Primary Ambulance Services Limited

Primary Ambulance Services Limited - Operations Centre

Quality Report

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Date of inspection visit: 29 March and 6 April 2017
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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information know to CQC and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

Primary Ambulance Services Ltd is operated by Primary Ambulance Services Ltd. The service provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 29 March 2017, along with an unannounced visit to the provider on 6 April 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we do not rate

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

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

- The service did not have any systems or processes in place for the reporting, investigating and sharing of learning around incidents. Incidents were not recognised. Staff had not received training in incident reporting.
- There was no process in place for the deep cleaning of vehicles to prevent the spread of infection.
- There was no system in place to monitor vehicle servicing and maintenance. There was no audit to ensure that vehicle daily checks were being completed accurately. We found faulty equipment in vehicles, which posed a risk to staff and patients.
- We were unable to gain assurances that staff had received the necessary mandatory training to carry out their roles safely and effectively.
- There was no contemporaneous record of decisions taken in relation to the care and treatment provided to patients by the service.
- Processes to assess patient eligibility were lacking. There were no inclusion or exclusion criteria in place.
- There was a lack of oversight of staff compliance with mandatory training. There was no appraisal process to assess staff competencies. There was a lack of regular and documented staff engagement.
- The service had weak governance systems and poor oversight of risk.

However, we found the following areas of good practice:

- Vehicles contained personal protective equipment for staff.
- All vehicles had an up to date MOT and tax.
- Staffing was sufficient to meet patient need and was planned in advance.
- Patient feedback was consistently positive.
- The service was planned and delivered to meet the individual needs of local people.
- Staff described management as approachable and supportive. They reported feeling valued in their role and felt that the service was a positive place to work.

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 section 29 Warning Notice that affected patient transport service. Details are at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Patient transport services were the main activity provided by the service. We found the service was in breach of three regulations of the Health and Social Care Act (2014). These were regulation 17, good governance, regulation 12, safe care and treatment and regulation 15, premises and equipment. As a result of this we issued a section 29 Warning Notice.

Primary Ambulance Services Limited - Operations Centre

Detailed findings

Services we looked at
Patient transport services (PTS).

Detailed findings

Contents

Background to Primary Ambulance Services Limited - Operations Centre

Primary Ambulance Services Ltd is operated by Primary Ambulance Services Ltd. The service opened in 2009. It is an independent ambulance service based in South Ockenden, Essex providing patient transport services to the public and private sector. The service primarily serves the communities of the London and Essex area.

The service has had the current registered manager in post since 14 May 2012.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and an assistant inspector. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Facts and data about Primary Ambulance Services Limited - Operations Centre

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury.

During the inspection, we visited the base, located in South Ockenden. We spoke with five members of staff including; directors, administrator and patient transport drivers. We spoke with one patient and one relative.

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 November 2013 which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (March 2016 to March 2017)

One of the two directors was the transport manager and primary driver for the service, which also had a bank of temporary staff that it could use.

Track record on safety

- No Never events
- Clinical incidents 0 no harm, 0 low harm, 0 moderate harm, 0 severe harm, 0 death
- No serious injuries
- No complaints

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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Summary of findings

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

- The service did not have any systems or processes in place for the reporting, investigating and sharing of learning around incidents. Incidents were not recognised. Staff had not received training in incident reporting.
- There was no process in place for the deep cleaning of vehicles to prevent the spread of infection.
- There was no system in place to monitor vehicle servicing and maintenance. There was no audit to ensure that vehicle daily checks were being completed accurately. We found faulty equipment in vehicles, which posed a risk to staff and patients.
- We were unable to gain assurances that staff had received the necessary mandatory training to carry out their roles safely and effectively.
- There was no contemporaneous record of decisions taken in relation to the care and treatment provided to patients by the service.
- Processes to assess patient eligibility were lacking. There were no inclusion or exclusion criteria in place.
- There was a lack of oversight of staff compliance with mandatory training. There was no appraisal process to assess staff competencies. There was a lack of regular and documented staff engagement.

Patient transport services (PTS)

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Are patient transport services safe?

Incidents

- No never events were reported between March 2016 and March 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Incidents were not identified, reported or investigated. No incidents had been reported between March 2016 and March 2017. However during our inspection the transport manager told us that a vehicle had had a puncture whilst out on the road the previous day. This had not been reported as an incident. This demonstrated that there was a lack of understanding of what constituted an incident.
- There was an incident reporting procedure policy. The policy stated staff should report incidents directly to the manager. Staff stated that they would call the manager or the control room to report any incidents. Incident forms were available, however these were not referenced in the policy and staff did not complete them.
- There was no process in place for shared learning from incidents. The service had a small number of staff and the manager and staff told us that they would share information informally. However no incidents had been reported. There was no process or documentation to confirm that information would be shared.
- All members of staff that we spoke with were able to demonstrate an understanding the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- Vehicles and equipment were not cleaned effectively. We inspected two out of the four vehicles in operation. Both were visibly dirty, window sills were dirty to touch and there was collected dust in corners. The mattress

on the stretchers in both vehicles were visibly dirty in the seams. The oxygen bracket in one vehicle was visibly dirty and rusty meaning that it could not be cleaned effectively.

- There was an ambulance cleaning policy in place. The policy stated that the vehicle should be cleaned every time it is operational. We saw a cleaning record for each of the vehicles dated from January 2017. The record showed the date and the level of clean the vehicles had received; C indicating clean and DC indicating deep clean. The record did not show when the vehicle was in service so we could not confirm that the vehicle had been cleaned every time it was operational as per the policy.
- There was no evidence that staff had received any formal training in the process of deep cleaning. There was no contract in place with an external contractor to provide a deep cleaning service for the vehicles. We raised this with the manager and when we returned for our unannounced inspection they told us that they were negotiating with an external contractor to provide a vehicle deep cleaning service.
- The ambulance cleaning policy stated that vehicles should receive a deep clean once a week. Records provided showed that the vehicle that was primarily in use for the patient transport service received a deep clean five times from 2 January to 27 March 2017 The ambulance cleaning policy indicated this vehicle should have been cleaned 13 times. This meant the weekly deep clean had been omitted on eight occasions.
- The cleaning records for the other vehicle we inspected showed that it had not received a deep clean over the same period. The record showed that the vehicle received 10 cleans between 5 January 2017 and 26 March 2017, however it was not recorded that any of these cleans were classified as a deep clean.
- There was no system in place to monitor the level of cleanliness. There was no detail as to what cleaning agents were used and cleaning methods used. There was no differentiation between cleaning methods for a daily clean and a deep clean. The manager told us that a deep clean used the same cleaning agents and process as a daily clean but the vehicles were emptied prior to the clean being carried out.
- Both vehicles had damage to patient seating. For example in one vehicle the front forward facing passenger seat had a tear with foam exposed. The rear forward facing passenger seat back compartment had a rip in the material of the chair and the foam was exposed. The folding chair at the base of the stretcher had an exposed spring adjacent to the seatbelt receptacle. Exposed foam was not able to be cleaned effectively and presented an infection control risk.
- A stretcher mattress had a liquid stain under the mattress and a dry yellow/white flaky substance along the zip on the underside of the mattress. This meant that it could be a potential infection control risk as this was an unidentified substance of unknown origin.
- The staff hand book included hand washing guidance advising staff to wash hands after every patient contact. Where it was not possible to access soap and water staff were advised to use hand gels in the vehicle.
- Hand gel dispensers were available in both vehicles. However, the automatic dispensing mechanism on one dispenser was not working meaning that the gel could not be dispensed. We advised the manager of this and when we returned for the unannounced inspection a new dispenser had been fitted.
- Personal protective equipment such as gloves and aprons were available in both vehicles.
- Staff were responsible for cleaning their own uniforms. Two members of staff confirmed that they washed their own uniforms. Both members of staff told us they carried a spare uniform in case of uniform contamination during a shift.
- Spill kits for the cleaning of body fluids including blood were available in both vehicles.
- The service used single use sheets and blankets that were disposed of after use.

Environment and equipment

- No systems were in place to maintain oversight of vehicle servicing and maintenance. Previous and next service and MOT dates were not recorded. When we returned for our unannounced inspection information relating to the due service and MOT dates were recorded on a white board in the office.
- We reviewed MOT and tax records which showed that at the time of our inspection all patient transport vehicles held an up to date MOT and tax.
- The service could not provide an up to date vehicle service record for the four ambulances in the fleet that were operational. We reviewed the vehicle folder and

this did not have a service history record for any of the four vehicles. Therefore we could not be assured that vehicles had received servicing within the recommended period.

- The service used vehicle check sheets which were completed by drivers before every shift. We reviewed eight vehicle check sheets and saw that they were completed and no issues recorded. However, we found one vehicle which had a sheet stating no issues, which in fact had two severely worn tyres. We could not confirm that the tyres were outside legal limits as no tread measures were available. However on one tyre the mesh was visible and on the other the wear was uneven and there was no tread on the outer edge. We were not assured that the vehicle checks were being carried out thoroughly before every shift. On our unannounced inspection the director showed us that they had purchased two pressure gauges and two tread measuring devices and told us that they would be training staff to use them.
- We informed the manager of the worn tyres. They told us that the badly worn rear tyre on the vehicle was the spare tyre that had been put on the vehicle the day before following a puncture on the roadside. However this tyre was heavily worn and therefore should not have been put on the vehicle. Two days following our inspection the service provided evidence that three tyres had been replaced, two on the vehicle and the spare tyre.
- There were no processes in place for the reporting and monitoring of faulty equipment. A stretcher locking mechanism floor bracket in one of the vehicles did not click in when the trolley was pushed into position and had to be manually lifted. If this was not done the stretcher would not be secured safely in the vehicle. We did not see any evidence that this had been reported or that steps had been taken to fix the mechanism.
- One staff member told us that any faulty equipment information was noted on the patient transfer request form, which was shredded after use. They gave an example of when the battery on the automated external defibrillator (AED) was low. They told us that they recorded it on the private transport request form and the battery was replaced
- A plastic guard at the side entrance of one vehicle was broken and taped. The tape had come away and the broken plastic was loose. This was highlighted on our announced inspection and had not been addressed by the unannounced inspection.
- Not all equipment on the ambulances was up to date with servicing. On one vehicle, the stretcher had a service sticker dated 25 February 2015. The carry chair had a service date sticker July 2013. On another vehicle, the fire extinguisher in the rear compartment of vehicle had last visible service dated August 2015 with next service date due August 2016. We asked if records were available to show that the equipment had been serviced more recently. The provider could not produce a service history record of equipment or confirm that they had been serviced.
- On both vehicles, we found out of date consumables. For example in the grab bags we found six nasopharyngeal airways, four nasal cannulas, two variable flow adult masks and three oropharyngeal airways all past their expiration date. We brought this to the attention of the transport manager. The items were disposed of immediately in the clinical waste. When we returned for our unannounced inspection we found that the vehicle was appropriately stocked with in date consumables.
- The service had a contract with an external company to dispose of clinical waste. There was a clinical waste bin at the depot, which was locked appropriately. There were no clinical waste bags on the vehicles we inspected. We raised this with the transport manager and at out unannounced inspection clinical waste bags were available in the vehicle.
- There were sharps bins available on the vehicles. These were assembled but the labels were not completed meaning that there was no information relating to when they were assembled and by whom.
- When vehicles were not in use all keys were secured safely. There was a key safe opened by a key code located in the store room. Staff could access the ambulance keys if required without the manager having to be present.

Medicines

- The service did not carry medicines, with the exception of medical gases. Due to the nature of patient transport services carried out this was not required.

- There was a policy in place to provide guidance for the safe transportation of medical gases. In both vehicles that we inspected we found that the oxygen cylinder was stored in a safe and secure manner.
- Spare oxygen cylinders were stored appropriately in a storage room with good ventilation. The cylinders were kept in a cage which was locked with a padlock. The padlock was open at the time of our inspection but the transport manager told us that this is usually locked but had been left open for our inspection. The key was kept in a key safe which could be accessed via a keypad code.
- The manager told us that staff had received medical gases training. However there was no evidence of this in the staff personnel folders. We requested the training compliance rate after our inspection however the service did not provide this data so we could not be assured that this training had been undertaken.

Records

- Patient details, care and treatment were recorded on the private transport request (PTR) forms and were shredded after use for privacy and confidentiality reasons. As the forms were shredded, there were no contemporaneous records of care and treatment provided to service users. This meant that if confirmation of treatment given to the patient whilst in their care was needed, the provider would not be able to produce this information.

Safeguarding

- The safeguarding adults policy was out of date and had not been reviewed since September 2012.
- Information about how to raise a safeguarding concern was available in the vehicle folder and in staff handbooks. Vehicles contained relevant telephone numbers and a safeguarding adult concerns form for staff to complete.
- The safeguarding lead for the service was the transport manager. This person was trained to level three safeguarding adults as recommended in the NHS England Intercollegiate document, Safeguarding Adults.
- The two members of staff employed by the service for patient transport did not have up to date safeguarding certificates in their personnel folder. We requested up to date training records from the service but we did not receive this.
- Safeguarding training was booked and due to take place on 13 May 2017 but the manager was unsure which levels this would cover and was unclear as to what training the staff providing the service needed. Therefore we were not assured that all staff had received appropriate safeguarding training.
- One of the staff members we spoke with was able to give an example of potential safeguarding situations and knew how to escalate any concerns. The second staff member was unclear as to what constituted a safeguarding concern.
- The service reported that no safeguarding concerns had been raised in the 12 months prior to our inspection.

Mandatory training

- The training policy outlined mandatory training requirements. These included manual handling, fire safety, road safety awareness, work place hazards and first aid.
- Information provided prior to the inspection showed that 100% of staff had completed first aid at work training, 100% had completed automated external defibrillator (AED) training and 80% of staff had completed manual handling training. After our inspection, we requested up to date mandatory training records from the service but we did not receive these.
- Training was delivered by a combination of in house training and external training. For example the service was an accredited approved centre of Association of First Aiders (AoFA). Training delivered included AoFAQ level 3 award in first aid at work and AoFAQ level 2 Award in emergency first aid at work. Safeguarding training was delivered by an approved external provider.

Assessing and responding to patient risk

- Risk assessments were carried out over the telephone at the point of booking. This information was recorded on the private transfer request (PTR) form. This form was comprehensive and recorded information including infection risk, whether the patient required oxygen, the service user's mobility and any equipment required for their transfer. This form was given to the driver.
- Staff told us that risk assessments were carried out at the point of contact with the service user. Any additional information was added to the PTR form and the control room was notified. PTR forms were shredded after use so we were not able to see a completed form.

Patient transport services (PTS)

- The service transferred one patient at a time and the same crew would accompany the patient if a return journey was required meaning that they would be aware of any additional risks.
- The service did not have a policy in place relating to management of a deteriorating patient. We spoke with two members of staff and asked what actions would be taken if a patient's health deteriorated during transfer. Both members of staff reported that they would contact the control room and if required divert to the nearest accident and emergency department or call NHS ambulance service for support.
- There was no violence and aggression policy in place so we were not assured that staff were sufficiently equipped to respond to these risks or protect themselves and patients from harm.

Staffing

- The service was small and employed two members of staff on a 'casual' basis. The majority of the patient transport was carried out by the transport manager. The staffing level was appropriate to meet the needs of the patients and the manager told us that the service was not experiencing any challenges with staffing levels, skill mix or recruitment.
- There were no fixed rotas or shift patterns for staff. When a booking was made staff would be contacted to see who was available to carry out the individual journey. This meant there was no risk of staff not receiving enough time off or becoming fatigued.
- Disclosure and barring service (DBS) checks was carried out on staff at the time of commencing employment with the service. We saw a copy of the DBS checks for all staff members employed to work in patient transfers.

Anticipated resource and capacity risks

- Unexpected or fluctuating demand was not an issue for the service because bookings were made as and when they were required. If they could not secure staff to provide the patient transfer requested the manager advised the person making the booking and the booking went to another provider.

Response to major incidents

- The service had a business continuity plan in place. This included procedures to follow in the case of events that may affect the delivery of the service including access to buildings, power cut and lack of staff.

Are patient transport services effective?

Evidence-based care and treatment

- The service had 27 policies in place including health and safety policy, incident reporting procedure policy, infection control policy, safeguarding policy and ambulance cleaning policy. However the policies did not have an implementation date or review date so we could not be assured that they were up to date with current guidelines and best practice. For example the safeguarding adults policy referred to the Mental Capacity Act 2007. This is not correct as the Mental Capacity Act is dated 2005 meaning that the policy was not following the correct legislation.
- Policies were not embedded, for example, the incident report policy stated that incidents should be reported by phone to the line manager. However, the staff hand books stated that an incident form should be completed. One staff member told us that they would complete an incident form and another told us that they would call the line manager. Therefore, we were not assured that policies were reviewed or adhered to.
- Policies were paper based. Staff could access the policies at the base location. We asked two members of staff how they would access relevant policies. Both members of staff confirmed they had access to paper-based policies and procedures at the base location.
- There was no formal audit process in place to ensure all aspects of the service were continually monitored.

Assessment and planning of care

- The private transport request (PTR) form included a notes section where information could be added relating to any additional or complex needs that a patient may have. This enabled the service to take into account a patient's individual needs.
- Control room staff received information about patients requiring transport at the point of booking. This enabled the service to ensure that an escort would be with the patient for the duration of transport if required. Staff told us that the majority of patients travelled with an escort who was either the person's carer or a relative.

Nutrition and Hydration

Patient transport services (PTS)

- The service did not routinely provide food and drink to patients due to the short length of patient stay in vehicles. However they told us that patients were welcome to bring refreshments.

Response times and patient outcomes

- The service was not formally monitoring and recording response times at the time of the inspection. The manager told us that the driver would call to confirm when they had arrived on site and call again when the patient was on board the vehicle. They said that they always ran on time. However, there were no records to monitor these outcomes.
- At the time of our inspection there was not a process in place to monitor the number of bookings received. No audit was in place to monitor the number of declined bookings. However, the manager told us that this did not happen very often as the current number of patient transfer requests was very low.

Competent staff

- The service did not carry out staff appraisals. Two members of staff confirmed they had not had a formal appraisal although they told us they received feedback on an informal basis.
- Staff received an induction when starting employment. This included mandatory training, a vehicle induction and a shadow shift working with an experienced member of staff. Two members of staff confirmed this. However, the attendance of induction was not recorded and details were not available in the staff personnel file.
- Additional staff training was provided. However, there was no formal process for recording training so we were unable to confirm what training had taken place and who had attended. At the time of our inspection only the transport manager had received training in conflict resolution. However we were told that conflict resolution training was due for rollout in the current year 2017
- A member of staff told us that the service was very supportive of training. They told us that when there was any change in the service staff were given training. They gave an example when an electric ramp had been replaced with a manual one and staff were trained in the use of the new ramp.
- Driving licences were checked on a yearly basis, via an online system. We reviewed three staff files for PTS employees which showed that all had a driving licence check in the 12 months prior to our inspection.
- The directors had not received training in root cause analysis or incident investigation. We could not gain assurances that the directors had sufficient skills and knowledge to apply the duty of candour and investigate incidents thoroughly.

Coordination with other providers and multi-disciplinary working

- We spoke with one patient who had travelled regularly with the service. They said that their journey details were well communicated to them in advance of transport and they were confident that they would be kept informed if there was going to be a delay. One time their journey had to be cancelled but they were notified in advance so they could make alternative arrangements.
- Upon completion of each job carried out on behalf of social services the crew contacted the social service's contact team to confirm that the patient had been transferred. At this time they would feed back if there was any additional information to the job originator. The outcome of this conversation was not recorded.

Access to information

- Patient transport staff received information about patients via the PTR form. This form was passed from the control room with information including the patient's name, pick up/drop off location, level of mobility and any other relevant information. Staff told us that further information would be given by the manager over the phone if required.
- Patient transfer forms had a specific box on the document to indicate whether or not the patient had a do not attempt cardiopulmonary resuscitation (DNACPR) order. Staff confirmed that they would record on the PTR form confirming that the correct paperwork had been received. The PTR form was shredded after use so we were unable to confirm this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Patient transport services (PTS)

- The service had a mental capacity Act (MCA) and deprivation of liberty Safeguards (DoLs) policy in place. However this did not have an implementation date or review date so we could not be assured that it was up to date with current guidelines and best practice.
- The service did not provide formal training for staff in relation to the MCA. We spoke with three members of staff and all three demonstrated a good understanding of the act and how it applied to the service they provided to their patients.
- The service did not provide training in the DoLS. We spoke with three staff members about their understanding of DoLS. Two could explain what this meant. All three staff members told us that they would not restrain a patient.

Are patient transport services caring?

Compassionate care

- The relative of a service user described how the service regularly transferred their relative and said that staff were always efficient friendly and treated their relative with dignity and respect.
- Staff described how they would maintain each patient's dignity by ensuring they were always suitably covered for example with the use of blankets.
- One service user described the staff as polite and helpful; another described the service as friendly and efficient.
- A relative of a service users said that staff demonstrated a friendly and good customer focused attitude to relatives and carers travelling with the patient.
- A patient satisfaction form was available in the vehicle for patients to complete. The manager told us they had not been proactive in encouraging patients to complete the forms and that this was something that they would do in the future. Patient satisfaction results were not recorded or monitored.

Understanding and involvement of patients and those close to them

- The service actively encouraged relatives or carers to travel with the service user to offer support. One relative told us that the crew was supportive and involved them in all decisions regarding their relative's care during transfer.

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 service was on the preferred supplier lists for three local councils and transferred patients following a prior booking. The majority of journeys were pre booked in advance.
- Due to the low number of journeys and the pre-booking of transfers the service was able to manage capacity well. The manager told us that if they were unable to fulfil a booking due to capacity issues they would advise the referrer at the time the transfer was requested.

Meeting people's individual needs

- The service only transferred one patient at a time meaning that the service could be tailored to meet the service user needs.
- The service was responsive to the needs of patients from different religious backgrounds. The manager gave an example of a Jewish family that requested their relative was transferred before sunset on Friday which they were able to accommodate.
- There was no limit placed on the number of bags a person could travel with, meaning that service users could keep their personal belongings with them when travelling between care settings.
- A telephone translation service was available for use for patients who did not speak or understand English. Information as to how to contact the translation line was available in the vehicle folder. The provider had recently established this service and two staff members that we spoke with were not aware that this was available.
- Staff had received dementia awareness training through the local council. We asked to see records of this but they were not available. However staff confirmed they had had received dementia awareness training and were able to describe adaptations that may be required when transporting a person living with dementia.
- One service user told us the provider was flexible and able to accommodate any special requirements their relative had.

Patient transport services (PTS)

Access and flow

- Bookings were mainly made on an ad hoc basis a few days in advance for both social service transfers and private transfers.
- The service took bookings in a variety of ways, dependent on the organisation or person requesting transport. Bookings were taken from one provider via a password secure email system. Other bookings were made over the telephone and the service confirmed the booking by email. Booking information was then transferred onto the patient transport request (PTR) form.
- When a booking had been received, the manager would check crew availability by telephone or SMS message if the transport manager was not able to carry out the transfer.
- Crew members telephoned the control room when they had arrived at the pickup destination. They recorded the time the patient was on board the vehicle on the booking form and would call the control room to confirm when they were ready to leave. This meant control room staff were able to monitor the progress of the journey and notify the receiving destination if there were any delays.
- The PTR form had boxes to record the pick-up and drop off times; however these forms were shredded after use. This meant the service was not monitoring pick up and drop off times so it was not possible to verify whether they were collecting patients at the pre booked time.

Learning from complaints and concerns

- The service reported they had not received any of complaints between March 2016 and March 2017.
- There was a complaints policy in place. This outlined the process as to how to respond to complaints including a letter of acknowledgement to the complainant, an investigation was to be completed and a timeline for a response. However, there was no reference to duty of candour and how this would apply.
- There was no process in place for joint investigations with other providers that work was contracted from. However, at the time of our inspection no complaints had been received.
- Service user feedback cards with self - addressed envelopes were available in the vehicles. The service had a website, which had a feature to enable patients to give feedback. The complaints policy did not outline how a patient should make a complaint. Staff told us that if a patient wanted to make a complaint they would refer them to the manager.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The service had two directors who were responsible for overseeing the work of ambulance staff and the control room. The control room manager had overall responsibility to plan bookings on a daily and weekly basis.
- We spoke with two staff members who described the directors as approachable, open to suggestions and supportive.
- Staff described the culture within the service as very positive with one member of staff describing it as the nicest patient transport service they had worked for. The service was very patient focused and staff were encouraged to do their best for their patients and their colleagues.

Vision and strategy for this this core service

- The manager told us that there was a vision in place for the service but was unable to tell us what it was or locate a copy at the time of our inspection. We asked if there was a business strategy in place but the manager was unsure and could not provide a copy.
- The staff handbook stated that the service goals and vision were “help without hate, care without rudeness and assistance that is freely given.” We asked two members of staff if they knew what the vision was. One staff member told us they were aware that a vision was in place for the service but did not know what it was. The other was not aware of the service vision.

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

- The service did not have a risk register in place at the time of our inspection. When we returned for our unannounced inspection, the service was in the process of developing a risk register. We reviewed this document

and found it did not contain current risks to the service. The risk recorded was a risk assessment of slips trip and falls. There was no review date documented or who was responsible for oversight of this risk.

- There was no effective governance framework in place. The management team did not monitor performance or quality. We reviewed one set of management meeting minutes which focused on financial issues relating to the business. They did not include evidence of discussions around risk, monitoring of the service and performance or audit data. We requested additional meeting minutes post inspection but did not receive this information.
- The managers did not have any oversight of policies and procedures. Policies lacked implementation and review dates and were not embedded. For example, the incident reporting policy was not being followed, as incidents were not reported, investigated or learning shared. The service did not have an inclusion/exclusion policy or a policy for the management of the deteriorating patient. These policies were required to enable staff to carry out their role safely and effectively.
- There were no risk assessments carried out in line with the Control of Substances Hazardous to Health (COSHH) Regulations to determine how to prevent harm to health from cleaning chemicals and implement control measures to reduce harm to health. This meant that we were not assured that employees were protected from substances hazardous to health or had been provided with adequate training.
- There was no central training record in place to monitor staff training and competency compliance and renewal dates. This meant that we were not assured that there was oversight of staff training requirements.
- There were no systems in place to monitor vehicle maintenance and servicing. This meant we were not assured that there was oversight of vehicle upkeep. The issues we noted with the vehicles maintenance and condition had not been identified by the management team.
- There were no systems in place to monitor the cleaning of vehicles and there was no process for the deep cleaning of vehicles. This meant that we were not assured that there was oversight of the cleanliness of the vehicles. The issues we noted relating to the cleanliness of the vehicles had not been identified by the management team.

Public and staff engagement

- We were not assured that staff engagement took place on a regular basis. The managers did not hold regular meetings with staff. At the time of our inspection there was no regular newsletter to provide staff with information although the manager told us that they were planning to introduce a newsletter. Communication with staff was informal, ad hoc and not documented.
- Staff described feeling respected and valued in their role. We spoke with two members of staff who confirmed that the control room made regular checks to ensure staff welfare whilst working remotely. They told us that they felt supported and were able to contact the directors at any time.
- Systems to engage with the public were limited to patient satisfaction cards.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that incidents are monitored, reported and investigated and that appropriate guidance and support is available to staff.
- The provider must ensure that there are robust processes in place to ensure the monitoring and oversight of vehicle checking, servicing and cleanliness.
- The provider must ensure that vehicles and equipment are clean, and properly maintained.
- The provider must ensure that accurate and contemporaneous records are kept in the respect of each service user.
- The provider must ensure that a policy is in place to ensure patient eligibility to use the service is assessed.
- The provider must ensure that staff competencies are overseen.
- The provider must ensure that relevant risks are identified and overseen.
- The provider must ensure that an effective governance framework is in place.
- The provider must ensure that staff receives training in incident reporting, duty of candour, infection prevention and control.

Action the hospital SHOULD take to improve

- The provider should ensure that it records and monitors service activities.

This section is primarily information for the provider

Enforcement actions

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment which states: (1) Care and treatment must be provided in a safe way for service users. (2) (a) assessing the risks to the health and safety of service users of receiving the care or treatment. (b) doing all that is reasonably practicable to mitigate any such risk. (h) assessing the risk of, and preventing, detecting and controlling and spread of infections including those that are health care associated. How the regulation was not being met: The provider had no risk assessments carried out in line with the Control of Substances Hazardous to Health (COSHH) Regulations to determine how to prevent harm to health from cleaning chemicals and implement control measures to reduce harm to health. The provider had no inclusion/exclusion criteria to ensure that patients were not transferred that were beyond the capabilities of the service. Incidents were not identified, reported or investigated. There was an incident reporting procedure policy but this was not being followed. There was no formal training in place for the reporting of incidents. The provider was failing to assess and prevent the risk of the spread of infection. Foam was exposed on three seats in two ambulances. This was not able to be cleaned effectively and presents an infection control risk. There was a liquid stain under a stretcher mattress and a dry yellow/white flaky substance along the zip on the underside of the mattress. This was a potential infection control risk.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment which states that : (1) All premises and equipment used by the service provider must be (a) clean (e) properly maintained How the regulation was not being met: There was no systems were in place to maintain oversight of vehicle servicing and maintenance. There were no systems in place to maintain oversight of equipment servicing. Not all equipment was up to date with servicing. The provider could not produce service history record of equipment. Vehicles were visibly dirty, window sills were dirty to touch and there was collected dust in corners. There was no system in place to monitor the level of cleanliness. There was no detail as to what cleaning agents were used and cleaning methods utilised. No system was in place for the deep cleaning of vehicles. There was no evidence that staff had received any formal training in the process of deep cleaning.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance which states: (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

This section is primarily information for the provider

Enforcement actions

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

(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;

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

How the regulation was not being met:

The provider did not conduct any audits to assess the effectiveness or safety of the service.

The provider did not have a system in place to monitor or mitigate risks to the service, service users or staff.

There was no systems were in place to maintain oversight of vehicle or equipment cleanliness or maintenance.

The provider was failing to maintain secure contemporaneous records of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This section is primarily information for the provider

Enforcement actions

The provider did not have systems and processes in place to monitor staff competencies and training compliance.