F.A.S.T. Ambulance Service Limited

# F.A.S.T. Ambulance Services

## 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.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

F.A.S.T Ambulance Services is operated by F.A.S.T Ambulance Services Ltd. The service provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 13 November 2017.

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.

**Services we do not rate**

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas that the service provider needs to improve:

- Systems to manage stock control and equipment maintenance were not effective.
- There was no evidence to indicate that vehicle defects identified by staff had been repaired or progress made.
- Equipment was not regularly safety tested.
- The staff toilet did not have adequate provisions to prevent the spread of infection; there was no soap, toilet roll or hand towels for staff to use.
- Arrangements for managing, tracking and storage of medicines were not sufficiently robust to provide assurance of safe practice. In particular, we were concerned about the lack of safeguards in relation to the management of controlled drugs.
- We were also concerned that medicines were not safely administered. Emergency Medical Technicians (EMTs) administered medicines without appropriate authorisation.
- The medicine storage system was not secure and access was not suitably restricted.
- Outcomes of reviews of patient care records were not readily available to demonstrate learning.
- The named professional responsible for safeguarding was not trained to level four for safeguarding in line with the recommendations in the intercollegiate document. 'Safeguarding children and young people: roles and competencies for health care staff' (2014).
- Systems in place to monitor training were not effective and did not provide assurance that staff were up to date with their mandatory training.
- Patients' care and treatment outcomes were not routinely collected and monitored. We were not assured that the organisation monitored the effectiveness of care and treatment and used the findings to improve them.
- Recruitment procedures were not operated in accordance with the recruitment policy. This meant the provider was not assured of the suitability, skills, competence and experience of staff for the work they were required to perform
- Governance processes were not effectively monitoring quality and safety.
- There was little evidence of clinical audit or similar arrangements to enable the service to benchmark themselves and review their clinical practice.

However, we found the following areas of good practice:

- The organisation managed incidents well.
- The environment was secure and suitable for safe storage of ambulances and equipment.

# Summary of findings

- All the staff displayed a genuine desire to help people in need and this was reflected in the feedback from patients and clients which was unanimously positive.
- Staff demonstrated empathy and patience. They spoke thoughtfully about being accessible to people of all ages and backgrounds, and told us they adapted their style of communication to the individual needs of those requiring the service.
- Capacity was planned to meet differing demands and resources were where they needed to be at the required time.
- Patient's individual needs and preferences were central to the planning and delivery of the service.
- The organisation treated concerns and complaints seriously and investigated them.
- There were effective systems to engage with the public to gain feedback on services and with staff.
- There was a commitment from frontline staff to provide a high-quality service for patients with a continual drive to improve the delivery of care.
- Staff were passionate about doing the best they could for the patients in their care and there were examples where they went the extra mile to support patients.
- The organisation's motto was to "treat as you wish to be treated" with a vision "to put compassionate care, safety and quality at the heart of everything we do." The aim was to deliver high quality care and to be a patient focused service that understood the needs of its patients and always put them first.
- The registered manager was highly visible and frequently worked alongside staff. He was respected by staff for his knowledge, experience and support.

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 two requirement notices. Details are at the end of the report.

The provider has given us an action plan to address the concerns we have raised through this report and we will follow-up these actions in due course.

**Amanda Stanford**
**Deputy Chief Inspector of Hospitals (South), on behalf of the Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| Patient transport services (PTS) | | F.A.S.T Ambulance provided a patient transport service.<br><br>We found F.A.S.T Ambulance did not provide a safe and quality service under the regulated activities and needed to make improvements.<br><br>At the time of this inspection we did not rate the service. |

# F.A.S.T. Ambulance Services

## Detailed findings

**Services we looked at**
Patient transport services (PTS);

# Detailed findings

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## Background to F.A.S.T. Ambulance Services

F.A.S.T Ambulance Services is operated by F.A.S.T Ambulance Services Ltd. The service has been operating for over 14 years. It is an independent ambulance service specialising in patient transfers. The headquarters are located in Trowbridge in Wiltshire and there are two vehicle bases; one in Frome in Somerset, and the other in Brighton in East Sussex. Services in Brighton are managed remotely from the headquarters.

F.A.S.T. Ambulance Services was registered on 4 October 2011.The registered manager is Tony Morrison, who is a director of the company.

The service has contracts with the local commissioning services in Somerset and Cornwall to provide non-emergency patient transfer services for local NHS trusts.

The service provides 24 hour, seven days a week cover, with weekend and out of hours work undertaken.

There are seven ambulances, one wheelchair car and one responder car at the Frome base, and 11 ambulances and six wheelchair cars at the Brighton base. These are acquired on a lease basis.

The organisation has 15 staff in Frome: one emergency medical technician (EMT) supervisor, eight EMTs, four ambulance care assistants (ACAs) and two advanced life support (ALS). There are 29 staff in Brighton including 28 ACAs and one ACA supervisor. There are also bank staff available including a doctor, ALS trainer and EMTs.

The teams are supported by a group senior manager, an operations manager, compliance manager, training manager, control team and accounts and administrative staff.

We inspected the service on 13 November 2017. This was an announced visit.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector and two other CQC inspectors. The inspection team was overseen by Dan Thorogood, Inspection Manager and Mary Cridge, Head of Hospital Inspection.

## Facts and data about F.A.S.T. Ambulance Services

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

# Detailed findings

During the inspection, we visited the vehicle base in Frome and the headquarters inTrowbridge. We did not visit the base in Brighton. We spoke with seven staff including: emergency medical technicians and managers. We also spoke with one patient. We reviewed 12 patient care records and six staff files.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service was last inspected in January 2014 where one regulation had not been met relating to the lack of a system to regularly assess and monitor the quality of service that people received.

During the period from September 2016 to October 2017 there were 1,062 emergency medical technician patient transfers undertaken and 2,867 patient transport journeys undertaken.

The provider had not reported any never events. There had been seven reported incidents in the last six months one of which involved an injury sustained by a member of staff which had been reported to the Health and Safety Executive. The service had received two complaints in the last six months.

# Patient transport services (PTS)

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |
| Overall | |

## Information about the service

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We found the following areas that the service provider needs to improve:

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- Equipment was not regularly safety tested.
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- Arrangements for managing, tracking and storage of medicines were not sufficiently robust to provide assurance of safe practice. In particular, we were concerned about the lack of safeguards in relation to the management of controlled drugs.
- We were also concerned that medicines were not safely administered. Emergency Medical Technicians (EMTs) administered medicines without appropriate authorisation.
- The medicine storage system was not secure and access was not suitably restricted.
- Outcomes of reviews of patient care records were not readily available to demonstrate learning.
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# Patient transport services (PTS)

- Systems in place to monitor training were not effective and did not provide assurance that staff were up to date with their mandatory training.
- Patients' care and treatment outcomes were not routinely collected and monitored. We were not assured that the organisation monitored the effectiveness of care and treatment and used the findings to improve them.
- Recruitment procedures were not operated in accordance with the recruitment policy. This meant the provider was not assured of the suitability, skills, competence and experience of staff for the work they were required to perform
- Governance processes were not effectively monitoring quality and safety.
- There was little evidence of clinical audit or similar arrangements to enable the service to benchmark themselves and review their clinical practice.

However, we found the following areas of good practice:

- The organisation managed incidents well.
- The environment was secure and suitable for safe storage of ambulances and equipment.
- All the staff displayed a genuine desire to help people in need and this was reflected in the feedback from patients and clients which was unanimously positive.
- Staff demonstrated empathy and patience. They spoke thoughtfully about being accessible to people of all ages and backgrounds, and told us they adapted their style of communication to the individual needs of those requiring the service.
- Capacity was planned to meet differing demands and resources were where they needed to be at the required time.
- Patient's individual needs and preferences were central to the planning and delivery of the service.
- The organisation treated concerns and complaints seriously and investigated them.
- There were effective systems to engage with the public to gain feedback on services and with staff.
- There was a commitment from frontline staff to provide a high-quality service for patients with a continual drive to improve the delivery of care.
- Staff were passionate about doing the best they could for the patients in their care and there were examples where they went the extra mile to support patients.
- The organisation's motto was to "treat as you wish to be treated" with a vision "to put compassionate care, safety and quality at the heart of everything we do." The aim was to deliver high quality care and to be a patient focused service that understood the needs of its patients and always put them first.
- The registered manager was highly visible and frequently worked alongside staff. He was respected by staff for his knowledge, experience and support.

# Patient transport services (PTS)

## Are patient transport services safe?

### Incidents

- The organisation managed incidents well.
- There was an incident reporting policy which set out the processes for reporting and managing incidents. All adverse incidents were reported using paper incident reporting forms.
- Staff were open, transparent and honest about reporting incidents and said they would have no hesitation in reporting incidents, and were clear about how they would report them.
- Staff said they understood their responsibilities to report incidents and near misses. However, they understood near misses to mean traffic collisions rather than patient safety incidents.
- The Operations Manager said staff were informed of outcomes of investigations by email. Staff confirmed they were able to get feedback on incidents they reported.
- There had been seven reported incidents in the last six months, one of which involved an incident where a member of staff sustained an injury which was reported to the Health and Safety Executive. An investigation had been carried out by an NHS ambulance service and the property where the incident occurred was risk assessed after the incident and staff informed of the outcome. Manual handling training was updated to reflect learning and disseminated to staff.
- The organisation recognised its responsibilities under the provisions of duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents and provide reasonable support to that person.
- Although there were no examples where duty of candour had been applied, staff demonstrated an understanding of their responsibilities and were aware of the policy which outlined the systems in place to meet the requirements.

### Cleanliness, infection control and hygiene

- There were systems in place to monitor and maintain standards of cleanliness and hygiene. However, we were not assured of their effectiveness.
- There were supplies of personal protective equipment, such as gloves and masks. However, not all vehicles had hand hygiene gel on board and one vehicle did not have antibacterial wipes. As soon as these omissions were raised with staff new stock was sourced and put in place on the vehicles. We did not see an inventory of stock held on each vehicle and the process for checking stock was not effective.
- We also found the staff toilet did not have adequate provisions to prevent the spread of infection; there was no soap, toilet roll or hand towels for staff to use.
- There was an infection prevention and control policy which included hand hygiene standards, bare below the elbow, waste management procedures, deep cleaning, decontamination, linen management, uniform standards and processes for dealing with accidents and spillages.
- The operations manager was responsible for implementing a monthly audit of staff compliance with the requirements of the infection control policy. We saw that supervisors at both Frome and Brighton bases monitored compliance on an ongoing basis. This information was collated in paper format and any risks or issues were raised at the bi monthly managers' meetings. Minutes of the meetings confirmed this and the actions taken.
- There were a total of 26 vehicles across the Frome and Brighton bases. We inspected three ambulances and a responder car at the Frome base. The vehicles were chosen randomly by the inspection team. Two of the ambulances and the responder car were observed while parked at the location.
- The vehicles were visibly clean and tidy. Staff said vehicles were cleaned at the end of each shift. An external company steam cleaned the vehicles at both the Frome and Brighton bases every month. Records were seen to support the schedules and provided assurance of cleanliness.
- Re-usable equipment, for example, splints and blood pressure cuffs were visibly clean. Surfaces, including seat and trolley covers were mostly intact and easy to wipe clean. However, on one ambulance we saw black duct tape had been used to cover a tear in the plastic on one of the folding passenger seats. On another ambulance the arm rest on the front folding passenger seat was unstable due to a loose screw. This was pointed out to a crew member.

# Patient transport services (PTS)

- We observed a good supply of clean linen. Staff said soiled linen was swapped for clean at the hospitals visited.
- All staff adopted the bare below the elbow dress code by wearing short-sleeved shirts whenever they were engaged in a direct patient care.
- An inspector accompanied staff on a patient transfer journey and witnessed them decontaminate their hands immediately before and after direct contact and care with the patient. The seat in the ambulance used by the patient was also cleaned after use.
- Staff were responsible for cleaning their vehicles at the end of their shift. An external cleaning company steam cleaned the vehicles at both the Frome and Brighton bases. The company had only recently started cleaning vehicles at the Frome location. Prior to this staff had been responsible for this task. We saw records of the cleaning schedules which provided assurance of cleanliness.
- Decontamination of a vehicle was carried out following the transportation of an infectious patient. Staff were able to tell us about the tasks to be carried out immediately following the occurrence but they were not outlined in the infection prevention and control policy.
- Staff were issued with a uniform, which included three pairs of trousers and polo shirts, soft shell shirts with qualification on the epaulettes, a fleece jacket and a high visibility tabard. They laundered their uniforms themselves. Should they become heavily soiled beyond domestic cleaning, they were disposed of and replaced. The staff we met had clean and tidy uniforms. Staff were expected to wear black safety shoes/boots.
- There was a clinical waste disposal policy which described the procedure for disposal. Waste was segregated and clinical waste was held in a secure marked bin and collected every month by an external contractor. Sharps bins were available on each vehicle. They were closed and none were unacceptably full.

**Environment and equipment**

- Although the environment was secure and suitable for the storage of ambulances and equipment we were not assured that systems were in in place to monitor equipment or to manage and track stock.
- The provider operated from an industrial unit. The ground floor could be accessed via the vehicle parking area. There was a main workshop/meeting area, small store room, kitchen and a toilet. The toilet had no lock on the door.
- There were two offices on the first floor. Two fire extinguishers had been installed at the top of the stairs between each of the two offices. Staff said that no fire drills had taken place at the location during the past year.
- Vehicle maintenance was subcontracted to external companies. There were records kept of vehicle maintenance and these were up to date. After the inspection we carried out MOT and tax checks on a randomly chosen sample of 20 of the provider's vehicles using www.gov.uk/check-mot-status. All had a valid MOT and tax certificate.
- Staff told us that their vehicles and equipment were well maintained and fit for purpose.
- There was a vehicle inspection policy which detailed the process to be undertaken by all staff at the start of their shift. Staff completed a Vehicle Defect Inspection (VDI) of the vehicle they would be using. The inspection included damage to the bodywork and wheels, checks of the condition and pressure of all tyres, water levels, engine oil and fluid levels. Exterior and interior lights were checked and the presence of the fuel and oil caps. All medical supplies on the vehicle were checked which included the serviceability of all manual handling equipment and electrical equipment.
- All staff recorded and reported any defects to the operations manager or administration support team.
- We saw a VDI being completed comprehensively prior to the crew going out on a call. We also reviewed forms for the month of October 2017 which were all completed thoroughly.
- However, there was no evidence to indicate that defects identified by staff had been repaired or progress made. This was raised with the Group Senior Manager who said they would work on producing a form to ensure that repairs could be tracked and progress given to the ambulance staff.
- We were told that one of the ambulances parked at the location had developed a defect last week (the rear doors would not close unless slammed shut). It was taken off the road the next day and the lease company

had been asked to collect it. The provider said that they were no longer going to use this vehicle. Laminated signs were available to let staff know that an ambulance had been taken out of service and should not be used.

- The sliding side door on another ambulance did not lock in place. When parked on a slope, as it was at the time of our inspection, the door did not remain locked in place (open) and was, therefore, a safety risk to patients and crew. The staff were made aware of this and the vehicle was taken out of action for repair.
- One ambulance at the Frome base had gaffer tape over the lights in the interior of the vehicle. The crew said that this was to make the level of lighting more acceptable to patients. The tape over the light fitting could possibly be a fire risk and adversely affect the level of lighting required to safely attend to patients' needs.
- In addition to the items on the VDI form we also saw a list of items held on vehicles which included: basic and advanced airway devices, duction equipment, defibrillation and cardiac monitoring, piped oxygen supply, spinal care equipment including scoop stretchers and spinal collars, patient diagnostic equipment, clinical waste bags and first aid consumables. However, there did not appear to be an inventory of items held on each vehicle and of those held in the store room.
- The vehicles we inspected were well stocked however; some of the stock was past its use by date. Some stock was also stored loosely on the vehicles. This could have an impact on stock inventory or cause the stock to be beyond use. We informed the manager who immediately removed these items from the vehicles. This included dressing pads and oropharyngeal (OP) airways. A new stock of OP airways was immediately ordered and the dressing pads were replaced with in date stock. We observed some out of date stock in the lockable store room including 15 containers of decontamination wipes. This room also contained some OP airways past their use by date. This meant that processes to monitor stock were not working effectively and staff could have been replenishing their vehicles with out of date stock.
- Stock items such as needles, syringes, gauze and dressings were all in date and had not reached their expiry date.
- There was a clinical waste disposal policy which described the procedure for disposal. Waste was segregated and clinical waste was held in a secure marked bin and collected every month by an external contractor. Sharps bins were available on each vehicle. They were closed and none were unacceptably full.
- On the floor of the store room we observed a defibrillator which should have been safety tested in March 2017. There were also items such as a temperature gauge, an automated external defibrillator (AED), suction units and an infarct bag valve mask, that were outside their safety testing period. A number of items should have been safety tested in October 2017 but the latter item was due for safety testing in November 2015. The Group Senior Manager advised that this safety testing task was being chased up for completion with the relevant external contractor. This meant that systems to monitor safety testing were not working effectively.
- We saw child seats that could be used on the ambulances and one of the four vehicles inspected had a trolley suitable for bariatric patients. Staff were required to report any near miss, minor collision or similar incident involving the vehicles to the registered manager. We saw examples where staff had used a template to report near misses. Subsequent actions were recorded, for example additional driver training where required.
- In the event of a vehicle breakdown whilst in operation there was a process in place to report the incident to a breakdown company for recovery to an appointed vehicle repair service. A replacement vehicle was organised or arrangements were made with another ambulance service to collect the patient to continue with the journey.

**Medicines**

- Arrangements for managing medicines were not sufficiently robust to provide assurance of safe practice.
- There was a medicine management policy, last reviewed in November 2017. This provided guidance to staff for the management of medicine and included training/education and competency of staff, safe storage and a list of medicines to be administered and by whom. The registered manager was responsible for the implementation of the policy.
- The policy did not include guidance on the supply and administration of medicines under patient group

directions (PGDs). A PGD is a legal framework, signed by a doctor and agreed by a pharmacist. This means a nurse or paramedic can supply and/or administer prescription-only medicines (POMs) to a pre-defined group of patients (PGD) following appropriate training in the use of particular medicines. There were no PGDs used in the service.

- The medicines management policy had two lists of medicines that could be carried and administered by various staff groups depending on level of competency. However, both the Emergency Medical Technicians (EMT) medicines list and medicines bag contained medicines that EMTs were not legally approved to administer, for example Domperidone (for nausea & vomiting), salbutamol and ipratropium bromide nebulisers (for breathing problems). The registered manager did not realise that EMTs lacked the appropriate authority to administer some of these medicines.
- The medicines management policy was, therefore, misleading and the registered manager showed a lack of understanding about medicines legislation. He indicated that medicines were administered in accordance with Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical guidelines. However, JRCALC does not provide a legal framework for administration of medicines. We advised the registered manager of this during the inspection.
- The registered manager had informed the lead inspector that all medicines except oxygen and Entonox gases had been withdrawn from operational use following our concerns.
- Controlled drugs were poorly managed. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse.
- There were no management arrangements set out in the medicines management policy in relation to controlled drugs. Therefore, staff did not have guidance for their use, storage or ordering.
- The service had a controlled drug record book but this was not completed correctly as we found controlled medicines were not booked in or out correctly. We also found a number of missing controlled drugs for which the registered manager could not account, for example there were six ampoules of Diazepam (for injection) missing.
- We did not see any controlled drugs stored within the ambulances. The registered manager told us that all medicines including controlled drugs were kept in a special medicine bag with the member of staff at all times, but we were unable to substantiate this.
- Access to controlled drugs was not restricted and the service did not have a Home Office licence to supply controlled drugs to their staff or provide reason for an exemption. This is a requirement for the possession and supply of controlled drugs.
- There was no waste exemption certificate from the environment agency for the destruction of controlled drugs. This certificate is required to comply with the requirements of the Misuse of Drugs Regulations 2001 by denaturing controlled drugs.
- The service told us they returned controlled drugs to the local NHS hospital who supplied them. We did not see evidence of this and the controlled drug book was incomplete and inaccurate.
- Responsibility for ordering medicines (including controlled drugs) was not covered in the medicines management policy. Any member of staff was able to order medicines including controlled drugs.
- The medicine storage system was not secure and access was not suitably restricted. The key to the filing cabinet which stored medicines, including controlled drugs, was kept in a key safe to which most staff appeared to know the number. Codes for door keypads and key safes were not regularly changed and the store cupboard in which the medicine filing cabinet was stored was not locked. There was no monitoring or oversight to ensure secure access arrangements.
- There was no assurance that medicines were kept at the correct temperature as there was no thermometer or temperature control. The room was very cold and some of the medicines should not have been kept at refrigerated temperature, for example Amiodarone solution (for injection). Room temperature was not recorded.
- The controlled drugs cupboard was used to store items other than controlled drugs.
- Records relating to medicines stock and issue were incomplete. Discrepancies identified in stock levels of medicines were not investigated. There were 'medicine

sign in and out' sheets to record issue and return of medicines. These were not completed correctly and were not an accurate reflection of stock movement or stock. There were significant discrepancies between the medicines on the sign in and out lists and the actual number of medicines available. The registered manager could not account for any of the missing medicines detailed below:

1. There were nine missing ampoules of atropine for injection.
2. There was an ampoule of Amiodarone 300mg/ml not accounted for.
3. Aspirin tablets and Chlorpheniramine tablets were not signed out although the medicine audit demonstrated medicines missing.
4. Two tubes of rectal Diazepam (controlled drug) were missing.
5. There were six ampoules of Diazepam for injection (controlled drug) missing.

- Audits were completed on stock levels at infrequent intervals. There was no evidence of any actions taken as a result of the audits when missing medicines were identified. This was not in accordance with the medicines management policy.
- There was no system to monitor expiry dates. A selection of medicines was checked and found to be within range of their expiry date. However, if the medicines had not been stored at the correct temperature as described in an earlier paragraph above, the dates could be void.
- There was an informal agreement with a local NHS hospital to supply medicines, including controlled drugs. The service used a pre-printed order book to order and buy their medicines. The registered manager told us that any out of date stock was returned to the hospital, however, we did not see evidence of this on the medicine sign in and out sheets.
- There was no evidence to show training and competency assessments to administer medicine had been completed. The registered manager told us staff had regular updates and training sessions on medicines every four to six months. This was informal and no records were kept of these sessions.
- The registered manager provided us with a copy of a medicine competency test paper. However, we did not see evidence of completion in the training records of the staff and it was not clear whether this paper was changed on a regular basis. We saw a list of staff that had completed it but this was undated and there was no other evidence such as completed questionnaires.
- There was a policy for the storage and administration of medical gases. We saw evidence of risk assessments for medical gas cylinders which detailed the control measures in place. These are required under legislation, The Management of Health and Safety at Work Regulations (6) and the Dangerous Substances and Explosive Atmospheres Regulations (DSEAR) (9). Storage areas should be located at ground level in an external area where there is good natural ventilation; storage within a building is not recommended. However, full oxygen cylinders were kept in a locked cupboard in a locked room which was not well-ventilated within a building. Empty oxygen cylinders were stored in a crate on the premises. The registered manager told us a new storage cabinet for oxygen cylinders had been ordered recently.
- The registered manager provided invoices and statements which showed the medical gases were supplied by an approved supplier.

**Records**

- Patient care records were completed for most contacts with a patient, whether they were treated or not, including patients admitted to acute trusts, inter hospital transfers, GP transfers, urgent transfers and transfers to primary care settings. In all situations, as a minimum, staff carried out and documented a full set of observations including: Glasgow Coma Score (GCS) respiratory rate, heart rate and oxygen saturations, blood pressure, pupillary response, pain score and assessment of patient skin.
- Other tests or observations were documented as appropriate, including ECG 3 or 12 lead and blood glucose level. In some circumstances, a second set of observations was documented on route. This enabled the staff and hospitals to gauge the effectiveness of treatment.
- Guidance for completion of records was contained in a Records Management Policy. Forms had to completed in ink, legible and dated and signed. If a mistake was made on the form or any other patient document, the error was amended by a line through it rather than scribbled or crossed out with the member of staff's signature.

There were two copies of the patient care form, the top copy (white) was retained by the provider and submitted for auditing and the bottom copy (green) was handed to the receiving clinician.

- Staff we spoke with understood the importance of accurate record keeping and told us this was frequently discussed.
- We looked at 12 patient care records. They had been completed in black ink, were legible, dated and signed and provided a clear account of the patient's presenting condition.
- Staff were required to return completed records to the base and they were stored securely in the Trowbridge headquarters.
- Records were reviewed to ensure they were fully and properly completed. The clinical lead would look at a random selection of patient records; however, no records were kept to show that these checks had taken place or whether any actions had arisen and any feedback had been given to staff on the completion of records.

**Safeguarding**

- There were policies, systems and processes for safeguarding children, young people and adults.
- Staff were clear that safeguarding was everybody's responsibility. They were able to demonstrate exactly what they needed to do should they have safeguarding concerns about people in their care, other members of the public or their colleagues. They informed us that children were always accompanied by a parent or nurse escorts when on the provider's vehicles.
- Staff were appropriately trained in safeguarding for both children and adults. All staff received level two safeguarding training in line with the recommendations for ambulance staff in the intercollegiate document 'Safeguarding children and young people: roles and competencies for health care staff' (2014).
- However, there was nobody in the organisation trained at level four safeguarding. A named professional is required to be identified and level four trained in line with the recommendations in the intercollegiate document.
- Training was delivered online via an e-learning service and included Child Protection and Safeguarding Adults. The training matrix, which had been in place since July 2017, showed a high compliance rate. All staff in Brighton had completed this training. In Frome 13 of the 17 staff had completed the Child Protection module and 11 of the 17 the Safeguarding Adults module.
- Safeguarding training also formed part of the training syllabus for staff undertaking the First Response Emergency Care (FREC) qualification.
- The registered manager told us there was an assumption that paramedics and doctors had completed safeguarding training as part of other NHS employment. We could not be assured staff had a suitable level of safeguarding adults and children training. This posed a risk staff that were not up-to-date to enable them to recognise different types of abuse and the ways they could report concerns.

**Mandatory training**

- We were not assured that all staff were up-to-date with all necessary mandatory training.
- Although systems were in place to deliver mandatory training, the monitoring processes were not effective enough to ensure staff were up to date with mandatory training.
- A programme of mandatory training was in place for all staff and was provided to all employees on induction and updated on a regular basis.
- An overview of mandatory training was available, and included Health and Safety, child protection, safeguarding, teamwork, risk assessment, data protection, first aid, and equality, food, infection control, mental capacity, leadership, neglect supervisory management, personal safety and additional certificates. There were also plans to source control and restraint training which had been discussed in the minutes of managers' meetings.
- Compliance was monitored by the Operations Manager based at the Trowbridge headquarters. The training was planned and delivered on a 12-month rolling basis.
- Staff were booked onto the training by one dedicated staff member based at the Trowbridge headquarters. The matrix contained the names of staff, training modules and what they had completed. However, there was nothing to indicate to the reader the date of module completion, how long it would be valid for, or explanations where 'completed' had not been indicated. This was pointed out to the Group Senior Manager.
- Training was delivered online via an e-learning service. Staff were given the option to complete the required

training during working hours or at home and received a bonus for completion. An automated email was generated and sent to staff to remind them about training updates.
- Some staff were working towards or had achieved the First Response Emergency Care (FREC) qualification. This is a regulated and nationally recognised qualification specifically designed for those seeking a career in the emergency services, ambulance service, the event and security medical sector or those who work in high risk workplaces.
- During the course staff gained the knowledge, skills and competencies needed to deal with a range of pre-hospital care emergencies, including assisting in advanced procedures, trauma life support, managing a patient's airways, catastrophic bleeding, management of fractures, medical emergencies and medical gases.
- The training programme included first aid, defibrillator / automated external defibrillators (AED), manual handling, fire awareness, safeguarding children and vulnerable adults, moving and handling people, scoop stretcher, spinal immobilisation board, hydraulic stretcher ramp, patient assessment for both medical and trauma situations.
- Staff completed driving training, including training to drive under blue lights and in the hours of darkness. One Emergency Medical Technician said he had received driver training via a police traffic officer and had completed the ambulance institute driver training and blue light D2 certificate training. However, there was no evidence to substantiate this on his staff record.
- The registered manager said there was an assumption that paramedics and doctors undertook relevant training with their main NHS employer. However, there were no systems in place to seek assurance or evidence from staff or their NHS employers that staff were up to date with their mandatory training.

**Assessing and responding to patient risk**

- Risk assessments were carried out for patients who were transported. This ensured the safety of staff and patients who used the service.
- Clinical information was obtained by the booking team prior to commencement of a booked journey to transport a patient and the registered manager and the duty manager carried out a risk assessment of each situation and assigned the appropriate crew.
- Staff undertook a dynamic risk assessment at the start of each journey using the clinical information available and their initial baseline observations.
- Systems were in place to manage patients who deteriorated either mentally or physically. Patients were assessed to identify the early risk of a deteriorating patient. Patient report forms showed that baseline observations were recorded to identify or eliminate serious or life-threatening illness or injury. Staff were also able to access telephone advice from a duty manager or they would summon support from the NHS ambulance service.

**Staffing**

- Staffing levels and skill mix for each patient journey were planned by the registered manager or duty manager on receipt of information provided by those booking the service. Levels for patient transport services were agreed with commissioners of the services and included in the framework agreement.
- Bank staff also provided last minute cover as required, due to sickness or last-minute absence or increased capacity due to demand. There were seven staff on the bank and they were all well known to full-time members of staff. They were always accompanied by a full-time member of staff and never worked alone.
- Managers were trained to operational commander level and were all actively involved on a daily basis as and when demand exceeded capacity. They also did an on-call night shift each week.
- The provider maintained a policy of compliance with the working time directive and every member of staff had the right to work no more than 48 hours a week on average, unless they chose to. However, some of the emergency medical technicians (EMTs) worked as street marshals as part of the security work undertaken by the organisation. Security staff and an EMT worked weekend shifts between 9.00pm and 3.30am in the city centre of Bath. This work was not reflected in the staff rota and conflicted with the policy of compliance with the working time directive.
- HR services were managed by an external provider including pay, sickness and disciplinary issues. We saw a sickness policy which outlined the process for managing absence due to illness and return to work and saw how this had been implemented in an individual's return to work.

# Patient transport services (PTS)

### Anticipated resource and capacity risks

- Anticipated risks were taken into account prior to patient transfers. Staffing levels and skill mix were calculated in liaison with the commissioners of patient transport services.

### Response to major incidents

- There was a process to cope with the effects of a major incident or emergency. This was outlined in a policy which defined the factors that might influence the normal day to day running of the service and the appropriate procedures that would ensure continuity of service.
- Where major incidents occurred at any of the hospitals serviced as a result of a bed crisis, electrical failure or extreme weather, support was provided to clear as many beds as possible and to transport hospital staff to and from the hospital during extreme weather. For example, the crews had transported hospital staff to and from their place of work during recent floods in Somerset where vast parts of the county were cut off for lengthy periods.
- There was also a plan in the event of a disruption to the provider's information technology (IT) infrastructure.

## Are patient transport services effective?

### Evidence-based care and treatment

- There were procedures for the implementation of national guidelines. This included the National Institute for Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), national service frameworks, national strategies, national patient's safety alerts and any other guidelines applicable to the service.
- Policies for staff were available in hard copy at the Frome base. Staff we spoke with said they were aware of the policies and procedures and were able to access them. We looked at a random sample of policies and they were all in date.
- Clinical updates and guidelines were reviewed and disseminated to staff. However, we did not see any evidence that staff had read and understood the information.
- The information recorded in patient care records was used for clinical review to evidence good patient care and rapid, high quality continuation of care for receiving clinicians. The clinical lead would look at a random selection of patient records; however, no records were kept to show that these checks had taken place or whether any education and development needs had been identified for staff.

### Assessment and planning of care

- People's needs were assessed and their care planned in accordance with Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guideline. There was no evidence that this was audited, although we were told that a sample of patient report forms was reviewed by the clinical lead and feedback provided to staff. There was no documentary evidence of this or indication that this was discussed at regular management meetings.
- Staff were made aware of patients' conditions prior to transportation so that they could plan transport accordingly. Information was dependent on that available from the booking team, which in turn was reliant on information from patients and hospitals.

### Response times and patient outcomes

- We were not assured that the organisation monitored the effectiveness of care and treatment and used the findings to improve them.
- The service monitored some relevant activities as part of their internal key performance indicators. This included the number of patient journeys, response times and patient time on vehicles. Monthly management information report templates and spend reports were completed and submitted to show records of all journeys. The management team met regularly with providers who commissioned their services to monitor performance.
- However, there was no evidence that this was reviewed by the management team and benchmarked internally or against other providers to identify areas for action or improvement. Patients' care and treatment outcomes were not routinely collected and monitored.

### Competent staff

- There was not sufficient assurance that staff had the skills, knowledge and experience to deliver effective care and treatment.
- The provider had systems to assure itself of the competency and suitability of staff on recruitment. There was a recruitment policy which stated that staff

would be selected in accordance with their experience and qualifications, evidenced by references, Disclosure and Barring Service (DBS)checks, registration and qualifications, right to work checks and verification of identity checks.

- Each staff file contained a signed comprehensive induction check list which included areas such as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR), risk assessments, vehicle defect inspections, basic life support, safeguarding and Disclosure and Barring Service (DBS) checks.
- There was no evidence that references for some staff had been obtained in accordance with the policy. Only one of the six records we checked contained a record of written references. This was for the newest member of staff who started at the end of August 2017. This meant that the provider could not be assured about the applicant's conduct in their previous employment.
- We checked the employment records for six members of staff. It was not clear in these whether a formal appraisal had been carried out for each person. Staff said appraisals were not happening regularly and managers explained this was being targeted as an area for improvement.
- One of the records for an emergency medical technician showed that this person's mandatory training ran out in May 2017. This was immediately raised with the group senior manager at the Trowbridge head office to follow up and resolve. This meant that processes were not sufficient to ensure staff approaching expiry of key qualifications were being picked up.
- Staff we spoke with told us they felt well supported with training and there was a commitment to training and education within the company. They told us they were encouraged and supported with training and to take responsibility for their own continuing professional development.
- Staff said informal supervision took place during training sessions and in the field with experienced colleagues and clinicians. However, there was no documentation to support this.
- A driving licence policy outlined the monitoring of all staff that held driving licences within the company. All staff engaged in any driving duties were required to hold a full current european driving licence relevant to the class of vehicle being driven with no more than three points on their licence. All operational staff had their licences checked every six months.
- The management team could request to see any member of staff's driving licence at any time. A period of 24 hours would be given or at an agreed time. However, there was no documentary evidence to show when this happened.

**Coordination with other providers and multi-disciplinary working**

- There were agreed care pathways contained in a framework agreement with NHS providers for whom they were contracted to carry out patient transfers. Monthly management information report templates and spend reports were completed and submitted to show records of all journeys. The management team met regularly with providers who commissioned their services to monitor performance.
- Patient report forms were carbonated so that information could be swiftly handed over to receiving NHS ambulance crews or hospital staff.

**Access to information**

- Information was documented on the patient report form to ensure effective assessment and management of patients' care.
- Ambulances were equipped with up-to-date satellite navigation systems.
- A communications policy outlined the processes for using paper-based and electronic information and was committed to the requirements of the Data Protection Act 1998.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Most staff understood their roles and responsibilities for consent, Mental Health Act 1983 and the Mental Capacity Act 2005.
- Training in consent and the Mental Capacity Act 2005 was included in the online training syllabus. The training matrix showed that most staff had completed this training.
- Details about the implementation of the Act were contained in the consent and capacity policy.
- We saw consent to treatment was recorded on patient care forms. This was evident on all of the records we

looked at. Staff said they presumed that the patient had capacity to consent or refuse treatment unless there was a reason to think otherwise. The reason was documented on the patient care record.

## Are patient transport services caring?

### Compassionate care

- F.A.S.T Ambulance Services had limited opportunities to capture patient feedback.
- The organisation's aim was to treat patients with respect, courtesy and compassion and to welcome patients and to let them know what to expect during their time with the service.
- Staff displayed a genuine desire to help people in need. During our inspection we observed one patient transfer where there were excellent interactions between staff and a patient. We saw the patient was treated with the highest levels of compassion, dignity and respect. The staff were skilled in talking to and caring for patients in a calm and relaxed manner. Staff introduced themselves and were open, friendly and approachable but always remained professional. They were very kind and gentle with patient.
- Dignity was ensured in public places and for those in vulnerable circumstances. All the vehicles inspected had working pull down plastic blinds to ensure patient privacy when being supported. In addition, one of the ambulances inspected had a sign on the outside sliding door that read "please knock and wait before entering."
- We saw feedback received from a carer who said, "the crew were brilliant … they stopped whenever they needed and really helped out." Others commented that they found the crew "helpful and friendly" "absolutely fantastic" "give you 10/10 and a gold star." We also saw praise for a crew for transporting an end of life patient home who "all showed great compassion and professionalism in a very emotional situation."

### Understanding and involvement of patients and those close to them

- The aim was to give patients full attention and to try to answer all questions in an open and honest way. Staff said time was allowed for the patient to ask whatever questions they wanted to.
- Staff told us that family members and friends were comforted, reassured and kept informed. If appropriate and safe, they were invited to travel in the ambulance with patients.

### Emotional support

- Staff told us that they took the time to provide emotional support to patients, family members and friends who were distressed, anxious or confused. When we asked them to describe events or situations where they or their colleagues had gone above and beyond the call of duty they said, "it's just what we do … we treat people how we would like our family members to be treated."
- Staff were mindful of how important it was to form a relationship quickly with patients to build their trust. They also understood the impact the care, treatment or condition might have on a patient and to provide extra support when required.
- The registered manager told us how the focus was always about delivering a personal service with the patient being at the centre. He said how proud he was of the way staff conducted themselves when transporting end of life patients to their home. The situation was often distressing for the patient and their family and staff went the extra mile to make the patient as comfortable and supported as possible during the journey and transfer to their home. He said it made a real difference commenting "it means everything to the patient and their family." Staff would also regularly make a drink and a sandwich when taking a patient home if they lived alone.

## Are patient transport services responsive to people's needs?

### Service planning and delivery to meet the needs of local people

- Capacity was planned to meet differing demands.
- The provider ensured resources were where they were needed to be at the required time. Planning was informed by liaison with commissioners of patient transport services where operating requirement frameworks were in place for both non-emergency passenger transport for a county council and a clinical commissioning group and for emergency patient transport for NHS trusts.

# Patient transport services (PTS)

- Patient transport services were mainly provided in the Somerset and Brighton areas but trips for repatriation took place across the country.
- A new field of work had been undertaken involving the transportation of patients with mental health issues from a local NHS trust under the Mental Health Act 1983. Two bookings had been completed and a nurse escort had been available to accompany the patient. Patients who went voluntarily to hospital would be transported but not those under section three of the Act who required extended detention. Restraint techniques were not used although there were plans to source conflict and restraint training to support staff in this new field of work. However, we were not assured that appropriate risk assessments had been carried to ensure the safety of this patient group and staff.
- The booking team were informed when patients were subject to a Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) decision. Patients travelled with their original documentation. Staff had a responsibility for the continuation of patient care and this included DNACPR decisions if they had been put in place by a hospital prior to discharge or transfer.
- Children were rarely transported and if they were they had a nurse escort and /or a parent.
- The majority of bookings were by telephone calls and emails, this included GPs and private transfer requests. Most bookings were made on the day but some were pre-booked.
- Work was undertaken for an NHS ambulance service in the south-central region and a number of NHS hospitals in Bristol, Bath, Somerset, Cornwall and Southampton.
- The operations manager rang or emailed the providers every morning to inform them of their capacity and availability.
- The operations manager worked from 8.30am to 5.30pm and took phone calls in the evening when on call. Crews were given details of their jobs by encrypted text on their work phones. The operations manager co-ordinated all work to streamline the service.
- All jobs were entered onto a booking form and the details were put onto a spreadsheet on a secure workforce management system. Details taken included: the date, time of journey and destination to and from; a description of the journey i.e. type of crew mobility of patient; the patient's details and any other relevant details. All data was encrypted to ensure safe storage.
- The system then generated a text message to the registered manager for an oversight of work in progress.
- Rotas were compiled and staff could make requests for shifts. Full time staff were contracted for 36 hours per week on 12-hour shifts, with no more than five shifts a week. The Operations Manager noted all shift swaps and these were transferred onto the computer system. However, the operations manager kept a note of extra shifts worked but these were not reflected on the rota we saw and a member of staff also said they regularly worked six days a week.
- A daily running sheet was provided for all crews to complete with details of the patient's name, collection and delivery address, times of arrival and departure and miles covered.
- Invoices were generated from bookings processed by the control room and generated weekly.

**Meeting people's individual needs**

- Patient's individual needs and preferences were central to the planning and delivery of the service.
- Staff spoke thoughtfully about being accessible to people of all ages and backgrounds. They showed an understanding of the different needs of people using the service, and told us how they adapted their style of communication to the individual needs of those requiring the service.
- A protocol was in place for the management of transporting mental health patients. On receipt of a request the control room discussed the request with the duty manager to arrange a suitable crew. A decision was made about the appropriate number of staff required to accompany the patient in the rear of the vehicle; either two or three staff depending on the information and risk assessment provided by clinical staff.
- Processes were in place if the crew experienced concerns about the patient including parking the ambulance in a safe environment; using emergency lights if necessary to warn other road usersand informing control of their concerns; and allowing the patient to leave the vehicle.
- New personal digital assistant (PDA) devices had been introduced with a panic alarm which sent a message to the control centre, informing the duty manager that there was an emergency in the vehicle.
- The duty manager, would up-date the police accordingly. The duty manager could also consider dispatching other resources should this be required.

- However, there were no communication tools available to staff to support patients with communication difficulties or people whose first language was not English. Staff we spoke with told us they had not experienced occasions when such tools were needed.
- There was no specific support available for people who were living with dementia, although staff told us that they would rarely encounter this patient group unaccompanied at events or for transfer.
- Equipment was available to accommodate bariatric patients.

**Access and flow**

- Systems were in place to ensure resources were where they needed to be at the time required.
- The provider recorded relevant timings of journeys and destination to and from. This was all recorded on the secure workforce management system
- The service was accessible and operational 24 hours a day, seven days a week, to receive calls, manage bookings and respond to queries. Out of hours and at weekends managers were available.
- The provider confirmed work at short notice could be undertaken if there were staff available with the specific skills and training needed. They told us the most difficult staffing problem was balancing demand with staff availability.
- Cardiac transfer for rescue angiogram, angioplasty, cardiac MRI and ICD / CRT and transfers to tertiary centres were both pre-booked and in emergency.

**Learning from complaints and concerns**

- The organisation treated concerns and complaints seriously and investigated them.
- There was a complaints policy. Staff were aware of the policy and the complaints received and any learning that had resulted. The policy and procedure aimed to ensure that complaints were dealt with efficiently, openly, fairly and consistently.
- The organisation's website contained information on raising concerns and making complaints.
- Prior to the inspection the organisation provided details of the complaints in the period from June 2017 to the time of the inspection. There had been two complaints and we saw details of the outcomes, actions taken and lessons learned.
- Complaints were reported to the duty manager who interviewed all staff involved and fully investigated. All findings were recorded and reported to the operations manager for review. Findings were presented to the senior management team and an action plan was discussed. The complainant received a verbal response within 24 hours and a written response within five working days.
- Action was followed up, including any disciplinary action needed or training identified. Meetings were held by the management team to discuss and review trends and outcomes. Minutes of the meetings showed evidence of the discussions and actions taken.
- A complaint or concern could be made verbally to any member of staff. That member of staff had responsibility for handling the issue and had a vital role to play in attempting to resolve the issue at the time eliminating the risk of it developing into a formal complaint requiring a written response.
- A log was maintained of all complaints and concerns and where there was learning for an individual member of staff this was copied to their personal file.

## Are patient transport services well-led?

**Leadership / culture of service related to this core service**

- The leadership of the service comprised the registered manager, the group senior manager, an operations manager, compliance manager and training manager. They had some of the skills, knowledge and integrity to lead the team but needed to improve in some areas. The registered manager was experienced and passionate about the service with a commitment to the patients who used the service, and to their staff. They were visible and available to staff, and we saw and heard about good support for all members of the team. Staff felt able to openly discuss issues and concerns with their managers. They believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed.
- Although the registered manager was very involved in operational functions his focus going forward was to maintain the business and develop core work and

relationships with clients to secure committed contracts. A recent investment had been made by employing an additional operations and compliance manager to oversee day-to-day functions.
- There was a clinical lead. This role was undertaken by an Emergency Medical Technician (EMT). The role was in its infancy. They reviewed a sample of patient care forms. None of these activities were documented and they recognised there was need to formalise their role and document their activities.

**Vision and strategy for this this core service**

- The organisation had a clear vision and strategy to deliver good quality care to patients.
- There was a business plan for 2016 – 2019 which outlined the recent restructure of the management team to include an additional operational and compliance manager to strengthen the governance aspects of the service. Business objectives were included in the plan and related to the review, monitoring and maintenance of services, and the completion of major tenders and growth in new business.
- The organisation's motto was to "treat as you wish to be treated" with a vision "to put compassionate care, safety and quality at the heart of everything we do."
- The aim was to deliver high quality care and to be a patient focused service that understood the needs of its patients and always put them first. To achieve this the provider required a competent workforce, effective communication, teamwork, dignity and respect for patients, clients and staff.
- Staff passionately articulated how important it was to them to make a difference which mirrored the organisation's values.
- The registered manager was committed to building the reputation of the organisation based on its performance alone, competing vigorously but not unfairly with others. He was passionate about building the business through hard work and was committed to developing new business contracts.

**Governance, risk management and quality measurement (and service overall if this is the main service provided)**

- Policies and procedures were available in a folder for staff to use. Most had been reviewed this year. However, staff said they were very detailed and did not always accurately describe the arrangements in place.
- All management functions for the Frome and Brighton bases were carried out at the headquarters in Trowbridge. There was a clear structure for governance with regular bi-monthly meetings with the directors, managers and supervisors from the Frome and Brighton bases. Minutes from these meetings showed that issues affecting the service were discussed and actions monitored. These included a review of key performance, risk, training, recruitment, policies and procedures, communication, complaints and commendations and the cleanliness of the bases. The importance of staff obtaining feedback from patients had been raised as a concern at one meeting and we could see this had been addressed with a drive to encourage staff to obtain feedback. Improvements were noted in subsequent meetings with details of the comments received.
- However, there was little evidence of clinical audit or similar arrangements to enable the service to benchmark themselves and review their clinical practice. Clinical governance arrangements were developing with the introduction of a new clinical quality strategy to ensure on-going improvement in quality and safety of patient care over the next three years. The new clinical lead was developing the clinical governance agenda and had been challenged to keep a good pace with this work.
- Risks were identified on a risk register and included clinical, non-clinical, corporate, business and financial risk. The Risk Management Policy outlined the approach to risk management achieved by building and sustaining an organisational culture which encouraged risk taking, effective performance management, and accountability for organisational learning.
- A risk register was maintained for all activities. Reports were discussed at each management meeting. However, we did not see any evidence to show how risks were mitigated.
- We saw insurance certificates for employee liability, medical malpractice and combined liability, motor fleet and breakdown.

**Public and staff engagement (local and service level if this is the main core service)**

# Patient transport services (PTS)

- There were systems to engage with the public to gain feedback on services. This was used for and learning and development. However, public engagement was challenging.
- Feedback was obtained through a client evaluation form. Questions included communication during the booking process, timekeeping, infection control, cleanliness of vehicle and staff, staff attitude and knowledge and professionalism and overall satisfaction. A score between one and five was available with one being unacceptable and five being excellent with a section for additional comments. There were also "How did we do today" forms to comment about the service received. Questions included whether the service and treatment and care was to an acceptable standard, whether the crew were polite and courteous, the vehicle was clean and tidy and how comfortable the journey was. Answers ranged from strongly agree to indifferent and strongly disagree.
- We looked at 23 forms from the period 28 March to 19 October 2017. Nine forms strongly agreed, the remainder had a combination of strongly agreed and agreed with one form disagreeing and strongly disagreeing that standards were acceptable. Comments included "the crews are amazing, really supportive, kind, passionate, and funny."
- There was a link on the website to the feedback form and communication was also available through social media. Feedback was collated and shared with staff.
- The manager realised that it was not always easy to actively seek feedback from patients being transported and was considering promoting greater opportunities for people to give feedback. Staff were also being encouraged to use the patient feedback form. On the staff notice board we saw a memo that reminded staff to "start using the patient feedback forms and attach to your daily running sheets." The 'How did we do today?' forms were available in each of the vehicles we inspected.
- We saw positive feedback where a police officer commented in a letter about a crew who went out of their way and stopped to assist with a collision on the M5, using their emergency warning lights on the vehicle to keep those involved in the collision safe until the police arrived. They remained on scene and continued to assist the officer who said he was "thoroughly impressed by how professional they were," they are a credit to themselves and your organisation."
- Feedback from a local hospital who used the service for patient transfers said, "I can testify that the company has always responded in a timely way to every request (for transfer services) that has been made." They continued that "over the years the crews have dealt with emergencies … the situations have always been dealt with effectively and efficiently. The service is professional, effective and cost effective and appreciated by staff and patients alike."
- There were also systems to engage with staff. A new staff handbook had been developed, however, staff said they had not seen it at the time of the inspection and had not been involved in its development.
- The staff we met said they felt valued and enjoyed being part of a team who worked together for the benefit of people who needed them. They were able to express their opinions and raise concerns. Information was provided to staff through regular newsletters and meetings. There was regular communication between staff and managers. Staff were proud of their work and the quality of service that was delivered to patients. There was a good culture among staff and they enjoyed their work.
- There was a communication diary at the base for staff to report any issues or problems. Staff said they could telephone their manager or each other for a debrief following difficult situations.
- There was a WhatsApp group for communication between management, directors, operational staff and external mechanics.
- The organisation had a stress policy which outlined a commitment to protecting the health, safety and welfare of their employees. Managers were responsible for identifying and reducing workplace stressors and for providing support to individuals. Staff had access to free counselling.
- The registered manager was responsible for implementing the equal opportunities policy within the organisation. The policy covered behaviour to one another as well as employment and career procedures. Unacceptable behaviour was challenged. However, we did not see any evidence to support this.

**Innovation, improvement and sustainability (local and service level if this is the main core service)**

- There was a focus on improving the quality of care for patients and developing services to ensure sustainability of the service.

# Patient transport services (PTS)

- A new workforce system had been introduced to allocate and invoice bookings and phones were available for all staff to receive encrypted messages about work allocation.
- We saw the organisation's corporate and social responsibility strategy which outlined the organisations aim to deliver services effectively whilst simultaneously maintaining and managing the sustainability of all services. It enabled the organisation to measure how they were delivering company objectives in line with environmental, social and ethical issues.
- A number of initiatives were in place to meet the goals of the strategy. These included fundraising for a local hospital appeal; yearly donations to charity; and a training scheme for local people helping both the community and the business; using local suppliers where possible which was achieved whilst renovating the head office.
- The provider was committed to reducing the carbon footprint by implementing a paperless document management system which had currently reduced the use of paper by 50%. All paper used for administration was recycled where possible.
- They were also committed to reducing the use of energy on all properties. All electrical items were switched off when not in use and the use of heating was kept to a minimum for a comfortable working environment.
- A commitment to a reduction of fuel usage was also encouraged. All employees were encouraged to car share where possible and the provider was currently scoping the possibility of sponsoring a cycle to work scheme.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital MUST take to improve

- Have systems in place to monitor safety testing of equipment.
- Have systems in place to manage and track stock held on each vehicle and in the store room to ensure it remains in date.
- Apply to the Home Office for a licence required for the possession and supply of controlled drugs.
- Review the arrangements for the management, tracking and storage of medicines.
- Make medicine storage systems secure and access suitably restricted.
- Regularly change codes for door keypads and key safes and ensure the monitoring and oversight of secure access arrangements.
- Review the policy for the management of medicines to ensure that it reflects arrangements in place and is fit for purpose, including controlled medicines.
- Ensure that PGDs are implemented to enable safe administration of medicines.
- Ensure that all staff only administer and supply medicines including medical gases they are authorised to do so within the legislation.
- Ensure medicines including medical gases and those requiring refrigeration are stored securely.
- Ensure there is evidence of medicine updates for all staff.
- Ensure at least one person in the organisation, the named professional, is trained in safeguarding level four.
- Ensure that records are kept to demonstrate that all staff on recruitment and throughout their employment, are of suitable character and have the appropriate skills, competence and experience which are necessary for the work they perform.
- Have systems in place to ensure training is up-to-date for all permanent and bank staff.
- Review all policies to ensure they accurately reflect the arrangements in place and to have a system in place to show staff had read new guidelines and policies.
- Implement effective governance arrangements to provide ongoing assurance of quality and safety.

### Action the hospital SHOULD take to improve

- Provide training for staff to ensure they understand the definition of near misses to mean patient safety incidents rather than traffic collisions.
- Provide soap, toilet roll and hand towels in the staff toilet for staff to use.
- Devise a system to ensure that vehicle repairs could be tracked and progress given to the ambulance staff.
- Conduct regular fire drills at all locations.
- Remove the gaffer tape over the interior lights in one vehicle.
- Continue to develop participation in clinical audit and to develop a system to demonstrate learning.
- Have a clinical quality dashboard or equivalent system to monitor safety performance.
- Have a system in place to track the progress of vehicle repairs.
- Provide clear signage for the storage of medical gas.
- Conduct risk assessments for those patients with mental health issues who are transported from a local NHS trust under the Mental Health Act 1983.
- Provide communication tools to support patients with communication difficulties or people whose first language was not English.
- Continue to look at ways of obtaining feedback from patient.
- Involve and inform staff about service developments.

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 | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>• Care and treatment must be provided in a safe way for service users<br>(2) (c) ensuring that persons providing care and treatment to service users have the qualifications, competence, skills and experience to do so safely<br>(2) (e) ensuring that equipment used by the service provider for providing care and treatment to a service user is safe for such use and is used in a safe way<br>(2) (f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs<br>(2) (g) the proper and safe management of medicines<br>How the regulation was not being met:<br>• Recruitment procedures were not operated in accordance with the recruitment policy. This meant the provider was not assured of the suitability, skills, competence and experience of staff for the work they were required to perform<br>• Systems were not in place to ensure training was up-to-date<br>• Systems were not in place to monitor safety testing of equipment<br>• Systems were not in place to manage and track stock to ensure it remained in date.<br>• Arrangements for managing medicines were not sufficiently robust to provide assurance of safe practice |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
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| Transport services, triage and medical advice provided remotely | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>**(2) Systems and processes must be established and operated effectively to prevent abuse of service users**<br><br>**How the regulation was not being met:**<br><br>• The named professional responsible for safeguarding was not trained to the appropriate level. |
| Transport services, triage and medical advice provided remotely | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**(1) Systems and processes must be established and operated effectively to ensure compliance with this Part**<br><br>**(2) Without limiting paragraph (1) such systems or processes must enable the registered person to**<br><br>**(a) assess monitor and improve the quality of the services provided in the carrying on of the regulate activity (including the quality of the experience of the service users in receiving those services)**<br><br>**How the regulation was not being met:**<br><br>• Policies and procedures did not reflect arrangements in place and were not effectively operated or fully complied with<br>• There was not an effective governance framework to support the delivery of good quality care |