Ambicorp Ltd

Ambicorp Ltd

Quality Report

Oakham Farm,
Forest Lane,
Walesby,
NG22 9PF
Tel:01623 880988
Website:http://www.ambicorpltd.co.uk

Date of inspection visit: 1, 2 and 15 August 2017
Date of publication: 29/09/2017

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

Patient transport services (PTS)

Summary of findings

Letter from the Chief Inspector of Hospitals

Ambicorp LTD is operated by Ambicorp LTD. The service provides patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 1 and 2 August 2017, along with an unannounced visit to the service on 15 August 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.

The main service provided by this service was patient transport services.

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:

- We observed staff followed infection prevention and control procedures to reduce the spread of infection. They kept vehicles visibly clean, tidy and well stocked.
- The system for servicing vehicles was effective. All vehicles had an up to date MOT, insurance and schedules were in place to monitor servicing dates.
- There were recruitment processes so all staff employed had the experience and competence required for their role. Appropriate pre-employment checks had been carried out.
- The service had a system for handling, managing and monitoring complaints and concerns.
- Feedback seen from patients and NHS trusts was overwhelmingly positive.

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

- The service was not auditing infection control procedures and could therefore not assure themselves of their effectiveness.
- Staff were aware of safeguarding and had received training however, the safeguarding policy was not followed and we were not assured that the level of training received was relevant to the role. However, at the unannounced visit all staff had been booked onto training appropriate to their role.

  Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve.

  Heidi Smoult

  Deputy Chief Inspector of Hospitals (Central Region), 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)		We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Ambicorp Ltd

Detailed findings

Services we looked at
Patient transport services (PTS

Detailed findings

Contents

Background to Ambicorp Ltd

Ambicorp LTD is operated by Ambicorp LTD. The service opened in 2011. It is an independent ambulance service based in Walesby, Nottinghamshire. The service provides non-emergency patient transport and primarily serves the communities of Nottingham, Nottinghamshire and Sheffield.

The Ambicorp LTD fleet consists of 19 ambulance vehicles comprising of three cars and 16 ambulances. The service is run by two directors, a vehicle manager and one part-time administration manager and 26 drivers on zero hour contracts.

The service has had a registered manager in post since 20 May 2011.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector, and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Facts and data about Ambicorp Ltd

Ambicorp LTD is an independent ambulance service, which provides non-emergency patient transport services. The service is staffed by ambulance care assistants.

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.
- During the inspection, we visited Ambicorp LTD's base and local NHS hospitals where services were provided from. We spoke with 12 staff including patient transport drivers and management. We spoke with five patients and reviewed ten patient booking forms.

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 August 2014 which found that the service was meeting all standards of quality and safety it was inspected against at that time.

Activity (July 2016 to June 2017):

- In the reporting period July 2016 to June 2017 there were 14,000 patient journeys undertaken.
- 26 patient transport drivers worked at the service, which also had a bank of temporary staff that it could use.

Detailed findings

Track record on safety (July 2016 to June 2017):

- Zero Never events

- Clinical incidents162 no harm,six low harm,0 moderate harm,0 severe harm,0 death

-Six serious incidents

- Four 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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- The system for servicing vehicles was effective. All vehicles had an up to date MOT, insurance and schedules were in place to monitor servicing dates.
- There were recruitment processes so all staff employed had the experience and competence required for their role. Appropriate pre-employment checks had been carried out.
- The service had a system for handling, managing and monitoring complaints and concerns.
- Feedback seen from patients and NHS trusts was overwhelmingly positive.

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

- The service was not auditing infection control procedures and could therefore not assure themselves of their effectiveness.
- Staff were aware of safeguarding and had received training however, the safeguarding policy was not followed and we were not assured that the level of training received was relevant to the role. However, at the unannounced visit all staff had been booked onto training appropriate to their role.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- There were no never events recorded in this service between July 2016 and June 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The service had an Incident Policy that set out how the organisation would learn from and act on incident reports from all personnel to improve the quality and safety of its service delivery. The policy set out the accountability, responsibility and reporting arrangements for all staff in relation to incidents. All staff we spoke with during the inspection were aware of the policy and were able to demonstrate how they would access it if required.
- All incidents were reported using email incident report forms which were available to all staff both on premises and in vehicles via work mobile phones . During inspection, we saw examples of completed incident report forms that were seen to be comprehensive and legible. Incidents were documented on the provider's incident log sheet for analysis and tracking completion of actions. Crews downloaded completed incident report forms from their work mobiles in real time onto a secure server for manager review and action.
- Between July 2016 and June 2017 there were 162 incidents reported. The majority of incidents reported were minor incidents relating to communication omissions from hospital staff. These were particularly in relation to DNACPR, (do not attempt cardiopulmonary resuscitation) and information being passed on to crews.
- In order to support crews and improve this problem the senior team had provided learning for staff in what should be completed on a DNACPR and liaised with hospital teams in relation to informing crews at patient handover.
- The service reported any incident causing potential patient harm as a serious incident. Between July 2016 and June 2017 there were six such incidents reported. For example, a skin tear on the back of a patient's hand. This was investigated and communication breakdown was identified as a contributory factor. This was addressed with both crew members during extra training and feedback to the wider team as a learning point via email and in a team meeting.
- The service had a duty of candour policy that was available to all staff. 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. Duty of candour should be discharged if the level of harm to a patient is moderate or above. The service were aware of the regulation but had not needed to use the process.
- Staff we spoke with had a good understanding about duty of candour. Staff talked about being open and transparent with the public.

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

- The service reviewed its incidents, complaints and response times through audits and fedback to staff at meetings, in email and displayed results on the staff notice boards.

Cleanliness, infection control and hygiene

- All staff completed infection control training on induction and on annual mandatory training.
- During the inspection we saw that vehicles were visibly clean, equipped with appropriate equipment including spillage kits, antibacterial spray and personal protective equipment for staff. We saw cleaning schedules, which were fully completed for the vehicles inspected.
- All of the vehicles were cleaned between patients and had a four to six weekly deep clean schedule which included steam cleaning of vehicles to reduce the presence of microorganisms.The service kept a record of the deep clean programme. In the event of a significant

contamination, a deep clean could be carried out at short notice as the equipment was available at base. The vehicle was taken off the road whilst the deep clean took place.

- We saw staff were diligent in relation to cleaning a vehicle after transporting a patient with MRSA. They insisted on the vehicle being thoroughly cleaned as per the policy despite on occasion being hurried by the hospital staff they were working with.
- Posters providing information on effective hand hygiene were placed above all hand basins in the service headquarters. Alcohol hand gel was readily available on all vehicles; we observed staff using this between patients.
- However, the Infection prevention and control (IPC) policy stated that there was an IPC lead and that quarterly IPC and hand hygiene audits were carried out .However, there was no identified lead currently in post due to recent staff changes in the management team. These audits could not be provided.
- All staff we spoke with had correct uniform with name badges in accordance with the uniform policy. Staff were provided with uniforms, which staff were responsible for laundering themselves.

Environment and equipment

- The ambulance base provided secure ambulance vehicle parking facilities. The base was located within a locked farm complex.
- All vehicles were locked when unattended. We found that vehicle keys were stored securely in a key safe to ensure only staff within the service could only access them.
- The service had 19 patient transport vehicles.We checked six vehicles and found that all were in good condition and well maintained despite some being in excess of 10 years old. Four vehicles were off the road awaiting repair and this was identified on the office whiteboard and a sign in the vehicles.
- The service used a local garage for the management of its fleet. They had three to four regular slots per week they could access and recently began to use one of the mechanics on site on a weekly basis.
- All vehicles had an up-to-date MOT, annual service and were fully insured.
- Each vehicle had an up to date satellite navigation system
- The service had a white board with some service details in relation to the fleet but this did not include a record of equipment servicing on a regular basis. None of the vehicle equipment, for example wheelchairs, stretchers, ramps and carry chairs, had any sticker or log of completion. We discussed this with the team during inspection and a full list of servicing of both vehicles and equipment was provided by the maintenance company from December 2016. This assured us that servicing of vehicles and equipment was taking place regularly.
- Essential emergency equipment was available on all vehicles inspected and was fully serviced and tested according to manufacturers' instructions. However, there were no asset numbers on any pieces of equipment so it was difficult to manage a testing schedule. Asset labels and a log were ordered as soon as we raised this with the service.
- On our unannounced inspection all equipment was logged as an asset and a comprehensive maintenance file was available for each vehicle and each piece of equipment. All equipment and every roadworthy vehicle had been maintained and a full service plan completed to ensure all ongoing maintenance was thoroughly documented and easily accessible.
- Each vehicle also had yellow bags for the safe disposal of clinical waste. All clinical waste was disposed of at the local hospitals the crews were working from each day.
- In order that vehicles were not overstocked at the end of each shift, crews would request which kit needed replacing and this was then left out for them from the main store.
- Packages containing sterile supplies were found to be out of date and partially open on four out of six vehicles. This was addressed immediately when identified.
- On our unannounced inspection all first aid kits had been replaced and the vehicle check lists required staff to document expiry dates to ensure thorough checking.The senior team and maintenance manager carried out spot checks in order to assess compliance.

- Fire drills were carried out monthly at the base with weekly documented checks of the fire alarm.
- Fire extinguishers on vehicles and in the station were stored securely but not all had a date sticker on them. The senior team booked an appointment for the fire officer to visit whilst we were on inspection.
- On our unannounced inspection the fire officer had visited and serviced any out of date extinguishers and all had service labels on them indicating the next service date. All unused extinguishers previously stored on site had been removed.

Medicines

- No medicines were stored or handled by any of the staff. Any medicines carried were the property of the patients.
- Oxygen was stored safely for use on vehicles, we checked six vehicles which all had cylinders stored securely.
- All staff we spoke with were aware of the policy in relation to the use of oxygen with patients in transport. The service introduced a check sheet for crews which also included the oxygen guideline.
- There were two areas at base for storage of oxygen cylinders. In the main area cylinders were stored securely and were in a well signed, ventilated room. A second area was used to store one cylinder available for the night crew if required. This was secured to the wall and correctly signed but was not in a well ventilated room. This was raised with the team immediately.
- On our unannounced inspection the cylinder stored in the second area had been relocated to the main store area.
- There were signs to alert staff and visitors to the flammable nature of the gases.

Records

- There were no paper patient records, all patient assignments were sent to a mobile device which was kept with the crew at all times.
- Data and patient sensitive information was downloaded at base at the end of each shift onto a secure server.
- When patients were transferred between two healthcare providers, patient records from the referring provider would be placed in an envelope, transported with the patient and passed onto staff at the destination.
- Ambicorp LTD was one of the preferred providers of patient transport services (PTS) for other CCGs around the country. We saw evidence of special notes recorded for these journeys. For example specific appointment details and a note explaining the exact location of a new hospital that was not on the satellite navigation systems. All crews we spoke with were aware of these special notes.
- We saw that staff personnel files were stored in a locked cupboard in the director's office. Only the directors and the office manager had access to the files to ensure the confidentiality of staff members was respected.

Safeguarding

- The provider's vulnerable adult safeguarding training was provided over a full day. It was comprehensive and included information on legislation, indicators of abuse and neglect, roles and responsibilities, sharing and reporting concerns.
- This course included a section on safeguarding children equivalent to level one training aligned with the, "Safeguarding children and young people: roles and competencies for healthcare staff – Intercollegiate document: March 2014." Training compliance in June 2017 was 96.2% (25 out of 26 staff).
- The training provided to the staff was delivered by a registered training provider appropriately trained to deliver the safeguarding training to staff.
- However PTS ambulance crews are required to undertake level two children's safeguarding training. We informed the senior team that they should review the level of child safeguarding training available to their crews in line with the 2014 intercollegiate document. Whilst we were still on site they arranged a date for the correct training to take place in September 2017.
- On our unannounced inspection all staff were allocated a training session for level two safeguarding children's training.

Patient transport services (PTS)

- At the time of our inspection the safeguarding lead for Ambicorp LTD was not trained at level four. However, they had booked a date in October 2017 for the safeguarding lead and a director to attend this training.
- The organisation's, safeguarding policy, was accessible to all staff. However, when asked staff were referring any patients they had concerns about to the transferring hospital. Whilst this ensured safeguarding patients was a priority it did not follow the policy of the organisation, which was to refer any patients requiring safeguarding to the local authority.
- However we did see evidence of crews with particular concerns over two patients' safety on arrival at their homes. The crews liaised with the hospital and managers on both occasions to have the patients readmitted to the hospital as a place of safety.
- On our unannounced inspection a laminated card had been produced for each vehicle with instructions and contact numbers for local authority safeguarding teams. All staff had been informed of this change by email and as an agenda item for the team meeting.
- Staff we spoke with during our unannounced inspection could describe how they would now make a safeguarding referral and were aware of the situations when they would be required to do so.
- Prevent duty training was not part of mandatory training (ThePreventduty is the duty in the Counter-Terrorism and Security Act 2015 by which staff in health care settings must have training to identify ways topreventpeople from being drawn into terrorism). During our inspection it was identified staff had not undergone this training.
- On our unannounced inspection 30% of staff had already undertaken Prevent training with the remainder booked to complete by the end of August 2017.
- 100% of ambulance staff had valid enhanced Disclosure and Barring Service (DBS) checks.
- We were able to see a check with the DBS had been carried out prior to staff commencing duties, which involved accessing patients and their personal and confidential information. This protected patients from receiving care and treatment from unsuitable staff.

Mandatory training

- Staff training was provided by registered outside agencies to the requirements of PTS crews within Ambicorp LTD.
- All staff undertook mandatory training which included the following topics with attendance figures from May 2017 to June 2017; first aid 100%, high dependency training 96.2%, safeguarding 96.2%, manual handling 100% and infection control 100%.
- Training was completed at weekends to minimise the effect on the service and also to ensure all staff were able to attend. All staff attended training as requested unless they were away on annual leave.
- Training took place at the Ambicorp head office in a dedicated training room.
- The high dependency course offered to staff included understanding the anatomy of breathing, use of oxygen and care of tracheostomies (artificial breathing tubes inserted into the windpipe).
- All staff had also during May and June 2017 completed updated equipment familiarisation. This included extra training for use of equipment on the ambulance that might not be used regularly for example the suction machine.
- We reviewed 10 individual staff records relating to driving observation and licence checks, these were recorded on the provider's driving spreadsheet. This was 100% compliant.

Assessing and responding to patient risk

- Staff were trained during their mandatory training to provide the skills and knowledge required for their role.
- The ambulance crews assessed all patients before acceptance for transportation. This included a risk assessment of the patient's condition and mobility.
- If staff were concerned that the patient was unfit for transfer the service had clear escalation processes in place. Staff called the senior team on a defined contact number to ask for advice and guidance. We saw evidence of this in relation to a team leader being asked to review a patient prior to transfer who was experiencing breathing difficulties.
- Staff have also now been given training in the National Early Warning Score (NEWS) and it has been agreed that

any patient scoring more than three will not be transferred by Ambicorp LTD PTS crews unless accompanied by a nurse or a documented safe to travel review from a doctor.

- All staff were aware of this protocol and regularly phoned for advice to ensure patient safety.
- On our unannounced inspection a laminated chart explaining NEWS had been provided to ensure they were able to review a check prior to accepting the patient and a guideline advising crews in relation to the most common 'do's and don'ts.' For example, not taking patients with cannulas or a patient requiring oxygen therapy without a prescription.
- If patients deteriorated during transportation, the crew were able to provide basic first aid and request 999 supports.
- The service had recently received contracted work from a local mental health trust. As a result of this 77% (20 out of 26) of staff have undertaken a Managing Violence and Aggression course and were able to transfer patients who were detained under the Mental Health Act. However if a suitably trained staff member was not available this service was not provided.
- Staff we spoke with were clear on the protocols they would follow to meet the support needs of patients who presented with challenging behaviour.
- Vehicles used for this kind of transportation were risk assessed for each patient and there was availability of specialist equipment, for example a ligature cutter which was signed out for the particular journey.
- We observed staff checking that patients were secured in their seats prior to the vehicle moving.

Staffing

- Managers told us that due to the nature of the commercial independent ambulance contracts, the service used contracted staff on zero hour contracts for the ambulance crews.
- Rotas were completed two weeks in advance, whilst this was relatively short notice it allowed for flexibility of annual leave requests. Staff could request leave as late as two weeks in advance without affecting the rota.
- Shift patterns were agreed with the contracting hospitals and worked on a 12 hour shift over 24 hours, seven days a week.
- Flexibility was built into the rota by the management team to ensure the right crews were available for the right jobs. For example, the use of staff trained in managing violence and aggression in a transfer for the police service.
- Managers we spoke with advised that if the service did not have sufficient personnel to deliver a service safely, then the contract or transfer would not be accepted.
- Bank and agency staff had not been used in this service in the previous six months.
- We reviewed ten sets of staff records, which demonstrated that staff training, and employment safety checks had been completed in accordance with policy.

Response to major incidents

- Managers told us they did not have a service level agreement (SLA) with local NHS trusts to be involved directly with their major incident policies. However if a request to provide services was made they would endeavour to meet those demands. Hospital sites requested extra crews and vehicles according to their own acuity on a day by day basis.
- Business continuity plans were in place in relation to loss of power, water heating and other facilities problems. Adverse weather conditions were addressed by the staff and managers collectively. If it was unsafe to travel, staff would be stood down until the weather conditions improved.

Are patient transport services effective?

Evidence-based care and treatment

- The service had a range of guidelines which were available on the provider's electronic system and in a paper version in a folder in the office. We reviewed seven guidelines, we found that all were up to date and referenced current best practice.
- Staff we spoke with were aware of guidance relevant to their practice. For example, in relation to the infection

control guideline following recommendations provided by NICE, (National Institute for Health care and Excellence), Quality standard [QS61]April 2014 Infection prevention and control.

- New or updated policies were circulated by email and printed out for reference in the staff area at the base. They were also available in hard copy in the transport manager's office.

Assessment and planning of care

- All PTS crews reported to the relevant NHS hospital site matron on commencement of each shift for allocation of patients.
- Staff were not involved in planning care for individuals.
- Handovers took place between shifts and staff we spoke with and observed were confident to handover to their receiving party. This meant that systems were in place to enable the continuity of care and treatment of patients.
- Patients being transported out of area from CCG commissioning bookings were planned and assessed by the call taker in the office. Patient information including any identified safety concerns or conditions that may affect the patient on a journey would be identified and recorded for the crew in special notes. For example, a patient with diabetes needing to stop for food on a long journey. The service ensured appropriately trained staff were allocated according to the risks identified.

Response times and patient outcomes

- Due to commercial competition the service did not complete any formal benchmarking with other providers of PTS services. They reported that they measured patient outcomes by reviewing completed job sheets and through the feedback they received.
- Information was collected for each local NHS trust they provided services too. This included numbers of patients carried on stretchers, in wheelchairs or walking patients. They also identified average time on vehicles. This information was used to
- Ambicorp LTD directors told us they were able to discuss this information to get the best use from crews and look at trends in patient mobility. This information was then collated and sent weekly to the NHS trusts for them to identify any concerns or changes they needed to address. Ambulance services and trusts that commissioned the service held meetings with the Ambicorp directors to review outcomes and discuss any issues identified by the service.
- Staff completed log sheets to record journey times. The senior team explained there were rarely any issues with the journeys and they prided themselves on having a workforce committed to providing high quality care.

Competent staff

- All staff were provided with the training to enable them to work in a knowledgeable and effective way.
- All staff undertook an induction training programme at the start of their employment. If staff passed a three month probationary period they would progress on to further mandatory training and supplementary training, for example in the use of specialist equipment.
- Staff were trained in areas such as safe moving and handling techniques, how to use ambulance carry chairs and slide sheets. This was monitored and updated by the vehicle manager.
- A line manager carried out clinical observations of crew 'on the road.' This included observation of crews, patient contact/handling, use of equipment and cleaning of the vehicle. We saw this documented for all 26 on a staff assessment spreadsheet.
- From January 2017 to July 2017, 88% (23 out of 26), of staff had received an appraisal. The remainder had dates for their appraisals booked before the end of August 2017.
- For new staff pre-appraisals were carried out in order to assess any extra training requirements or concerns they may have during the first three to four months of employment.
- We saw the appraisals were a standard form which included a score out of 10 for time keeping, appearance, communication, ability to work as part of ateam and accuracy of documentation. Areas for development and improvement were discussed and any extra training opportunities.
- We spoke with five staff about the appraisal process; all of them reported it was useful and helped them develop within the team.

Patient transport services (PTS)

- The appraisal process was every six months but more regular meetings could be arranged if there were any identified training needs.

Coordination with other providers and multi-disciplinary working

- We witnessed staff transfer a patient's care to another healthcare provider; they ensured the handover they gave was clear and precise to enable the staff receiving the patient to provide ongoing care.
- The service had received positive feedback from senior staff from local NHS trusts. One NHS trust had been using Ambicorp LTD services for many years. They described the service received as, "without a doubt exceptional, the trust is now looking at using the company on a more frequent basis. There have been no issues with the service provided by the company, they are always willing to go that extra mile and provide the best quality care for the patients. The service provided is effective and efficient, flexible to meet the needs of the trust at peak times ensuring excellent patient care continues. Ambicorp should be very proud of the service which they provide to the trust."
- A representative from another NHS trust said, ".they always finds a solution to help our patients get home. In fact I would go as far as to say if a crew from this company cannot get the patient home then it is not possible without modification. The crews are always polite, tidy in appearance and kind. The owners and manager at Ambicorp are always available to resolve issues and work with us on a sensible solution."

Access to information

- Staff felt they had access to sufficient information for the patients they cared for. If they needed additional information or had any concerns, they spoke with the Ambicorp LTD managers.
- Staff told us that most of the time 'do not attempt cardiopulmonary resuscitation (DNACPR) orders were discussed with the staff on the wards prior to leaving. If the DNACPR order was not current, a discussion with the nurse and doctor would take place to ensure a current order was written for the patient prior to transferring them. On occasions where crew were not informed an incident report was raised and the senior team would highlight the concern with the particular NHS trust involved.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training in the Mental Capacity Act 2005. An external trainer provided this training, information provided by the service showed all staff had attended training or were subsequently briefed and were up to date.
- Directors and staff we spoke with showed awareness and understanding of the Mental Capacity Act (2005) code of practice and consent processes. They described how they would support and talk with patients. For example, they told us they would seek the patients' verbal consent before providing care and treatment and when they used seatbelts or straps to restrain them safely.

Are patient transport services caring?

Compassionate care

- Patient feedback we received was extremely positive in terms of patient care.
- The service trained all staff in safe moving and handling of patients and this helped staff to maintain patient dignity during patient transport. We saw staff ensuring patients were covered with a blanket prior to any transportation. We also saw staff drawing curtains around a patient on a ward prior to transferring them onto the stretcher.
- We observed staff providing care that was compassionate and patients being treated with respect for their privacy and dignity at all times.
- Patients said staff had respectful and caring attitudes to relatives and carers travelling with them.
- A patient we spoke to said relatives were welcomed by staff on journeys and were always included it the conversation and any arrangements.
- Feedback we reviewed from families and patients was positive about all aspects of the care they had received.

Patient transport services (PTS)

We saw feedback from patients and relatives stating, “Fantastic, always helpful and on time, 10 out of 10 absolutely perfect.”, “Outstanding service. “Really friendly, would recommend to friends and family.”

- All of the patients we spoke with who used the service told us staff were kind and very professional.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they were fully involved in their transfer plan and staff explained everything to them throughout their journey. Two patients told us of occasions where they had been not quite ready for transfer when the crews arrived but that the crews had been happy to wait until they were completely ready.
- All of the patients we spoke with who used the service told us staff explained the care given to them.

Emotional support

- Managers and staff created a strong, visible, person-centred culture and were highly motivated and inspired to offer the best possible care, including meeting service users emotional needs.
- We observed staff giving emotional support to one patient throughout their journey even though the patient was unable, due to their medical condition, to communicate effectively in return.
- One staff member told us how when a patient had passed away on arrival home they were able to support the family until other relatives arrived. Speaking calmly with them and offering assistance as much as possible.
- Another member of staff explained a situation where a patient became aggressive towards one of the crew members. In order to resolve this crew members swapped places on the vehicle in order to reduce the patients’ anxiety and calm the situation.

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

Service planning and delivery to meet the needs of local people

- The non-emergency patient transport service was contracted to two local NHS hospitals with extra ‘ad hoc’ provision to meet the needs of patients and workloads. Staffing requirement was planned to meet these needs.
- Service review meetings were held with the two local NHS hospitals Ambicorp LTD had contracts with. These meetings were held quarterly to review contracts, discuss invoices and plan for possible increases in acuity. In a meeting held in May 2017, Christmas service delivery was discussed and agreed in order to allow for staff planning.
- Private and commissioning preferred provider booking requests were taken by the administration team or the directors and quotations would be submitted. If the transport organiser wanted to proceed they would then advise the service, who would schedule the appropriate level of staff.

Meeting people’s individual needs

- The out of area booking process meant people’s individual needs were identified. For example, the process took into account the level of support required, the person’s family circumstances and communication needs.
- All staff we spoke with told us they did not have problems communicating with patients whose first language was not English.
- There were no formal arrangements for interpreting services. For patients with communication difficulties or who did not speak English, we were informed there were staff who spoke Russian and Polish who could be contacted to assist those patients if required. Demographic studies of the local population had been carried out to look at the likelihood of needing a regular translation service. This study did not identify a need.
- The service did not have any communication aids, to support patients who were unable to speak due to their medical condition or who had complex needs. There was a potential risk of patients not being able to explain what was wrong or what they understood.
- There was seating in the ambulances to allow family members or additional medical staff to travel with the patient.

Patient transport services (PTS)

- Ambulances had different points of entry, including sliding doors, steps and ramps so that people who could walk or were in wheelchairs could enter safely.
- The vehicles were designed to provide a safe and dignified transport solution to those whose weight, or condition, required specialist transport.
- Staff told us they would transport a patient in their own wheelchair if possible, rather than transferring them to a trolley, so they were more comfortable.
- Specialist equipment had been purchased in order to assist a patient that required vertical transportation up a flight of stairs.
- The identification of patients with complex needs, such as those living with dementia, learning disabilities or physical disabilities, were identified both at the transport booking stage and through crew interaction with their patient.
- During our announced inspection it was identified that staff were not trained in dealing with patients living with dementia. Three staff members thought this would be useful training as many of their patients were living with dementia.
- On our unannounced inspection all staff had agreed to undergo a 10 week distance learning course facilitated by the Northern Advisory Council for Further Education (NCFE). This course was a Level 2 Certificate in the Principles of Dementia Care.
- A further course was being sourced to give staff an understanding of dealing with patients with other complex needs including learning disabilities.

Access and flow

- The service accepted allocated work details which were recorded electronically and were used to inform the resource required in order to effectively fulfil the booking. Journey information including name, pick up point, destination, mobility requirements and any specific requirements based on individual needs.
- Data was collected from staff completing job record sheets, which were reviewed internally by the office manager to inform resource planning, and which were shared with the senior team.
- Directors confirmed that patient transport services did not do emergency transfers and patients transported were medically stable.
- If a journey was running late, the driver would ring ahead to the destination with an estimated time of arrival and keep the patient and the hospital informed. Any potential delay was communicated with patients, carers and hospital staff by telephone.
- If a vehicle broke down during a journey a replacement vehicle would be taken out for the crew and the patient transferred whilst the vehicle manager waited for vehicle recovery. This ensured the patient was not held up on their journey.

Learning from complaints and concerns

- A feedback form was given to the patients following a completed journey, which enabled them to give feedback in writing or they could give feedback by telephone. There was also a link on the company website. However, there were no posters detailing the complaints contact details on any of the vehicles. Staff could provide complaint information if requested.
- The service had a management of patient complaints policy, which gave detailed directions of how a patient complaint should be investigated. From May 2016 to June 2017 the service had received no written complaints. There had been four verbal complaints, which, on review had been managed appropriately.
- If a complaint was to be received formally, it would be forwarded to the patient service lead for complaints. The lead was responsible for the investigation of complaints and providing feedback to the patient.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The service was a small business and the leadership team consisted of two directors, a transport manager and a part time operations administration assistant. The directors looked after the welfare of the staff and were responsible for the planning of the duties undertaken.
- Staff were able to tell us who the managers and team were and their roles in the service.

Patient transport services (PTS)

- The staff we spoke with said they felt valued by management, who kept them well informed.
- Staff told us that managers were accessible and that they would have no concerns in raising any issues directly with them should the need occur. They could access managers in the main office during working hours or managers were contactable 24 hours a day, seven days a week by telephone.
- We observed a positive culture throughout the service. Staff we spoke with were proud of the work that they carried out.
- Staff spoke positively about their roles and said they were part of a team committed to providing an excellent service.
- Staff spoke positively about the directors of the service. They had confidence directors had the appropriate skills and knowledge for their roles, felt able to raise any concerns with them and found them easy to contact. Staff we spoke with said the organisation and the directors were good to work for and they felt they were well looked after.
- Staff said they were proud to work for the service. They wanted to make a difference to patients and were passionate about performing their role to a high standard.
- All staff we spoke with were passionate about their roles and were dedicated in providing excellent care to patients.
- Staff told us that when they encountered difficult or upsetting situations at work they could speak in confidence with the directors.
- The directors we spoke with during the inspection had a clear understanding of the concerns we raised and how they would address these to ensure compliance.

Vision and strategy for this this core service

- The service did not have a written vision and strategy statement. However, they had values of compassion and a service committed to excellence. All staff we spoke with were aware of these values and could express them in terms of their role.
- The directors provided a mission statement during our inspection which detailed the ethos of the company as "the patient comes first." This was evident throughout our inspection.
- The team focus was "to continue to build firm working relationships with the NHS trusts they provide services to currently and secure further contracts with other local trusts."
- We saw communication to the staff informing them of the validity of contracts with local NHS trusts.

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

- Managers' governance meetings were held on a weekly basis. We reviewed 11 sets of minutes from meetings held between March 2017 and May 2017. The meetings followed a standardised agenda to ensure consistency of reporting and included agenda items such staff matters, training issues, workload, vehicles and equipment, premises and financial concerns.
- Managers had good understanding of the service improvements required and they acted on them immediately.
- The service had a mechanism to identify and manage risk. The service held a risk register to identify and monitor the highest risks to the organisation, both clinical and non-clinical. However, this did not reflect all risks identified during the inspection for example there was no mention of services dates for equipment such as stretchers, wheelchairs or fire extinguishers.
- On our unannounced inspection these risks had been reviewed and mitigated by the actions taken.
- There was a formal system to disseminate learning from incidents, safeguarding and complaint outcomes. This was via team meetings and email to all staff.
- We reviewed the managers' staff email where the managers updated staff with any issues such as changes in policy or training.
- The service did not carry out audits to measure the quality and effectiveness of the service delivered such

as cleanliness and infection control. However, patient information was audited and information and learning was shared with staff during formal and informal development discussions.

- We reviewed ten staff files and found them all to be complete. They all had enhanced disclosure barring checks (DBS), two references and induction training completed.

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

- The service did ask the public to provide feedback. There were cards provided to staff to give to patients.
- Complaints to the service were usually sent via the particular NHS hospital trust patient advice and liaison services. In the past year the only complaints that were received were in relation to timeliness of patient collection. These were all investigated and shown to be related to the late allocation of patients to Ambicorp LTD rather than as a result of Ambicorp LTD service provision.
- Team meetings were held every three to five weeks and were well attended by staff. These meetings were minuted and actions taken forward and discussed. We reviewed 12 sets of minutes between January and June 2017.
- The service did not provide a staff survey. However they had provided an anonymous suggestion box for staff to use.
- The service had a web site with information for the public about what the organisation could offer and a link to provide feedback to the service.

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

- The service was developing and there was consistent growth. The managers hoped to expand to have further local NHS trust contracts.
- The managers had advertised for an office manager. There had been interest and they were due to shortlist to interview very soon.
- Ambicorp LTD had an ISO accredited management system ISO 9001:2015.quality management system that helped with continued monitoring and managing quality across the business to identify areas for improvement.
- Ambicorp LTD had secured a pilot to an NHS provider to transport urgent bloods and organs.

Outstanding practice and areas for improvement

Outstanding practice

- Patients told us of occasions when crews went further than other transport providers to help them. One patient told us the crew stopped at a local shop to collect some milk on the way home. Another patient told us they had been allowed to finish a meal prior to leaving the hospital, the crew had waited and did not cancel the journey as, according to the patient, had happened with other providers on other journeys.
- Staff attended at weekends and on days off for extra training when it was required, in most cases without financial remuneration. This highlighted their dedication to patient care.

Areas for improvement

Action the hospital SHOULD take to improve
Action the provider SHOULD take to improve:

- The provider should ensure its processes for safeguarding children are adhered to. It should ensure staff are trained to the appropriate level for their role, there are appropriate reporting arrangements in place, and that this is monitored.
- The provider should ensure it follows its own safeguarding policy for the reporting of all safeguarding referrals.
- The provider should ensure there are appropriate infection control and prevention arrangements. The provider should audit cleaning activity and hand hygiene assessments in order to follow the provider's infection prevention and control policy.
- The service should ensure provision was made for patients who did not speak English or had communication difficulties.
- The provider should ensure the risk register reflects all identified risks.
- The provider should consider having a written vision and strategy for the service.