of the inspection and staff removed the suction unit.
- Conveyance in vehicles were safe and secure, and we observed staff using the seatbelt in the back of ambulance vehicles to keep patients secure through their journey. The seatbelts and trolley straps were in working order in all vehicles we checked.
- Staff knew the process to follow if their vehicle broke down or was involved in an accident, addressing the immediate needs of any patients first and then liaising with the manager on call.
- Ambulances were all equipped with tracking devices. The service had 20 radios that had a computer aided dispatch facility. However, the radios were not working and were awaiting repair during our inspection and crews had to use their own mobile telephones instead.

Medicines

- No emergency medicines were carried on the PTS ambulances and PTS staff did not administer medicines. Patients or their accompanying carers were responsible for their own medicines administration whilst in transit. PTS staff would ensure medicines provided by the hospital for patients to take home would be stored securely in a red bag on the ambulance.
- Medicines at the station were stored in the clinical room in a locked secure cupboard, monitored by video surveillance and accessible by digital fingerprint lock.
- The service had individual medicine packs for paramedic and ambulance technician use at public events. These contained a medicine list that identified what medicines could be administered by paramedics or ambulance technicians and for staff to record what medicines had been used.
- Paramedics and ambulance technicians recorded administration on a medicine administration record (kept with the medicine pack) and the patient record forms. The administration records identified the medicines the paramedics and technicians had administered and who was accountable for the administration.
- There was a tagging system in use for ambulance medicines packs. Packs were tagged green or red to identify packs ready for use and those that needed replenishing. All medicines seen were in date and suitable for use. However, we found in one public event vehicle two technician bags that were not tagged and contained medicines that had expired.
- The service held an account with the local pharmacy for the supply and disposal of medicines.
- Oxygen cylinders were carried on vehicles; an appropriate health care professional had to prescribe the oxygen so staff could administer it or the patient had to have a home oxygen order form in place. We saw completed documentation when staff had administered oxygen to patients.
- The service kept medical gas cylinders in a locked cage in a sheltered location outside. Storage of medical gases was secure and there were signs to alert staff and visitors to the flammable nature of the gases. However, full and empty cylinders were not appropriately segregated and the temperatures were not monitored. We raised this during the inspection to the management team, on the unannounced inspection we found the manager had installed another cage to appropriately segregate full and empty cylinders.
- Oxygen cylinders were not always appropriately stored on the ambulances. We observed unsecured oxygen cylinders on two vehicles, which posed a safety risk. If the vehicle was in an accident, an unsecured oxygen cylinder could be thrown around inside the vehicle placing the patient or staff at risk of harm.
- An electronic system using barcode on oxygen cylinders was used to monitor stock. This was replaced frequently by a medical gas company.

Records

- PTS drivers received work sheets at the start of a shift. These included collection times, addresses and patient specific information such as relevant medical conditions, mobility, and if an escort was travelling with the patient. Information was stored in the driver's cab out of sight, respecting patient confidentiality.
- The local NHS ambulance trust created patient records at their control centre and PTS drivers received them on

an electronic tablet. Control staff collected relevant information during the booking process to inform the drivers of their patient's health and circumstances. For example, any information regarding access to property or illness issues would be collected.

- The local NHS hospital trust and the local NHS ambulance trust provided ambulance crews with patient details such as 'do not attempt cardio pulmonary resuscitation' (DNACPR) information and any special notes or instructions. We observed staff asking about DNACPR and documentation when collecting patients from the hospital.
- When providing medical cover at events the service used patient record forms which were completed manually, by the staff member attending to the patient and a duplicate copy was given to the patient. The record included appropriate details about the patient, for example the patient's consent and any medication administered and allergies.
- On PTS vehicles, drivers kept written records of pick up and drop off times for each patient. This was then provided to the office as part of the crews' timesheets.
- Patient's medical records were carried in a red bag whilst the patient was being transported to ensure confidentiality. Upon arrival at the destination, the crew handed the documentation to the relevant member of staff or carer.
- We saw patient information and patient record forms kept within locked metal cupboards at the station.
- The staff personnel files were stored in a locked cupboard on the service premises. We were told only the administration staff and managers had access to this key to ensure the confidentiality of staff members was respected.

Assessing and responding to patient risk

- Information about patients' needs was collected at point of booking and communicated to PTS staff on their work sheets or via mobile telephones. Staff working with the local NHS ambulance trust would receive information on an electronic tablet.
- Patients' needs were assessed by the local NHS hospital trust and the local NHS ambulance trust, not by the ambulance staff. Staff told us that they would perform dynamic risk assessments and would only accept patients they had the skills to care for and the appropriate equipment.
- Staff followed a clear pathway to manage patients who became ill during their journey. They informed us they would stop the vehicle as soon as it was safe to do so and call for the assistance of an emergency vehicle. They would then inform their managers and would support the patient as best they could until help arrived. Staff completed basic life support training and some staff had completed first person on the scene training.
- When the service attended public events, a risk assessment was undertaken of the location where the event was held. Staff provided verbal examples of risks they had encountered, and how these risks were controlled. For example when attending a large event they would undertake a survey of the site to ensure they were aware of the most direct routes to the exits.
- During our observations we saw appropriate manual handling techniques used for the transfer of all patients. This ensured that staff and patient safety was maintained and injuries avoided.

Staffing

- The staff based at the ambulance station consisted of the operations director, operations assistant and an accounts administrator. Ambulance care assistants (ACAs) staffed PTS. Paramedics, advanced paramedic practitioners, advanced nurse practitioners, ambulance technicians and non-emergency ambulance crew staffed events.
- An electronic rostering system was used to plan shifts. Shortfalls in cover were shown on this system and staff could request to work additional shifts. The electronic rostering tracked sickness and holidays.
- Staff did not raise any concerns about access to time for rest and meal breaks.
- There was a process in place for the ambulance crews out of hours and in case of emergencies. They had a direct number to the duty manager on call. Staff we spoke with knew how to escalate concerns when working out of hours.
- All ambulance staff had valid enhanced Disclosure and Barring Service (DBS) checks.
- We were able to see evidence that a check with the DBS had been carried out prior to staff commencing duties, which involved accessing patients and their personal and confidential information. This protected patients from receiving care and treatment from unsuitable staff.

Patient transport services (PTS)

- We observed ambulance crew and hospital staff giving and receiving handovers. Ambulance crew gave handover information clearly and competently.

Anticipated resource and capacity risks

- There was good joint working between the service and the local hospital. There were daily calls between the operations assistant and the hospital. This allowed issues to be picked up to assist planning for the day and for concerns to be escalated to managers when necessary. For example areas of particularly high demand or a shortfall in vehicles due to maintenance would be communicated to staff.
- The service managed anticipated resource risks by scheduling rotas in advance and managing pre-planned holidays and other leave.
- There was a business continuity plan for adverse winter weather. This included the use of four wheeled drive vehicles for use throughout the autumn and winter months to assist crews getting to and from work.
- The service considered the impact of different resource and capacity risks and could describe the action they would take. There had been a phased implementation of new contracts so that staff could adjust to the new rotas, areas covered and different key performance indicators (KPIs). This also enabled managers to address any immediate concerns in a manageable way.

Response to major incidents

- A major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services and would generally include the involvement, either directly or indirectly, of large numbers of people.
- As an independent ambulance service, the provider was not part of the NHS major incident planning. However management staff informed us that they had been utilised when the NHS hospital trust had a major incident, to transport patients home.

Are patient transport services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Staff were competent in carrying out their responsibilities, felt they received appropriate training, and support for this.
- Staff could access written guidance to support patient care that was based on best practice and legal guidance.
- We saw and heard evidence supporting good co-ordination with providers and multi-disciplinary working to meet patients' needs. The local NHS hospital staff were very positive about the service.
- Local commissioners had agreed set performance targets for PTS, such as providing transport within one hour of the request for 90% of bookings. From April to July 2016 the performance figures provided by the service showed 98% of departures were carried out within the agreed times.
- Staff could access the information they required to meet specific patient needs such as nutritional, behavioural or physical needs. Each vehicle had bottles of water for patients should they need it.

Evidence-based care and treatment

- The service provided policies based on best practice and legal guidance. Clinical and Operational Guidance Sheets (COGS) were available for staff to use to ensure crews provided patients with the most appropriate care. The COGS were based on guidelines from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). For example, consent, deteriorating patient and PTS patient observations.
- Ambulance staff were able to access policies and procedures online or at the station.
- Clinical and procedure updates were also accessible to staff online. If staff did not have access to the internet hard copies were given to them.
- The service had a PTS Eligibility Policy (2016). The staff did not set or assess patient's eligibility to travel on patient transport in line with the guidelines in the Department of Health 'Eligibility criteria for patient transport services' document. The eligibility criteria was set nationally and it was the responsibility of the providers booking patient transport to make sure it was used for patients who meet the criteria.

Assessment and planning of care

- During the booking process, information was gained regarding mobility aids, whether or not a stretcher was

required and details of any oxygen required. Staff told us they were able to make dynamic assessments of the needs of patients at the point of pick up and make adjustments where necessary.
- Staff did not transport a patient if they felt they were not equipped to do so, or the patient needed more specialist care. PTS staff were not clinically trained, but did seek advice from clinical staff at the hospital as necessary or the manager on call for the service. If a patient was observed or assessed as not well enough to travel or be discharged from hospital, the ambulance care assistants made the decision not to take them.

Nutrition and hydration

- There were arrangements in place to provide drinks for those patients that were on a vehicle for a long period of time. Water bottles were carried on ambulances and could be provided if required on long journeys or hot days.
- No food was carried on board the ambulances for patients. We were told that the ambulance crew would ensure that patients had enough food at home and would stop at the shop if required before taking them home.

Patient outcomes

- From January to July 2016, there had been 4381 patient journeys. Of these, 61% were categorised as 'same day' bookings. The level of activity was increasing each month and managers reviewed data in relation to themes and trends.
- The service monitored pick up times, arrival times and site departure times through the crew worksheets.
- Local commissioners had agreed set performance targets for PTS, such as providing transport within one hour of the request for 90% of bookings. From April to July 2016 the performance figures provided by the service showed 98% of departures were carried out within the agreed times.
- We saw evidence that the service had an internal set target of answering calls within 25 to 32 seconds; if they were unable to answer calls within 18 to 20 seconds an automated introductory message was played. The management team informed us that the service was currently answering call within the desired response times.
- The ambulance care assistants ensured patients were not left at home without being safe and supported. Some patients were discharged from hospital and had a package of care to be arranged at home. If the support person or team had not arrived when the patient came home, the ambulance care assistants called the hospital to find out where they were. The patient would not be left alone until either the care team arrived, or the patient was safe in the care of their family or carer.

Competent staff

- All staff had the appropriate skills and knowledge to do their job. All PTS ambulances were staffed by ambulance care assistants who were appropriately trained and supported.
- All new PTS staff were required to undertake a set induction programme plus a workbook that refreshed and tested knowledge on safeguarding, manual handling, infection control and health and safety. Personnel files showed staff had completed the induction training.
- During the induction process, staff accompanied a two-person crew for three days to observe and learn. If a new member of staff felt they wanted a longer period of being the third crew member, this was at the discretion of the manager.
- The newly appointed staff we spoke with told us their induction had been useful and had equipped them well for their role.
- Staff portfolios contained personal statements, induction checklist, certificates in restraint training, infection control, health and safety and a driving level assessment. Records also showed staff were provided with practical guidance and training on the use of all vehicles and equipment.
- Appraisals were completed on an annual basis and ambulance care assistants confirmed these were regular and helpful in supporting them. Information provided by the service showed that eight out of 13 staff had received an appraisal.
- Driver and Vehicle Licensing Agency (DVLA) checks were conducted at the start of employment and on an annual basis. All crew were aware of the need to notify the managers of any changes to their license in line with the driving standards policy.
- All staff were required to complete a driving assessment on commencement of employment which was carried out by the service. This included an observation of their driving skills and completion of a test on road signs.

Patient transport services (PTS)

- The clinical lead told us new starters were supervised and receive 1:1 sessions throughout the year. Ambulance crews were observed through Crew Observation, Review and Evaluation (CORE) shifts by members of the management team. We saw records that supervision and CORE shifts were undertaken.

Coordination with other providers

- Staff at the local NHS hospital trust reported good working relationships with ambulance care assistants, managers and the operations assistant. We observed effective co-operation between different providers to coordinate patients' transport around their care, treatment and discharge.
- We spoke with staff from the hospital discharge lounge who told us the service responded well to their requests for transport. They told us if they had any problems, the ambulance crews were very responsive and always provided assistance upon request.
- Staff from a nursing home we spoke with stated staff were always 'outstanding', a pleasure to deal with, reliable, well trained and professional.
- PTS crews said they have good relationships with staff at the different hospitals they visited.
- We observed good interactions between the PTS crews and nursing staff at the hospital when moving patients. Hospital staff commented on the good rapport PTS crews had with their patients and were always pleasant to staff working on the wards or various departments.

Multidisciplinary working

- We observed good team working across the different staff groups within the service and external organisations. Staff were committed to providing good care to patients.
- We observed PTS crews and care home staff sharing key information when collecting patients to attend hospital appointments. This was important for the patient's wellbeing and ensured they were prepared and adequately supported for their planned journey.

Access to information

- Ambulance care assistants received printed daily job sheets at the start of each shift when supporting the local NHS hospital. These included collection times, addresses and patient specific information such as relevant medical conditions, complex needs, mobility, or if an escort was travelling with them.
- The local NHS ambulance trust had access to 'special notes' about a patient such as pre-existing conditions, safety risks or advanced care decisions, this information was provided to the crews when they were dispatched.
- Staff felt they had access to sufficient information for the patients they cared for. If they needed additional information or had any concerns, they spoke with the local NHS hospital trust or the local NHS ambulance trust.
- General information for staff was accessed through the staff portal which all staff had log in details to. The staff portal stored a range of information including policies and training information.
- The managers sent out staff announcements via the portal including company news and any feedback about the service such as complaints. The portal was accessible to employees from home and at work. Announcements were also sent out via email; however, there was no guarantee that staff had read the information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment. Verbal consent to treatment was recorded on patient record forms.
- Staff had received training in the Mental Capacity Act 2005. This training was via eLearning, information provided by the service showed all staff had completed this and were up to date.

Are patient transport services caring?

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

- All feedback from patients and hospital staff was consistently positive about the care staff provided to patients when delivering patient transport services. Patients and hospital staff described situations where staff had gone the extra mile.
- Staff helped patients feel comfortable and safe on board the vehicle and responded compassionately when patients needed additional help or support.

Patient transport services (PTS)

- Patients were treated kindly and compassionately. We observed positive and courteous interactions between staff and patients.
- Staff we spoke with were passionate about their roles and providing excellent care.

Compassionate care

- We observed positive interactions between staff and patients, which were caring, compassionate and responsive.
- Feedback from all the hospital staff we spoke with was positive about the care they saw staff providing for patients. They commented on their professional but friendly approach and consideration of the total needs of the patient, not just their medical needs.
- We observed care provided to patients during their journey to or from the hospital. We heard ambulance staff speaking to patients in a kind and supportive manner while moving them on and off vehicles. Staff clearly explained what was going to happen and asked patients before for permission before administering care.
- Staff asked patients their preferred name and ensured patients were comfortable. They maintained patients' privacy and dignity by keeping doors closed between unloading and loading other patients.
- We saw staff using blankets to keep patients warm during their journey. Staff told us they had spare blankets on each vehicle; these were especially useful during the winter period.
- Staff were respectful, friendly, kind and compassionate when providing care to patients. They spoke with patients in a gentle manner and offered reassurance, particularly if the patient was distressed or in pain.
- The interactions we observed demonstrated that staff respected patients and relatives as individuals, including those from vulnerable groups such as the elderly and those with mental ill health. The crew showed great support and understanding when caring for a patient who showed signs of living with dementia, taking time to chat about things that interested the patient.
- Wherever possible vulnerable patients, such as those living with dementia or a disability, could have a relative or carer with them while being transported.
- All staff we spoke with were passionate about their roles and were dedicated in providing excellent care to patients.

Understanding and involvement of patients and those close to them

- We observed patients being involved in decisions about their care and treatment. Ambulance crews gave clear explanation of what they were going to do with patients and the reasons for it. Staff checked with patients to ensure they understood and agreed to the treatment offered.
- Patients described having confidence in the staff providing their care, and patients were involved as much as possible when planning their journey to and from the hospital.
- Staff provided clear information to patients about their journey and informed them of any delays.
- Staff showed respect towards relatives and carers of patients and were aware of their needs; explaining in a way they could understand to enable them to support their relative.
- We observed the crews including a family member in the care of the patient and ensuring that they understood what the crew were doing.

Emotional support

- Ambulance care assistants did not routinely transport patients who were end of life or had passed away. However, staff were aware of the need to support family or other patients should a patient suffer a cardiac arrest or die during a journey.
- We saw staff checked patients' wellbeing, in terms of physical pain and discomfort, and emotional wellbeing.
- We observed good rapport between PTS crews, patients and their carers whilst accessing vehicles and during journeys.

Supporting people to manage their own health

- Hospital staff informed us that the crews would make cups of teas for patients when they took them home and would call into the shops to make sure patients had food at home.
- Staff supported patients to manage their own care needs to maximise their independence. Patients were encouraged wherever possible to use their own mobility aids when entering or leaving the vehicle. We also observed crews walking alongside patients and offering their arm for additional support.

Patient transport services (PTS)

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

By responsive, we mean that services are organised so that they meet people's needs.

- We observed staff meeting patients' individual needs. Staff were provided with key information from the local NHS hospital trust and the local NHS ambulance trust regarding the needs of patients.
- The service planned to meet the needs of its contractual arrangements with health service providers. The service utilised its vehicles and resources effectively to meet patients' needs.
- We saw information about how to make a complaint available in all of the vehicles we inspected. Staff and patients were aware of and knew how to access the service's complaints and compliments system.
- Specially adapted ambulances were available to accommodate bariatric patients.

Service planning and delivery to meet the needs of local people

- The service provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. The service supported hospital discharge across the Oxford region.
- Over the last year, management staff had worked with, the local NHS hospital trust to secure a new contract. The contract provided a seven-day service from 8am until midnight.
- The operations assistant at the station managed all the bookings from 8am until 5pm which ensured they could be responded to quickly. Each booking would come via telephone or by an online booking form. If calls were not answered they were diverted to one of the managers' mobile telephones.
- The local NHS hospital trust allocated jobs directly to PTS crews who worked from 12pm to 12am and crews who worked 10am to 10pm were allocated jobs directly from 4pm onwards.
- The service was also working intermittently with the local NHS ambulance trust providing PTS services.
- The service took advance and on the day bookings and workloads were planned around this. Hospital staff told us the service was good at responding, even on short notice bookings.
- Staff told us their workload was variable, it ranged from transporting one to two patients a day to considerably more than this on some occasions, there were no trends to this variation.

Meeting people's individual needs

- The booking process meant people's individual needs were identified. For example, the process took into account the level of support required, the person's family circumstances and communication needs.
- For patients with communication difficulties or who did not speak English, we were informed staff had access to interpreting services through language line, a telephone-based interpreting service provided by the local NHS hospital and ambulance trust.
- During our unannounced visit we observed phrase books, containing key questions in 41 different languages were available on all vehicles, to use should they not have access to an interpreter. This also contained a short section on sign language.
- The service had vehicles equipped with a bariatric stretchers and other specialist equipment to support bariatric patients. Bariatric patients are those with excessive body weight which is dangerous to health.
- Ambulances had different points of entry, including sliding doors, steps and tailgates so that people who were ambulant or in wheelchairs could enter safely.
- For patients living with dementia and those with reduced mental capacity their support needs were assessed at point of booking. Escorts could be approved or a two-man crew arranged as required.
- We observed that staff from care homes were able to provide specialist support, to ensure the right level of patient support was provided.

Access and flow

- The service operated within the core hours of 8am to midnight. The service was currently negotiating drawing together a contract with a local NHS hospital trust which would require the service to be available 24 hours a day.
- Requests for ambulance vehicles were received from local NHS hospital trust by telephone, or through a

pre-booking arrangement. The administrator at the station would take bookings for the day before and until 4pm. After 4pm, bookings would then be managed by local NHS hospital trust until midnight.

- Work requests by the local NHS ambulance trust were received on an intermittent rather than a contractual basis and the service responded at short notice.
- Bookings made by the local NHS ambulance trust would be made directly to the crews via an electronic tablet or staff mobile telephones.
- Staff told us that first aid and ambulance assistance at public events was organised with event organisers to ensure the needs for each event were addressed appropriately. We reviewed the positive feedback the service received from event organisers which confirmed that their needs were addressed.
- Managers confirmed that patient transport services did not do emergency transfers and patients transported were usually clinically stable.
- If a journey was running late the driver would ring ahead to the destination with an estimated time of arrival and keep the patient and the hospital informed. Any potential delay was communicated with patients, carers and hospital staff by telephone.

Learning from complaints and concerns

- The service had a system for handling, managing and monitoring complaints and concerns. For example, each vehicle had self-addressed feedback forms available for patients to complete.
- We reviewed the feedback responses received from patients, which were used to forward complaints, concerns and compliments about the service. Patient feedback was positive and very few complaints were received.
- The service had not received any formal complaints for the last 12 months.
- The complaints and compliments policy outlined the process for dealing with complaints initially by local resolution and informally. Where this did not lead to a resolution, complainants were given a letter of acknowledgement within five days of receipt followed up by a further letter within 25 working days, once an investigation had been made into the complaint.

Are patient transport services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high- quality person-centred care, supports learning and innovation and promotes an open and fair culture.

- There was no formal risk register in place at the time of the inspection which limited the services ability to monitor their risks and put plans in place to mitigate them. However, since the inspection we have been provided with a risk register.
- A vision and strategy had not been developed and embedded across the service.
- A lack of audits meant that the quality and performance of services were not assessed to ensure correct processes were understood by staff, applied in practice and patients were not put at risk.
- Staff had limited understanding of the duty of candour at the time of the inspection.
- The service had not had a CQC registered manager in post for over six months.

However,

- The service proactively engaged with staff, to ensure that the feedback from all staff were captured and acted on. There were positive processes in place for staff and public engagement. The service was seeking feedback to improve the quality of services wherever possible.
- The culture amongst the staff we spoke with was good and they liked working for the service.
- All staff felt supported by the managers of the service and said the managers were very accessible should they require any advice.

Leadership of service

- At the time of the inspection, EMC Blewbury did not have a manager who was registered with the Care Quality Commission, to carry out the day to day running of the service. The Health and Social Care Act 2008 requires the Care Quality Commission to impose a registered manager condition on organisations that requires them to have one or more registered managers for the regulated activities they are carrying on. This meant, at the time of the inspection, EMC Blewbury was

in breach of their registration conditions. We met the members of staff who were submitting an application to be registered with the Care Quality Commission as joint managers.

- The day-to-day management of the service comprised of an operations assistant, an operations director and the clinical compliance manager who both worked three days a week and an accounts administrator. The managers looked after the welfare of the staff and were responsible for the planning of the day to day work.Some of the management team also formed part of the operational staff for public events.
- Staff spoke positively about the leadership of the service.They had confidence mangers had the appropriate skills and knowledge for their roles, felt able to raise any concerns with them and found them easy to contact. Most staff we spoke with said the organisation and their manager were good to work for and they felt they were well looked after.
- The service had a clinical director, who was a registered paramedic. Their roles and responsibility included the safe management of medicines. However, we identified that there was no contingency in place should they be unavailable for a period of time. We were informed that the clinical director did not have scheduled days at the station.

Vision and strategy for this service

- The management team acknowledged that a written statement of vision, strategy and guiding values had not been prepared but that work was being done with staff to develop this. They informed us their strategy was to stabilise, develop and sustain the business. Also to improve staffing and the quality of service provided.
- We were told the vision of the service was to continue to evolve as a company seeking to always be better, striving to be “excellent” at what they did.
- Staff we spoke with told us they did not know what the vision and strategy for the service was.
- Managers had a good understanding of the commercial aspect of the PTS, ensuring they remained competitive, this was demonstrated by the service securing a new contract.
- Staff felt the service had kept them informed about the changes following the introduction of the new contract; this included those staff that were self-employed.

Governance, risk management and quality measurement

- At the time of the inspection, there was no local or corporate risk register used to record risks identified, regarding patients, staff or the business. This meant there was no formal process for identifying and prioritising risks and recording measures implemented to mitigate the identified risks within the organisation. However, since the inspection we have been provided with a risk register which identified three areas of concern which were driving standards, safety of medical gases on vehicles and technician bags left in vehicles.
- Senior managers were clear on their three top risks for the service: maintaining their contract, staffing and crew retention.
- There was limited awareness of duty of candour. The director told us training for duty of candour was a new initiative within the service and something that would be integrated into the incident reporting process.
- Internal audits had been set up to monitor compliance with areas such as cleanliness and infection control but these were not completed as advised by the service policies. There were potential risks to staff and patient safety, through lack of observation and monitoring of performance.
- We observed no evidence of governance meetings taking place. The four senior managers did not meet regularly or record any meetings.
- There had been three operational office meetings from June 2016 to August 2016 to discuss finance, recruitment, safeguarding and health and safety.
- The service had a lone working policy in place to ensure the safety and welfare of staff whilst at work.

Culture within the service

- There was a strong emphasis on staff well-being and the managers organised a number of social events for the staff to attend as a team.
- Staff said they were proud to work for the service. They wanted to make a difference to patients and were passionate about performing their role to a high standard.
- Staff told us they had a number of suggestions on how the organisation could improve the services, and some of these had been implemented.

- Staff told us that when they encountered difficult or upsetting situations at work they could speak in confidence with the managers.

Public and staff engagement

- A crew representative meeting took place in August 2016 where the crew set the agenda. The agenda included training and development, communication and health and safety. It gave the crews an opportunity to raise concerns to senior management. However, we did not see any evidence that this occurred on a regular basis.
- Staff were encouraged to complete crew survey ideas and crew suggestions on line. For example, we observed the clinical room was divided into a clean and dirty area by different colours on the walls as a consequence of a staff suggestion
- Staff were invited to give their views about working for the service through a survey conducted in October 2014. The survey was completed by 17 staff the majority of which were casual staff. The questions covered areas, such as enjoyment of the job, any improvements made to make the job easier and to improve the overall patient experience. An action plan was produced to address the areas of concerns raised.
- Patient feedback was encouraged through access to forms on vehicles. Forms were printed on 'freepost' cards which could be posted by patients. Alternatively patients could hand their feedback forms to ambulance crews. The majority of the cards we looked at were complimentary about the care and treatment they had received from staff.
- A noticeboards in the ambulance station displayed staff briefings, education updates, alerts regarding equipment and information on staff wellbeing. Communication to staff was through media forums, emails and displayed in the station.

Innovation, improvement and sustainability

- The service had registered as an Edexcel Pearson, Institute of Health and Care Development (IHCD) training provider and had also registered with Qualsafe (OFQual) to enable them to offer an in house training programme to crews.
- There was genuine positivity about the future of the service with a hope that the service would eventually expand. Staff were delighted that the service was considering tendering for further PTS contracts and felt confident about their future.
- Senior managers considered the sustainability of the service during contract negotiations, extending the operating hours of the service to meet the needs of patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure robust systems are in place to assess, monitor and improve the quality and safety of the services provided.
- Ensure a vision and strategy for the service is developed and to ensure this is embedded across the organisation.
- Ensure systems and processes are in place to implement the statutory obligations of duty of candour.
- Ensure a manager for the regulated activity is registered with the Care Quality Commission.
- Ensure oxygen cylinders and medicines are stored safely and securely and do not pose a risk to others.
- Ensure the Care Quality Commission is notified of safeguarding incidents and incidents affecting the running of the service as required by the Health and Social Care Act.

Action the hospital SHOULD take to improve

- Ensure hand held communication systems for staff are in a useable condition and available for use.
- Should review its process for including operational issues within a strategic overview or central risk register related to internal risks.
- Ensure all staff are trained in duty of candour.

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 Treatment of disease, disorder or injury	Regulation 5 (Registration) Regulations 2009 Registered manager condition **1. The registration of a service provider in respect of a regulated activity is subject to a registered manager condition.** **Regulation 5 (1)**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • Adequate audit, risk management and control systems were not in place. • There were insufficient quality and monitoring processes in place to review systems and procedures and to take learning to make improvements. **Regulation 17 (2) (a) (f)**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met:** • The provider needs to ensure systems and processes are in place to implement statutory obligations of Duty of Candour. **Regulation 20 (1)**