R & K Healthcare Limited

Quality Report

4 The Limes Business Centre
8 The Street
Charlwood
Gatwick
RH60BY
Tel:01293 863054

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

R&K Healthcare Limited provides an independent patient transport service that helps people access healthcare throughout the United Kingdom and parts of Europe. In Surrey, the provider has an informal agreement with the local NHS trust to provide transport services to meet demand for transport requests. The provider also transports private patients when required.

The service is free at the point of use for NHS patients who meet eligibility criteria and were unable to use public or other means of transport.

We have inspected this service once before, but we did not rate it at that time. We inspected the service this time using our comprehensive inspection methodology. We gave the provider 48 hours' notice to ensure that everyone we needed to speak with was available. We carried out short notice inspection on 8th October 2019.

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

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

This was the first time we have rated this service. We rated it as **Good** overall.

- Since our last inspection, the service had made positive changes based on our previous recommendations. At this inspection, the registered manager responded to our concerns and acted immediately to implement changes and update staff.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- 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. Managers regularly reviewed and adjusted staffing levels and skill mix.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service provided care and treatment based on national guidance and evidence-based practice. There was no formal process to monitor staff compliance to the guidelines. Staff protected the rights of patient's subject to the Mental Health Act 1983; however, they had not received any formal training with regards to Mental Capacity Act (2005).
- The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.
- Patients and hospital staff told us that the service provided outstanding kind and compassionate patient centred care. Crews went the extra mile to ensure vulnerable people were looked after with dignity, and respect. The team were responsive to the needs of their local NHS hospital. Hospital staff told us how they could rely on the service to support people's emotional needs and help with access and flow across the NHS service.

Summary of findings

- The registered manager was keen to make improvements that would help service provision and had invested in new digital systems that were designed to improve staff performance and patient safety.

However, we found the following areas of that require improvement.

- The service transported vulnerable and frail people, but the provider did not offer staff training in dementia awareness or Mental Capacity Act (2005). This training is essential for workers involved in the care and treatment of people who may lack mental capacity.
- Staff lacked understanding regarding the contents of the service's safeguarding policy, and did not report concerns within the service, although they did report them to the NHS trust they were aligned to. The policy laid out guidelines and contained a safeguarding reporting form, but staff did not use these. There were no completed safeguarding referral forms at the location.
- We found that although staff signed to acknowledge policy reviews, the policy naming convention may confuse staff when trying to find the right information regarding certain aspects of care. For example, the staff equality and diversity policy, could be found under the main heading of children and vulnerable people policy and procedure.
- The service did not provide us with a policy or procedure that ensured no discrimination of people with protected characteristics under the Equality Act (2010).
- The registered manager failed to complete statutory notifications under Regulation 17 1,2 (f) of the Care Quality Commission (registration) Regulations 2009 (Part 4); We found the provider lacked awareness on the contents of the services safeguarding policy and the procedures' contained within this.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, to help the service improve. We also issued the provider with one requirement notice.

Nigel Acheson

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

Overall summary

When we inspected the service in 2018 we did not rate the service. However, we did make recommendations to the provider, which can be viewed in the previous report found on the CQC website. During this inspection we found that the registered manager had made changes based on our recommendations and requirement notifications.

We found the following areas of good practice:

- Since our last inspection, the service had made positive changes based on our previous recommendations. At this inspection, the registered manager responded to our concerns and acted immediately to implement changes and update staff.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Summary of findings

- Patients and hospital staff told us that the service provided outstanding kind and compassionate patient centred care. Crews went extra mile to ensure vulnerable people were looked after with dignity, and respect.
- The team were responsive to the needs of their local NHS hospital. Hospital staff told us how they could rely on the service to support access and flow for patients and their families.
- The service had invested in new digital systems that were designed to improve staff performance and patient safety and provided accurate data which would drive services forward in the future.

However, we found areas for improvement

- Although the service transported vulnerable and frail people, the provider did not offer staff training in dementia awareness or Mental Capacity Act (2005). This training is essential for workers involved in the care and treatment of people who may lack mental capacity.
- The service did not have a robust system to monitor or mitigate risk. We found that the providers risk register was blank, and the registered manager had a lack of awareness on what risks should be recognised in the risk register.
- We found that although there was a safeguarding policy which included safeguarding forms. Staff reported safeguarding concerns to the local NHS trust, they did not formally document or raise safeguarding incidents within the provider service.
- The registered manager failed to complete statutory notifications under Regulation 17 1,2 (f) of the Care Quality Commission (registration) Regulations 2009 (Part 4). We found the provider lacked awareness on the contents of the services safeguarding policy and the procedures' contained within this.
- The provider did not meet with staff formally on a regular basis, nor keep minutes of the meetings and keep records of actions to make sure changes were safely implemented and concerns were followed up.

Following this inspection, we told the provider that it must take one action to comply with the regulations and that it should make other minor improvements, to help the service improve. We also issued the provider with one requirement notice.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good	R & K Healthcare Limited provide patient transport services via an informal contract with a local NHS trust and private transportation services when required. The service transports people throughout the UK and Europe. **We found the following areas of good practice** • Since our last inspection, the service had made positive changes based on our previous recommendations. At this inspection, the registered manager responded to our concerns and acted immediately to implement changes and update staff. • Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. However the service failed to provide the CQC with statutory notifications • Patients and hospital staff told us that the service provided outstanding kind and compassionate patient centred care. Crews went the extra mile to ensure vulnerable people were looked after with dignity and respect. • The team were responsive to the needs of their local NHS hospital. Hospital staff told us how they could rely on the service to support access and flow for patients and their families. • There was a positive culture within the organisation the registered manager was approachable and honest, and staff felt respected, because good performance was recognised. • The service had invested in new digital systems that were designed to improve staff performance and patient safety. **However:** • Although the provider transported vulnerable people who may lack capacity, the service did not provide training in dementia awareness or Mental Capacity Act (2005).

Summary of findings

- Although staff reported safeguarding concerns to the local NHS trust, they lacked understanding about reporting safeguarding concerns within the service. The policy laid out guidelines and contained a safeguarding reporting form, but staff did not use these. There were no completed safeguarding referral forms at the location.
- The service did not provide us with a policy or procedure that ensured no discrimination of people with protected characteristics under the Equality Act (2010).
- We found that the provider had no clear method for using data to make improvements to the service.
- The registered manager failed to complete CQC statutory notifications and lacked awareness of the full contents of the services safeguarding policy and procedures.

Summary of findings

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Good

R & K Healthcare Limited

Services we looked at

; Patient transport services;

Summary of this inspection

Background to R & K Healthcare Limited

R&K Healthcare Limited opened in 2014. It is an independent ambulance service which transports patients throughout the UK and parts of Europe. The service transfers patients to and from hospital appointments and returns patients to their homes after a stay in hospital, or on to a care home, nursing home and hospices. The service covers the county of Surrey, East Sussex and the borders of Kent.

The provider did not have any formal contracts. Instead the service had an informal arrangement and worked on an ad hoc basis supporting transportation of patients to and from a local NHS trust. The service did not provide clinical care, but they transported patients who were vulnerable or had complex needs. If patients had extra needs, they were accompanied by a nurse or support worker organised via the hospital who were responsible for deciding the eligibility of patient's suitability for the journey.

The service has had a registered manager in post since 29th September 2014, who is the company director.

The service is registered to provide the following regulated activities:

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

The provider had one senior manager, four full-time patient transport drivers working for the service, and a bank of three temporary staff that it could use to cover any surges in demand. The service had four vehicles.

Activity (April 2019 to September 2019)

In the reporting period there were 677 patient transport journeys undertaken.

Track record on safety

- No never events or clinical incidents

- No complaints

The local NHS trust that uses the service told us that no negative concerns had been raised regarding the service R&K provided during the reporting period (August 2018 to August 2019).

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

The service has been inspected once before in May 2018 but we did not rate the service.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,a supporting CQC inspector, and a paramedic specialist advisor with expertise in emergency and urgent treatment and patient transportation. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the provider headquarters in Horley, Surrey, and the local NHS trust where staff were based for transfers. We spoke with the registered manager and five staff including; two crew and two office staff. When we visited the local NHS hospital, we spoke with two NHS hospital staff. We telephoned three patients and one relative. During our inspection we reviewed five staff files and five patient feedback forms, written within the last three months and looked at two of the service's patient transport vehicles.

Summary of this inspection

Information about R & K Healthcare Limited

When we inspected the service in 2018 we did not rate the service. However, we did make recommendations to the provider, which can be viewed in the previous report found on the CQC website. During this inspection we found that the registered manager had made changes based on our recommendations and requirement notifications.

We found the following areas of good practice:

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- The team were responsive to the needs of their local NHS hospital. Hospital staff told us how they could rely on the service to support access and flow for patients and their families.
- The service had invested in new digital systems that were designed to improve staff performance and patient safety and provided accurate data which would drive services forward in the future.

However, we found areas for improvement

- Although the service transported vulnerable and frail people, the provider did not offer staff training in dementia awareness or Mental Capacity Act (2005). This training is essential for workers involved in the care and treatment of people who may lack mental capacity.
- The service did not have a robust system to monitor or mitigate risk. We found that the providers risk register was blank, and the registered manager had a lack of awareness on what risks should be recognised in the risk register.
- We found that although there was a safeguarding policy which included safeguarding forms. Staff reported safeguarding concerns to the local NHS trust, they did not formally document or raise safeguarding incidents within the provider service.
- The registered manager failed to complete statutory notifications under Regulation 17 1,2 (f) of the Care Quality Commission (registration) Regulations 2009 (Part 4). We found the provider lacked awareness on the contents of the services safeguarding policy and the procedures' contained within this.
- The provider did not meet with staff formally on a regular basis, nor keep minutes of the meetings and keep records of actions to make sure changes were safely implemented and concerns were followed up.

Following this inspection, we told the provider that it must take one action to comply with the regulations and that it should make other minor improvements, to help the service improve. We also issued the provider with one requirement notice.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Patient transport services

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

Are patient transport services safe?

Good

We rated it as **good.**

Mandatory training

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

The registered manager had responded to the recommendations from our last inspection and now kept records of staff training. We saw records that showed the service had mandatory training arrangements for all staff. Training included basic first aid, and manual handling and infection control.

The service had identified staff roles and which training courses they needed to complete. We saw staff had received mandatory training on the provider's electronic spreadsheet and paper staff records.

One hundred percent of staff were compliant in their annual manual handling and first aid training. However, only 29% of staff (two staff) were compliant with infection control prior to our inspection for the reporting period from August 2018 to August 2019. After the inspection we saw records that showed annual hand hygiene training had been completed by all staff for the year April 2019 to April 2020.

The service's system used to monitor training compliance was under review. The provider had recently employed an external company to manage training. We were shown the new electronic system which would track staff training, enable e-learning modules and highlight when training had expired. The registered manager told us that the system will be implemented during November 2019.

Safeguarding

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

There were systems and practices that protected people from abuse, and neglect or breaches in their dignity or respect.

The service's safeguarding policy had been reviewed and updated and contained processes for both adults and children. The provider also had an appointed safeguarding lead who was trained to level 3 safeguarding. However, the registered manager and staff did not have a formal process for reporting any safeguarding concerns within the service.

Records showed all staff (were trained at level 2 safeguarding children and level 2 safeguarding adults in line with national guidance.

Staff had a comprehensive awareness and understanding of potential abuse and could give us examples. Staff made sure that people in vulnerable situations or who were isolated within the wider communities were highlighted concerns to healthcare professionals.

Historically staff acted on recommendations by the NHS trust they were aligned to. Safeguarding concerns were to be reported to hospital staff that organised the patient

journeys. Staff gave us an example of how concerns raised by R & K crew had created good outcomes for vulnerable people. However, the provider failed to provide the CQC with statutory notifications.

Staff gave us an example of reporting a concern. The crew had transported an elderly patient home from hospital and had concerns for their safety and wellbeing. The crew reported this to the local NHS discharge co-ordinator on their return to the hospital safeguarding team and the safeguarding was managed well.

The services safeguarding policy included instructions on how to document and report risk; however, staff lacked awareness of the contents of the policy and the referral forms that were enclosed within this document. Staff did not know that safeguarding concerns should be reported to the local authority and the CQC in line with regulations.

On the day of inspection, we raised this with the provider. Following the inspection, the provider made the appropriate changes to the safeguarding process, by updating the policy to include the correct reporting systems and informed all staff about the changes.

Cleanliness, infection control and hygiene

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

Standards of hygiene and cleanliness were maintained. Staff carried out daily cleaning, equipment and vehicle checks, and used a smartphone application (app) to record this. We were shown data inputted by staff on the day of our inspection. However, we did not see any regular audits carried out by the registered manager to ensure staff were fully compliant with all aspects of infection control.

The service had recently reviewed its infection control policy which included a section on the national standards for hand hygiene de-contamination. The National Institute for Health & Care Excellence (NICE) quality standard 61 statement 3 states: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of care. We saw that alcohol-based hand sanitiser was available for use on all vehicles. Staff told us they wore gloves at the point of care. We did not view any patient care so were unable to assess whether these were used correctly.

On inspection of the vehicles we noted that personal protective equipment (PPE) was readily available in-date and stores were well stocked.

Crew wore clean uniforms which were provided by the local NHS trust. However, we did not see any bespoke company uniforms on the day of our inspection.

The hospital risk assessed patients for journeys and informed the provider of any infection risks. These risks were inputted to the crew's phone app, so cleaning could be followed up at the end of the journey. We were told by hospital staff that they witnessed staff carrying out regular checks at the beginning of shifts.

Vehicles were cleaned at the location. The provider labelled and stored safely anti-microbial cleaning products for the cleaning of equipment and the vehicles. All cleaning products were easy to access in clean clearly marked wall dispensers.

In addition to the electronic app for ensuring cleanliness, we reviewed cleaning logs for all vehicles. We saw that all vehicles were cleaned daily, and deep cleaned following any exposure to bodily fluids, or every six weeks depending on which came first.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

The provider location was not used for patient care. During our inspection we looked at two vehicles which were stationed at the provider location; one of which was awaiting a new tail gate light. One vehicle was in use on the day of the inspection and stored at the hospital with another vehicle.

The vehicles had up-to-date servicing documentation and recent Ministry of Transport (MOT) certificates and we saw records of these. They were clean, well-stocked and equipment was available to enable the moving and handling of patients.

Safety checks to vehicles were made daily via an app on staff work mobile phones. We saw that the check lists included mandatory fields to make sure staff completed all

information. The app also timed entries and made staff could not skip equipment or safety checks. The registered manager could monitor these remotely on the office computer which was secured by personal password details.

Daily vehicle checks included, lights, petrol, mileage, vehicle hoist, tyre pressure and tread. The registered manager was able to make sure that checks had been completed on their computer. The office manager audited these daily. Servicing of the vehicles was in date and we were shown the documentation for all vehicles owned by the provider.

We saw that the automatic external defibrillators (AED) had been recently serviced and had electrical safety testing certificates. Single use defibrillator pads were in date and easily accessible in the event of an emergency.

Records were kept for equipment maintenance and schedules. An external company was used to inspect and check all equipment. The registered manager showed us an invoice that confirmed that all equipment had undergone recent checks.

The vehicles provided bins for normal waste and sharps bins for sharps used by patients who may need to self-administer medication. Sharps bins were dated, but empty on the day of the inspection. The registered manager advised us that these would be given to the hospital for disposal when they were full.

Crew had access to technology which could assist patient mobility and access to the hospital and when they returned home. The ambulance vehicles contained equipment which included, ad defibrillator in the event of a patient experiencing a cardiac arrest; clean sheets and blankets and a trolley with clean mattress covering.

Patients were appropriately secured using vehicle seatbelts, and straps used for wheelchairs and stretchers.

The service had vehicle breakdown cover, and staff had access to the phone numbers.

The vehicles had built in satellite navigation systems, and staff used a mobile device secured to the dashboard in the event of malfunction of the in-built system.

The premises used by the provider provided a space for company administration, staffing and training to take place. The space was suitable to provide administrative support.

On the day of inspection, we saw that one of the fire exits was partially blocked by provider's home contents because they were in the process of moving. We highlighted this to them and they immediately ensured that this was cleared and created another clear route at the back of the premises which they signposted.

The service occasionally carried children and crews had access to child seating equipment.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

There were policies and procedures to support staff to manage and assess risk. The service had a risk management policy which had been recently reviewed. This policy stated 'Assessments relating to the health and safety of service users receiving care and or treatment would be undertaken prior to the commencement of services. Staff followed policies to protect people. However, they did not have remote access to the policies. When staff had queries relating to procedures, they called the registered manger.

Since our last inspection, the provider had worked closely with the local NHS trust to minimise risk. Patients were booked for journeys using an eligibility criterion which was determined by the NHS trust and checked at the start of each journey using the app.

The physical, mental health and social needs were normally assessed prior to transportation by the NHS trust commissioning the service. The registered manager d risk assessed private patients based on their medical condition or mobility. Staff triaged private passengers with a brief list of questions which included medical history, mobility, medication, and property access details.

Patients who were transported and detained under the Mental Health Act were accompanied by a carer provided by the NHS trust. Any private work arranged by the service was risk assessed and planned by the provider through verbal consultation and the smartphone app.

The registered manager told us that when they transported children, they were accompanied by a parent, carer or nurse depending of the outcome of the risk assessment.

Good

Patient transport services

Comprehensive risk assessments were carried out for people who used the service. During our inspection staff showed us how they used the app to assess risk and plan care accordingly. The risk assessment app template included questions relating to the patient mobility, medication sent home with patients, current Do Not Actively Resuscitate (DNAR) documentation and buildings access.

Staff knew the importance of healthcare professionals having access to "Do Not Attemept Cardio-pulmonary Resuscitation" (DNAR) documentation. This document helps medical professionals make decisions relating to cardiopulmonary resuscitation and should always travel with the patient. The service's policy which had recently been reviewed, this reminded staff of the importance of patient choice and consent.

We were told that crew took preventative action at the point of care to keep people in good health and protected from harm. When concerns were highlighted, or patient conditions deteriorated crew told us how they made the appropriate referrals to other health care professionals.

The service did not transfer high dependency patients. Hospital staff told us that the service risk assessed patients before discharge and only moved low to moderate risk patients with mobility problems. For patients requiring end of life transfers home, a trained health care professional accompanied them.

Staff were trained in first aid at work, which meant staff could care for a collapsed patient until the emergency services arrived. The NHS trust who commissioned the provider was aware that the team were not trained as healthcare professionals and therefore risk assessed patients prior to transfer.

Crews knew how to identify deteriorating patients. We asked staff what they would do in the event of a collapsed patient. They told us this had happened in the past and as they were still close to the hospital, they turned around and took the patient to the emergency department staff. Staff said they knew to make the patient safe and call 999 if a patient collapsed on route. All staff were trained to use the defibrillator which was checked daily; we saw records that confirmed this.

The cardiac arrest policy was dated January 2018 and stated that minimal training level at work of first aid, cardiopulmonary resuscitation (CPR) and use of Automated External Defibrillator (AED) equipment must be completed by all staff. Staff told us that in the event of a patient not breathing crew would call an emergency ambulance and begin resuscitation.

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. Managers regularly reviewed and adjusted staffing levels and skill mix.

There were enough staff available with the right skills to make sure that service was safe and that they could respond to unforeseen circumstances.

Since our last inspection, the provider had employed an accounts/governance manager, four full time drivers, one of whom was the lead for training staff. The registered manager also had access to three bank drivers on standby to work during the winter months.

Rotas were based on a four on four off basis and staff told us they were happy with this arrangement. Staff rotas were kept at the office and accessible online or via a printed copy. Any overtime was managed via their staff mobile application.

Staffing cover was assessed and monitored by the registered manager and the hospitals discharge co-ordinator who commissioned the patient journeys. This enabled the service to provide seven day a week cover in line with the requirements of the informal contract between the service and the local NHS trust.

Unfulfilled shifts were covered by the registered manager or one of the extra drivers when necessary. Staff sickness rates were low, and all staff felt supported by their managers to deliver a safe service.

We were told by staff that if they were required to travel long distances then arrangements were made for two drivers to travel and swap driving halfway through the shift.

Since our last inspection changes had been made to the recruitment system and the service made sure that the right staff were recruited to keep people safe from harm through pre-employment checks. The provider had created

a recruitment checklist which included, photo identification, driving license and disclosure and barring checks. Prospective employees were also required to submit references.

Records

It was not a requirement of the service to store patient medical records. These were the responsibility of the NHS trust who made the final decision regarding patient eligibility to use the service.

The service had a patient data policy dated January 2018. This referred to the Data Protection Act (1998) and contained guidance and advice for crews such as not leaving documentation on display. Computers at the office location were made secure by use of staff personal passwords.

The service did not keep any copies of patient's medical records for either NHS or private patients. The crew had access to patient journey risk assessment and requirements during their journeys; via a transport slip provided by hospital staff. Journey information was inputted and stored on the web-based app and could be accessed via the office computer. This app also recorded the crew members, the mileage reading at the start of the journey, vehicle registration and had a section to document incidents.

We saw that on collection of the patient, the crew completed a checklist form via their digital smart app. This included any patient mobility concerns, any personal medication, exposure to infection and a DNAR form. The information was then uploaded to the registered manager or governance lead's main office computer.

Medication

The service did not store or use medication other than oxygen. If patients needed to transport medicines with them on their journey, they reminded the responsibility of the patient throughout the journey.

Oxygen was prescribed to patients by hospital medical staff and was self-administered. Vehicles carried one large and one small oxygen cylinder which were in date and stored safely. Vehicle insurances covered the carriage of oxygen cylinders.

Staff told us they were able to photograph and list controlled drugs that may be sent home with patients in the event of any confusion over what medication had been dispensed by the hospital.

Incidents

The service managed patient safety incidents. Staff knew how to recognise and report incidents and near misses.

During the reporting period there were no concerns raised by people who used the service regarding safety issues reported to the CQC. Furthermore, we were advised by hospital staff that they had no record of any incidents involving the provider.

Safety was monitored using information documented by staff via the smartphone app, which had a drop-down tab that allows staff to record incidents. This information can be accessed via the registered managers main computer system, which means they could remotely monitor information documented on the app. This aspect of the smart app had been used once to photograph a difficult patient access, so staff could inform the NHS trust.

Staff recorded incidents in the incident reporting folder which was stored at the service location. These included road traffic accidents, bad weather alerts, challenging patient behaviour, patients not discharged home with the correct documentation and delays in transferring patients.

There was one minor incident recorded during the reporting period. One minor road traffic collision (RTC) was documented within the folder. This had been fully investigated and clearly documented by the crew and the registered manager. The incident folder contained a section for actions and route cause analysis in the event of other incidents.

The governance lead was responsible for reviewing and investigating safety and safeguarding incidents and events when things went wrong. However, the registered manager told us that the service did not have a formal process for discussing outcomes with staff, partner organisations, or people who use the service. Staff would be informed of changes to policies or procedures via text or email.

External safety alerts were emailed to the registered manager by the NHS trust and messages would be sent to staff. However, there were no formal arrangements for reviewing inquiries or investigations.

Good

Patient transport services

Staff were able to tell us how they would inform patients if things had gone wrong. They would either inform the NHS trust who arranged transportation, or the registered manager. Staff understood the need to be open and honest and comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 Duty of Candour.

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

Good

We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, there was no formal process to monitor staff understanding of changes to policy or guidelines.

The policies that we looked at had been updated within the last three months. Based on recommendations from our last inspection, each policy had been written in line with the provider's practice and relationship with the local NHS trust. There were references within the policies to current evidence based national guidelines. For example, the Mental Capacity Act Policy was aligned to the Mental Capacity Act 2005.

There was a process that made sure staff were informed of changes in policies and review dates, via a spreadsheet on the office manager's system. Staff signed each policy once they had read this and this was checked by the governance lead. However, this was not effective as staff we interviewed had limited knowledge to the contents of the safeguarding policy, which highlighted the lack of staff monitoring on the services' policy contents. The registered manager verbally discussed processes and procedures with staff and verbally highlighted any changes to care and treatment,

The service's naming convention caused the inspection team some confusion and this was highlighted to the provider. For example, the Equality and Diversity Policy we viewed was listed under the main title of Children and Vulnerable Adults Protection Policy and Procedure, with a sub heading of Equality & Diversity which may cause some confusion. The provider immediately rectified these and made sure headings were clear.

Staff had access to the paper copies of policies at the service location and had to sign when they had seen and read the policies. Due to staff working off-site, the provider told us that they were investing in a new system that would allow staff to have remote access to policies in the future.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health if required.

Journeys were planned around patient mealtimes. Water was available on board for patients and in the event of long journeys snack boxes were provided by the NHS trust.

Crews told us they waited for patients to finish their meal at the hospital and often settled patients into their home by making them a drink or sandwich before they left the residence. Hospital staff supported this and told us that patients would feedback how the crew had taken time to make a drink or feed the patient when they arrived home after discharge from hospital.

Response time/Patient Outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

As the service did not have a formal contract with the NHS trust, key performance indicators (KPIs) were aligned to the local hospital's requirements.

Our last inspection noted that the service did not monitor key outcome data; however, this had been rectified. The provider now monitored basic outcomes. These included transport response times, patient journey times and the number of journeys taken during each shift, via the electronic app. This information was fed into the main computer and the registered manager showed us how they could access this data immediately to monitor service response times via the location computer system.

The NHS trust monitored outcomes for people who used the service and compared this with similar services they used to transport patients. We were told by hospital staff

that R&K performed well, and patient outcomes were positive. We were told this was due to crews spending quality time assessing patient care and treatment. The crew were stationed on site at the hospital, this provided quick access and response times.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance them to provide support and development.

The provider made sure that the needs of people were consistently met by competent staff who had the right knowledge, skills, experience, attitudes and behaviours.

The last inspection found gaps in the management and support arrangements of staff. The provider had recruited four full time crew staff who were previously bank staff and an office manager to support the governance and training of staff.

Recruitment and retention were important to the service. We were shown safety was promoted within the recruitment process, which included mandatory disclosure and baring service (DBS), two reference checks per applicant, medical fitness and driving license checks. Staff records confirmed that the service now checked and copied photo identification, and this was stored within staff records, along with address checks. The service also held records of penalty points checks made to the Driver and Vehicle Licensing Agency (DVLA)

One new driver had been recruited in the last year. The new member of staff confirmed that they were subject to DBS and identity checks. They could not start until they had DBS clearance and had completed mandatory training in first aid and use of the defibrillator.

One crew staff member had been given the role of training lead. The staff member was sent on a train the trainer course so that they could implement annual mandatory training and new courses.

Staff had a thorough induction that gave them the confidence and skills to carry out their roles and responsibilities effectively and to meet the needs of the patients. The service had created a formal induction programme since our last inspection and a checklist for all new staff to complete. The induction included safety awareness checks, training and first aid. The registered manager told us they accompanied new staff on journeys for the first few days and then they worked with an experienced member of staff.

We saw from staff records that all staff had performance reviews, which contained development plans, and review dates for training, driving license and DBS checks.

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.

Although the provider had an informal agreement with the local NHS trust, crews could give us examples of how they were included in decisions made by the wider multidisciplinary team of healthcare professionals.

Hospital staff told us the crew were very approachable, hardworking, adaptable to change and would work closely with hospital staff to deliver good quality care.

The service engaged pro-actively with other health and social care agencies to provide individualised care plans for end of life patients. NHS hospital staff told us staff acted upon their recommendations for the best interests of the patient. We were given an example of when the registered manager and crew had liaised with the hospital to transport end of life patients who wanted to return home and made sure that the journeys protected the patient's dignity and safety.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health although they were not formally trained in the Mental Capacity Act (2005).

Staff were made aware if patients had mental health concerns at the point of booking. Staff did not transport patients if they were not equipped to do so and only transferred moderate risk patients who were accompanied by nursing staff or carers.

Good

Patient transport services

The service had a written Mental Capacity Act and Mental Health policy that had been recently reviewed and implemented.

Staff always asked for people to give consent for their care and treatment. Staff considered patients capacity to make decisions and knew what to they needed to do to make sure decisions were made in people's best interests. Staff told us that they would carry out a brief memory function test. Any concerns were discussed with the hospital's discharge co-ordinator. However, there no was no specific training for assessing mental capacity or making best interest decisions. As the service transported patients with limited mental capacity there was a risk that care might not be delivered in a way that best met patients' needs.

Staff were keen to protect the needs of the patients and demonstrated an understanding of dealing with people who lacked mental capacity, one staff member had highlighted to the registered manager that the team would benefit from current dementia awareness training. The registered manager told us they were taking action to implement training in dementia awareness and mental capacity training soon. They showed us an email trail that demonstrated the process to employ a dementia trainer had begun.

Are patient transport services caring?

Outstanding ☆

We rated it as **outstanding.**

Compassionate care

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

The service had a strong, visible person-centred culture and was exceptional at helping people to express their views, so they understood things from their point of view. Staff at all levels were fully committed to this approach.

NICE quality statement 15 statement 1: recommends that patients were treated with dignity, kindness, compassion, courtesy, respects, understanding and honesty. We were given examples of how staff attitudes and values contributed to all aspects of meeting these recommendations.

The hospital used the provider on a regular basis, so we found they had formed good relationships with patients who needed regular visits to the hospital. Hospital staff told us that R&K crew were valued members of the patient transport services used to transfer patients. Staff were regularly seen talking to patients and undertaking risk assessments with the people prior to and after the journey ended, which meant staff were able to provide truly individualised patient centred care.

Staff always protected patient's dignity, they made sure that patients were appropriately prepared for transportation by checking their documentation, assessing their needs and if required using blankets to cover them when required to protect their dignity.

Crews told us that they wanted to care for patients, as they would hope their families would be cared for. The whole team demonstrated a passion for delivering high quality care that put the patient at the heart of the journey.

Although we were unable to witness patient care, we telephoned three, recently transferred patients, one relative, two NHS hospital staff and saw five patient feedback forms that were all positive and complimented staff on their care and treatment of people.

They told us that staff understood and respected the social, cultural and religious needs of the people who used their service. They always listened to people and took the patients' needs into account and we were heard many examples of this from hospital staff and people who used the service. Staff we interviewed could demonstrate an understanding of individual religious and cultural needs. Patients that had special requests around end of life transportation, like being accompanied with valued family members, or time to stop to pray or be reassured by relatives and carers had their needs respected by the service.

We were shown patient feedback forms from the period from January 2019 to October 2019. One relative described the team as "Marvellous". Another stated the crew were always respectful, made them feel safe and ensured they were secure in the vehicle; when they were dropped home, crew made sure they were safe and that the heating was on.

Another patient told us how crew were kind and compassionate which made them feel comfortable and

cared for. On arrival home they went to make the patient a drink discovered they had no milk and went to the shop to buy some, so they would not be left without hot drinks through the night.

Hospital staff told us that the crew often went the "extra mile" in providing care and support, sometimes working over their shift time to make people feel safe and cared for. Staff told us that they always acted with integrity and holistically responded to the needs of the patients they were transporting. The hospital co-ordinator told us that the service was happy to transport one patient at a time with a carer to make sure care was tailored to meet all their needs.

Emotional support

Staff always provided emotional support to patients, families and carers to minimise their distress.

Staff clearly understood the impact that a person's care and condition had on their wellbeing both emotionally and culturally and we were given many examples of this.

Emotional support and information were provided for patients and families, via leaflets, and conversations on route. Crew made sure they told people how to access other support services by giving them patient leaflets and informing carers and relatives.

The hospital staff told us that staff worked well to raise concerns regarding patient's emotional wellbeing. The crew would make frequent visual and verbal assessments of the patients psychological and physical needs. They would routinely take patients home and make them a hot drink and support them, they gave an example of one carer whose partner had died, the staff stayed with the carer and made sure family were contacted before they left the home environment.

We were told by hospital staff that one patient who wanted to travel home at the end of their life, had requested the presence of more than one family member for the journey, because they felt anxious and emotional. The registered manager worked to adapt the vehicle and provided enough staff for the journey, so they were on hand to assist with emotional support for them and their family.

One patient who used the service to travel to a hospital further afield, told us, the crew adapted care to minimise the distress when they had been left stranded by a different patient transport service. The patient told me they had been left feeling upset, and crew ensured that they were comfortable and well hydrated on the long journey; the patient told us that the team were "Fantastic".

The services protected people at risk of isolation and loneliness and recognised the importance of social contact. Patients and staff told us that they would call relatives and carers when and if required to ensure patients were not isolated or alone.

Understanding and involvement of patients and those close to them

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

Staff communicated well with patients and relatives to provide care and treatment that put the patient at the heart of the journey, and we were given examples of this.

Hospital staff told us that they provided patients and relatives collected from home, with clear information about journey times, crew members and length or journeys. People told us they were informed about times they would be picked up before and after appointments. Patients told us they felt able to raise concerns. One example was a patient worried about being stranded after an appointment at a hospital in a different county. She told us staff clearly explained where they would wait for her to contact them when she finished her appointment.

Our inspection team witnessed how the service actively sought to involve patients and relatives in their care via hospital staff statements and patient feedback forms which were shown. This were regularly used by patients and relatives to give positive feedback of the service. We viewed five feedback forms, two stated that staff clearly explained and involved the patients in their care.

Staff cared for and supported people that matter to people who were the end of their life, with empathy and understanding. Staff at the hospital told us that the team routinely took passengers that have specific wishes and ensured patients were involved and respected on their journeys.

Are patient transport services responsive to people's needs?

Good

Patient transport services

(for example, to feedback?)

Good

We rated it 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 the local NHS trust to plan care.

The main service was a patient transport service which provided non-emergency transport for patients and people who were unable to use public transport due to medical conditions. People who used the service were part of the local population. The provider ensured flexibility, choice and continuity. People received consistent, personalised care, treatment and support so they were able to live or receive end of life care where they chose.

Journeys were planned to support the operations of the local NHS staff. Staff at R&K always tried to make sure patients' needs, and choices were met, and took patients that contracted services could not cater for. Discharge staff at the hospital explained that the crew were flexible and receptive to completing longer journeys.

When the inspection team visited the hospital, we found a positive and collaborative relationship with hospital staff and crews. Hospital staff told us that crew understood the challenges within the system and the needs of the local population and made themselves visible to deliver services to meet the needs of patients, carers and relatives.

Meeting people's individual needs

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

Care and support plans were essential to providing good person-centred care. They reflected the patient's needs, choices and preferences. Changing needs were identified by crew during the journey, because normally two crew were used to transport patients one driving and one monitoring patients. Any changes to care could be discussed and planned with patient and their families.

Crews would be made aware of patient conditions by the hospital booking system. The date was entered the provider app which prompted staff to check that patients carried the correct medication and documentation which included discharge information and where relevant a DNAR document.

The ambulances we inspected contained visual aids to assist those people with protected characteristics, for example patients with learning disabilities or dementia. Staff told us that where possible they would transport a carer or a relative with the patient to help with communication and understanding.

We saw that the vehicles contained picture books that were devised to aid patient communication. Staff had used language line and a language translation app on occasions when they transported patients whose first language was not English. Staff told us the hospital usually arranged an interpreter, if needed.

People living with dementia were taken back to care homes with a care home support worker. In unusual circumstances whereby a carer could not attend, then one crew member would sit with the patient and made sure they felt safe by explaining the journey and making reassuring conversation when necessary.

The vehicles had rear access hoists and safety straps, the crew had access to bariatric equipment and stretchers and undertook mandatory moving and handling training which supported transportation of these patients. Bariatric patients were patients whose body mass index (BMI) is over 40, which means providers must make reasonable adjustments to transfer these patients.

Staff told us that patients who had out-of-area and long-distance appointments would be taken by two crew members. Crews would take turns drive and would make stops to allow patients have a comfort break or take some refreshments. Patients told us that the crew would help them gain access to toilets.

Hospital staff told us they engaged with the provider to determine eligibility of patients with complex social needs. We were told how the service played an integral part in providing care that deeply involved the patient and their relatives. We heard how end of life services were tailored to meet the individual needs of the patients. The provider continually developed approaches of crew to sustain the

highest quality emotional support, care and treatment. We heard how staff were highly motivated and inspired to offer kindness and emotional support and were creative in overcoming obstacles to achieve this.

For example, the provider liaised with the multidisciplinary team for end of life care, to transport a patient who wanted to return home to Europe at the end of their life. The end of life team had requested that the patient be transported alongside a nurse and close relatives of the family. Three crew members were used for the journey to make sure safe driving and regular stops were made on route, the team manage to repatriate the patient to their home town.

One patient we spoke with told us that crew had made sure plans were made prior to the trip to assess wheelchair access to their property. The patient told us staff asked permission to take photographs of their doorway, so they could demonstrate to staff at the hospital an issue with width dimensions. Staff kept the patient fully updated on how they planned to move them to the vehicle and made sure the correct wheelchair was available for them to use.

Crew interviewed by us had a good insight into the needs of people with learning difficulties, dementia, mental illness, hard of hearing or deaf. For example, for deaf patients they would write messages down on paper and usually invited relatives to accompany the patient.

Access and flow

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

The service offered cover seven days a week with shift cover from 8.30am to 8pm Monday to Friday and 10am to 6pm at the weekends. However, there was some flexibility we were told by NHS staff that the provider was very flexible and had on occasion help transport patients outside of these hours.

The local NHS trust had a verbal agreement with the provider to provide a seven day a week service. The service provided patient transport for the local NHS trust; bookings were undertaken via direct contact with the trust. The provider focused on the needs of the people rather than their diagnosis.

Due to the flexible arrangement with the NHS trust R&K did not formally monitor access and flow, however the hospital discharge staff advised us that the crew were commissioned by them to support hospital access and flow times. Records showed the service averaged five transfers per day.

The registered manager monitored journey times and liaised closely with the hospital to ensure service times and adequate performance. This fact was later corroborated by the NHS trust discharge co-ordinator. When patient booked privately, the provider would make an assessment over the phone and then plan the journey. Extra crew would be rostered in to cover the private journeys to avoid delays.

The hospital discharge staff told us how they were able to provide their own monitoring of journeys via a route map data base which could track vehicles and highlight any traffic concerns and redirect crews if needed. Journeys were planned and monitored at the hospital site. Provider crews liaised with hospital staff to plan journeys.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

The provider had a recently reviewed the complaints policy and procedure, which stated that complaints would be taken seriously, and initial investigations would be dealt with within 14 days, However, no complaints had been made during the reporting period August 2018 to August 2019.

We saw a patient feedback folder which contained a tool to investigate any complaints, and the registered manager could explain how this was used. Furthermore, hospital staff told us that they had not received any complaints about the service.

The service made sure patient feedback forms were accessible on all journeys, and patients fed back their experiences. There had been no formal complaint since the last report.

Are patient transport services well-led?

Requires improvement

We rated it as **requires improvement.**

Leadership

Good

Patient transport services

The provider was developing skills and abilities to run the service. The registered manager understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. Staff were supported to develop their skills and take on more senior roles.

The overall lead for the service was the registered manager. The provider had created an organisation which included, a human resources and accounts manager who was responsible for governance. An operations manager (who was also a crew member) had recently been appointed as training manager.

The provider told us that after the previous inspection they had entrusted the office manager with the everyday running of the business, but the person had recently left the service.

This had left gaps in the management of the service. The registered manager told us the event had created an opportunity to redefine services. The provider had recruited a new office manager who was responsible for the accounts, governance and safeguarding. Staff we interviewed had the included a volunteer family member who helped support the everyday administration of services.

The provider demonstrated integrity to the inspection team was open and honest and was able to reflect on the shortfalls of the service.

Staff told us that the provider was always available, very approachable and open to suggestions. For example, a staff member had highlighted a gap in dementia training. The registered manager was in negotiations with the local NHS trust to organise and deliver this training for the crew.

The provider encouraged staff development into senior roles and was arranging for one of the crew to attend a train the trainer course. They told us that they were considering rewarding her with a percentage of the business, because the crew member demonstrated the core values of the service and had worked hard to contribute to improvement.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The vision of the service was patient centred and included in the provider's Statement of Purpose which states: "R&K healthcare aim to provide a personalised service that ensures care and support is given in ways which have positive outcomes for everyone". Hospital staff corroborated this statement and it was obvious that R&K crew were highly valued by the NHS trust.

The provider told us that the vision was to provide the best care for those who used the service and maintain their current positive reputation with local NHS trust. The provider understood their limitations and currently had no have plans to grow the business beyond the local population. Nevertheless. they wanted to improve and sustain the current service provided and knew that the services reputation for providing safe and effective compassionate care.

The registered manager told us it was common for small patient transport services to have verbal agreements instead of fixed term contracts.

There was a good understanding between the hospital and R&K. In the current healthcare climate business was sustainable. This was due to access and flow pressures placed on NHS trusts. Since our last report R&K have been provided with a regular workload.

Staff who work from the NHS site, were engaged with the strategy and vision and had regular contact from the leaders and quarterly team meetings. Most of service planning was influenced by the needs of the hospital, who liaised daily with the provider.

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.

Good

Patient transport services

The culture of the service was to treat patients like valued family members. Staff we interviewed showed a passion for delivering a caring safe and compassionate service to the local population. They genuinely cared and valued people who used the service.

Staff we interviewed felt supported respected and valued. One staff member was able to give examples of support they had from the registered manager in developing their knowledge and skills. The lead for training had been actively encouraged to attend a train the trainer course to obtain the skills required to provide staff members with regular training updates.

The provider was proud of the team; they were loyal, reliable and hard working. The registered manager advised that they did not have to take serious action to address staff behaviour because everyone worked as a team and currently there were no issues that affected performances.

There was a positive culture within the service, where patients and their families and staff could raise concerns without fear. Staff were encouraged to be open and honest at all levels of the organisation, this included people who used the service. The registered manager was passionate about the team, and acted with integrity and when concerns were raised, and acted upon them. For example, one staff member highlighted the fact that currently the provider does not offer dementia training for staff, the RM was actively seeking to rectify this situation, to ensure staff had the knowledge and skills to provide a high-quality service.

Patients told us that they felt able to speak to the crew freely and that the crew were helpful, professional and kind.

The provider recognised the importance of promoting equality and diversity within the team. There was a service policy for staff equality and diversity, which demonstrated the services open culture, but this was listed and the Children and Vulnerable adults heading. We highlighted to the provider who immediately rectified this. Staff we spoke to felt they were treated as equals. However, nobody was currently employed with protected characteristics under the Equality Act 2010..

Staff were co-operative and shared workload and care responsibility. The crew had set up a closed social media group whereby they could liaise with each other, to work collaboratively, swap shifts and when required arrange cover.

Governance

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

The new governance lead had been provided with level 3 safeguarding training. In the last four months they had reviewed and revised all the company's policies in line with current national guidelines and legislation. However, on the day of our inspection they were not available for interview.

The governance lead was responsible for reviewing and updating policies, and was appointed the safeguarding lead and accounts manager and divided their working time to manage each aspect of the role. We viewed policies that had recently been reviewed, and we saw that the service had asked all staff to sign to acknowledge the updated documents.

There was ample opportunity at the services location for all staff to speak to the governance lead, or registered manager. Staff told us that changes to procedures were provided to staff via emails or team newsletters which we were shown. Any staff concerns could be explored via phone calls or in person at the service location.

On the day of our inspection we asked the registered manager what incidents needed to be reported to the CQC. The provider was not fully aware of the contents of the safeguarding policy. We found that the service failed to provide correct governance processes for notifications of incidents under Regulation 17 1,2 (f) of the Care Quality Commission (registration) Regulations 2009 (Part 4) this was a breach of regulation and we issued the provider with a notice to make immediate changes and update staff.

The registered manager acknowledged the lack of clarity and took swift action to make changes. After our inspection, the RM revisited policy and made sure staff were updated about their responsibility to the service. A paragraph was included in the policy regarding the

responsibility of the service to notify the CQC, and local authority in the future of any concerns relating to abuse or abuse of patients. Staff were also sent a letter which included the updated changes and we were shown evidence of this.

Despite this, staff we spoke with said they had clear roles and understood what they were accountable for. However, the inspection team noted crew reported to the local NHS trust. Therefore, accountability for safeguarding and patient care was seen to be the responsibility of the hospital until our inspection.

Managing risks, issues and performance

Leaders used systems to manage performance effectively. They recognised relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Since our last inspection, the provider had introduced a business continuity policy which had recently been reviewed. The policy included details on how to manage, major increase to demand, major incident, fuel disputes and widespread illness. The service had processes to manage current and future performance. For example, they had two back up vehicles in the event of vehicle breakdown. They had three bank staff available to cover staffing disruptions, and they were able to adapt vehicle tyres for seasonal weather conditions.

Crew managed risk assessments well via the service smart app and which we were shown. Staff who identified risks could enter the information in the 'incident' tab of the telephone smart app. The electronic app used by staff contained a portal whereby staff could document risks, examples given were, vehicle defects, equipment defects, road traffic collisions (RTC) and access issues.

The service had a corporate risk register, but there were no entries in this. The registered manager told us that the service would only normally document moderate to major risks.

The provider had a risk reporting process in place for staff to report issues that could impact on the service for example vehicle or mechanical breakdown, short staffing, and delays in transfer that may affect patient's conditions.

We saw evidence that two service risks had been investigated. However, there was no evidence of shared lessons learned with the whole team and the wider service to mitigate risk.

The key pressure faced by R&K healthcare was the lack of fixed contract with the local NHS trust that provided most of their patients for transportation. The provider was reliant upon trust and the good reputation of the service to ensure the future of the business.

Managing information

The service collected reliable but limited data and reviewed it but did not always use it to inform improvement. The information systems were integrated and secure.

The provider demonstrated an understanding of performance, the service was able to collect information of performance, operation and finances. However, there was no clear method of using this data to improve services changes.

Improvements were either made based on verbal agreements, between staff and the requirements of the local hospital that commissioned their service. We highlighted this to the registered manager who hoped that the new technology being installed would enable the service to act upon themes to drive forward changes.

Since our last inspection, the service kept accurate data including journey times, crews would notify the NHS trust of any delays due to road traffic conditions and reasonable adjustments to workload can be made.

The registered manager was able to monitor data relating to journey response times, and travel times and adjust workload accordingly, via the web-based app. However, effectiveness of these arrangements could not be clearly described by the provider because the service was influenced by information collected by the local NHS trust.

The provider had recognised that there were limitations in managing paper staff records, and policies and was in the process of moving all aspects of the business to a digital management system.

During our inspection we were shown plans to update technology. The new digital system included a new staff app, which would provide access to e-learning modules, policies and staff rosters. An external company had been

commissioned to manage to the service's HR and training needs and remote access to company policies. The new systems were due to be introduced by mid-November 2019.

The provider was unable to advise us on the effectiveness of ensuring data or notifications were submitted to external bodies and was not fully aware of what notifications they needed to send to the CQC. We reminded them that they should access the CQC provider portal and familiarise themselves with all the recommendations.

Engagement

Leaders and staff actively and openly engaged with patients and staff. They collaborated with partner organisations to help improve services for patients.

The registered manager told us that the service does not hold regular formal engagement meetings for staff. They take a more informal approach and meet quarterly after work to discuss business, however no minutes of these meetings were taken or stored. The registered manager told us they arranged a quarterly staff meeting, but there were no minutes to support this. The provider updated staff either face to face or via the services closed social media group, of any changes to service planning and delivery.

The registered manager told us that quarterly team outings were arranged to help staff discuss concerns, outcomes and updates in care. However, formal minutes were not taken of any meetings**.**

Since our last inspection people's views and experiences were gathered via patient feedback forms that were available on the vehicles. Records were kept of feedback were stored in folders at the provider location. When we reviewed these there had been no negative feedback during the reporting period from August 2018 to August 2019.

The registered manager was able to identify common themes amongst patients that used the service. Staff liaised with hospital staff to make any required changes to the service. journeys and equipment could be adapted to promote equality.

Interactions with partners, for example the local NHS trust or care homes were on an ad-hoc basis. The registered manager liaised with hospital staff and vice versa; however, the team did not attend regular external meetings with the wider third-party agencies within the local community.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.. Leaders encouraged innovation and participation in new models of care.

It was clear to the inspection team that the registered manager was pro-active and keen to continuously develop their staff through continuous learning and improvement measures. The provider had resourced and employed an external company to provide a more robust HR and training system. The service digital software systems were being updating to allow all staff open access to policies, procedures, and collect more robust data that could be monitored and audited.

The provider anticipated the new style app would improve services and collect data that could maintain current business strategies and influence future service development.

The registered manager had learnt from previous recommendations of our last inspection had made some improvements that helped staff provide a better service. The registered manager had good reputation amongst the local population was clearly explained by staff at the local NHS trust. The provider promoted a caring culture whereby all staff felt comfortable to explore new ways to improve and develop. Staff strived for excellence trough consultation and reflective practice.

Outstanding practice and areas for improvement

Outstanding practice

- The service provided a one to one service that was patient centred, holistic, compassionate and tailored to people's individual needs. Crews went the extra mile to make people safe from harm and isolation. It was not unusual for the crew to make hot drinks and food for people when they arrived home, or for crew to call family members or carers to make sure people were not isolated. They included people and families in the decisions at every point of the care pathway.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all notifications required by the regulations must be submitted to the CQC in line with the regulations. (Regulation 17 1,2 (f) of the Care Quality Commission (registration) Regulations 2009 (Part 4).

Action the provider SHOULD take to improve

- The service should provide training in dementia awareness or mental capacity act 2005 for all staff.
- The service should review its risk reporting strategy, the internal risk register should be managed more effectively with clearly defined pathways, that categorise, minimal, moderate and major risks and have methods to update staff on outcomes.
- The service should create a policy for caring for people with protected characteristics under the Equality Act 2010.
- The provider should meet with staff formally on a regular basis and take minutes of the meetings and keep records of actions to make sure changes were safely implemented and concerns followed up.
- The service should undertake more regular audits, for infection control, safeguarding reports and track seasonal workload.

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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 1,2 (f) of the Care Quality Commission (registration) Regulations 2009 (Part 4).