Medi Wav LTD

Medi Wav LTD

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We have not rated this service before. We rated it as requires improvement because:

- The service did not meet Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as part of their recruitment processes.
- The service did not always follow their own policies in infection control and Control of Substances Hazardous to Health (COSHH) management.
- The service did not always implement their policies in risk management.
- The service did not conduct audit activity.
- The service did not complete formalised meetings with staff or have formalised processes to support staff feedback.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. The service-controlled managed safety incidents while learning lessons from them.
- Staff gave good care to patients. Managers checked the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs and helped them understand their conditions. They gave emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services using information systems that were not always up to date. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. Leaders focused on the needs of patients receiving care. The service engaged well with patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Medi Wav LTD

Medi Wav Ltd is an independent non-emergency patient transport service based in Eastbourne, East Sussex. It provides services to a large NHS ambulance provider which supplies the vast majority of their work and a second ambulance service based in London. The service serves the communities of Surrey, Sussex and London. Vehicles have been adapted to convey patients in wheelchairs, but the service does not convey patients requiring stretchers. The service is managed from one office location with vehicles remotely monitored on the road and stored at the home address of each driver.

The service is registered to provide the following regulated activities:

• Patient transport services

• Triage and medical advice provided remotely

The service was registered with the Care Quality Commission in November 2020. This is the first time we have inspected this service. Medi Vav Ltd is run by two managing directors who divide their time evenly between management responsibilities and driver duties. Medi Vav Ltd has a vehicle fleet of 17 wheelchair accessible vehicles and a staff of 17 drivers. The service employs all drivers. The service transports approximately 4,063 people each year. The service does not transport patients who require secure mental health transport needs or those with acute medical needs.

How we carried out this inspection

During this inspection we visited the main office of the service. We spoke with three drivers and both managing directors. No patients were interviewed as part of the inspection as none were available to speak with.

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure all staff employed after May 2022 have a contract signed, two employment references, a full employment history, interview notes, and DBS checks recorded in their staff file in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Any gaps in employment history must be discussed with the employee and a reason documented. Regulation 17(2)(d)
- The service must ensure they carry out control of substances hazardous to health (COSHH) assessments for cleaning and disinfectant products. Regulation 17(2)(b)
- The service must ensure that records of all patient journeys are kept independent of the NHS ambulance service. Regulation 17(2)(c)
- The service should ensure labelling equipment once staff have cleaned it to reflect Infection Prevention and Control practice. Regulation 12(2)(h)

Summary of this inspection

- The service should ensure governance processes for daily vehicle safety checks. Regulation 12(2)(e)

Action the service SHOULD take to improve:

- The service should ensure the arrangements for meeting and receiving feedback with their staff and how they intend to record this. (Regulation 17)
- The service should ensure reviewing their policies to ensure they align to the company's current processes. (Regulation 17)
- The service should ensure governance processes for the oversight of mandatory training. (Regulation 17)
- The service should ensure governance and risk processes for the deep cleaning processes of their vehicle fleet. (Regulation 12 and 17)
- The service should review with staff the service eligibility criteria for patients especially around patients with medical gas requirements. (Regulation 12 and 17)
- The service should ensure managers and staff have specific training for dementia and learning disabilities.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Patient transport services

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

Are Patient transport services safe?

Requires Improvement

We have not previously rated the service. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to staff but did not always record this effectively.

Staff received and kept up-to-date with their mandatory training. Mandatory training was provided to staff and all staff had received suitable training for their job roles. At the time of inspection managers were unable to provide us with up to date training records as they were being moved to a new electronic system. However, the records were provided to us following inspection.

Managers did not always monitor mandatory training effectively and did not always alert staff when they needed to update their training. On the day of our inspection managers were unable to provide evidence that mandatory training was monitored effectively as their electronic system did not always reflect an accurate picture of their driver's training record.

Following the inspection, managers completed the movement of records into the new system which included a full review of all staff training and a face to face review with staff where certificates were checked.

Managers had created a new tracking spreadsheet to monitor mandatory training which outlined when training modules would expire, and which members of staff needed to complete their remaining modules.

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.

Staff received training specific for their role on how to recognise and report abuse. Drivers were trained at level two training for adult and children safeguarding. The safeguarding lead had completed level three training. 100% of staff were trained at the correct safeguarding levels for their roles.

Staff could give examples of how to protect patients from harassment and discrimination. Staff showed awareness of safeguarding principles and could give examples of what to look for. For example, staff gave an example of suspected abuse and reported this through their NHS ambulance provider. This led to a positive outcome for the patient.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns. The service used the NHS ambulance service safeguarding processes which meant that staff reported all concerns to the NHS duty safeguarding lead as well as the safeguarding lead for the service. Managers told us they were sent feedback from the NHS ambulance provider following the investigation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could explain the process they would follow if they had safeguarding concerns. Staff had awareness of the safeguarding policies and who the safeguarding lead for the service was. Managers were available if staff needed support in reporting a safeguarding.

Cleanliness, infection control and hygiene

The service did not always control infection risk well and did not always follow their infection control policy. Staff did not always use the correct equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

Vehicles were clean and had suitable furnishings which were clean and well-maintained. But deep cleaning arrangements were not in line with the service policy. Three vehicles were inspected out of 17. All were visibly clean and well cared for. Wheelchair ramps were clear of dirt and staff cleaned touch points in the vehicles and on wheelchairs between each patient. Drivers had access to spill kits for the safe disposal of bodily fluids in all vehicles we inspected. Managers performed ultra-violet scans using a disinfectant fog spray and random spot checks on vehicles, but they did not record this.

However, staff used different cleaning products and had not received guidance about the correct ones to use. We looked at the infection control and Control of Substances Hazardous to Health (COSHH) policies and could not find clear guidance for staff to follow. Managers had not implemented their COSHH policy which was dated as August 2020 and their infection control policy was not always applied correctly to their vehicles. For example, different seat covers were used in different vehicles and drivers explained different rationales for managing infection control risk.

Following the inspection, managers provided evidence of deep cleaning that had occurring on some vehicles in operation, but there was not a clear system for how vehicle deep cleaning was checked across the vehicle fleet. Managers also provided evidence that confirmed seat covers were fitted to 10 of the 16 vehicles in operation. Managers advised us that further seat covers were on back order and that disposable plastic apron were expected to be used as an alternative. The Infection Prevention and Control (IPC) policy stated that vehicles should be deep cleaned every six weeks. The IPC policy did not specify that seat covers were a requirement but that measures for deep cleaning and the spillage of fluids needed to be in place.

Cleaning records were up-to-date and proved that all vehicles were cleaned regularly, but not always to the required standard. Drivers conducted daily cleaning checks as part of a vehicle safety checklist form, however there was no reporting process for managers to check that this had happened. Vehicles were cleaned monthly through different valet services. Following the inspection, deep cleaning certificates were reviewed to demonstrate deep cleaning processes for the fleet had been conducted but managers were transparent that these arrangements had been disrupted and were seeking alternatives.

Requires Improvement

Patient transport services

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff used PPE, for example, disposable aprons, face masks and gloves. Hand sanitiser, clinical wipes and PPE was available on all the vehicles we reviewed.

The service recognised that extra infection control measures needed during the Covid-19 pandemic and had produced an extra policy for this. Staff completed lateral flow testing twice a week and informed managers of their results. Managers held a stock of lateral flow tests at the premises that staff could pick up when needed. Staff used their NHS vaccine passports when picking up patients from nursing and residential care homes. However, vaccine status was not recorded in recruitment files.

Staff cleaned equipment after patient contact. Staff confirmed that wheelchairs were cleaned after each use. However, there was not a labelling system that confirmed this had been completed.

Environment and equipment

The design, maintenance and use of facilities, vehicles and equipment always keep people safe and managed clinical waste well.

Staff carried out daily spot checks of specialist equipment.The service used an outside company to source their wheelchairs which was the only specialist equipment held in the vehicles. Wheelchairs issued met the required safety standards and labels were on all wheelchairs we viewed to reflect this.

The service had enough suitable equipment to help them to safely care for patients. The service kept a record for the maintenance and repair of each vehicle. Managers had a spreadsheet which showed when vehicles from their fleet were scheduled for their next MOT. Managers had records for the servicing and maintenance of each vehicle in their fleet. Staff completed daily safety checks of their vehicle. However, there was not a process for sending the forms to manager once they were completed.

Staff disposed of clinical waste safely. Each vehicle had a supply of orange clinical waste bags. Drivers would dispose clinical waste safely in clinical waste bags at the nearest hospital.

Assessing and responding to patient risk

Staff did not always update risk assessments for each patient. They did not always remove or minimise risks. However, staff did identify and quickly act upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient's health. Staff were able to describe action they would take if a patient's health deteriorated. For example, one staff member described actions they took following a complaint of a patient feeling nauseous. The driver pulled over at a safe location and reported the concern to their manager for advice.

The NHS ambulance trust that contracted the service assessed all patients before allocating them to the service. The agreement that existed between the two organisations was to convey low risk patients who could walk independently or used a wheelchair. Staff were clear that they could not transport medically unstable patients or those that required secure mental health transport. Staff felt the arrangement worked well and had the opportunity to decline a patient if it was outside the service's remit. Staff were encouraged in these circumstances to log an incident if this occurred. However, Staff on some occasions did transport patients outside their service remit despite these arrangements. For

example, staff said that they did transport patients on some occasions who had portable gas with them. The vehicles did not have a secure location for compressed gas to be stored and staff explained different methods for how they secured gas cylinders. Managers said that staff should not be transporting patients with portable gas and that they would investigate this further.

Staff did not record risk assessments for each patient on arrival. Staff did not fill out documented risk assessments for each patient they transported as this was completed by the booking team of the NHS Ambulance Trust which staff and managers had access too.

Managers confirmed that journeys booked by their other ambulance service they provided services for were not shared with the service. Managers said that they had requested access to the provider's electronic booking system to avoid complications occurring. No cancellations of patient journeys were recorded by the service in the last 12 months.

Staff knew about and dealt with any specific risk issues. The wheelchairs provided by the service did not have a standard neck support installed to prevent whiplash on the wheelchairs we inspected. However, managers had a risk register which had taken account of potential accidents involving whiplash and staff had arrangements for neck rests to be installed into a wheelchair when travelling. Managers also had access to a remote system which aligned to driver cameras which provided alerts to them when aggressive driving was identified. These incidents would then be reviewed with the member of staff, but they were not documented.

Staff shared key information to keep patients safe when handing over their care to others. Staff told us that, when taking patients to healthcare providers they would always verbally handover any concerns or significant information that occurred during the journey that fell within their remit of care.

Staffing

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

Recruitment records for drivers was incomplete. We looked at the recruitment records for five members of staff and found gaps in documentation for each. Driver records had no documented notes from their interviews, four of the five records held insufficient references from previous employers and one record of the five did not have documentation to support a driving licence check. This is contrary to Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Managers acknowledged that obtaining references had been challenging for them and that interviews for some staff had not been documented which was not in line with their recruitment policy.

The service had enough drivers to keep patients safe. Patients were allocated to each driver and vehicle according to the time needed for each journey. Managers had systems to ensure that drivers were available and staff rotas were prepared in advance taking into account the potential for absent staff. The service does not use bank and agency drivers.

The manager could adjust staffing levels daily according to the needs of patients. If a journey took longer than expected, for example, unexpected traffic jams. Managers would review the remaining journeys for that driver. If necessary, other drivers or a manager would be allocated to later patient journey booking. Managers could monitor journey times and vehicle location using an electronic tracking system.

The service had low turnover rates. Managers had recruited a large number of drivers since March 2021. The service has recruited 17 drivers to allow them to meet the demand associated with their current agreements with ambulance services. Staff spoke of being happy and settled in their roles.

The service had low sickness rates. Managers told us that general staff sickness was low. One driver was on long term sick leave at the time of our visit.

Records

Staff did not keep records of patients' care and requirements. Staff had access to patient records but did not have the ability to add to them.

Records were stored securely by the NHS ambulance trust and second provider. Drivers were not given access to patient records. Drivers were asked to sign into a bookings portal to retrieve their booking list from the NHS Ambulance trust. Separate arrangements with the second ambulance service also restricted amending patient records. Managers did not keep individual records of the journeys undertaken by the service that included events and what had occurred. This meant that if information was requested regarding an individual journey there would not be an accurate record of the care and treatment provided. However, managers did record incidents that occurred during patient journeys. Personal information was destroyed in confidential waste bins, and managers encouraged drivers not to print their booking lists out.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents but did not share lessons learned with the whole team. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff could give examples of incidents they reported and the process for reporting incidents. Six incidents were recorded by the service in the last 12 months and all incidents were recorded on the NHS ambulance trust system. Managers kept records of incidents reported.

Staff raised concerns and reported incidents and near misses in line with the service's policy.

Staff followed guidelines and could describe the process for reporting incidents. Managers investigated incidents and lessons were learnt to prevent similar incidents occurring.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff could describe the importance of being open and honest with patients and their families. However, there were no incidents recorded by the service that required the duty of candour in the last year.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff said they received feedback from incidents, but it was unclear how this feedback was given as meetings were not conducted or recorded with staff.

There was a process for responding to patient safety alerts. Relevant alerts were sent to the service by the local NHS ambulance service. Managers reviewed alerts and any relevant changes were made and communicated to staff using their electronic messaging platform.

Requires Improvement

Patient transport services

Are Patient transport services effective?

Good

We have not previously rated the service. We rated it as good.

Evidence-based care and treatment

The service did not always provided care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance.

Staff did not always follow up-to-date policies to plan but did deliver high quality care according to best practice and national guidance. There were no assessments for the control of substances hazardous to health and some policies did not follow the service's current processes. For example, disinfectants. Managers did not have mechanisms or governance processes to check that staff were following national guidance.

The service did not provide clinical treatment for patients and so opportunities for evidence-based practice were limited.

However, managers said they often checked the Information Commissions Office, Health and Safety Executive, Care Quality Commission, and the Quality Management System (associated with the International Standard of Quality Management Office (ISO)) for relevant updates associated with patient transport services.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Managers trained staff in the mental health act as part of their mandatory training. 71% of drivers of the team had completed this training when we reviewed the training records following our inspection. Staff could give examples of support they offered patients who had mental health needs.

Nutrition and hydration

Staff assessed patients' nutrition and hydration requirements to meet their needs during a journey.

Staff made sure patients had enough to eat and drink. Managers and staff said that journeys conducted by the service were not long in duration. Staff showed awareness for patient's hydration needs and checked that patients felt well before they began their journey.

Journey times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients.

Managers checked journey times for five different categories of patients for the NHS ambulance trust. This included renal patients being taken to and from dialysis units, non-renal out-patients, pre-planned ward discharges, unplanned ward discharges and A&E discharges. The service met all agreed response times.

Competent staff

The service ensured staff were competent for their roles. Managers appraised staff's work performance but did not hold supervision meetings with them to provide support and development.

Requires Improvement

Patient transport services

Staff were qualified and had the right skills and knowledge to meet the needs of patients. Staff displayed good understanding of their role for the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Managers carried out induction training for new drivers with the help of their senior drivers. Managers told us that induction training usually lasted for three weeks but that this was flexible. For example, new drivers could conduct the programme at a slower pace where they needed to. This meant they could be certain that new staff had been trained in key skills before they worked unsupervised.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers had completed their first appraisal recently for their staff. Managers had recruited all staff in the last year and all except one had not been employed long enough for an appraisal to be indicated.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Managers meet with their drivers on a one to one basis in between journeys to discuss their needs and establish if drivers needed any extra support. However, managers did not document these meetings. Managers did not ensure staff attended team meetings or had access to full notes when they could not attend. Managers expressed that due to the remote nature of the business, it was difficult for staff to be brought together on a regular basis.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meeting to discuss patients and improve their care. Staff described good teamwork between different groups of staff. Staff gave examples where they communicated effectively with other healthcare providers to deliver good patient care when transporting and handing over patients. Managers held meetings with the local NHS ambulance trust to share information about the service and discuss performance. These were conducted every three months.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could access booking information in advance if a patient was likely to be confused because of cognition concerns. Staff aided the transport of a patient's escort or carer where this would help reduce distress or confusion.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes. Staff gave examples where patients from care homes required reassurance regarding where they were going and why they were going there. Staff showed through their examples patience in allowing patients to make decisions and at times did not conduct a journey if they felt that the patient was distressed and unable to understand why they were leaving. Staff could also describe circumstances where the patient fell outside the service remit and therefore staff could not be assured that they had gained consent and rescheduled the journey as a result.

Requires Improvement

Patient transport services

Staff did receive training in the Mental Capacity Act. Managers said that Mental Capacity Act training was covered as part of the care certificate that drivers were expected to complete. The service did not transport patients who were subject to secure mental health transport needs or a deprivation of liberty authorisation.

Staff could describe and knew how to access policy on Mental Capacity Act. Staff were able to tell us where the policies for the Mental Capacity Act were held in the offices and confirmed they could access them.

Are Patient transport services caring?

Good

We have not previously rated the 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.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. Although we were unable to speak with patients, we reviewed 23 positive items of feedback from the service's feedback forms.

Comments included,

"The crew member was very courteous, helpful, knowledgeable and had the patients interests at heart."

"The drive to the hospital was delightful and reinvigorating, smooth and professional!"

"He is a really caring gentleman who will help us no end, I feel that he has really out shone his requirements".

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Staff could describe several examples of compassionate care which included what actions and support they provided. This included allowing carers or families to attend the journey with the patient, offering reassurance when patients were attending an appointment, and making patients smile through telling funny stories and supporting them with positive messages.

Staff followed policy to keep patient care and treatment confidential. Staff understood the principles of patient confidentiality and knew that personal details should not be shared with unauthorised persons.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. They understood the impact that patients' care, transfers and condition had on the patient's wellbeing. Staff knew the importance of treating patients as individuals with different needs.

Requires Improvement

Patient transport services

Staff supported patients who became distressed in an open environment and helped them keep their privacy and dignity. For example, a patient was unsure of why they were attending an appointment and had become distressed when entering the vehicle. The driver outlined the action they took to both calm and ensure the patient was returned to their residence safely while protecting their privacy and dignity.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.Managers supplied several examples of feedback where patients praised drivers for their personal approach and how this had reduced their anxiety about an upcoming trip to hospital.

Staff supported patients when they were referred or transferred between services. Staff communicated with staff from pick up and drop off locations and gave feedback to them to ensure that the patient care was maintained. Staff gave examples of showing consideration towards patient's wellbeing. For example, one driver explained that ward drop offs at busy hospitals did mean they felt they needed to help some patients to find their destination within the hospital.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care. Staff gave examples where patient carers or family members were kept informed about the journey time frame and why they were taking particular routes to a destination.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.Staff encouraged feedback through feedback slips which were available from drivers in their vehicles. Staff offered feedback slips at the conclusion of each journey. Managers collected the feedback slips when they met with staff remotely.

Patients gave positive feedback about the service. We saw several examples of positive feedback from patients and their loved ones.

Are Patient transport services responsive?

Good

We have not previously rated the service. 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 others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The service provided non-emergency transfers between a range of locations, including care homes and hospitals. Journeys could be booked in advance or on an ad-hoc basis. The service worked closely with the local NHS ambulance trust to help with the discharge of patients from local emergency departments. They looked carefully at the locations involved and re-deployed nearby drivers if this did not delay other patients.

Requires Improvement

Patient transport services

Facilities and vehicles were appropriate for the services being delivered. Managers showed three vehicles for our inspection and confirmed that all vehicles in their fleet were the same brand and model. Managers converted all vehicles to wheelchair accessible vehicles, and this met the remit that the service was focused on.

Facilities at the base of the service were suitable and shared with their human resources contracted office. Managers were moving offices at the time of our inspection within the same building and were looking to optimise space for other activities such as training and meetings.

Managers monitored and took action to minimise missed journeys. Staff would contact their service partners if they were unable to make a journey in advance and this was then the responsibility of the booking team of the service partner to rebook.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff knew each patient's needs in advance. Patients were given a choice to use their own wheelchair or one provided by the service. They worked closely with carers to explain what was happening in terms that the patient could understand. Extra time was given for people with learning disabilities or confusion. However, managers did not have specific training for dementia and learning disabilities to support staff with this.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff gave examples of helping patients who had hearing, sight and mobility loss. For example, patients with sight loss had access to Brille services, patients with mobility loss had staff assist them by naming areas of the vehicle for support that they could use when entering and exiting the vehicle, and picture prompts were used for patients hard of hearing. All information leaflets and feedback forms supplied met the accessible information standards (AIS).

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff had access to online or telephone language translation services. They were aware of the need to adhere to privacy and dignity when transporting patients. For example, they offered patients a choice of male or female crew and worked to meet individual requests that would help people feel more at ease.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. We looked at data for the three months between April 2022 and June 2022. Expected response times over several parameters ranged from between 84% to 100%. Parameters included pre-planned ward discharges, patients being picked up for and collected from renal dialysis units, and unplanned ward and emergency department discharges. The local NHS ambulance service praised managers for their performance in the meeting minutes we reviewed between the two services.

Requires Improvement

Patient transport services

Managers worked to keep the number of cancelled journeys to a minimum and when patients had their journeys cancelled at the last minute, managers made sure they were rearranged as soon as possible. Managers had overall responsibility for communicating with the booking team of the NHS Ambulance trust and other services when journeys required rebooking. Bookings were organised separately and did not come under the service remit of the service. Managers confirmed that they had not cancelled any journeys in the last 12 months due to service capacity.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them but did not always shared lessons learned with all staff, including those in partner organisations.

Patients, relatives and carers knew how to complain or raise concerns. Staff had feedback forms available in the vehicles informing patients how to raise concerns or give feedback. Managers had received seven complaints in the last 12 months.

Managers investigated complaints and identified themes. Managers reviewed all complaints and investigated the reasons for why they had occurred and learnt lessons from them. Managers responded to written complaints within a suitable timeframe. Where the local NHS ambulance service was involved, they were included in all stages of the investigation.

However, Managers did not always share feedback from complaints with staff. Managers did not complete regular group meetings with staff. It was unclear how learning and feedback from complaints were shared with staff. Managers said that they would meet staff individually if a complaint had directly affected them, however these were not documented and there was no formalised system for this.

Are Patient transport services well-led?

Requires Improvement

We have not previously rated the service. We rated it as requires improvement.

Leadership

Leaders did not yet have the skills and abilities to run the service. They did not always understand or manage the priorities of the service but understood issues the service faced. They were visible and approachable for staff.

The managing directors formed the service in March 2020 and the registered manager started in their post during July 2020. The service was registered with the Care Quality Commission in November 2020. The service conducted their first journey in March 2021. Since this date, the service has expanded obtaining new contracts and new vehicles which has been overseen by both managing directors.

Managers led the service using a remote approach which did not involve group meetings with their staff but instead managers completed one to one meetings on the road in between patients. Leaders used electronic messaging

applications to give messages to their drivers as an alternative to group meetings and messaging histories were seen during our inspection. This appears to work well and there was good natured communication seen from the messages. However, this did not act as a system that monitored staff activities effectively and this was evidenced in sections of this report.

Managers did not conduct recruitment in a suitable manner and risks associated with this were not anticipated. Staff worked independently and had different approaches to their work which sometimes contradicted service remit and policy. There was an ineffective oversight from managers that this was occurring, and this led to areas of unsafe practice.

However, managers talked to their drivers by telephone during our visit on a consistent basis. It was clear that they knew the drivers well and understood their roles. Drivers told us that managers were supportive, approachable and easy to contact. Both managers acted as drivers themselves and divide their time between driving duties and administration duties on a 50:50 basis.

Vision and Strategy

The service had a vision for what it wanted to achieve but there was a clear strategy to turn it into action.

Managers had a vision and strategy for the future of the service. This was built on gaining contracts with further large transport providers and NHS ambulance providers. Although there were informal agreements between the local NHS ambulance service and their other transport provider partner, there were no formal contracts at the time of our inspection. Managers had tried to agree a contract but, to date, this had not proved possible due to resistance from the services. Despite this there was frequent communication between the two organisations and service had been provided with a standard operating procedure for both partners.

Managers felt that growth was possible for the service due to their existing providers continuing to offer available journeys which has contributed to the rapid expansion of their driver workforce and vehicle fleet.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were proud of the work that they carried out. They enjoyed working for the service and were enthusiastic about the care and services they provided for patients. Staff described the service as a good place to work.

Staff felt that their concerns were addressed, and they could easily talk with the managers. They described positive working relationship with each other. Staff told us about a “get together” at Christmas and managers had prepared Easter eggs for the Easter holiday period.

When patients raised concerns, they were addressed in a timely and courteous manner. Staff showed a good understanding of the complaints process and managers maintained accurate records on complaints which included lessons learnt where relevant.

Governance

Leaders did not always operate effective governance processes although it did co-operate with the governance processes of partner organisations. and did not have regular opportunities to meet, discuss and learn from the performance of the service.

Managers had systems for all areas of the business, but there were examples found where the systems were not implemented correctly or there was an ineffective audit system to ensure effective governance was maintained to monitor the quality and safety of the service. For example, there were no audits in place to ensure that managers conducted safe recruitment practices. This meant the managers were unaware of the gaps we found in recruitment records. However, managers ran enhanced checks with the disclosure and barring service before drivers could look after vulnerable adults and children and evidence was seen of this in the files reviewed.

Managers were not always able to supply audit activity for the safe running of their vehicles. For example, staff conducted daily vehicle checks using a paper-based assessment form, but there was not a system for returning these forms or analysing the findings. Staff were expected to ring managers when a problem occurred. Following the inspection managers provided evidence that some areas of risk had been assessed through their risk register.

Managers did hold governance meetings aimed at monitoring and improving quality and safety with the local NHS ambulance service they were providing services for which formed 90% of the business. However, there were no ongoing governance meetings with their other contracts.

Managers did not conduct regular documented meetings with staff. Managers met informally with staff individually on the road to discuss any concerns they held. However, managers were available to staff and were always contactable by phone when journeys ran. Managers sent messages through electronic messaging applications on mobiles and these messages were seen during the inspection and reflected messages on the daily operations of the service.

Management of risk, issues and performance

Leaders did not use systems to manage performance effectively. They did not always identify or escalate relevant risks and issues. Actions identified to reduce their impact were not always carried out. They had plans to cope with unexpected events.

The service had a risk register which was the central document to managing risk across the business. It held 32 risks which had been given a score depending on the degree and likelihood of harm that the risk could produce. Risks were reviewed annually with some examples seen where events of updates in guidance had caused an update to be documented. The risks reflected concerns raised by staff and some of the issues we found during our inspection. There were action plans to reduce these risks, but there were some examples where this was not carried out. For example, deep cleaning arrangements had disrupted due to the impact the existing arrangement had on service delivery. Managers did not note this in their risk register.

Managers did not meet to discuss risk. There were no meetings regularly scheduled to discuss ongoing risk and drivers did not meet with managers formally to discuss risks being encountered. However, managers did log incidents when they occurred and gained learning lessons from this.

Important processes for driver safety and monitoring were not implemented despite their policy stating this. For example, an internal driving licence which checked incidents picked up by drivers' remote cameras wasn't operational or recorded. Managers did say that incidents were discussed with drivers when they occurred, but we could not see a record of these discussions.

There was a business continuity plan which gave guidance to staff should unexpected events such as power cuts or floods take place.

Requires Improvement

Patient transport services

Information Management

The service did collect reliable data or analyse it. Staff could not always find the data they needed to understand performance, make decisions and improvements. The information systems were always integrated or secure. Data or notifications were consistently submitted to external organisations as required.

Managers collected data to satisfy performance criteria needed as part of their agreement with the local NHS Ambulance service. However, this performance data was not shared with staff as there was not a system or meeting structure to enable managers to do this.

Trackers had been installed in vehicles to record if they were exceeding the speed limit or if braking and acceleration was too harsh. However, there was no record of managers checking this data which formed part of their policy.

Managers had information about each vehicle and accurate data was maintained regarding the servicing and licencing requirements for each vehicle. Computers used in the office were password protected and staff switched off computers when not in use to maintain security of data. Booking data was held securely and staff were aware of the requirements associated with General data protection regulation and patient confidentiality. Facilities were seen in the office for confidential waste.

Engagement

Leaders actively engaged with patients to manage services. They collaborated with partner organisations to help improve services for patients. However, this information was not always shared with staff.

There was information available to patients to encourage them to communicate with the service. There were feedback forms in all vehicles and staff encouraged patients to provide feedback on their experience. The service had a website which provided information on services, provided contact information and answers to frequently asked questions.

Managers held quarterly meetings with the local NHS ambulance service, but the information discussed at the meetings was not shared with staff. Managers communicated with drivers on a day-to-day basis but there were no staff meetings to allow staff to express issues of concern or address long-term issues and changes to the service. However, informal group messages were sent to drivers via mobile messaging platforms did provide an alternative to staff meetings.

Managers did not have a staff survey and feedback mechanisms for staff to express concerns formally were limited. However, managers were receptive to concerns that were received from individual members of staff.

Managers spoke of their flexibility towards paying their staff with a choice of to be payed weekly which had received positive feedback from staff and been a reason for attracting new staff to the service.

Learning, continuous improvement and innovation

The service was committed to continually learning and improving services.

Managers spoke about developing web site feedback mechanisms which including live feedback functions to improve their service.

Managers also expressed their pride in forward facing CCTV cameras on all their single crew vehicles which they felt was unique within the industry.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: • The service did not ensure they labelled equipment once staff had cleaned it to reflect Infection Prevention and Control practice. • The service did not ensure governance processes were suitable for daily vehicle safety checks. • The service did not have effective governance and risk processes for the deep cleaning of their vehicle fleet. • The service did not have suitable oversight of staff when considering the service eligibility criteria of the service for patients especially around patients with medical gas requirements.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: The registered person had systems or processes in place

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Requirement notices

that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- The service did not ensure they reviewed their policies to ensure they aligned to the company's current processes.
- The service did not ensure governance processes for the oversight of mandatory training were implemented effectively.

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- The service did not ensure that records for all patient journeys are kept independent of the NHS ambulance service they were sub contracted to.

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

- The service did not ensure that staff employed had all documents recorded in their staff file in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was additional evidence of poor governance. In particular:

- The service must ensure they carry out control of substances hazardous to health (COSHH) assessments for cleaning and disinfectant products.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing Requirements in relation to staffing

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Requirement notices

How the regulation was not being met

The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

- The service did not have effective governance processes for the oversight of staff mandatory training.