Advance Medical Transport Services Limited

Advance Medical Transport Services Limited

Quality Report

Buckmore Park Race Circuit
Maidstone Rd
Chatham
ME5 9QG
Tel:07881951592
Website:
www.advancemedicaltransportservices.co.uk

Date of inspection visit: 3rd December 2018
Date of publication: 25/03/2019

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Advance Medical Transport Services Limited is operated by Advance Medical Transport Services Limited. They are an independent medical transport provider based in Chatham, Kent. The service provides patient transport and high dependency transfers.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection 3rd December 2018.

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 is patient transport service.

We found the following areas of good practice:

- There was a system to ensure all incidents were recorded and monitored, with learning and outcomes shared with staff.
- Staff followed infection prevention and control procedures to reduce the spread of infection to patients. We found all vehicles were in good condition, well maintained and visibly clean and tidy.
- Journeys were planned and considered patient safety by using information provided at the time of booking.
- Records were clear, accurate and up to date.
- Patients were cared for and staff were respectful to patients.
- The service had a system for handling and managing complaints and concerns.
- There was a positive culture within the organisation and leaders were approachable.

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

- Staff understood their safeguarding responsibilities and what constituted abuse but staff records did not tell us if they were trained to the correct level for safeguarding children and adults. However, action was taken by the provider to improve training records after the inspection.
- There was no risk register for the organisation or system to ensure the effective oversight of the potential risks to the service and there was no governance framework for quality assurance.
- There were no audit processes which meant there was no way of checking protocols were being followed.
- There was no policy for managing the use of medical gases or how to manage deteriorating patients. However, the provider issued a policy that detailed how to manage deteriorating patients after the inspection.
- Policies and procedures were not always tailored to the company or dated, given a version number or date for renewal.
- The service did not assess staff competence and relied on the fact staff worked elsewhere within the NHS or for other providers. There were no staff appraisals or monitoring to assess how well they were performing within their roles.
- Paper copies were kept of incidents and risk assessments but there was no log or reporting tool to show trend analysis to prevent recurrence.
- Consent or Mental Capacity Act training was not included in the e-learning package nor was it on the checklist of skills that staff must have.
- There was no provision on ambulances to support people who were unable to communicate verbally or if English was not their first language.

Summary of findings

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected this patient transport service. Details are at the end of the report.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (South East), 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)		At the time of this inspection; we regulated this service but did not rate it. This is because we issued a provider information request to gain data prior to the inspection before 2 July 2018. Inspections where provider information requests are sent to independent ambulance services after 2 July 2018 will be rated. • Governance and risk management processes required further development to be effective. • Policies and procedures did not reflect best practice or national guidance. • The provider did not use journey data to monitor service efficiently. • There was a lack of communication aids and access to interpretation service for people with complex needs or those who do not speak English as a first language. However, • Incidents were reported, investigated, and learned from to prevent recurrence. • There was enough staff with the right skills to meet patients care needs. • Staff made safeguarding referrals and told us that if they had concerns then they knew when to alert the police or the local authority. • The provider ensured the staff were competent to undertake their roles. • Patients received care that protected their dignity and meet their individual needs. Staff cared for patients in a professional and kind manner.

Advance Medical Transport Services Limited

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Advance Medical Transport Services Limited

Advance Medical Services Limited has been registered with the CQC since 2017. It is an independent medical transport provider based in Chatham, Kent. The service primarily serves the communities of Kent.

The service has had a registered manager in post since 2017. Advance Medical Services Limited provides patient transport services and high dependency transfers as a sub-contractor to two main NHS providers.

The journey types of patient transport included outpatient appointments, admissions and discharges from hospital, hospital to hospital transfers, high dependency transfers and patients requiring renal dialysis. This included transporting both adults and those under the age of 18.

The vehicle fleet consisted of eight ambulances and could transport bariatric patients. All staff were self-employed. The service operated seven days a week.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,two other CQC inspectors, and a specialist advisor with expertise in ambulance services.The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Facts and data about Advance Medical Transport Services Limited

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the base in Chatham. We spoke with six staff including an administrator, patient transport crew, a vehicle washer and the management team. We did not speak with any patients or relatives. We reviewed ten sets of patient records, information submitted by the provider prior to inspection, and five staff files.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC, which found that the service was meeting most standards of quality and safety it was inspected against.

Track record on safety

- Zero never events since it became operational.
- The service was unable to tell us how many incidents had been reported.

Detailed findings

- No serious injuries were sustained by patients since the service became operational.
- No formal complaints.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

Patient transport services (PTS)

Are patient transport services safe?

Incidents

The service managed patient safety incidents. Staff recognised incidents and reported them appropriately.

- The service had no never events since registration. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death, have occurred in the past, and are easily recognisable and clearly defined.
- The service had a system for reporting incidents. These were reported using a paper based system if an incident occurred whilst staff were conducting a patient journey. The incident and dangerous occurrences reporting procedure had a timeline for recording incidents. Staff were given copies of this process on induction to the organisation and paper copies were also available in the office area.
- We reviewed an incident report form dated June 2018. A patient sustained a skin tear on the hand when being positioned in an ambulance. The crew immediately acted to have the wound seen and dressed by a nurse. The ambulance staff had apologised immediately to the patient and the registered manager had reviewed the incident. The report documented that there were actions and lessons to be learnt. The learning actions included reminding staff to be fully focussed when loading patients and to ensure the patient was fully secure before diverting attention to others.
- Incidents were shared with staff through the message portal which was a closed social media group administrated by the registered manager.
- However, the service could not identify or analyse any themes or trends as they did not record the reported incidents in one log for systematic review choosing instead to simply file paper copies of incidents.
- There was a duty of candour policy for the service that contained a well scripted sample letter to send to affected patients but the policy was not dated or have a review date. 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. This includes giving them details of the enquiries made, as well as offering an apology. Staff asked were aware of this policy and its importance but there had been no instances when an incident had met the threshold for the application of the duty of candour.

Mandatory training

The service provided some mandatory training in key skills to staff and made sure everyone had completed mandatory training when recruited.

- All staff were self-employed and the registered manager hired them on the basis that they had been trained elsewhere in key areas and key skills. Individuals had to have safeguarding training, infection control, manual handling and equipment use to work for the service. The provider used a spreadsheet to keep a record of mandatory training compliance. However, the record did not show the date training was delivered or the renewal dates. Certificates for some competencies obtained elsewhere were photocopied and placed amongst staff files.
- There was an online, e-learning training package for those staff who had missed elements of mandatory training. Staff were given a log-in for this and had to complete a test to pass training modules.
- There was no blue light training provided by the company and there were no current driving assessors working for them. The manager planned to source another agency to do this work once people needed revalidating or if new staff started. There was a process to identify which staff required blue light training and when it was needed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked with other agencies to do so.

- The organisation made safeguarding referrals and told us that if they had concerns then they knew when to alert the police or the local authority.
- Staff knew what constituted a safeguarding referral when asked and said how they would escalate concerns

if they had any. The process involved contacting the registered manager or operations manager in the first instance who then contacted the relevant bodies dependent on the nature of concern.

- The provider told us that safeguarding training had occurred and provided a spreadsheet which showed safeguarding training compliance. However, this did not have dates when staff had completed their training or the dates it needed to be renewed. Safeguarding vulnerable adults and children and young people was part of mandatory training and once completed was valid for three years.
- We saw safeguarding training had been completed by staff but this was with other employers. Therefore, the manager was unclear what had been covered in their safeguarding vulnerable adults or children and young people training and at which level. The manager responded to later requests for information to confirm what level of safeguarding training was held. Staff had level two and level three training.
- National guidance recommends that all ambulance staff including communication staff should be trained to level two. This is applied to all clinical and non-clinical staff who have contact with children/young people and parents/carers. There was no information to tell us which level staff were trained to when on inspection.
- The service had an up-to-date safeguarding policy which combined processes for both children and adult safeguarding and this outlined the procedure for staff to follow if they had a safeguarding concern. This was included in the employment policies and procedures manual issued to all staff.
- The manager said that their workload was booked via other companies or the NHS provider. These organisations informed the service in advance of safeguarding issues or protection plans and the service worked according to the referring organisation's guidelines.
- The service ensured patients under the age of 16 were accompanied by a responsible adult, usually a relative or medical escort, during transportation.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.

- Advance Medical Transport Services had procedures for staff to follow to maintain safe working practices. The service had an infection control and prevention policy which detailed how staff could follow universal precautions and deal with communicable diseases.
- All staff complied with the organisational standards of hygiene and infection prevention. These included a vehicle cleaning schedule, control of substances hazardous to health (COSHH) assessment, health and safety, and an environment risk assessment.
- All the crew staff wore uniforms and all knew to be bare below the elbows when in clinical areas. The company provided the uniforms and staff laundered their own.
- The service had a designated member of staff who thoroughly washed all the vehicles once a week and cleaned the interior. They also deep cleaned vehicles twice a month or sooner if a vehicle had been used to transport a patient with a known infection, or became contaminated with body fluids (such as urine or vomit). The service had a clearly defined process for deep cleaning and had clear instructions how this would be done including the products to use. A deep clean involved cleaning a vehicle to reduce the presence of certain bacteria, to prevent cross-contamination and records were available to detail the frequency of vehicle cleaning.
- Ambulance crew had responsibility for checking the vehicles were clean before starting a shift and on return to the base.
- We checked two ambulances at the base and they both were very clean and tidy.
- However, the provider had no assurance that staff complied with the policies and procedures to minimise the risk of cross infection. Managers said they did not carry out any infection prevention and control or hand hygiene audits.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- We saw fire safety checks were completed and they were up-to-date.
- Most single use equipment on vehicles was within the expiry date and stored appropriately. We found one out of date suction tube that was not in packaging and two ripped packets on in date equipment. All other stock checked was within expiry limits.

- All ambulances contained standard first aid kits, emergency breakdown kits and fire extinguishers. These were stored safely on the vehicles. We saw oxygen cannisters safely secured that had adequate levels of oxygen left.
- All vehicles had good external condition, had no worn tyres or excessive rusting.
- The service secured vehicle keys safely within the base and staff had fuel cards to use for fuel and toll road charges when required.
- The service had a local arrangement with a garage to ensure they carried out vehicle maintenance including MOTs (an annual check of vehicle safety) and servicing.
- Equipment to safely seat children was provided; such as child seats, harnesses and a paediatric stretcher. The service also had specialist bariatric equipment to support the transporting of obese patients.
- The manager told us they did not have an equipment replacement schedule. Staff reported any defects or faults during daily vehicle checks and the company mechanic replaced or maintained as appropriate. Staff provided this information at commencement of duty each day or at the end of the shift.
- The administrator was responsible for stocking a shelved area of the premises. This area was well stocked with cleaning materials. There was a good supply of basic medical supplies such as disposable sick bowls, urine bottles and commode pans, packs of dry wipes, gloves, hand gels and alcohol wipes, medical and other general devices.

Assessing and responding to patient risk

Staff knew how to assess patients' needs and prepared journeys in advance.

- Patients individual requirements, such as their medical conditions, were identified during the booking process. Any extra needs were then planned before the patient's transport arrived.
- Staff told us they would administer first aid and call an emergency ambulance where required if they identified a deteriorating patient. They conveyed the patient to hospital using blue lights if they had a blue light trained driver in the vehicle. Staff completed a form for each instance that they used blue lights to transport a patient.
- We saw that 25 staff had undertaken 'blue light' driving training.
- However, the service did not have a policy on transporting patients or the management of a deteriorating patient.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- The service did not require staff to report sickness nor did they monitor sickness as all staff were self-employed.
- Recruitment had been by word of mouth so advertising was not necessary. Managers carried out an interview for each potential recruit and checked identification and qualifications before a new person started work for the service.
- Staff completed an availability form a month in advance of allocation of work to ensure that the shifts were covered and this worked well for the service and for staff.

Records

Staff kept detailed records of patients' care and treatment. Records were generally clear, up-to-date and easily available to all staff providing care

- Patient records were held securely and kept confidential. Journey forms were completed by the crews daily and returned to base at the end of a shift. An administrator subsequently entered the information onto the office computer the next day. Recorded details included patient's name, date of birth, pick up and drop off addresses, any cancellation reasons, mobility, bariatric needs, escort, pick up and leave time, arrival at destination and ready time, and a comment column for additional information.
- We reviewed five patient journey forms undertaken in 2018 and four were fully completed, legible, dated and signed. One record had no date on the paperwork but all other sections were completed.
- The service did not carry out audits on patient journey forms. Any learning that might arise was fed back to staff directly; however, we did not see any records of this.
- All staff records were filed in between named dividers, however, each of the records were kept loose rather than in a folder which potentially meant papers might become misplaced or disorganised. Staff records

contained a curriculum vitae, staff contract, copy of disclosure and barring service (DBS) certificates and driver's licence, a 'code of good practice' – signed and dated by the manager and staff, and their individual training certificates.

- We reviewed five staff records; two of the five records did not contain details of the staff DBS status. When raised with the manager, she took immediate action to contact the staff and later verified that these staff were DBS cleared. Their DBS status had been checked on appointment and the manager was not obliged to retain copies of these certificates

Medicines

The service did not have a medicines management protocol or guidance for staff to follow on the use of medication or medical gases.

- Medical gas cylinders were kept on-site and complied with the British Compressed Gases Society guidelines. We saw completed risk assessments for this and cylinders were locked in a secure area.
- For patient transport services, the service did not supply medicines, did not keep any on-site or use medicines. The service ensured patients looked after their own medicines (if any) while being transported.
- Medical gases were available for certain journeys as part of a contractual agreement with a hospital trust. This gas was self-administered by patients and prescribed by doctors from the dispatching hospital. Staff had competencies to oversee the use of the gases but there was no medicines management policy, governance or protocol to support this.
- We found over the counter medicines in one vehicle. A manager said they only used this vehicle for event work. They stored the medicine in the office area when not in use. There was no event work occurring that day and the vehicle was not being used at the time. When we raised this with the manager, they clarified that the vehicle could also be used for transporting patients therefore the service had not stored the medicine securely.

Are patient transport services effective?

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance and evidence of its effectiveness.

- People's needs were assessed and transport was provided to patients through eligibility criteria provided by the booking agent. A patient's health and mobility status determined the suitability to use the patient transport service.
- There were not any clinical policies or standard operating procedures that referenced best practice or national guidance. There were policies in the employees' handbook that staff signed to say they had read during the start of employment. There were 13 policies which had no version number nor review date.
- The service did not have their own "do not attempt resuscitation (DNAR)'' guidelines but they followed the DNAR instructions that were supplied to them for patients from the referring agency. All DNAR orders were communicated to the crew by the hospital or by patients who carried their own copies.

Nutrition and hydration

- Food or drink was generally not provided to patients as journeys were local and short. During warmer weather, however, small bottles of water were kept on vehicles to offer to patients. Patients or carers were expected to provide food and drinks for patients in other circumstances.
- Journey breaks could be facilitated on long trips for all patients being transferred if they were mobile and able to get on and off the vehicle. A food and water pack was provided to patients on repatriation journeys and when travelling long distances.

Response times / Patient outcomes

- The service had different numbers of vehicles operating on any given day dependent on the jobs referred to them.
- The service did not formally monitor patient outcomes. There were no contractual or service level agreements from providers to do so. The manager sent performance data relating to each journey, such as collection and delivery time for each patient to the referring company or organisation.

- Adverse patient outcomes such as falls or deterioration in their presentation needed to be logged through the incident reporting system. There had been no adverse patient outcomes reported since the company started operating.
- Crew members ensured patients were not left at home without being safe and supported. Some patients were discharged from hospital and had a package of care to be arranged at home. If the support person or team had not arrived when the patient came home, staff called the hospital to find out where they were and waited until they knew the patient was safe and settled.

Competent staff

The service made sure staff were competent for their roles.

- All staff were provided with a company handbook that detailed the company policies, rules for employees and local safety arrangements. We saw where staff followed policy, for example, when reporting any vehicle defects immediately to the manager.
- Driver and Vehicle Licensing Agency (DVLA) checks were conducted at the start of employment and on an ad hoc basis. All crews were aware of the need to notify the managers of any changes to their licence in line with the service driving standards policy.
- The service did not carry out appraisals but held informal one to one conversations with staff. The manager ensured they obtained a copy of training certificates from all self-employed staff who were employed by other providers.
- The service funded additional training for staff if required. However, they would recover monies through the individual staff wages for incomplete training or courses.
- There was an e-learning training package for staff who needed training in key areas. This package had safeguarding and mental health awareness training. The manager was unsure about which safeguarding training level this offered and could not be assured of the level of training staff needed.
- We reviewed 10 staff competency records. All had the first person on scene level three qualification, ambulance emergency driving and paediatric first aid. Only four of the 10 staff had safeguarding training certificates. However, it was not clear whether they were adult or child safeguarding training and did not state which training level. We raised this as a concern with the manager who was keen to remedy and check on the status immediately.
- All new staff received an induction. However, we did not see a record of this in all the staff records we reviewed although they all contained the 'code of good practice' that included the protection of information and internet use policy for example.
- The service carried out driving competencies through 'drive outs' with a driving assessor at the start of employment. Both driving assessors had recently retired and the management team were looking at recruiting or contracting a driving assessor.

Multi-disciplinary working

Staff of different kinds worked together as a team to benefit patients

- We did not witness any multi-disciplinary working apart from passing interactions between the managers, crew and the administrator in the office environment. There were no complaints from any patients or providers to suggest that the crew did not have a good relationship with them.
- Minutes of a team meeting in May 2018 showed that the manager gave feedback from site practitioners at hospitals and two providers that they did subcontracted work for. The points made included that staff needed to be more visible to site managers when dropping patients at hospitals and ensuring some paperwork was completed correctly but feedback was generally positive.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005

- There was no formal training for consent, mental capacity or deprivation of liberty. There was a mental health training module available via the available e-learning package but this did not address the legislation around these topics.

However, staff understood their roles and responsibilities for gaining consent from patients before transporting them. Dementia training was incorporated into the mental health training module.

Are patient transport services caring?

Compassionate care

Staff cared for patients with compassion.

- The crew maintained the dignity of patients during transportation. A staff member described what they would do to protect the dignity of patients. This included providing blankets to cover patients and closing the shutters at night in the back of the ambulances.
- Staff took time to interact with people who used the service in a respectful and considerate way. A staff member told us they spent extra time with older people to ensure their heating came on and made them a cup of tea before leaving.
- Staff ensured equal treatment and respect when transporting two patients in the same vehicle. One staff member told us if two patients were onboard at the same time, one person sat in the back between the patients so they could support them equally. The crew also introduced the patients to each other to encourage them to respect each other.
- There was a process for staff continuity for regular patients. A manager told us they aimed to have the same staff for regular patients so that patients and staff became familiar with each other. They told us about a regular patient they transported who needed a particular mobility aid to alight the ambulance and tried to have the same crew each time if possible to address this need. This was comforting to the patient.
- We did not speak with any patients as the service did not store patient phone numbers so we were unable to call them to ask their views. We saw two written compliments from patients' relatives that said, "many thanks for the fabulous care of my son" and "thank you again for bringing my son home". We did not observe any care being given due to the nature of the service.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- We were given an example of how staff provided care following an unexpected development on a patient transfer to home. The patient was returned to hospital to minimise their distress and confusion.
- Staff provided support to those that die in their care. We learned of a patient who died in transport to a hospice. They respectfully transferred them to the nearest accident and emergency department for a doctor to confirm death.
- Staff provided respectful and dignified support to the relatives of those that die in their care. A manager told us about a patient who died mid transfer and the crew ensured a doctor confirmed their death on arrival at the accident and emergency department. One of the crew stayed in the ambulance with the patient and accompanying relative during that process. The crew then offered the relative time alone with the patient in the privacy of the ambulance.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- Feedback from people who use the service, those who are close to them and stakeholders was positive about the way staff treat people. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff are positive. People felt supported and say staff care about them.
- Staff showed respect and care to patients travelling with them, for example, they ensured a parent sat close to their child during transport with 'blue lights'. They also said they explained to the parent about the journey and what to expect before setting off.
- Staff supported those travelling with patients. A manager told us staff ensured they assisted accompanying relatives with mobility requirements to get to and from the ambulance when required.
- The service involved patients in planning their transport. A manager said patients could make requests and communicated these to crews on their job sheets.
- Staff communicated with people to ensure they understood their care and treatment. Crews supplied patients with bowls for travel sickness if needed and the crew would check with the patient they had everything they needed before setting off.

- Crews welcomed and treated people's carers, advocates and representatives including family members and friends as important partners in the delivery of their care. Managers encouraged crews to get relatives or friends to travel with the patients and encouraged them to talk with the patients during travel to help patients' experience.

Are patient transport services responsive to people's needs?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

- The service planned to cope with the differing levels and nature of demand. Managers told us they adapted the service to meet the daily demand. Some work came in the day before and the service had a process to meet this variability and to respond to changes needed quickly. They had recently implemented an on-call crew overnight to meet any changes that had to be made in the out of hours period.
- The service was mostly subcontracted by other patient transport providers to fill in when needed. The administrator showed us a graph which demonstrated the times that they responded to large increases in demand on their services - almost doubling journeys made in one month.
- The managers were contactable by email or phone to request additional resources. We read two written compliments from organisations they worked with; both thanked the service for their assistance in difficult times.
- The service had the appropriate facilities and site to deliver the services. They had an area that was flood lit at night to store their ambulances and for staff to park. Staff used toilets, changing areas and showers as needed. There was adequate office space to coordinate the service.

Meeting people's individual needs

The service did not always take account of patients' individual needs.

- There was limited access to interpretation services. There was no telephone interpreting service available to staff, which meant that patients who did not speak English might have difficulty communicating with the crew. Staff told us they could use an application on their mobile phones to translate into different languages. If they identified patients who did not speak English from the transport request form then they tried to match up these patients with staff able to speak the patient's language.
- The service did not have any aids to help communicate with patients with reduced communication ability. This potentially meant that some patients with complex health needs might not be able to express their needs to staff.
- Patients received personalised care that was responsive to their needs and planned service provision. For example, the crew ensured a patient who did not like small spaces sat in the ambulance in a position that had a good view out of the vehicle. This eased the patient's discomfort.
- Adjustments were made to support access to their service by bariatric patients. Stretchers were available and expanded quickly to accommodate a bariatric patient. Crews had adequate electric equipment to move bariatric patients up and down stairs. People with reduce mobility used this equipment if needed.
- Adjustments to equipment was possible to suit children and younger people. A device was used to adapt an adult stretcher to safely secure and transport a child or younger person.

Access and flow

People could access the service when they needed it.

- The service did not track if their journeys ran to time. We reviewed 30 patient records of their journey times. Although the service recorded them, they did not use the data to monitor their performance. The data was sent to their subcontracted providers and relied on them to raise any issues.
- The service did not have a system to keep people informed of any journey delays. Crews reported delays to the operations manager but it was up to the provider who they had subcontracted the work from to tell patients of delays to their pick-up times, not Advance Medical Transport Services.
- The service prioritised some people with the most urgent needs. If they came across people at the side of

the road needing urgent assistance they would stop and offer any help they could. For their own patients, they completed journeys as assigned by the provider they had the subcontracted work from.
- Self-funding patients had access to the service. They recently transported a patient who was prepared to pay for transport but needed an ambulance to travel in. This patient had a choice of another transport provider free of charge but were unhappy with that provider's service, and were willing to pay for an alternative.

Learning from complaints and concerns

The service did not have any formal concerns or complaints.

- The managers told us they had no formal complaints but had received informal, low key complaints and comments via telephone calls from other providers. They did not record these as complaints and therefore were unable to establish the number of verbal complaints they received. The emphasis was on resolving the issue at the time rather than logging detail.
- The service ensured patients were made aware of the complaint process. Posters were displayed in the ambulances with contact details and clear information on how to complain.
- Staff described the information they would give to patients wishing to make a complaint. Complaint contact details were also printed on a business card stored in the ambulance ready to be handed out if they wished to make a complaint.
- There was not a clear timeline for responding to complaints. The manager responsible for complaints could not tell us about the 30-day timeframe to respond to complaints detailed in their policy but stated that they aimed to respond to complaints in one or two days for complex complaints. This process was untested though as the service had not had any formal complaints.
- As they did not receive any formal complaints, the managers were unable to describe any learning from them.

Are patient transport services well-led?

Leadership of service

Managers in the service had some skills, potential and abilities to run a service providing good quality sustainable care

- The registered manager who was the nominated individual and an operations manager provided leadership to the staff within the service.
- The managers understood the challenges of the service they provided and were keen to improve generally and to learn from our inspection visit.
- Staff spoke positively about the management team and felt able to approach them with any difficulties and issues. They told us they spoke to the managers daily and were able to discuss anything with them during this time.
- The two managers we spoke with were committed to providing a good service.

Vision and strategy for this service

The service had a vision for what it wanted to achieve and formative plans to turn it into action.

- The service had a clear vision that it did not want the business to become vast and expansive. They planned to retain the friendly, familiar feel that existed already through the retention of a few choice business contracts.
- A strategy meeting took place in June 2018 to discuss financial matters, investment, organisational roles and the customer base. This was a low-key meeting attended by the manager and the account holder.

Culture within the service

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

- The service was small and friendly. One employee said this was the best ambulance service they had worked for. The staff had all been invited out to dinner and bowling as a thank you for working hard during inclement weather conditions in the previous winter. The service had also organised a social event and BBQ for staff in the summer.
- The registered manager spoke to the staff on duty every day and staff felt managers supported them if there were any problems. When the registered manager was not available, staff talked to the operational manager.

Governance

Patient transport services (PTS)

The service did not have systems to improve service quality and standards of care.

- The service had a document that outlined roles and responsibilities of the managing director, the operations manager, crew team leader and the administrator. There was also a list of useful websites and organisations including an interpretation service although the manager had not paid to use this. This document was not dated nor did it reference a framework for improving the quality of the service.
- Staff were notified of changes to policies verbally or through the message portal. This did not allow for detailed discussion or provide assurance that all staff were aware of changes at the same time or that staff fully understood the implications of the information they received.
- The company did not undertake regular audits or quality monitoring of the service.

Management of risk, issues and performance

The service had some systems to identify risks, plans to eliminate or reduce them, and cope with both the expected and unexpected.

- The service did not have a risk register so there was no documented way of reviewing organisational risks. There were individually scored risk assessments for the site, for storage of medical gases, moving and conveying patients and risks associated with the office environment.
- The registered manager said the risks to the organisation were risks to staff and vehicles from road users and loss of work contracts. However, the registered manager did not recognise some risks within the workforce. For example, risks were thought to lie with the provider that they obtained subcontracted work from. The organisation's statement of purpose noted that ''We also provide patient transportation, for the NHS and other hospital providers, so currently work under their protocols and procedures when doing so''. Although this meant that there were instructions to follow when conveying patients, it did not negate the fact that this service needed to work within their own risk-assessed guidelines.
- There was a business continuity plan but this was not dated nor tailored to the company. This policy stated that the 'Head of Emergency Preparedness and Business Continuity Manager are the professional leads within the organisation' which was not the case. These kinds of errors invalidated the plan and meant the service was not robust.
- Indeed, there was a failure to monitor trends and theme analysis on incidents. Without oversight of these themes, the registered manager was unable to be satisfied that the business was operating safely or performing satisfactorily. Similarly, the lack of a deteriorating patient policy, the absence of a daily vehicle checklist and poor monitoring of complaints told us that risks and performance were not being formally acknowledged.

Public and staff engagement

The service engaged with patients, staff, the public to plan and manage appropriate services, and collaborated with partner organisations effectively

- The service had a website with information for the public on the services provided and their contact details. Each vehicle we inspected had feedback posters for patients which allowed the public to give opinion and comments about the service via email, the service website or by phone.
- Staff were well informed about organisational changes such as the loss of contracts and knew the hospitals or providers they would be working with. Communication was mainly through the message portal and there were notices on display boards in the office for staff to read.
- However, staff had few opportunities to meet formally as a team to discuss risks within the service, cascade information or for team development. There were occasional events organised by the manager but these provided opportunity for staff to meet only in a social context.
- Staff meetings were not easy to organise as all the staff were self-employed and had other work commitments. We saw minutes of a staff meeting from May 2018 and the issues discussed included team working and vehicle cleaning. We were told the service organised another staff meeting after this but they had regrettably cancelled it and had not rearranged another one.

Innovation, improvement and sustainability

- The managers of this service were clear they did not wish to grow or expand the business at this time.

Patient transport services (PTS)

- The service was, however, flexible and willing to adapt to meet local needs and provision by doing a variety of events work, high dependency work and patient transport.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure effective governance processes including the gathering of service risks and the mitigating of actions are in place.
- The provider must ensure that systems are established to effectively monitor and take action to improve governance in: infection prevention and control, mandatory training, incident management and shared learning.

Action the hospital SHOULD take to improve

- The provider should keep a clear record of safeguarding training that demonstrates staff have the correct level of safeguarding to carry out their role.
- The provider should have up-to-date mandatory training records for each staff member and detail when training was completed, the level of training reached and the renewal date.
- The manager should consider appraising staff to measure their performance within the service.
- The provider should have a programme of audit for infection control.
- The provider should have a medicines management policy.
- The provider should have a standard vehicle checklist.
- There should be formal training for consent, mental capacity and deprivation of liberty.
- There should be a wide range of communication aids and access to interpretation services for people with complex needs or those who do not speak English as a first language,
- The provider should have a policy for conveyance and management of the deteriorating patient.
- The provider should formally record and log incidents and complaints and monitor for themes and trends.
- The provider should ensure that all polices reflect best practice and national guidance and are tailored to the organisation. The provider should ensure the detail within them is correct and relevant. Policies should be dated and have a review date
- The provider should use journey data to monitor service performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 17: Good governance 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity