Mind and Behaviour Limited

Aero Medical Ambulance Service

Quality Report

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

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

Aero Medical Ambulance Service is operated by Mind and Behaviour Limited. The service provides patient transport and is an independent provider of emergency and non-emergency private ambulances. The services covered include the repatriation of people from overseas, short and long distance ambulance journeys within the greater London and surrounding area.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 28 February 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 of good practice:

- The service had processes and systems in place to keep patients and staff safe from avoidable harm. This included a process for reporting incidents, effective cleaning regimes, and appropriate maintenance of equipment.
- There was a safety culture surrounding the management of medicines, with a medical director taking ownership of the process. Medicines were stored, administered, and disposed of appropriately.
- Patient records had detailed risk assessments and were found to be legible. Identifiable information was stored securely. The service was registered with the Information Commissioner's Office.
- Staff completed training appropriate to their roles and responsibilities.
- The service worked collaboratively with local healthcare providers and individual patients to provide a safe transfer between locations. Transfers were bespoke to the individual's needs and the service was able to facilitate the transfer of patients with additional needs, such as patients living with a dementia, registered blind and bariatric.
- Local policies and guidance were largely based on national guidance and recommendations.
- The service used a template to record all relevant patient information for transfer and event bookings. This ensured that all staff were aware of the details of the service being provided. Copies of the information was shared with the patients.
- The service had systems in place to ensure staff competence prior to completing any roles. Bank and agency staff completed a service induction programme and worked alongside the manager who would identify any learning needs.
- Staff had completed Mental Capacity Act training and were aware of their roles and responsibilities in ensuring consent and escalating concerns.
- Facilities were appropriate to the needs of the service. Ambulances were secure.
- The registered manager had the appropriate skills and experience to manage the business, and was supported by clinical experts to provide a safe service.
- The service had a clear vision for development. This included the introduction of a quality assurance framework and quality dashboard.
- The service had a risk register, which was descriptive and detailed actual and potential risks.

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

Summary of findings

- To consider keeping a formal vehicle maintenance log: however, we found that there was evidence to support that all necessary maintenance was completed when it was required.
- The service did not have a major incident policy or plan.
- A small number of policies were not dated with the year of writing nor had a date for next review.
- Due to the small size of the service, there was no formal audit process or audit calendar in place but we saw evidence of equipment and checks carried out when required.
- Due to the small size of the service, it did not formally record any details of one to one discussions, coaching or mentoring sessions. The service was in the process of transferring to an electronic management system, which would facilitate this process.
- Due to the small size of the service, there was a limited governance system but there was evidence of an audit trail of email discussions about quality improvement.
- Due to the specific nature and small size of the service, it did not have any key performance indicators and did not routinely monitor performance, although it did capture patient feedback through questionnaires.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Edward Baker

Deputy Chief Inspector of Hospitals (Central Region)

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Aero Medical Ambulance Service is a small ambulance provider based in greater London. The service primarily completes private patient transfers between healthcare providers and the patient's home. A smaller portion of the workload is the provision of first aid services at planned events such as 'fun runs'. There are three ambulances and one people carrier registered to the service, with one vehicle being used regularly. The remaining vehicles were used as support vehicles. The registered manager was the only substantive member of staff, who was supported by a medical director and supplemented by bank and agency staff. Effective processes for reporting incidents, cleaning regimes, and appropriate maintenance of equipment were in place. There was a safety culture surrounding the management of medicines, with a medical director taking ownership of the process.

Aero Medical Ambulance Service

Detailed findings

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Patient transport services (PTS)

Detailed findings

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Background to Aero Medical Ambulance Service

Aero Medical Ambulance Service is operated by Mind and Behaviour Limited. The service provides patient transport and is an independent provider of emergency and non-emergency private ambulances. The services covered include the repatriation of people from overseas, short and long distance ambulance journeys within the greater London and surrounding area. The service also provides first aid cover for planned events such as 'fun runs'. The service does not provide an emergency response service.

The largest proportion of clients are those transferred from the local international airport to private hospitals, transfers between hospitals or transfers to or from a patient's home and a hospital.

The service was previously inspected in May 2012, February 2013 and January 2014 and was found to be compliant in five key questions including treating people with respect and involving them with their care, providing care, treatment and support that meets people's needs, caring for people safely and protecting them from harm and the quality and suitability of management.

Aero Medical Ambulance Service is operated by Mind and Behaviour Limited. The service opened in 2008. It is an independent ambulance service in Abbots Langley, Hertfordshire. The service primarily serves the communities of the greater London area.

The service has had a registered manager in post since 2008.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,Justine Eardley, and one other CQC inspector. The inspection team was overseen by Phil Terry, Inspection Manager.

How we carried out this inspection

Aero Medical Ambulance Service provides the transportation of patients between providers, locations and patients' homes. The majority of services are provided around greater London and the surrounding counties: however, the service does transfer patients over longer distances upon request.

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Transportation Services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

During the inspection, we visited the base unit. We spoke with the registered manager. During our inspection, we reviewed 20 sets of patient records. We inspected four vehicles at the base site. This included three ambulances and one staff transportation vehicle.

Detailed findings

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in December 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (January 2016 to January 2017)

- In the reporting period January 2016 to January 2017, there were 508 patient journeys undertaken and the service provided cover at four planned events.

The service employs one full time and two part time bank staff members. A named medical director assisted with the clinical management of the service.

Track record on safety:

- No never events
- No clinical incidents
- No serious injuries
- No complaints

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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Summary of findings

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There are three ambulances and one people carrier registered to the service, with one vehicle being used regularly. The remaining vehicles were used as support vehicles. The registered manager was the only substantive member of staff, who was supported by a medical director and supplemented by bank and agency staff.

Effective processes for reporting incidents, cleaning regimes, and appropriate maintenance of equipment were in place. There was a safety culture surrounding the management of medicines, with a medical director taking ownership of the process.

Patient transport services (PTS)

Are patient transport services safe?

Are services safe?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- The service had processes and systems in place to keep patients and staff safe from avoidable harm.
- Although the service had reported no incidents, no serious incidents and no never events, staff were aware of their roles and responsibilities to report, investigate and learn from incidents, offering apologies and explanations to patients in an open and transparent manner.
- Infection control and prevention practices were maintained by staff through the effective use of cleaning regimes, protective equipment and quality checks.
- The service managed the use, storage, and disposal of medications and medical gases safely.
- Facilities were appropriate to the needs of the service. Ambulances were secure.
- Patient records were legible and detailed information relevant to the service. Identifiable information was stored securely.
- Staff had appropriate training and qualifications to complete their role effectively. This included safeguarding children level 2, intermediate life support and manual handling training.
- Patients, planned journeys and events were risk assessed prior to completion. Templates were used to collect key information such as past medical history, any clinical risks, mobility issues, and equipment needs.
- Patients requiring specialist care were accompanied by a clinical specialist for the duration of their journey.

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

- To consider keeping a formal vehicle maintenance log: however, we found that there was evidence to support that all necessary maintenance was completed when it was required.
- There was no major incident policy or plan.

Incidents

- Staff were aware of their roles and responsibilities in the reporting of incidents, near misses and concerns.
- The service had systems in place for the recording and management of incidents. This included a written report at the time of the incident by a member of staff involved, a process for investigation by the manager and feedback of any findings in person.
- During inspection, we were told that there had been no incidents or serious incidents, which required investigation. The service did not use a database for the recording or monitoring of incidents, investigations, outcomes or learning. However, the manager was in the process of implementing a computerised management system, which had this facility. As there had been no incidents reported, we did not see any evidence of incident recording, investigations, or feedback to staff.
- We saw that incident-reporting forms were available on each vehicle to enable them to be completed at the time of the incident.
- The manager attended all transfers and was therefore, in the event of an incident, able to update staff with any changes in policy or guidance and any learning. All updating and sharing of information was completed verbally, with no formal written communication across the team.
- The service reported no never events from February 2016 to February 2017. A never event is a serious patient safety incident that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious harm or death but neither need have happened for an incident to be a never event.
- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were aware of duty of candour and their responsibilities in informing patients when something went wrong. We were told that apologies would be made and the patient would be involved with the investigation and informed of any resulting action.

- The service had a duty of candour policy and procedure, which was undated; however, it did outline guidance on actions to be taken by staff when an incident occurred. The policy also contained an incident log template to be used in the event of all incidents.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- Due to the small size of the service, there was no quality dashboard in place. The manager monitored activity and patient satisfaction, using questionnaires and feedback forms to identify areas for improvement.
- The service was in the process of compiling a quality dashboard using an external provider. We saw samples of dashboards, which would be used, which outlined staff training, number of complaints, incidents and audit results. The manager was planning to have the dashboards in place by mid-2017.

Cleanliness, infection control and hygiene

- The service had effective systems in place to ensure the cleanliness of equipment to maintain patients' safety and protect them from healthcare associated infections. This included pre and post-use cleaning regimes and monthly quality control checks.
- We saw that the service had an infection prevention and control policy, which detailed routine practice and control measures for all staff. This included guidance on uniform, personal protective equipment and cleaning regimes.
- All equipment was visibly clean at the time of inspection. Equipment was stored appropriately to ensure that it remained free from dirt and dust.
- There was a robust cleaning schedule, which detailed the frequency, method, standard and responsibilities of cleaning the equipment in use and the ambulances.
- We saw a record of cleaning for each vehicle and were told that the crew would complete the initial vehicle cleans following a patient transfer. Vehicle maintenance operatives provided deep cleaning.
- Staff informed us of the cleaning processes used between patient transfers and described different cleaning materials for different items of equipment. We were also informed of the processes used for specialist cleaning following blood spillage, and saw that blood spillage kits were available on each vehicle.
- When the service provided a working environment for multiple patients, such as a 'fun run', staff used clinical wipes to clean equipment between use with different patients.
- There were cleaning logs recorded monthly, which detailed swab results of cleaned equipment. This process confirmed that equipment had been cleaned appropriately and was safe to use. The manager completed the audit.
- Personal protective equipment, such as gloves and aprons, were available on each ambulance.
- We saw that sanitising hand gel was available on each vehicle. Staff were able to account for when this would be used.
- As the service completed only pre-planned transfers, staff could be informed of any communicable infection risks prior to completing the transfer. Additional precautions such as goggles and masks were available if necessary.
- If concerns arose regarding the possible risks of contamination, the service lead spoke with the medical director who would advise on appropriate actions to be taken.

Environment and equipment

- The service was managed from the private address of the registered manager. Ambulances were located onsite, with an equipment store attached to the address. The address had a designated office area with secure cupboard for records and business related files.
- There was a detailed equipment policy, dated December 2016, which outlined the processes for maintaining medical devices, staff responsibilities for single use items, and the reporting and repair of faulty equipment.
- We saw that all vehicles were registered with valid Ministry of Transport (MoT) certification, with appropriate insurance in place. All keys were kept securely within the property.
- The service predominantly used one vehicle, which was found to be in good condition. There were two other ambulances available, which were reported to be used in emergencies and classed as "back up". One vehicle had recently been collected by the service and was not in use.
- Due to the small size of the service, the manager maintained a a record of all vehicle checks that were carried out on a regular basis by filing receipts of work

logged by date of work completed. The manager told us that an additional, separate vehicle maintenance log would be an unnecessary duplication of work. The manager reported that this was due to the type of service that if anything was wrong with a vehicle, work was completed as soon as possible. We saw that the manager maintained records relating to work completed by external companies, such a fan belt replacement and regular servicing.

- Similarly, any faulty equipment was removed from service by the manager and a replacement provided. Faulty equipment was referred to an external provider for any maintenance work under a local agreement. There was sufficient equipment available to enable maintenance work to be completed, without affecting the service or patient safety. All equipment was returned to the service within an agreed timescale.
- The service had systems in place to ensure the safety and maintenance of equipment. All equipment was serviced and maintained annually. We saw records for all equipment used showed date of service and date of service expiry. The manager informed us that equipment was routinely serviced from January to March each year. Equipment had stickers to show the date of last service and the date the next service was due.
- Equipment provided was similar or the same as that used by the local NHS ambulance service which meant that staff were able to use the equipment safely. The manager told us that new staff completed an induction programme, which included familiarisation with equipment to ensure patient and staff safety.
- We saw that equipment was available to ensure patient safety throughout a journey. This included a bariatric chair and wheelchairs, which could be strapped into place for safety.
- Although the service did not routinely transfer children, staff had access to paediatric straps and child booster seats for children aged one month to five years. On occasions where children were transported, they were accompanied by a specialist nurse and or doctor who provided any equipment. This included emergency equipment. The service had a stock of children's airways equipment for emergencies.
- Patients using the service, who had their own equipment such as wheelchairs, were assessed prior to agreement of the transfer by the service lead. This process ensured that the vehicle was appropriate and that the transfer would be safe.
- As the service routinely completed one transfer at a time, returning to base between patients, maintenance of equipment and replenishment of stock was completed after each patient journey.
- The service provided appropriate waste disposal systems, which included domestic waste, clinical waste and sharps bins. This was stored in a secure cage until collection by an external provider. We saw that clinical waste was collected at six weekly intervals.
- Fire extinguishers were available in the vehicles and had undergone checks to ensure safety.
- The service was not used for the transfer of patients detained under the Mental Health Act (1983).

Medicines

- The medical director and registered manager took responsibility for the safe provision and management of medications. There was an effective system in place to manage medicines. Medicines were prescribed by the medical director, and were collected and stored securely by the manager.
- The service had a medicines' management policy in place, which outlined the details for purchasing, storing, disposal, and recall of medications. The policy was dated December 2016 and contained relevant details for staff to follow.
- Apart from oxygen and nitrous oxide (Entonox, a medical analgesic gas), medicines were not routinely provided by the service. Clinical specialists accompanying patients provided their own medications for transfers. Private patients were responsible for their own medications and the service would offer a secure location for their safe keeping during the journey only.
- A medical gases provider provided oxygen and nitrous oxide (Entonox) in cylinders. We saw that spare cylinders were stored securely in cupboards. We were told that small sized cylinders were secured on the patients' stretchers using a bracket during transfer. The use of medical gases was also logged and recorded by staff. This enabled the service lead to identify usage.
- Small oxygen cylinders were available on ambulances to enable the transfer of oxygen dependent patients to and from the ambulance.

- The service provided a small stock of medications for events only. Medications used included salbutamol (for difficulty in breathing) and epinephrine injections (for anaphylaxis reactions). The manager explained that these were stocked according to the nature of the event. The manager said that salbutamol was required for treatment of asthma attacks brought on by a 'fun run', and epinephrine injections as first line treatment for anaphylactic reactions (for wasp and bee stings). On these occasions, the medical director would prescribe a small number of stock medications for individual practitioners to administer according to their registration. These were collected from the pharmacy by the manager and stored in secure cupboards when the ambulance was not in use.
- We saw that staff maintained a record of the name of and amount of medication given, the batch numbers, and patient details, alongside any stock numbers and date of supply and destruction. We were told that medications were held by the service for a short period only and then returned to the pharmacy for destruction. We saw evidence of this process being completed.
- The service did not use controlled medications (drugs that need extra checks and special storage arrangements because of their potential for misuse).
- To ensure medication administration was in line with best practice, staff completed annual assessments and updates.

Records

- We looked at 20 patient transport forms and medicine charts and saw that they were accurate, complete, legible, and up to date.
- Patient information from other providers was held electronically and stored on password-protected computers. We were told that the service completed regular back-ups of the electronic information, as a safety measure for any incident where records were not accessible.
- Patient information was recorded on paper templates, which were stored securely at the service address after use. These were archived after use.
- The service was registered with the Information Commissioner Office (ICO), which regulates the use and storage of personal information. The manager ensured that all information relating to patients was stored within the regulations detailed by the ICO.

Safeguarding

- The service had systems, processes, and practices in place to keep patients and staff safe from avoidable harm.
- The safeguarding children policy and safeguarding adults' policy, both dated December 2016, outlined contact details for the local safeguarding team, in addition to details of types of abuse, process of referral and confidentiality.
- Staff were aware of the process for reporting any safeguarding concerns and were able to describe events, which may trigger a referral. The manager attended all transfers and was therefore able to advise staff of referral processes and update staff on any outcomes of investigations as necessary.
- The service had not had to complete any safeguarding referrals from January 2016 to January 2017.
- An external provider provided safeguarding training. Staff completed safeguarding adults and safeguarding children training level 2. We asked if staff required safeguarding level 3 training for when the service transported children between addresses, and we were told that specialist children's nurses or doctors always accompanied children, therefore training to this level was not necessary for the ambulance crew.

Mandatory training

- An external company provided mandatory training annually. We saw records showed that training included manual handling, basic life support, intermediate life support, medical gases, governance, and ethnicity and diversity. Training compliance was 100%.
- The service lead kept details of staff training compliance. All information was in the process of being transferred to a database, which staff could access from home. This would enable staff to complete training and update their training records from home.
- The manager reviewed agency staff training records prior to agreement of working for the service. This ensured that staff were appropriately trained and qualified to complete the tasks required.
- Staff who were responsible for the driving the ambulances, were provided with appropriate training to enable an application for the appropriate class of driving licence.
- Staff were trained to use the manual handling equipment and were assessed by the manager to

ensure patient and staff safety. We were told that one member of staff had reported difficulties in manual handling, due to physical health, and their role had been amended to reduce the risk of harm. We saw that all staff had annual manual handling training.

Assessing and responding to patient risk

- The service was small with one full time member of staff who managed activity and allocation of work. The manager completed most planned bookings with the support of either part-time bank staff or agency staff recruited through an external agency. When the manager was not available, bookings were not taken.
- The service completed risk assessments for all planned activities. This included a risk assessment of the patient's conditions, their location and access to the building. Risks for staff attending were also reviewed to ensure that staffing numbers and abilities were appropriate to the needs. We saw that the risk assessments were completed prior to the date of activity.
- The service completed transfers by arrangement for a number of local healthcare providers. Scheduling was managed by the service lead, who took details of the transfer and patient. We saw that records varied according to the requesting agent. For example, some private hospitals provided the service with details of the patient's name, illness, treatment and contact details. Other providers supplied detailed accounts of pick up and drop off locations, and a more detailed account of the patient's name, medical history and any treatment.
- Patients whose transfers were booked directly with the service were assessed by the manager prior to agreement. Prior to completion of a patient transfer, patients were assessed for their appropriateness for the transfer requested. The risk assessment detailed any issues that may affect the patient's safety such as poor mobility, past medical history and any access difficulties. This was completed by the patient and reviewed by the manager prior to confirming the ability to complete the requested transfer. This ensured that the correct level of staffing and service was provided for the patient.
- When specialist medical staff accompanied patients, the service did not complete records during the transfer. The service recorded the journey, patient's name, and a record of any medical gas usage only, with any treatments and interventions being recorded by the specialist team on their own records.
- The ambulance crew recorded patient observations and any treatments provided during transfers and shared this information with staff on arrival at the destination.
- The service had clear escalation processes in place. A named medical director offered advice and guidance. In addition, due to the service's role, a medical team normally accompanied high-risk patients, and the service provided transportation only.
- All patients were monitored during their transfer. When a designated medical team did not accompany patients, the service provided an escort, who monitored the patient's condition. We saw that the National Early Warning Score (NEWS) was used to monitor patients' clinical observations.
- If patients deteriorated during transportation, the crew were able to provide emergency support as needed and would either call emergency services for back up, or transfer to the nearest acute hospital. There was no formalised contract for this.
- We were told that staff were informed of active do not attempt cardiopulmonary resuscitation orders (DNACPR) prior to completing the planned transfer. On any occasion where DNACPR was not discussed prior to transfer, patients would be resuscitated in line with policy.
- The service did not transfer patients who were detained under the Mental Health Act or any patient who had a history of violence or aggression.
- When the service provided cover for outdoor events, an external company completed risk assessments. We saw that the service was provided with details of the planned activity, expected number of attendances, map of the site and details of contacts. The manager told us that on these occasions, the service provided mobile staff to patrol the site, in addition to the ambulance. Radio contact was maintained with the manager and the event organisers to ensure that information was shared.
- The manager told us that the team reported to the event organisers prior to the event opening to introduce themselves and set up their post. The team remained on site until after the event had closed. Staff were able to triage any urgent cases when called to review patients following any incidents.

- Seasonal or loss of infrastructure variances were planned for as the service had access to additional vehicles with 4x4 capabilities and additional equipment to replace anything faulty. This meant that the service could change to meet the demands of the patient and maintain a fully functioning service.

Staffing

- The service had one substantive member of staff (the registered manager) who was supported by a medical director, and regular bank staff. The medical director was responsible for the overall safety of services, offering medical advice, clinical guidance, medication support and mentorship for the manager. The manager was responsible for the safe staffing of all transfers and activities. The bank staff attended work on an ad hoc basis, accompanying the manager for transfers or activities as scheduled.
- Agency staff supplemented the service when activity was high. These were recruited through an external agency provider, who ensured that the service had access to staff details, training records and competencies prior to agreeing their attendance. We were told that the majority of agency staff worked within the local NHS ambulance service and were known to the manager, attending regularly for work when required. A substantive member of staff always supervised agency staff.
- The allocation of staff was arranged as per transfer booking. We saw that the service provided the appropriate number of staff for each booking. This was agreed prior to the transfer depending on the activity, for example, for a patient transfer between two hospitals, two members of staff were required. For events, additional staff was required depending on the number of people attending the activity.
- Specialist services were not provided directly by the staff in the service. For example, patients being transferred who were sedated and ventilated were accompanied by relevant anaesthetic staff provided by the referring provider.
- We were told that staff recruitment was difficult and the manager saw recruitment as the largest challenge to the service. The manager was in the process of advertising and shortlisting health care assistants. There was an effective policy in place relating to the recruitment, training, and management of staff. The policy was reviewed in December 2016.
- Newly qualified staff were not currently employed within the service, and therefore preceptorship was not currently available.
- All staff worked alongside the manager, which enabled training, supervision and mentorship. There was a local induction programme, which included the orientation to service, equipment and staff. The manager kept a record of staff inducted to the service and noted any training or orientation provided.
- Due to the type of work provided, the service did not complete handovers between staff or shifts. Each transfer was completed as an individual activity with adequate time between for rest.

Response to major incidents

- The service did not have a major incident policy in place and did not provide an emergency response service.
- In the event of a major incident, the service would refer to the emergency services for support, and complete tasks that they were competent and qualified to manage.
- For events' management, the service manager worked collaboratively with the events team to provide appropriate safety measures. This included the ensuring staff awareness of risks, actions required and escalation processes.

Are patient transport services effective?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Policies and guidance were largely based on national guidance and recommendations.
- Actual and potential patient information was collected by the service prior to confirming any bookings. This included a templated record of the patient's details, the journey and equipment required for patient transfers, and type of event, expected numbers and risks for event cover.
- The service had systems in place to ensure staff competence prior to completing any roles. Bank and agency staff completed a service induction programme and worked alongside the manager who would identify any learning needs.

- Staff had completed Mental Capacity Act training and were aware of their roles and responsibilities in ensuring consent and escalating concerns.

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

- We saw that some policies were not dated and did not have review dates recorded. The mental capacity policy was not detailed or dated.
- Due to the small size of the service, there was no formal audit process or audit calendar in place but we saw evidence of equipment and checks carried out when required.

Evidence-based care and treatment

- We saw that local policies were largely in line with national evidence based guidance: however, not all were dated or detailed dates for next review. The safeguarding policy and procedure was undated but detailed current national guidance. With the exception of the mental capacity policy, which was undated and did not contain details of capacity assessments or referral processes, policies generally gave clear instructions for staff on their roles and responsibilities.
- Patients were assessed, their care planned and delivered in line with guidance and policy.
- We saw that the manager regularly accessed the national central alerting system website to identify any clinical or equipment safety alerts, which may affect the service. The manager informed us of the process undertaken and was able to recall the most recent alert, which had been published.
- Due to the small size of the service, the manager told us they maintained a spreadsheet for all equipment within the vehicles which was updated as the items were replaced, updated or changed. A formal audit process was not therefore maintained. We saw evidence that cleanliness and equipment maintenance were assessed a minimum of monthly, and actions taken to address any issues identified.

Assessment and planning of care

- The manager was informed of the patient's condition at the time of booking; this enabled the service to provide the necessary equipment and staffing numbers. Bookings were usually planned several days or weeks in advance, however the service did complete short notice transfers when able. Short notice transfers were completed following the same format as pre-planned, with completed risk assessments, shared information about the patient and transfer details.
- The service completed a small number of events cover, with four events managed from January 2016 to January 2017. These were risk assessed to ensure adequate numbers of staff provided. We were told that the service provided a response service to event participants and first aid treatment. We saw examples of the booking arrangements and patient treatment cards and were satisfied that they were appropriate to the needs of the service, with adequate information captured to keep patients safe and detailed patient assessments.
- The service used national assessment tools for the monitoring of pain, and offered basic analgesia when necessary, during events. This was provided following an assessment and record of allergies, in line with the practitioner's registration. Analgesia was not provided for patients being transferred between services.
- Nutrition and hydration was not routinely provided by the service. However, at events when patients were at risk of dehydration the service provided bottled water to suspected cases of dehydration.
- We were told that drinks or frequent refreshment breaks were provided for patients travelling on hot days or those on longer journeys.

Response times and patient outcomes

- As the majority of work completed by the service was the transfer of patients between locations, there were no defined patient outcome measures to record.
- The manager recorded types of transfers. From January 2016 to January 2017, the service completed 508 patient transfers, which consisted of 191 private patients, 144 hospital transfers, 105 other ambulance transfers, 52 insurance transfers, 12 emergency transfers and 4 event transfers..
- Response times were not routinely recorded, as all transfers were pre-planned. The service aimed to attend all calls within two hours of referral; however, this was not recorded.
- Due to the size of the service, the manager did not plan any transfers if there was not enough capacity. Adequate time was allowed for handover, traffic problems, vehicles preparation, and cleaning. The service reported no delays in transfers.

Patient transport services (PTS)

Competent staff

- Staff had the appropriate qualifications and experience for their role within the service. The manager held a pre-hospital emergency practitioner qualification and regular bank staff were registered paramedics and student nurses.
- We saw that each staff member completed local induction training on commencing employment with the service. The manager supervised the induction process.
- Training needs were identified through discussion with the manager, although we saw no written records relating to these discussions. We were given examples of when training needs were identified and were told that external training courses were sourced to ensure meet the demands. For example, one staff member had required additional driving skills to drive the ambulance. Training was provided through an external company and an advanced driving licence obtained.
- Companies who specialised in healthcare training provided all training.
- Supervision, mentoring and coaching was possible due to the close working relationship of the manager, plus regular bank and agency staff. Details of any supervision, coaching or one to one discussions were not recorded formally.
- Driving licence checks were completed prior to commencement of employment, and checked annually by the manager to confirm staff's ability to drive the ambulances. We saw that regular drivers had completed blue light training courses for enhanced driving skills for emergencies.
- Agency staffs' skills and experience were assessed prior to commencing employment with the service. We saw the agency staff training records, curriculum vitae, registration details and disclosure and barring service checks were shared with the service lead.
- We saw that the service had a staff appraisal template, which was planned to be used with substantive staff. As the service had one employee at the time of the inspection, there was no evidence of completed appraisals.
- We saw that the service was developing a staff handbook, which would be shared with all personnel on commencement of post. This would include guidance on health and safety, incident reporting, manual handling, and general information on expectations.

Coordination with other providers and multi-disciplinary working

- The service completed pre-planned transfers for a number of services, including private hospitals and private ambulance services. All transfers were arranged through the manager. The service did not complete emergency transfers, however, it did complete urgent transfers, aiming to collect patients within two hours of referral.
- We were told that the manager had spent considerable time promoting the business to local healthcare providers; this had resulted in a small number of frequent users who would refer patients at regular intervals. The service also had a small number of regular private patients.
- For transfers between hospitals, the referring agent coordinated the transfer according to staff and patient availability. Likewise, the repatriation of patients from overseas was dependent on airplane times. Booking details were confirmed with the ambulance crew, who would arrive at the specified location at the appropriate time. This included out of hours transfers.
- All other transfers were coordinated through the manager. For example, we saw that patients requested arrival to a specific location at a certain time. The manager discussed the distance, possible traffic conditions due to area and time and any waiting times prior to confirming the booking. This process ensured that the ambulance and staff were at the appropriate location at the right time.
- All referrals were placed through a telephone or email booking. Details of the service required were collected on a template, which were held securely at the base office. A carbon copy of the template was issued to the patient or referring service following completion of the transfer.
- The time of discharge varied according to the transfer type. Patients who booked an ambulance for a specific journey discussed the details with the manager prior to confirming the time of appointment. Some appointments were set, however some were not time dependent. For example, we were given examples of patients using the service to attend a family funeral and transferring a patient to a new home address.

Access to information

Patient transport services (PTS)

- All patient details were collected prior to transfer. We saw the booking forms completed upon referral included patient demographics, medical history, location, and journey planned. The booking forms were scanned into the service database for archiving.
- Any special requirements were recorded during the booking to ensure that appropriate facilities were available. This included details of any patient risks, such as epilepsy or diabetes. Knowledge of these factors enabled staff to be prepared for any onset of the condition.
- The referring agent informed staff of additional information, such as advanced decisions and resuscitation status, during the booking or collection phase. This process ensured that staff did not provide care that was not necessary or outside the patient's wishes. Details of advanced decisions or resuscitation status were recorded on patients' transfer records and handed over between staff at every step of the journey.
- When transferring patients between locations the ambulance crew were provided with a transfer letter from the collection point for staff at the destination. This was in addition to the information shared by the referring party with the ambulance crew during booking.
- When patients were transferred between two healthcare providers, patient records from the referring provider would be transported with the patient and passed onto staff at the destination.
- The crew would record patient's observations throughout the journey and provided staff at the destination a copy of the record.
- The service used up to date information for journey planning, and had access to satellite navigation systems.
- When completing event work, we were told that the service had access to the event teams' radio system, which enabled a coordinated approach to managing any incidents. The medical team used digital radios, and had access to telephones as a backup for any failure. Roles and responsibilities were agreed prior to commencing event cover. This ensured that staff were aware of who was coordinating activity.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood their roles and responsibilities for gaining consent and staff told us that consent was obtained from patients prior to all interventions, treatments and transfers.
- Patients signed booking forms to confirm consent for the planned journey.
- Staff were aware of the Deprivation of Liberty Safeguards and were able to describe their roles and responsibilities in assessing mental capacity and providing care in patients' best interests. The service had not completed any mental capacity assessments or best interest referrals from January 2016 to January 2017.
- There was an effective Deprivation of Liberty Safeguards policy and procedure, which was undated. This detailed the rationale for the policy, scope of practice, the procedure to be followed, and details of authorisation.
- The service had a limited Mental Capacity Act policy, which was undated. This outlined details of the Mental Health Act and details of mental disorder definition. The policy did not refer to how staff should manage patients who lacked capacity. The manager told us that capacity was not routinely assessed as there was no clinical need, and this did not affect the transfer provided.
- Staff completed mental capacity training through an external provider. Training was 100% complaint.

Are patient transport services caring?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Patients were treated with compassion, in a respectful and dignified way.
- Patients were encouraged to be involved with their care and treatment. Staff adapted the service to meet the individual needs of the patients to ensure their understanding and comfort.
- Relative and patients were included in all decisions, with their requirements being placed at the forefront of the journey.

Compassionate care

- Staff were found to be respectful of patients' personal needs and wherever possible accommodated the

service to meet the individual's needs. For example, the ambulance crew would allow additional time to assist patients into the ambulance when they needed assistance with mobilising.

- Patients we spoke with told us that staff were respectful, considerate and sensitive to their needs, keeping them informed of any issues that may arise during the journey. For example, one patient told us that when traffic delaying the journey, the ambulance crew would call the destination, informing them of the situation and the planned time of arrival. Patients told us that this meant they did not have to worry about their appointments.
- Ambulance crews maintained patient's privacy and dignity by completing treatments behind closed doors and seeking permission prior to any personal activities. Appropriate covers were provided by the staff for warmth and to maintain dignity. Ambulance window blinds were used when necessary. Patients told us that they were treated in a dignified manner by staff.
- We were told that staff "did everything they could to make the journeys as comfortable as possible", responding "quickly to needs". We did not speak to any patients who had been provided analgesia.
- When patients are accompanied by relatives or carers, we were told that the ambulance crew would ensure that all passengers were comfortable and safe prior to commencing the journey.
- One patient told us that the ambulance crew would assist with their mobility which was "difficult due to" them "being bulky". The ambulance crew would assist with the stairs and provided appropriate equipment to make the journey comfortable.
- One patient told us that the service was the "only one they would ever use" having experienced an exceptional service for the last two years.

Understanding and involvement of patients and those close to them

- Patients told us that staff communicated well, explaining procedures, plans and any treatments. Ensuring that they were understood before completing any tasks.
- Staff were able to demonstrate an understanding of patients' needs, giving examples of when care and journey details had been changed to provide a safe and comfortable journey. This included advice on journey times and waiting for appointments to finish, taking patients directly home.
- Patients told us that they were encouraged to ask any questions throughout their contact with the service. This was from the initial contact regarding planning a booking, until completion. Patients were given a copy of the risk assessment for the journey for their records.
- As the service primarily assisted patients with transfers between sites, staff ensured patient safety and monitored patients' medical conditions between pick up and destination only.
- One stakeholder told us that the service was always open about their ability to perform the booking and their capacity to complete it when requested. Stating "they always tell us whether something is out of their capacity which enables us to find the right provider from the start".

Emotional support

- Patients told us that the ambulance crew fully supported them during the planning and completion of patient transfers. All patients told us that the service was punctual and professional, which meant that they did not have to "worry" about the journey.
- The ambulance crew provided patients and their relatives with timely support, responding quickly to calls for assistance and completing last minute bookings when requested.
- Patients told that the ambulance crew were always happy to talk and listen to their concerns. Staff offered relevant support or advice of who to contact to assist with decision-making when required.

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

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- The service completed bespoke transfers, which met the needs of the referring healthcare provider or individual patient.

Patient transport services (PTS)

- The service was able to facilitate the transfer of patients with additional needs, such as patients living with dementia, registered blind and bariatric.
- Bookings were taken according to the availability of staff and equipment.
- The service had not received any complaints from January 2016 to January 2017. Staff were aware of the complaints process and were able to direct patients or escalate concerns effectively.

Service planning and delivery to meet the needs of local people

- Due to the service being small, there were limitations to the service planning and delivery. The lead told us that once additional staff were recruited, the business could expand to provide a higher number of transfers and service a wider area: however, expansion was not planned until all facilities were in place to enable this to be completed safely.
- The service was planning to develop healthcare roadshows, where an ambulance crew would visit areas and offer a drop in health check to the public. The manager had included details of this in their current business plan.
- The service offered bespoke transfers for referring agencies or patients. These were flexed where possible to meet the specific demands of the referrer. Stakeholders confirmed that the service was responsive to their needs, completing bookings as discussed to a high standard.
- Information about the needs of the local population was used to inform how services were planned and delivered. For example, the size, location and expected number of attendances at an event determined the number of staff, types of vehicles and any medications provided.
- We saw that the event organisers and stakeholders were involved with the planning of the service. The team were hired to complete specific roles, such as first aid, which were determined in advance through discussion.
- We were told that a number of private patients used the service regularly for routine appointments. This enabled patients to familiarise themselves with staff and equipment, and offered some continuity of care with the event organisers and manager.
- The facilities and premises were adequate for the needs of the service. Ambulances were located off road, with CCTV surveillance. The main office was within the manager's home. Written information was stored in secure cupboards and computers were password protected.

Meeting people's individual needs

- Services were planned according to patients' needs during initial assessments. A variety of specialist equipment was available and additional staffing could be sourced according to the needs of the booking.
- Patients with any additional needs were identified prior to the transfer. Patients who had impairments such as, those living with dementia, a learning disability or visually impaired were accompanied by a regular carer or relative for any planned journeys. Staff had had dementia awareness training. The service generally did not cater for patients with advanced cognitive impairments.
- All ambulances were accessible by wheelchair users with a rear ramp lift to enable access. We were given examples of occasions when patients with mobility difficulties were assisted into ambulances using either their own mobility aids or ambulance provided equipment.
- The service's ambulance was capable of transferring bariatric patients and the service had access to a variety of bariatric equipment. The manager told us that local hospitals frequently referred bariatric patients to the service for discharge or transfer, due to the availability of specialised equipment.
- The service did not have access to a translation service, although staff reported that on occasions where patients whose first language was not English were transferred, a translator was provided by the referring hospital. The service also confirmed that they used language apps on their phones to assist with any communication, if necessary.
- Patients who were being transferred over a long period were offered regular breaks for toileting or refreshments. We were given examples of when this had occurred.
- We were told that when staff attended to patients, they would inform the driver of the intervention, so driving could be adapted to prevent injury to staff or patients. We saw that this practice was clearly outlined in the service's policy document, which was undated.

Access and flow

- Emergency treatment or transfers were not provided by the service, although the team did complete initial assessments of people requiring first aid during events. Anyone requiring first aid at events would be seen on a first come, first served basis, following a self-referral.
- Due to the size of the service, there were limited facilities for multiple bookings. The manager agreed all bookings in advance and allocated adequate time for completion. If contacted for an urgent transfer, the manager would review the pre-planned bookings to determine whether the additional work could be facilitated. Similarly, when staff were not available, bookings were not taken.
- We were given examples of delays that had affected service delivery, such as traffic, road closures and accidents. Staff told us that passengers and staff at the destination were kept informed of any incident that may affect timescale.
- Due to the specific type of pre-booked service provided, response times, on the scene times, and turnaround times were not recorded or monitored.

Learning from complaints and concerns

- The service did not have a specific complaints' policy but had a set procedure named "information to patients on how to make a complaint" dated December 2016. This outlined the process of recording complaints, escalating them and details of the patient information leaflets available.
- Booking confirmation slips contained a feedback section, which patients were able to complete either during or after a planned transfer or treatment. We saw that feedback from patients had been positive.
- We were told that patients being transferred by the service were informed of their right to raise concerns and were signposted to the Care Quality Commission.
- The service reported no formal complaints from January 2016 to January 2017. The manager reported that patients would occasionally complain about the temperature of the vehicle, and action was taken to immediately correct this, whether by providing additional blankets, heating or air conditioning. These low-level concerns were managed locally and not recorded.
- We did not see any displays informing staff on how the business was performing in relation to complaints or concerns.

Are patient transport services well-led?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- The registered manager had the appropriate skills and experience to manage the business, and was supported by clinical experts to provide a safe service.
- The service had a clear vision for development. This included the introduction of a quality assurance framework and quality dashboard.
- The service had a risk register, which was descriptive and detailed actual and potential risks.

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

- Due to the small size of the service, there was a limited governance system but there was evidence of an audit trail of email discussions about quality improvement.
- Due to the specific nature and small size of the service, it did not have any key performance indicators and did not routinely monitor performance, although it did capture patient feedback through questionnaires.

Leadership / culture of service related to this core service

- The service had a CQC registered manager in post, who was responsible for the daily running of the service, provision of staff, equipment and booking all work. The manager was fully aware of the Care Quality Commission registration requirements for the service.
- A named medical director worked alongside the manager to assist with clinical leadership, advice and medical supervision and support. The medical director had a substantive post in an acute NHS trust and maintained competence through that service. The registered manager monitored details of competence.
- The service had a very flat structure, with the registered manager working alongside a small team of staff who were allocated roles according to their training and competence.
- The registered manager was a trained pre-hospital emergency practitioner and was in the process of completing an international nursing qualification.

- The manager was fully aware of the scope and limitations of the service, based on the size, numbers and type of staff, and type of work booked for.

Vision and strategy for this this core service

- We saw that the service had devised a business plan, which detailed the objectives, products, and services available, a strength and weakness analysis and an ongoing strategy. The objectives included the quick response to customer enquiries and problems, an outstanding customer service, learning from clients' problems and adapting to meet their needs and making the service accessible to all. The business plan was not dated.
- Objectives detailed within the business plan for the healthcare roadshows included the provision of accessible clinics and the enabling of early detection and diagnosis of medical conditions.
- The service was designed and focused on a specific type of work activity for pre-booked patient transfers, with some occasional event cover provided.

Governance, risk management and quality measurement

- Due to the service having a small number of substantive staff, there was a limited formal governance structure. We saw evidence of a business risk register, and monitoring of quality through regular reviews (for example, cleanliness and hygiene audits) and changes to practice following patient feedback. We did not see a formal audit calendar or vehicle maintenance log, although we saw evidence of regular audits and records of ongoing servicing of equipment and ambulances.
- The service was in the process of implementing a governance structure using an external provider. We saw evidence of the database which would record and track complaints, staff records, training data, safety alerts and audits, and provide a service quality dashboard. This system was not fully functioning at the time of inspection.
- We saw that the risk register recorded risks associated with equipment, staffing and patients, along with any mitigating actions and outcomes. The risk register did not follow the traditional risk-rating format, however was clear and concise, and reflected the risks in the service at the time of our inspection.
- The service did not use any key performance indicators to monitor performance and patient care. There was a patient feedback questionnaire, which was given to patients when bookings were confirmed. The manager requested completed questionnaires once transfers were completed. We saw that all responses were positive.
- There were no formal systems in place to monitor performance other than records of business activity such as type and frequency of bookings, and the collection of patient and stakeholder feedback.
- The manager and medical director had regular meetings to discuss the service, to review planned events and discuss any concerns: however, these meetings were not formally recorded and did not follow a set agenda. The manager told us that conversations were recorded through emails, and we saw these were kept as an audit trail of management meetings, decisions made and ongoing actions to be taken.

Public and staff engagement

- Stakeholders told us that the service was flexible, reliable, with professional and dedicated staff.
- We saw that patient feedback was very positive, complimenting staff on their helpfulness, punctuality and all recommending the service for future use.
- All patients told us they would recommend the service to others, and would not use another provider.

Innovation, improvement and sustainability

- The manager had a clear idea of how the service should develop, with a goal of providing a drop in health roadshow. This was an innovative approach to providing accessible healthcare.
- The manager was aware that to improve sustainability and aid growth, additional staff were required.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- To consider a system so that all supervised practice sessions, one to one meetings, and team meetings are recorded.
- To complete formal appraisals of all staff to identify training needs and areas for development.
- To consider keeping a formal system for logging of vehicle servicing and maintenance.
- To consider a structured system for carrying out routine audits to confirm safe practice and adherence to policy.
- To review all policies so that they are dated and updated at regular intervals to ensure they contain the most up to date guidance.
- To consider a system for monitoring and recording key performance and service quality data for ongoing analysis to drive improvements in the service.