

Kent Central Ambulance Service Ltd

Kent Central Ambulance Service Ltd

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 known to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location

Good



Emergency and urgent care services

Not sufficient evidence to rate



Patient transport services (PTS)

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Kent Central Ambulance Service Ltd is operated by Kent Central Ambulance Service Ltd. The service provides emergency and urgent care and patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 28 May 2019, along with a patient telephone interview on 29 May 2019.

This was the service's first inspection since registration.

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.

NHS non-emergency patient transport services help people access healthcare in England. It is free at the point of use for patients who meet certain medical criteria and are unable to use public or other transport. This service was subcontracted to provide support to primary contract holders that supply this service to the people in Maidstone and the surrounding area including parts of London.

The service also provides high dependency transfers for patients travelling between hospitals. This is the only aspect of the service that is provided under the emergency and urgent care section.

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

We rated it as **Good** overall because:

- The service ensured that only staff that had completed mandatory training could be involved in patient care.
- The service adapted to the changes in infection control practice for several contract holders.
- The service had high standards of cleanliness and had invested in an external service to monitor their cleaning performance.
- The service had effective systems to keep their equipment maintained.
- The service kept patient records up to date and secure.
- Patient feedback was positive about the services staff being courteous and caring.
- Stakeholders reported the services as very professional and working together for service improvement.
- Staff reported the leadership team were very open and approachable. Also, that they felt supported in their roles by their managers.

However,

- The service did not record investigation outcomes for all incidents or document reasons for not having investigation outcomes.
- The service was not reporting concerns of abuse directly to the local authorities but changed their practice immediately on being told this was their responsibility.
- The service had limited support for patients who required additional support with communication.

Summary of findings

- Crews had limited awareness of the service's vision and strategy.
- The service did not have a structured approach to governance.

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, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected patient transport services and emergency and urgent care services. Details are at the end of the report.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service

Rating

Why have we given this rating?

Emergency and urgent care services

Not sufficient evidence to rate



Urgent and emergency services were a small proportion of activity. The main service was patient transport services. Where arrangements were the same, we have reported findings in the patient transport services section.

The service provided high dependency transfers for patients that needed to travel between hospitals. These patients due to their needs could not travel with a patient transport service.

Patient transport services (PTS)

Good



The service was a sub-contractor for several larger providers to provided non-emergency patient transport service to the areas around Maidstone.

Kent Central Ambulance Service Ltd

Detailed findings

Services we looked at

Emergency and urgent care; Patient transport services (PTS)

Detailed findings

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Background to Kent Central Ambulance Service Ltd

Kent Central Ambulance Service Ltd was operated by Kent Central Ambulance Service Ltd. The service opened in February 2018. It was an independent ambulance service in Maidstone, Kent. The service primarily serves the communities of the areas around Maidstone.

The service undertook work on an ad-hoc basis from larger providers of patient transport services. The service had two senior managers and five office staff. The service also had 70 vehicle crew on a mixture of zero-hour contracts and self-employed contracts. This allowed them to adapt to the changes in demand each day. They

offered transport services for people attending outpatient appointments and admissions or discharges from hospitals and inter-hospital transfers. This included high dependency transfers. The service transported adults and children of all ages including babies.

The service had a registered manager in post since February 2018 and at the time of the inspection they were registered with the CQC.

We had not inspected this service before.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC assistant inspector, and a specialist advisor with experience ambulance services.

The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection (South East).

How we carried out this inspection

During the inspection, we visited their base in Maidstone and accompanied a crew on a vehicle. We spoke with 12 staff including; crew, office staff and management. We spoke with one patient and looked at five compliments

sent to the service by patients. During our inspection, we looked at 14 sets of patient records, ten of these patient records were for patient transport and four were for high dependency transfers.

Detailed findings

Facts and data about Kent Central Ambulance Service Ltd

The service is registered to provide the following regulated activities:

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

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

Activity (May 2018 to April 2019)

- There were 1,307 high dependency transfer journeys undertaken.

- There were 15,023 patient transport journeys undertaken.

Track record on safety

- Zero never events.
- Clinical incidents; 32 no harm, ten low harm, six moderate harm, zero severe harm, zero death.
- One serious injury.
- Zero complaints.

The service had service level agreements with companies to collect clinical waste, carry out testing on the effectiveness of their cleaning, and with a local NHS trust to allow crews to clean vehicles at hospitals.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Patient transport services	Good	Good	Good	Good	Requires improvement	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Emergency and urgent care services

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

Information about the service

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

The service provided high dependency transfers for patients requiring transfer between hospitals. These would include patients that needed additional support during transport such as cardiac monitoring or high flow oxygen therapy. The service did not undertake any other aspect of emergency and urgent care. Responding to 999 calls was not part of their service.

Summary of findings

We found the following areas of good practice:

- The service ensured that only staff who had completed mandatory training could be involved in patient care.
- The service adapted to the changes in infection control practice for several contract holders.
- The service had high standards of cleanliness and had invested in an external service to monitor their cleaning performance.
- The service had effective systems to maintain their equipment maintained.
- The service kept patient records up to date and secure.
- Patient feedback was positive about the services staff being courteous and caring.
- Stakeholders reported the services as very professional and working together for service improvement.
- Staff reported the leadership team were very open and approachable. Also, that they felt supported in their roles by their managers.

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

Emergency and urgent care services

- The service did not record investigation outcomes for all incidents or document reasons for not having investigation outcomes.
- The service was not reporting concerns of abuse directly to the local authorities but changed their practice immediately on being told this was their responsibility.
- The service had limited support for patients who required additional support with communication.
- Crews had limited awareness of the service's vision and strategy.
- The service did not have a structured approach to governance.

Are emergency and urgent care services safe?

Not sufficient evidence to rate



We inspected this service as part of our inspection process. However, we were unable to provide a rating for this core service due to insufficient evidence to support a rating decision.

Incidents

- **The service managed patient safety incidents. Staff recognised incidents and near misses and reported them appropriately.** When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. Managers investigated all incidents however this was not always clearly documented.
- See patient transport service section for main findings.
- The service had 13 incidents reported by high dependency transfer crews. However, managers were not able to confirm which incidents related to high dependency transfer and which to the patient transport services as the crews undertook both types of work. The service investigated incidents reports by these crews the same as they would for patient transport services core service.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- See patient transport service section for main findings.
- The service had specific training for crews carrying out high dependency transfers. These staff were required to do their yearly mandatory training and also a first response emergency care level three course. This course also had a refresher training each year. Records we looked at showed the 24 staff carrying out high dependency transfers were up to date with their training and that three staff were not up to date. Managers told us that these three staff had left the service.

Emergency and urgent care services

- The service ensured that all staff driving on blue lights had been trained. The service had a blue light training program. Crew that were certified to use blue lights had up to date training. We looked at three records that contained blue light certificates.

Safeguarding

- **Staff understood how to protect patients from abuse, the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse.
- See patient transport service section for main findings.

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.
- See patient transport service section for main findings.
- The service adapted to the changes in infection control practice for several contract holders. As crews could work for different contract holders each day and the information provided was not consistent as each of these had their own process to follow. Staff told us that they adapted to each of the different providers ways of working. Crews would also ask staff or the patient when collecting them about mobility and any relevant medical history. Crews recorded this information for high dependency transfer patients.
- The service provided the same level of training on infection control to their high dependency transfer staff as they did for their patient transport service staff.

Environment and equipment

- **The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- See patient transport service section for main findings.
- High dependency transfer vehicles were equipped with a cardiac monitor, nitrous oxide, and electric power outlets to supply additional medical equipment. Managers told us that as these journeys were pre

planned and if any medical intervention would be required during the journey a qualified nurse or medical escort from the hospital would travel with the patients and be responsible for these actions.

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.
- See patient transport service section for main findings.
- The service recorded more detail in relation to risk for high dependency transfers than for patient transport service. This included a section for current medical treatment. We looked at one record that included details of the patient's current oxygen therapy in use and intravenous fluids currently running. This record also detailed that a nurse would be acting as escort and what aspects of the patients care this escort would be responsible for. Managers confirmed crews did not handle intravenous fluids so if a patient has these running they would be occupied by a health professional from the hospital.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- See patient transport service section for main findings.
- The had systems to select staff with the correct skills and training to carry out high dependency transfers. The service had a spreadsheet which we reviewed and we found it included the training staff had completed and the skills they had. This included a column that identified if the staff member was a patient transport service staff member or an emergency care assistant. The service also had some staff recorded as advanced ambulance care assistants which was an old term for emergency care assistant. Only those recorded as emergency care assistants or advance care assistant were asked to work high dependency transfer shifts.

Emergency and urgent care services

- The service did not recruit any staff as registered health care professionals and if a transfer required medical interventions then a nurse or medical escort would be required.

Records

- **Staff kept records of patients' care and treatment.** Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- See patient transport service section for main findings.
- The service recorded clinical information for patients on high dependency transfers. For these transfers crews completed a patient record form. We looked at four forms and saw staff had fully completed these including; name, date of birth, past medical history, allergies, current medical condition and treatments, if an escort was needed, and mobility of the patient. They also included clinical observations including; pulse, oxygen saturations, blood pressure and respiration rate. The service did not carry out audits on these records to ensure they were being completed in their entirety and to an expected standard.

Medicines

- **The service used systems and processes to safely administer, record and store medicines.**
- See patient transport service section for main findings.
- The service had an up to date medicine policy that described the safe administration of oxygen and nitrous oxide. We looked at records which showed the service had a service level agreement with a private supplier to restock their oxygen and nitrous oxide supply when needed.
- Staff who transport patients via high dependency transfer received training on the administration of oxygen and nitrous oxide.
- Staff recorded if they used nitrous oxide or not on patient records and records we looked at indicated this.

Are emergency and urgent care services effective?

Not sufficient evidence to rate

We inspected this service as part of our inspection process. However, we were unable to provide a rating for this core service due to insufficient evidence to support a rating decision.

Evidence-based care and treatment

- **The service provided care based on national guidance.** Managers checked to make sure staff followed guidance.
- See patient transport service section for main findings.

Response times / Patient outcomes

- **The service monitored the effectiveness of their care. They used the findings to make improvements.**
- See patient transport service section for main findings.
- The service recorded their journey times. We looked at four patient records that showed the service had pick up and drop off times recorded. However, the service had no performance indicators against which to monitor their performance.

Competent staff

- **The service made sure staff were competent for their roles.** Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- See patient transport service section for main findings.
- High dependency staff were given additional training to keep them competent for this role. This course included airway management, medical gases, patient monitoring, and automated external defibrillation.
- The service had reviewed this training and were moving to use a new training system. This was similar to the course they had been using but was said to be being used nationally by similar service providers. Manager told us that this was to improve the standard of their training and make their training in line with the other

Emergency and urgent care services

services that they worked alongside. At the time of our inspection they had trained 12 staff on this new course. The service set a standard of achieving level three to be able to be part of a high dependency crew.

Multi-disciplinary 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.**
- See patient transport service section for main findings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their journey.** They knew how to support patients who lacked capacity to make their own decisions.
- See patient transport service section for main findings.

Are emergency and urgent care services caring?

Not sufficient evidence to rate

We inspected this service as part of our inspection process. However, we were unable to provide a rating for this core service due to insufficient evidence to support a rating decision.

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- See patient transport service section for main findings.

Emotional support

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- See patient transport service section for main findings.

Understanding and involvement of patients and those close to them

- **Staff provided emotional support to patients, families and carers to minimise their distress.**
- See patient transport service section for main findings.

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

Not sufficient evidence to rate

We inspected this service as part of our inspection process. However, we were unable to provide a rating for this core service due to insufficient evidence to support a rating decision.

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local people.**
- See patient transport service section for main findings.
- The service has capacity to supply vehicles and crews 24 hours a day, but they only deployed crews when specifically requested and they mostly received request for cover between seven in the morning and midnight.
- The service also supplied crews and vehicles for shifts that covered high dependency transfer journeys. The contract holder would specify if they needed a crew that could undertake high dependency transfer journeys. When they needed this the service would only contact their staff that were competent in high dependency transfers.

Meeting people's individual needs

- **The service took account of patients' individual needs. The service made reasonable adjustments to help patients access services.**
- See patient transport service section for main findings.

Access and flow

- **People could access the service when they needed it.**
- See patient transport service section for main findings.
- The service did not have any specific processes to monitor their high dependency transfers.

Emergency and urgent care services

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service had a policy that described that they would investigate concerns or complaints and shared lessons learned with all staff, including those in partner organisations. In the reporting period they had not had any formal concerns or complaints.**
- See patient transport service section for main findings.

Are emergency and urgent care services well-led?

Not sufficient evidence to rate

We inspected this service as part of our inspection process. However, we were unable to provide a rating for this core service due to insufficient evidence to support a rating decision.

Leadership of service

- **The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.**
- See patient transport service section for main findings.

Vision and strategy for this service

- **The service had a vision for what it wanted to achieve and formative plans to turn it into action. However, staff lacked awareness of the vision.**
- See patient transport service section for main findings.

Culture within the service

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

- See patient transport service section for main findings.

Governance

- **The service did not have formal systems to improve service quality and standards of care. However, they did have informal processes to look for improvements.**
- See patient transport service section for main findings.

Management of risk, issues and performance

- **The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**
- See patient transport service section for main findings.

Information Management

- **The service collected and managed information well to support all its activities, using secure electronic systems with security safeguards. However, did not always analyse or use this information to seek improvement.**
- See patient transport service section for main findings.







Public and staff engagement

- **The service engaged with patients, staff, and local organisations to plan and manage services, and collaborated with partner organisations effectively.**
- See patient transport service section for main findings.

Innovation, improvement and sustainability

- **The service was committed to improving services by learning from when things go well and when they go wrong, promoting training and innovation.**
- See patient transport service section for main findings.

Patient transport services (PTS)

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

Information about the service

The service undertook work on an ad-hoc basis from larger providers of patient transport services. The service had two senior managers and five office staff. The service also had 70 vehicle crew on a mixture of zero-hour contracts and self-employed contracts. This allows them to adapt to the changes in demand each day. They offered transport services for people attending outpatient appointments and admissions or discharges from hospitals and inter-hospital transfers.

Summary of findings

We found the following areas of good practice:

- The service ensured that only staff that had completed mandatory training could be involved in patient care.
- The service adapted to the changes in infection control practice for several contract holders.
- The service had high standards of cleanliness and had invested in an external service to monitor their cleaning performance.
- The service had effective systems to keep their equipment maintained.
- The service kept patient records up to date and secure.
- Patient feedback was positive about the services staff being courteous and caring.
- Stakeholders reported the services as very professional and working together for service improvement.
- Staff reported the leadership team were very open and approachable. Also, that they felt supported in their roles by their managers.

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

Patient transport services (PTS)

- The service did not record investigation outcomes for all incidents or document reasons for not having investigation outcomes.
- The service was not reporting concerns of abuse directly to the local authorities but changed their practice immediately on being told this their responsibility.
- The service had limited support for patients who required additional support with communication.
- Crews had limited awareness of the service's vision and strategy.
- The service did not have a structured approach to governance.

Are patient transport services safe?

Good



We have not previously inspected this service. We rated it as **good**.

Incidents

- **The service managed patient safety incidents. Staff recognised incidents and near misses and reported them appropriately.** When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. Managers investigated all incidents however this was not always clearly documented.
- NHS England defines and publishes a list of never events, reviewed yearly in consultation with healthcare providers and other stakeholders. Providers are obliged to report never events for any patient receiving NHS funded care and the occurrence of never events may highlight potential weaknesses in how an organisation manages fundamental safety processes.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Never events relevant to patient transport services include chest or neck entrapment in trolley (or bedside) rails. Managers told us that they had not had any never events in the past 12 months.
- The service had one serious incident reported in the past 12 months which related to moving and handling. We looked at records showing the service were carrying out an investigation and were working with other agencies. The investigation included statements from the crew involved, a review of the events, and route course analysis. They had not completed the investigation process for this but had a timeline to complete this.
- The service had recorded 48 incidents during the reporting period. There were 35 that were reported by patient transport service staff. The remaining 13 were reported by high dependency transfer crews but as these crews also do patient transport service work they

Patient transport services (PTS)

could have been patient transport incidents. These incidents included reports of safeguarding, vehicle damage, patient safety incidents, and administration issues.

- The service had systems to grade incidents. We looked at their policy which had been reviewed in 2019, and this clearly defined each incident type and grade. We looked at an email a manager had sent with the definitions of each type of incident as a reminder to staff. However, staff and managers were not clear on these definitions. Their policy identified which types of incidents should be investigated. However, as definitions of incidents was unclear with staff we were not assured all opportunities for learning from incidents were taken.
- Staff knew how to report safety incidents. We spoke with five staff about incident reporting and all knew how to report incidents. Staff used paper forms to record incidents. They would also report that an incident had occurred to the services control room and the contract holders control room.
- The service investigated incidents. Managers reported all incident were investigated but there was not always a formally investigation record. We looked at six incident records. Four had investigations. These included statements taken from crews and evidence related to the incidents. Three had outcomes and learning that had been shared. One of these four had no outcome recorded as the incident related to a crew member who left the service before the investigation had been concluded.
- Managers showed us a document that showed a manager had reviewed the two records without investigations. However, this record had no information about why there was no investigation. Following the inspection, the service shared with us documents that showed they have up dated their incident forms to include sections for recording the outcome, investigation ownership, and lessons learnt.
- The service investigated incidents when asked to by stakeholders. Managers told us the four incidents with investigations were investigated following requests from the primary service contact holder. One of these was related to staff not reporting a near miss, the service had

taken statements and had produced a lesson learnt bulletin. We reviewed this, and it reminded staff that they needed to report near misses and how to do this. This was shared with staff via a notice board and email.

- Staff received lessons learnt information. We asked two staff that both told us they had seen the lessons learnt bulletins. However, they also reported that they did not receive feedback from individual incidents that they raised.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The service had identified staff roles and which training courses they needed to complete. The service had two different levels of training requirements. Crew that did patient transport services only did their one-day face to face yearly mandatory training. This covered safeguarding children, protecting vulnerable adults, mental capacity, infection control, moving and handling, first aid at work and understanding dementia. We looked at records that showed that 19 staff were up to date with this mandatory training and that five were not up to date. We were shown information that these five staff members for a variety of reasons were not working with patients and therefore did not require training.
- The service had mandatory training target of 100%. The five staff files we looked at all had up to date training certificates. The monitoring records were out of date but on inspection we confirmed that all crew that were working were up to date with their training.
- Managers told us the training summary they submitted to us was not up to date and did not have an up to date summary to provide at the time of inspection. The service had recently recruited a compliance officer but were still working to update the training summary. A manager told us that this was a high priority and they had set a target for this to be completed by the following week.
- The service had systems to remind staff to complete their mandatory training. Staff told us that when they

Patient transport services (PTS)

were due to do mandatory training they would get an email reminder. Staff and managers told us that they were aware of who needed training and reminded them to book onto a course before their training expired.

- The service had reviewed their training matrix and were moving to use a new training system. This was the first response emergency care system used nationally by similar service providers. Manager told us that this was to improve the standard of their training and to make the training inline with the other services that they work alongside. At the time of our inspection they had trained 12 staff.
- The service did not allow staff that were out of date with their training to work until completing their training. Managers told us that they would not allow staff to be allocated shifts until they were up to date with their training. They also told us staff who with a substantive role with another provider and had completed equivalent training this would be acceptable as long as they provided a completion certificate. We looked at a staff record that included photocopies of accepted certificates.
- The service had a mixture of zero-hour contracted staff and self-employed staff that crew the vehicles. Managers told us that this did not affect the requirements for them to complete all the same training.

Safeguarding

- **Staff understood how to protect patients from abuse, the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse.
- The service had an identified safeguarding lead to provide support to the service. This was the registered manager and they were trained as a designated safeguarding officer at level 3 for both safeguarding children and protecting vulnerable adults. Managers told us they had plans to train their safeguarding lead to level 4 and then level 5 in both safeguarding children and protection vulnerable adults.
- The service had an up to date safeguarding policy that had been reviewed this year. This was written in line with some national guidance but did not include the need to notify the care quality commission if a concern

of abuse or risk of abuse was identified. The service also did not follow their policy as they did not routinely notify the local authorities directly. The service had been notifying the safeguarding lead from the NHS trust that the patient was being taken to or from. The service also reported these concerns to the contract holder that they had been subcontracted by using their respective reporting systems.

- We identified to the service that they had a responsibility to report these concerns directly to the local authorities. The service immediately changed their practice to comply with this. They also did a retrospective review of their previous incidents and reported this to the relevant local authorities.
- Crews were trained in “safeguarding children in social care settings” and “safeguarding adults home care 9” within their yearly one-day mandatory training. A review of five staff files showed they had completed both of these safeguarding training courses. The certificates did not include a level however the service produced records to show these were for level 1, 2 and 3. However, this training did not fulfil the requirement in the intercollegiate document (2019) “safeguarding children and young people: roles and competencies for healthcare staff” for example at level three the required training time was eight hours of study for safeguarding children. The service was currently doing their safeguarding children and vulnerable adult training courses in one day of training which did not leave enough time to complete the required time.
- Staff had a good understanding of how to report concerns of abuse. We spoke with five staff that could all describe the way they would report a concern. Crews would report a concern to the services control room, complete an incident form that would be taken back to the base at the end of their shift and they would report their concern to the control room of the primary contract holder. The services control room staff would alert the safeguarding lead for the related trust.
- The service had an up to date policy on prevent. The prevent strategy is a government initiative to; protect vulnerable people, challenge the ideology that supports terrorism, and support action against radicalisation.

Cleanliness, infection control and hygiene

Patient transport services (PTS)

- **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.
 - We looked at their infection control policy which was up to date. This was based on national guidance. We saw colour coded mop handles and buckets for each vehicle. The mop heads used were single use so were thrown away after each use.
 - The service had commissioned a specialist company for support with their infection control and prevention. This service monitored the effectiveness of their cleaning processes by swabs taken from several areas in the vehicles before and after cleaning. We looked at a record that showed before and after results of contamination levels. They also support the service with infection control training for their staff. We saw records showing staff had completed this training.
 - Vehicles and equipment were cleaned and decontaminated to ensure patients and staff were protected from acquiring infections during their journey. We saw staff using wipes to disinfect equipment. We looked at records that showed when vehicles had been deep cleaned last and when they were due to be completed. Vehicles were deep cleaned every six weeks. The five vehicles and the equipment we saw was visibly clean.
 - The service had procedures for cleaning vehicles that become very dirty. These were either brought back to the base to be cleaned or could be cleaned at local NHS trust hospital sites, the service had an agreement with.
 - All crew that we saw were bare below the elbow in line with the service's policy and the crew's uniforms were visibly clean.
 - The service carried out hand hygiene audits. The service had recently purchased an ultraviolet light box to provide practical training for staff in hand hygiene. We looked at their hand hygiene audit that had been completed with all staff and achieved 100% compliance. A manager told us that this was done with all staff during the introduction and would be continued monthly.
 - The service had effective cleaning procedures for their premises. The base, vehicle garage, toilets, kitchen area and crew room were visibly clean tidy and not cluttered.
 - The service adapted to the changes in infection control practice for several contract holders. As crews could work for different contract holders each day the information provided was not consistent as each of these had their own process to follow. Staff told us that they adapted to each of the different providers ways of working. Crews would also ask staff or the patient when collecting them.
- ## Environment and equipment
- **The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
 - The service had a contract for annual equipment testing. We checked 15 items, and all had service labels and equipment records showed all the items had been tested and serviced in line with manufacturers' specifications. This included five automated external defibrillators.
 - The service had an effective system to restock their vehicles. The five vehicles we checked had been restocked. This included clean linen supplies, cleansing wipes, hand-cleansing gel, and protective equipment such as gloves. We saw in the five vehicles we check that all gas cylinders were securely stored.
 - The service stored vehicle keys securely. We saw that vehicle keys were kept inside the building within a locked crew area. This was accessed by a key code on the main entrance door, and then a key code locked key safe to get the key to the locked crew area. This prevented unauthorised staff from accessing the vehicles.
 - The service had systems to ensure that vehicles maintenance was completed. The service had employed a dedicated mechanic to carry out maintenance on their vehicles. We looked at five vehicle service records. These included; an up to date department of transport (MOT) certificate, deep clean record, vehicle tax record, user guide, vehicle log book (V5C), and vehicle defect sheet with record of repair works. Managers told us that servicing was done every

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15,000 miles. We looked at records which showed vehicles were serviced in line with this guidance. We looked at records which showed mileage was recorded each day a vehicle was used. Managers told us this was then added to totals recorded for each vehicle and alert were triggered at pre-set limits to prompt when servicing was due.

- Vehicle defects were reported using a communication sheet. This was handed over to the service's mechanic. This included equipment that was faulty, the service had a contract with a service that provided maintenances of their equipment. We looked at records that showed crews reporting faults and completion of repairs. Crew told us that they had access to the equipment they needed.
- The five vehicles we checked had good external condition, had no worn tyres or excessive rusting. They also had functional and well-maintained communication equipment.
- The service provided protective equipment and cleansing products to promote effective infection control. We saw in the five vehicles we checked that they had; hand-cleansing gel, decontamination wipes, clean linen, clinical waste bin, and gloves.
- All staff received training in the manual handling equipment. We looked at records that showed this was also covered yearly in their update training.
- There was limited parking for office staff. The service had identified this as an issue and had acquired more parking permits for them to use.
- The service had arrangements for managing waste that kept people safe. We saw clinical and non-clinical waste was segregated correctly into different coloured bags in line with national guidance. We also saw in vehicles that the clinical waste bins had been recorded when the bag was last changed. Clinical waste was stored securely in locked bins while awaiting collection by a service they had contracted for disposal.

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.

- The service had processes to alert vehicle crews to patient risks. Managers told us that their crews received patient information by phone from the control room of the service that had subcontracted that day's work, and this was then recorded on the crew's work sheet. We saw this information when we looked at these work sheets. Crews we spoke to confirmed they received information about patients in this way. Crews also told us that they felt most of the time this information was sufficient for effective care. Two crew told us that they would also talk with patients and staff when collecting patients to confirm the information they had been given. They would also ask for any other information of concern at pick up.
- The service recorded information about risks. We looked at ten patient records that all showed mobility level and if an escort was travelling with them and the reason for an escort. One of these records also had a special note about access to the property at the destination.
- We reviewed five risk assessments that managers had produced for tasks that crews completed including the use of wheelchair, stretcher, carry chair, and first aid. These had descriptions about the risk, the training required to do the action, and mitigation that should be used such as protective equipment.
- The service had an up to date policy based on national guidance for deteriorating patients. This said if a patient deteriorated during a journey the ambulance crew were to find a safe place to pull over and call 999 for emergency treatment. This was confirmed by one manager and four crew when discussing management of a deteriorating patient which gave us assurance that staff understood action to be undertaken in this situation.
- All ambulance crew completed several mandatory training courses including a first aid course and a basic life support course. These allowed staff to provide patients with basic life support, airway management and support patients with first aid.
- The service did not prepare their staff to manage aggressive or agitated patients. The service had no de-escalation training for staff. Crew we spoke with told us that they would try to talk and reason with patients that were agitated, but that they had not had any training.

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Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- All crew were employed on either zero-hour contracts or were self-employed. Managers told us they were looking at being able to offer some full-time contracts but that did not have the consistency of work to be able to offer this yet. Crew reported that they liked the flexibility of the zero-hour contracts.
- Staff completed an availability form a month in advance of allocation of work to ensure that the shifts were covered, and this worked well for the service and for staff. The service covered all their shifts. The service did not use agency staff.
- The services recruitment practices kept people safe. The service had a recruitment policy that had been reviewed in March 2019. All staff recruited were interviewed by the managing director. They then decided if the applicant had the required skills and experience for the role. Pre-employment checks were completed including identity verification, right to work, employment history, references, criminal record, and driving licence. We checked five staff files and these all contained reference checks completed in line with the services policy.
- The service completed criminal records checks via the discolour and barring service. All crew had an enhanced check and in the five staff files we looked at there was a record of this check having been completed.

Records

- **Staff kept records of patients' care and treatment.** Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- Patient records were held securely and kept confidential. Journey forms were completed by the crews daily and returned to base at the end of each shift. On return to base the forms were posted into a locked post box inside the station. An administrator accessed the post box and scanned the records onto the service's cloud storage system. We looked at ten records for patient transport service patient journeys all were fully completed. These recorded details including;

patient's name, mobility, pick up location, time patient collected, destination, drop off time, if the journey was a patient transport service or high dependency transfer. Also, on this form was details of any escorts that were travelling with the patients. The paper originals were kept in a locked cabinet in an officer that had limited staff access. The records were kept for six years in line with their policy.

- The service did not carry out audits on these records to ensure they were being completed in their entirety and to an expected standard.
- The service recorded the need for blue light use. On the ten patient records we looked at they had recorded if blue lights were used and none had used blue lights.
- The crews recorded patient information when contacted by phone by the control room of service that was subcontracting that day's shift to the crew. Two crew told us that they then checked this information when collecting the patient to ensure accuracy.
- The service used secure cloud storage for their records. The service had a contract with cloud service that was in line with national guidance for the storage of clinical records.
- The service had systems to ensure do not attempt cardio pulmonary resuscitation (DNACPR) orders were complied with and validity was checked. The service had an up to date DNACPR in line with national guidance. Managers and crews told us that they only accepted a patient with an original document that was signed and dated by the patient's doctor. Managers told us they were working with local stakeholders to review their policies as there had been introduction of digital DNACPR orders and how to integrate these into their service.
- The service recorded special notes for patient transport journeys. There was a space on the back of the journey form for other comments. One of the ten records we looked at had a special note about access to the property. This space was also used to note if an incident had happened and that there was an accompanying incident form for staff to complete.

Medicines

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

Patient transport services (PTS)

- The service only used oxygen and nitrous oxide. No other medications were stored or used by the service.
- The service stored medical gases safely. We saw 'in date' cylinders of oxygen securely stored on vehicles and in purpose-built cages at the both sites. Cylinders on vehicles were positioned so the fill gauges could be seen. Cylinders and regulators appeared clean (dust and oil free) and immediately usable. This was in line with national guidance for storage of medical gases.
- The service segregated gas cylinders well to prevent staff accidentally taking an empty cylinder onto a vehicle. The two staff that were responsible for replenishment of vehicles explained how they segregated their cylinders. We saw in the cage they had empty cylinders at the front and full cylinders at the back.
- The service had an up to date medicine policy that described the use of oxygen. We looked at records that showed the service had a service agreement with a private supplier to restock their oxygen supply when needed.
- Staff received training on the administration of oxygen. Patient transport service crews did not use nitrous oxide this was only for use by crews employed for high dependency transfers.

Major incident response planning

- **The service planned for emergencies and staff understood their roles if one should happen.**
- The service had plans to allow them cope with adverse weather. We looked at the services cold weather business continuity plan. This had details of supplying patients with extra blankets and extra check on vehicles to check heaters were working. Crew we spoke with were aware if there was adverse weather they would contact the on-call manager or the ambulance coordinator for advice.

Are patient transport services effective?

Good



We have not previously inspected this service. We rated it as **good**.

Evidence-based care and treatment

- **The service provided care based on national guidance.** Managers checked to make sure staff followed guidance.
- The service had policies based on national guidance. We looked at 20 policies that had been reviewed, had a version number and a date for their next review. All policies were up to date and included; mental capacity, complaints, duty of candour, confidentiality, infection control, equal opportunities, safeguarding, incident reporting, and access to records.
- The service supported staff to follow the policies. Each vehicle had a folder with guidance sheets that summarised information from the policies. We looked at four of these sheets including one on the management of deteriorating patients and they were in line with national guidance. Crew we interviewed told us they would refer to this folder if unsure on policies or they could access a copy at the base station.
- The service had systems for managers to check if staff followed their policies. The undertook audits on staff compliance with policies such as their hand hygiene audit. The service included checks during staff appraisals of some aspects of policies such as uniform standards and cleaning of vehicles. Also, when we asked staff about what they would do if a patient deteriorates on route described actions in line with the service's policy.

Nutrition and hydration

- **Staff assessed patients' hydration requirements to meet their needs during a journey.**
- The service supplied water for patient when needed. The two crew we asked told us that there was always water in bottles on the vehicles for patients. We checked five vehicles, and these had bottles of water.

Response times / Patient outcomes

- **The service monitored the effectiveness of their care. They used the findings to make improvements.**
- The service had inconsistent systems for monitoring their performance. The service had meetings with some of the providers who sub contracted work to them. In these meetings they discussed their performance against that contract holder's key performance

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indicators. Minutes were not recorded for these meetings, so there was no documentation to confirm this was happening. The service also did not record these performance results, so the service was unable to review them to identify areas to improve.

- The service did not have any performance targets set by themselves or others. We asked managers if they monitored late journeys and they told us, they were not given the time patients had been waiting, only the time they were given the patients details. So, they could not monitor how long patient had been waiting.
- The service had made an improvement to reduce the time patient spent on vehicles. Managers and crew told us about the satellite navigation system had live traffic up dates and this would plan routes around busy areas. Managers told us they had changed the satellite navigation system in the vehicles to reduce time patients spend on vehicles being held up by traffic. However, they did not have any formal system to monitor this.
- The service recorded their journey times. We looked at ten patient records that showed the service had pick up and drop off times recorded. However, the service did not use his information to monitor performance.

Competent staff

- **The service made sure staff were competent for their roles.** Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- The service provided appraisals for staff, but completion did not meet their target. The service had a completion rate of 76% for crews and had not reviewed their completion rate for management staff. Managers told us that their target for appraisals was 100% and that they had not met this as they had set up the service quickly, so were working to achieve their target.
- Appraisals were completed three months after joining the service and then every 12 months. These included looking at uniform compliance, time keeping, vehicle cleaning, equipment use, driving performance, and procedure awareness.

- Appraisals were used to look for positives as well as areas for development. Managers told us that if staff had development needs then they would receive training and then tailored training would be offered for any individual needs.
- The service stored staff files securely and in an organised system. Staff records were stored in individual named files that kept all documents together preventing them from getting misplaced. We looked at five staff file and these all included; disclosure and barring service check, medical questionnaire, induction training checklist, appraisal form, and training certificates. These were stored in a locked cabinet.
- The service had a system to monitor their ambulance crew's driving licences. They checked crew's licences as part of recruitment and then every six months. We check five staff files and these all contained driving licence checks.
- The service had systems to monitor driving performance. We looked at a system the service used to monitor vehicles. This reported and recorded information about the way a vehicle was being driving and by whom. This included; harsh break, cornering forces and breaking speed limits. Managers told us that if a vehicle travelled faster than a speed limit, this would alert the managing director, who would follow this up with the driver.
- The service had an induction training program. This was a one-day face to face training session that covered all mandatory training. New staff were also required to complete three shifts alongside an experienced member of crew. Any issues raised during this time either resulted in longer time working alongside an experienced crew member or send them back to retake the training day. If staff were sick during the face to face training session, then they were rebooked. Managers told us no staff were allowed to look after patients without completing the training course.

Coordination with other providers and multi-disciplinary 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.**

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- All necessary staff worked in a coordinated way to provide care to patients. Crews reported good relationships between themselves and the control room staff.
- Staff worked together with other professionals outside the service. Staff at a discharge lounge told us that the service's staff were friendly and professional. We saw crews interacting in a collaborative way to plan when patients would be ready for travel.
- The service had working partnerships with a local NHS trust. This allowed them to use their sluice facilities to clean vehicles at hospitals. This resulted in the vehicles being unavailable for shorter periods.
- The service coordinated with local stakeholders to provide effective care. Managers told us that they had monthly meeting with the services that subcontract to them. These meetings were not recorded in anyway, so we could not review the content. Stakeholders gave feedback that the service engaged with them in a positive way seeking improvement.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their journey.** They knew how to support patients who lacked capacity to make their own decisions.
- Staff could describe how they would help patients that lacked capacity. We spoke with four crew members about how they would help patients who lacked capacity. They described helping patients and working with them to reach a decision.
- The service provided staff with support in their knowledge of the Mental Capacity Act. We saw on the five vehicles we checked that there was a folder with guidance on mental capacity and the four crew members we spoke with, knew that this was where they would look for more information on this. The service also had an up to date policy on mental capacity which was based on national guidance.
- We did not observe patient care as the crew we accompanied were not allocated any patients to transport while we were with them. The service did not transport secure mental health patients.

Are patient transport services caring?

Good



We have not previously inspected this service. We rated it as **good**.

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Due to the nature of the service, we only spoke with one patient on the telephone during the inspection. We did attend some patient journeys but were unable to observe patient care.
- Staff we spoke with told us that they treated patients with respect, compassion and empathy. They told us they introduced themselves to patients and relatives and explained who they were.
- The service encouraged patients to provide feedback from their experience after journeys and captured them for two patients each day. We looked at results from the patient questionnaire from December 2018 till May 2019 which had positive reviews and included praise about the staff and the way they provided care. One patient wrote that the staff were 'courteous and professional throughout and understood their needs'.
- Patients and relatives expressed positive comments about the service. One patient we spoke with described the service as 'highly professional, caring and remarkable in their presence and delivery'.
- The thank you cards we looked at all indicated positive responses and described staff as 'going above and beyond, very helpful, engaging and supportive'.
- Patients we spoke with told us, they would recommend the service to their own friends and family.

Emotional support

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

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- Staff we spoke with told us that they communicated with patients in a clear manner, so they understood their care, treatment and condition. They told us they allowed time for patients to ask whatever questions they wanted.
- Patient we spoke with felt they were fully informed of progress or delays and always had their questions answered.
- The service shared feedback with us from patients. One patient stated that staff had let them travel with their daughter for which “they were very thankful”.

Understanding and involvement of patients and those close to them

- **Staff provided emotional support to patients, families and carers to minimise their distress.**
- We spoke with staff about providing emotional support for patients and their friends and relatives. Staff told us that they saw this as an important part of their role. However, the service did not provide any written information to those close to people who used the service, including carers and dependents.

Are patient transport services responsive to people's needs?

Good



We have not previously inspected this service. We rated it as **good**.

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local people.**
- The service was a sub-contractor for larger ambulance services. The service received most of their work from these providers with one day's notice. This was mostly for patient transport service work.
- The main service was non-emergency transport for patients who were unable to use public or other means of transport due to their medical condition. Patient transport services were mostly provided to patients attending hospitals, diagnostics, renal and outpatient clinics and those being discharged from hospital wards.

- The service was designed to ensure patients had timely access to care and treatment and to increase flow. The patient transport service operated a 24-hour, seven days a week service from their base at Maidstone.
- The service adjusted the number of vehicles used each shift depending on demand. Managers told us that this was between 15 and 20 vehicles each day on weekdays and at weekend was between two and eight vehicles.
- The service responded to the demands from the service that held the contracts from commissioning groups. The service would receive most of their work with one days' notice. This would mostly be a request for a number of crews and vehicles for 12-hour shifts. These requests included if they needed a patient transport service crew or a high dependency transfer crew. Sometimes they would also receive requests for individual patient journeys although managers told us this was mostly for long journeys. The managers then rang their staff to find crews to fill these shifts. Managers told us they had a list of the crews' availability so knew which crew were able to work each day.
- The service planned to cope with the differing levels and nature of demand. Managers told us they adapted the service to meet the daily demand. Some work came in the day before and the service had a process to meet this variability and to respond to changes needed quickly. The service kept a list of availability for their crews so knew how any staff they had available for the next day.
- The service did not take booking direct from patients so did not have call handlers for patient interactions.
- The service also did a small amount of work doing repatriations from other countries.
- The service had facilities suitable to deliver the services they were subcontracted. This include a covered garage area for multiple vehicles, a crew kitchen, toilets, and office space for management of the service.

Meeting people's individual needs

- **The service took account of patients' individual needs. The service made reasonable adjustments to help patients access services.**

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- Adjustments were made to support access to their service by bariatric patients. Stretchers were available and expanded quickly to accommodate a bariatric patient. Crews also had equipment to aid people with reduce mobility such as wheelchairs.
- Adjustments were available to safely adapt equipment to suit children and younger people. A device was used to adapt an adult stretcher to safely secure and transport a child or younger person. Baby carriers for babies from two kilograms to eight kilograms were also available.
- The service had produced a short training session for their staff during Ramadan to increase their awareness around this. This included guidance on considering low blood sugar levels as patients may not have eaten during the day.
- There was limited access to interpretation services. Staff told us they could use an application on their mobile phones to translate into different languages. If they identified patients who did not speak English, they would ask if they had an escort to travel with them that could translate for them. However, there was no telephone interpreting service available to staff, which meant that patients who did not speak English might have difficulty communicating with the crew.
- The service did not have any aids to help communicate with patients with reduced communication ability. This meant that some patients with complex health needs might not be able to express their needs to staff.

Access and flow

- **People could access the service when they needed it.**
- Patients access the service by booking transport with one of the providers that subcontracts work to Kent Central Ambulance Services Ltd. Then some of these patients were allocated to the crews provided by Kent Central Ambulance Services Ltd. The service did not record how long patients wait or have any targets related to this.
- The service was only contracted to provide a predetermined number of crews and vehicles for a set

period of time. The service was not contracted to provide predetermined numbers of transport journeys or to transport a predetermined number of patients. Patients do not access the service directly.

- The service did have systems to monitor their vehicles transport times. Managers told us that if one of their clients raises a concern with a specific crew then they review information about patient journeys by downloading the vehicle information. This information included driving performance, times and places the vehicle has stopped. However, they do not routinely monitor this performance information.
- The service has capacity to supply vehicles and crews 24 hours a day, but they only supply crews when requested and they mostly receive request for cover between seven in the morning and midnight.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service had a policy that described that they would investigated concerns or complaints and shared lessons learned with all staff, including those in partner organisations. In the reporting period they had not had any formal concerns or complaints.**
- The service had an up to date complaints policy. This had been reviewed recently and had a due date for the next review. A manager told us that they follow a flow chart when handling complaints although they noted that they had not had any complaints. We looked at this complaints flow chart and observed that there was no reference to this flow chart in their policy.
- This flow chart showed that they aimed to resolve complaints within 24 hours but that if this was not possible then they would provide an initial response within three days. There was no clear timeline for the investigation process beyond the three days for a response. Managers told us although they had not had any complaints they would aim to send a resolution to all complaints within three days.
- The service had made some efforts to make patients aware of the complaint process. Posters were displayed

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in the ambulances with contact details and clear information on how to complain. However, there were no leaflets or handouts that the crews could give patients with these details.

- As they did not receive any formal complaints, the managers were unable to describe any learning from them. The service did however record negative comments from their patient feedback forms.

Are patient transport services well-led?

Requires improvement



We have not previously inspected this service. We rated it as **requires improvement**.

Leadership of service

- **The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.**
- There was a managing director who was the lead for the service. They were also the registered manager with CQC. There was an operations manager that reported to the managing director. There were four office staff with individual roles that reported to the operations manager. The four office staff were; two controllers, a data protection officer, and a compliance administrator. The service also had two staff that worked in the garage on maintenance and vehicle preparation.
- The leaders were visible and approachable. The six crew that we spoke to all reported that the management were approachable. They also said that they had gone to them with issues and been given support.
- The day to day operations were run by the operations manager and the controllers. They received request for ambulances to help other providers. They would then look for crews to fill these requests. They would also organise paper work for crews to let them know which provider to report to. Then crews would report to these providers control rooms which would handle the crew's workload during that shift.

Vision and strategy for this service

- **The service had a vision for what it wanted to achieve and formative plans to turn it into action. However, staff lacked awareness of the vision.**
- The service had a mission statement. We looked at this statement which had been recently reviewed and contained information about services goals to provide safe care in accordance with the law. The leader of the service told us that their vision for the service was to be the best and safest private ambulance service that has repeat business. They also said that they want to work with external stakeholders to achieve this vision.
- The service had not involved their staff in the creation of their vision. Staff could not tell us about the service's vision or strategy.
- The service had an informal structure to their strategy to achieve their vision. Managers told us they had looked at CQC guidance to make improvements to their service but had no action plan to continue improvements.
- The service had a plan to bid for contracts directly from the commissioner so that they did not rely on other service providers to supply them with work. However, we were told by the leadership team this was only an idea at the time of the inspection. We saw no records that related to this plan at the time of inspection.

Culture within the service

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff felt valued and respected by their managers. The six staff we spoke with confirmed this. Two crew members told us that the service felt like a family.
- All managers and staff we spoke with told us that they felt proud to work for the service as they were helping people every day.
- The service had a system for reporting concerns about the managing director. Managers told us that if staff wanted to report an issue but did not want to talk to the managing director, then they would talk to the operations manager. Then they would raise this with the managing director on their behalf.

Governance

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- **The service had limited formal systems to improve service quality and standards of care. However, they did have informal processes to look for improvements.**
- The service did not have a formal governance structure. There were no governance meetings to discuss the results of their audit program or risks. The service also undertook SWOT (strengths, weaknesses, opportunities, and threats) analysis. These identified areas the service was doing well at and areas for improvement. One of these was to utilise experience from incidents and accidents to improve systems and procedures. There were also no recorded meetings to discuss the results of these SWOT analysis.
- The service had reviewed some aspects of their service and taken actions to improve these. A manager told us that they had looked at CQC's frameworks and identified that the service should be doing hand hygiene audits. They then purchased an ultra violet light box to be able to do these audits in line with national standards. These audits had been started when we visited the site.
- The service had been engaging with the service that subcontracted work to them. Leaders had been meeting with some of these services to discuss improvements they could make. However, these meeting were not recorded. In addition, they had not started this engagement process with all services.

Management of risk, issues and performance

- **The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**
- The service had a risk register. We looked at their risk register, and this included the risk level associated with each risk identified. These also included the mitigating actions taken, date each was last reviewed and who was responsible for these risks.
- One risk the service had identified, was about intermittent disruption at the local ports and the channel tunnel. They had identified that this causes traffic congestion on a major local motorway. To mitigate this, they alert staff when these disruptions occur and alternative routes they should use.
- The service collected patient journey times but did not have any targets set against these or any other aspect of the information they recorded. Managers from the service did however meet with some of their stake holders to discuss their performance.
- The service collected driving performance data and used this to promote safer driving. This system was also be used to track their vehicles so that controllers knew where crews were.
- The service looked for improvements to the service. Managers undertook four audits; vehicle cleanliness, uniform compliance, vehicle equipment, and infection control. The vehicle cleanliness audit reviewed swabs taken before and after cleaning to monitor cleaning performance.

Information Management

- **The service collected and managed information well to support all its activities, using secure electronic systems with security safeguards.**
- The service used secure cloud storage for their records. The service had a contract with cloud service that was in line with national guidance for the storage of clinical records. The service also used this cloud storage to store their operational records. The service had a system that gave each person a unique username and password which allowed managers to track who has access what information. The system also uses two-factor authentication to protect their data. This means that when access is requested with an approved username and password there is also an additional code sent to the service's office that also has to be used to gain access.
- Patient records were held securely and kept confidential. Journey forms were completed by the crews daily and returned to base at the end of each shift. On return to base the forms were posted into a locked post box inside the station. An administrator accessed the post box and scanned the records onto the service's cloud storage system. We looked at ten records for patient transport service patient journeys all were fully completed. These recorded details including; patient's name, mobility, pick up location, time patient collected, destination, drop off time, if the journey was a patient transport service or high dependency transfer. Also, on this form was details of any escorts that were

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travelling with the patients. The paper originals were kept in a locked cabinet in an office that had limited staff access. The records were kept for six years in line with their policy.

- The cloud service they use also encrypts emails to prevent emails being read by being intercepted and between sender and the destination. Managers told us that they only need to include a phrase in the subject of the email and the system would automatically encrypt the email.
- The service provided information governance training at induction for their staff to give them a basic understanding. This included information about data protection and the general data protection regulations from the European union.
- The service paper records were kept securely in a locked filing cabinet in a locked office. When the service disposed of confidential records these were put into a cross cut shredder. They had a service level agreement with a company to collect confidential waste for disposal.

Public and staff engagement

- **The service engaged with patients, staff, and local organisations to plan and manage services, and collaborated with partner organisations effectively.**
- The service had a patient survey that was completed each day. This was completed by the controller handing out two patient feedback forms to a randomly chosen crew each day. The service used these feedback forms to look for improvements they could make.
- The service had a website with information for the public on the services provided and their contact details.
- Each vehicle we inspected had feedback posters for patients which allowed the public to give opinion and comments about the service via email, the service website or by phone.
- The service had processes to gain feedback from their staff. We saw the service had a suggestion box with cards to submit suggestions to improve the service. This was located in the crew kitchen area and was easily accessible to the crews. Staff had asked for annual leave

forms be available in the crew area to allow them to complete these out of office hours. We saw that this had been actioned. However, the service did not have a staff survey. Managers told us they had plans to introduce a staff survey.

- The service aimed to hold staff meetings once a month. Managers told us they had managed to organise staff meetings once every four months. We looked at minutes from their staff meeting in October 2018. These meetings went over changes in the service or policies. They also included reminders about process and practices that had been highlighted through incident reports or meetings with stakeholders.
- The service held engagement meetings with their stakeholders and partner organisations. We approached these services and received three responses. All these responses described the service as very professional and working together for service improvements.

Innovation, improvement and sustainability

- **The service was committed to improving services by learning from when things go well and when they go wrong, promoting training and innovation.**
- The service had identified that they had more improvement to make. Managers told us that they needed to make action plans to address some of the issues that we highlighted during our inspection.
- The service had made improvements after receiving suggestions from staff via their suggestion box. We saw that they had installed additional lighting to the mezzanine area in the base to improve safety for crews using this area.
- The service had also reviewed the CQC website to look for improvements that they could make. One of these the service had implemented was to purchase an ultraviolet light box to allow the service to teach their staff improved hand hygiene. They also started a hand hygiene audit at that time.
- Managers at the service had undertaken a SWOT (strengths, weaknesses, opportunities, and threats) analysis. They had identified that they opportunities to improve their incident investigation and learning process. Also, they had identified that through data analysis they will be able to identify more areas for improvement.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

Action the service **MUST** take to meet the regulations:

- The service must take prompt action to address significant concerns identified during the inspection in relation to the lack of a structured governance of the service including not having formal meetings to discuss; audit results, infection control, incidents, and risks.

Action the hospital **SHOULD** take to improve

Action the service **SHOULD** take to improve:

- The service should keep their mandatory training monitoring up to date.
- The service should embed their new process for handling concerns raised about abuse or risk of abuse.
- The service should improve their support for patients who have communication difficulties.
- The service should increase their staff's awareness of their vision and strategy.
- The service should increase their engagement with their staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The service lacked a structured approach to governance. The service had no formal governance meetings to discuss; audits, infection control, incidents, or risks. The service did not keep records to support good governance. The service could not show us minutes from meetings, action plans, or improvement plans. This meant the service could not identify all areas for improvement.</p> <p>Regulation 17 (1)(2)(a)(e)(f).</p>

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements

Start here...

Where these improvements need to happen

Start here...