Advance Medical Transport Services Limited

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Inspection report

Buckmore Park Race Circuit
Lower Paddock Maidstone Road
Chatham
ME5 9QG
Tel:

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as requires improvement because:

- The service did not have a management system or process for the recorded assessment of risk and the services ability to meet the needs of the patient during triage at the booking stage.
- Up to date formal agreements with client partners, did not clearly cover the services provided or agreements associated with arrangements for risk assessment and triage responsibility.
- Medical gases were safely stored in a secure location however, gas bottles were not clearly separated.
- The medicine policy did not reflect the current processes associated with the staff scope of medicine administration.

However,

- The service had enough staff to care for patients and keep them safe. Staff mostly had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Advance Medical Transport Services Limited

Advance Medical Transport Services Limited is an independent medical transport service based in Chatham, Kent. The service provides patient transport services, medical cover at events, and repatriations. These services were provided to adults and children 24 hours a day seven days a week.

The provider is registered to provide the following regulated activities:

• Transport services, triage and medical advice provided remotely.

The service is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC regulates the Patient Transport Service and treatment of disease, disorder and injury service provided by Primary Ambulance Services. The other services provided are not regulated by CQC as they do not fall into the CQC scope of regulation. The areas of the Primary Ambulance service that we do not regulate are events cover and repatriations made on behalf of service users by their employer, a government department or an insurance provider with whom the service users hold an insurance policy.

This focused inspection was triggered when we received information of concern about the service.

The service was last inspected in April 2022 when the service was found to be requires improvement. During this focused inspection we have inspected the safe and well led domains. The rating for safe improved to good and the rating for well led remained the same as requires improvement. The rating of good for caring and responsive remains the same as does the rating of requires improvement for effective. The overall rating for this service remains as requires improvement.

The service uses the term client to refer to the organisations they have contracts with to deliver the service on their behalf. Therefore throughout this report the Care Quality Commission have used the same terminology.

How we carried out this inspection

The inspection team included of a lead CQC inspector, a Patient Transport Service (PTS) specialist advisor and a pharmacist specialist. We spoke with 4 members of the management team, 2 drivers, and 2 support staff working for the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must operate effective systems and processes to make sure they assess and monitor their service when conducting regulated activities. Regulation 17 (1)

Action the service SHOULD take to improve:

Patient Transport Service

- The service should ensure that Nitrous Oxide and Oxygen cylinders are always clearly separated in their secure location. (Regulation 12)
- The service should ensure that the mandatory training curriculum includes modules on learning disability and autism patients. (Regulation 18)
- The service should ensure it has up to date formal agreements with all clients currently aligned to the service. The agreements should give clear remits to each individual party and reflect the responsibilities held by each party in their risk assessment and triage of patients. (Regulation 17)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Good	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Requires Improvement

Patient transport services

Safe	Good
Well-led	Requires Improvement

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key areas to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. Managers provided a electronic record which showed 100% of staff had completed their mandatory training. Staff had access to their own individual electronic record where they could complete their selected courses and track their progress.

The mandatory training was comprehensive and met the needs of patients and staff. Managers supplied a recognised curriculum for the service. Managers set modules at the right levels for the staff undertaking them. Managers provided face to face training where needed and there was a nominated manager for training and development.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had oversight of staff's individual training records and were able prompt staff who were due to complete or renew their training.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. Staff completed training that included both the Mental Health Act and Mental Capacity Act. Managers supplied separate modules for Deprivation of Liberties (DoLs) and Dementia. However, we did not see training modules for Learning disabilities and Autism. This meant that staff may not have the skills and training needed if patients with these conditions used the service. Managers are now required under the Health and Social Care Act 2022 to provide modules that cover these topics. Since the inspection, managers have introduced new modules associated with Learning Disabilities and Autism and we will verify this on our next inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. A safeguarding awareness raising campaign and enhanced training was used to raise the profile of safeguarding in the service. Three individuals within the leadership team had completed safeguarding training at level 4. Staff training for adult and child safeguarding was level 2 and the service had a 100% completion rate.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with understood safeguarding principles and what potential incidents should be reported. Managers had provided extra training on safeguarding. Managers used advertising materials in staff areas and safeguarding presentations to improve staff knowledge. The safeguarding lead provided us with this presentation for reference.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff and managers could explain their current safeguarding processes. Managers with safeguarding responsibility shared information with their client partners who would process the safeguarding referral with the local authority for the area where the potential incident occurred. Managers kept records associated with when they reported the incident, however there was not a feedback mechanism with their contractor once managers had passed the incident on.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

All vehicles were clean and had suitable furnishings which were clean and well-maintained. We reviewed 6 vehicles as a sample of the vehicle fleet out of 20. All vehicles were clean. Furnishings were suitable for the vehicles and deep cleaning records were available for all vehicles reviewed. Managers had individual checklists associated with deep cleaning which a nominated staff member was responsible for completing.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Managers had individual records for cleanliness associated with each vehicle. These records had been changed to electronic versions recently and therefore we reviewed a combination of paper and electronic checklists for the vehicles. However, other than checklists, managers did not have any further quality markers for the effectiveness of their deep cleaning processes. Managers therefore had their ability reduced to pick up on specific themes and trends that could optimise cleaning processes.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were dressed in the correct PPE and vehicles had the correct PPE available to them for patient care to be conducted safely.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment. We reviewed the service history, Ministry of Transport (MOT) compliance and Insurance on 5 vehicles in the service fleet. All 5 vehicles were inspected by our team and found to be compliant in all aspects of safety.

Managers had a dedicated member of staff responsible for the preparation of equipment for vehicles at the service location. Daily checks for the vehicle were completed by the crew who were allocated to the vehicle for the day. This was documented on paper-based records, but managers had upgraded their systems recently to electronic checklists which allowed managers to have more readily accessible data regarding their fleet. Managers had evidence of recent safety checks for equipment which included equipment calibration and relevant risk assessment checks for equipment such as Lifting Operations and Lifting Equipment Regulations (LOLER) checks for wheelchairs.

Managers had an equipment register. The equipment was in good condition and staff were responsive to any concerns we raised regarding individual pieces of equipment.

However, areas where broken equipment was stored were untidy and poorly signed in certain areas. We raised this with staff responsible for equipment storage who acknowledged that this can be challenging for them due to limited space in areas of the site.

The service had enough suitable equipment to help them to safely care for patients. Staff showed that the location had enough equipment for the number of vehicles being deployed daily.

Staff disposed of clinical waste safely. Staff and managers could give a clear process for the disposal of clinical waste in a specified location that was secure. We saw the clinical waste area and clinical waste bins were secure and locked.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, the location did not have processes or policies that triaged patient needs or provided sufficient oversight of the process at their registered location.

Staff identified deteriorating patients and escalated them appropriately. Managers ran the service as a Patient Transport Service (PTS) only. However, there were aspects of the service that involved the transport of patients who had medical concerns that exceeded the traditional remit of a PTS service. Managers called this aspect of their service, a “High Dependency Unit” (HDU) Transfer. Managers told us that both their PTS and HDU transfers were treated in the same manner in terms of the policy and process staff followed when responding to a deteriorating patient.

Staff told us that they would pull over at a suitable location and make a call for an acute ambulance to attend as soon as possible. Staff would conduct first aid if the patient became unconscious and non-responsive in line with their clinical competency. HDU journeys would involve a separate clinical team responsible for patient care in Intensive care unit (ITU) and Paediatric Intensive Care Unit (PICU) transfers.

Staff completed risk assessments for each patient on arrival. Managers told us that HDU transfers covered stable cardiac patients, patients that needed advanced moving and handling and ITU/PICU transfers. Staff were only responsible for the running of the vehicle in ITU/PICU transfers as a separate team was responsible for the clinical aspects of the patient’s care. This would be a doctor or nurse and there were processes that managers followed to ensure this was happening. Records were also available that managers could reference to verify the process was safe and that their staff were not working beyond their own clinical competency.

Managers told us that they had dialogue with their client partners about any request for a journey. Managers would triage and then nominate staff to ensure that correctly trained staff were nominated to the journey.

Staff called the client’s duty manager if they had queries associated with the suitability of a patient they were asked to transport. If concerns were raised by staff and the client found this to be true, staff would provide this information through their provider’s tablets for management oversight. Managers would then record this as an incident or near miss and we saw examples of this.

Duty managers took calls that covered operational matters throughout the day, and we saw this during the inspection.

Requires Improvement

Patient transport services

Managers told us that staff crews handling the transfer of any HDU level journeys were trained to a minimum standard outlined in their policies and procedures. Managers planned rotas 5-6 weeks in advance with a large pool of ambulance personnel who were trained to the required standard.

Managers told us that one vehicle was dedicated to HDU transfers as part of their agreement with their clients, but this was not formally specified in any service level agreement.

Staff knew about and dealt with any specific risk issues, but managers did not have an effective oversight of triage processes associated with this.

Managers had an acceptance criteria with clients which was agreed by email. Managers told us there were clear parameters for the patients the service would take.

However, we did not see triage systems that showed effective risk oversight that patients were assessed as suitable for the service at the provider's base of operations. Managers told us that the location did not conduct any triage of patients and that this was completed by their clients. The clients booked patients onto their own system and sent the information about all patient details and their requirements during the journey, directly to the provider's crews.

Staff were then expected to enter this information into issued tablets, and clients' tablets, which populated a patient data spreadsheet, so that the provider and clients had records of all journeys completed. The spreadsheet gave a summary of patient needs that could be reviewed by drivers but there was no process for reviewing these summaries to ensure that the patients were suitable for the service.

Managers for the service had access to GPS for all vehicles while they were on the road to ensure staff were safe and running to time. All vehicles had remote monitoring that could show reckless driving, speed of vehicles and the use of blue light functionality.

Managers and staff told us that any HDU transfer had enhanced measures for safety. This included clinical parameters such as stable observations, a maximum patient need of 6 Litres of oxygen during the trip and that the patient was clinically stable. Staff would verify this within their care remit through a set of observations that were completed before and after the journey. Records reviewed reinforced that this was happening.

For cardiac patients, Staff would apply a 3 lead Electrocardiogram (ECG) which ran during HDU journeys. Staff received extra training in the use of ECG monitors, but care remits were restricted on their ability to read and act on ECGs to reflect their clinical competency levels. Managers would request clinical staff from the discharging hospital if the patient was thought to require further clinical intervention beyond this. Doctors were able to request copies of ECG recordings if they needed to after the patient had arrived at their destination.

Managers gave us examples where staff had refused patient journeys on safety grounds. This was always communicated with the service client. However, we could not find evidence of an oversight process that followed up cancelations when this occurred. Staff could call a duty manager if they felt uncomfortable to refuse journeys where information previously given had changed. However, we did not see any documented evidence of this occurring.

Staff shared key information to keep patients safe when handing over their care to others. Staff and managers told us that handovers for patients were dependent on the independence and suitability of the patient to do this for themselves. Staff expressed that when a patient needed support, they would offer this within their clinical remit and records supported these actions.

Requires Improvement

Patient transport services

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough staff to keep patients safe. Managers confirmed that the service recruited staff on a self-employed basis. The service employed between 45 and 50 individuals. 5 members of staff were not frontline staff and had administration responsibilities.

Managers accurately calculated and reviewed the number of staff needed for each shift. Managers had a spreadsheet for each individual journey. Staff had the opportunity to request work for individual shifts which managers confirmed using a software platform that alerted staff to their available shifts. Managers communicated with staff via electronic messaging within the software platform. Managers outlined that they were exceeding their contracted number of journeys with their main client and felt confident they had the staff to manage this demand.

Managers could adjust staffing levels according to the needs of patients. Managers adjusted the journey slots scheduled 5-6 weeks in advance. Managers assessed this weekly and had the ability to add and remove proposed journeys when variations occurred.

Managers had staff trained in First Response Emergency Care (FREC) level 3 and 4 alongside ambulatory care assistants and one technician. Managers told us that staff crews handling the transfer of any HDU level journeys would be trained at minimum FREC Level 4. Managers planned rotas 5-6 weeks in advance with a large pool of drivers who were trained to the required standard.

The number of staff matched the planned numbers. Managers had the flexibility and planning processes to ensure that staff were available when they needed to be. Managers told us that when a staff member pulled out of a shift, there was enough staff available both at short notice and over longer periods of time. Managers did not declare any incidents associated with staffing shortfalls. We saw evidence to support all the planning and processes outlined were successful in avoiding short staffing situations.

Managers made sure staff had a full induction and understood the service. New members of staff were offered an induction. Managers provided material to support this process and recruitment files showed that inductions were completed.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Managers provided records retrospectively during our inspection process. We reviewed 25 records as part of this inspection. Staff completed a journey log for each trip. The information recorded included but was not restricted to patient identification forms, patient needs and considerations, timings of journeys, and the method of mobility transfer. Staff completed records that gave details of care interventions by staff such as basic observations for example. This was enhanced for HDU transfers which included hospital staff responsible for the clinical care of the patient.

Managers showed a framework which allowed staff to add specific forms where an incident or noteworthy event occurred. Staff had access to a range of reporting forms. This included a Patient's overall report, Safeguarding Reports, Incident Report Forms and Blue light Authorisation Forms. Managers used these forms in conjunction with their records to ensure that the service had an accurate record of any care or events that occurred during a journey. Managers told us that these forms were being converted to electronic formats. This meant staff could fill out on the move to promote ease of use and improve the security of patient records.

Records were stored securely. The provider's electronic tablets had security provisions which were in line with General Data Protection Regulation (GDPR) requirements. Paper based records which held patient information such as safeguarding forms and patient reports were stored securely in offices and locked to protect patient data.

Medicines

The service used systems and processes to assist patients to self-administer medicines and safely store medical gases.

Staff followed systems and processes to assist patients to self-administer medicines safely. Staff were only able to support patients to self-administer medical gases such Oxygen. Nitrous oxide was used in the non regulated activity therefore outside of scope. Staff showed an understanding of current service policy and their remit about the administration of medicines. However, the medicines policy underpinning this was not reflective of current practices. Staff told us that Nitrous Oxide was mostly used outside of CQC's regulatory remit for event management work the provider conducted. However, if used as part of the PTS or HDU services, a prescription for Nitrous Oxide was provided by the medical teams responsible for clinical care before any administration of Nitrous Oxide was administered.

Staff stored and managed all medicines safely. Managers confirmed that medical gas including Oxygen and Nitrous Oxide were the only medicines provided by the service. Staff showed us a medical gas storage area where there was clear separation between full and empty cylinders. However, we saw Nitrous Oxide cylinders were mixed with oxygen cylinders which managers assured us were empty following the inspection.

The storage area had signage to inform individuals of medical gas and the potential risks associated with this, but there was an absence of contact details within the signage so that concerns could be raised if needed. We saw staff correctly secured cylinders in all vehicles we reviewed.

Staff learned from safety alerts and incidents to improve practice. Managers received safety alerts and actioned alerts of concern. Managers shared safety alerts with staff when it was needed. However, the remit of medicines only included medical gases which meant that this was a rare occurrence at the service.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff had reported a total of 27 incidents and 8 vehicle accidents as part of their reporting processes making a total of 35 events in the last 12 months. Managers provided a

spreadsheet of incidents which included vehicular accidents, safeguarding concerns, near misses and patient journeys where cognition and their physical health had caused distress. Staff could tell us the actions they took if an incident occurred and this aligned to the service policy. Managers shared incidents in meeting minutes with the staff to highlight good practice.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff showed a good understanding of duty of candour. Managers had policies and processes that they would follow if duty of candour was needed. However, the service had not recorded an incident in the last 12 months where duty of candour processes was needed as none had occurred.

Staff received feedback from incidents. Managers provided feedback from incidents through meeting minutes to optimise learning with staff members. Managers would seek opinion from staff and ask if there were better ways to approach their job if an incident had directly affected or challenged their existing policies and processes. However, we did not see a direct example of this.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had a framework of responsibility which was made up of director positions responsible for different areas of the business. Leaders had specific lead roles for finance, operations, safeguarding and training. This included the registered manager who oversaw all aspects of the transport business as a managing director.

Leaders were able to outline their priorities and speak about operational issues that they faced. Leaders were accessible and visible to the workforce and there were communication frameworks for remote working so that staff could gain support and assistance when needed. Staff we spoke with reinforced this and felt leaders were responsive to their needs and concerns.

Leaders showed a positive attitude towards continuous improvement. The service had a leadership structure dedicated to training and development and used areas of their base of operations to conduct some face to face training.

Leaders provided promotion opportunities when possible to staff if leadership positions became available, however staff worked on a self-employed basis which limited the promotion opportunities associated with driving roles.

Vision and Strategy

Requires Improvement

Patient transport services

The service had a vision for what it wanted to achieve and a strategy to turn it into action.Leaders and staff understood and knew how to apply them and monitor progress.

The service did not have a documented vision and strategy for the service, but they were clear that they wanted to provide the best service that they could for their patients. Managers told us they were comfortable with the size of the business and the contracts they currently held with their clients. The performance parameters for their clients were central to their strategy and performance monitoring.

Managers told us PTS was a smaller proportion of the business at certain times during the year as their resources were centred more towards the events management season which typically occurred in the summer.

The service was delivered over a large geographical region. Managers told us that their strategy was linked to the key performance indicators in their agreement with their main contractor which checked service delivery.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development where possible. The service had an open culture where patients and staff could raise concerns without fear.

Managers provided team bonding events which took place at the location of the offices. Managers gave examples including a summer BBQ and a fireworks evening where staff families were also encouraged to attend. Managers also provided informal arrangements to allow for staff to get to the base of operations in the morning if bad weather occurred.

Staff were happy to work for the service. Staff were recruited as freelance ambulance personnel and those we spoke with were comfortable with the employment arrangements. Staff told us managers had an open-door policy and wanted to have a good relationship with their staff. Managers were keen to develop their staff and offered training which staff expressed was a key reason for them continuing to work for the service. Managers told us that where they were unable to provide a career structure for ambulance personnel, they promoted opportunities in leadership roles as they became available for staff to consider if they were interested.

Managers welcomed feedback from both staff and patients and were receptive to information they received to improve the service provided. Managers outlined the frameworks the service had for this purpose which met the requirements of the regulations.

Governance

Leaders operated governance processes, throughout the service and with partner organisations that were not always effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Managers aimed to conduct face to face meetings every month but were not always able to achieve this. Managers told us they had managed a frequency of meetings every two months. Meeting minutes were detailed and covered several operational themes.

Managers and staff were clear about their accountabilities and the leadership structure supported each aspect of the business. Meeting minutes were structured, comprehensive and delivered messages clearly to staff. A quarterly newsletter for staff was developed to further inform staff about policies and trends within the business.

Staff told us that they felt there was good communication and that the meeting frequency meant there was a timely sharing of messages with managers and staff. Managers felt communication was good and that the recent introduction of tablets allowed them to have a greater level of communication with their team. Staff told us they had a full understanding of their role and the responsibilities associated with it. Managers also utilised electronic messaging applications during the working week to encourage communication.

Formal client agreements were out of date but did outline parameters for performance measuring. The agreements did not show all aspects of what the service provided. For example, HDU transfers and their parameters were not specified in any agreements. However, evidence was seen that showed correspondence between the parties and the continued agreement of the baseline contracts agreed at the beginning of their working relationship alongside enhanced services such as HDU transfers. Managers also showed their own processes around acceptance criteria, policies and procedures to ensure that it was clear on their remit of care and could meet the needs of patients using the service safely. However, not all of these processes were recorded. This meant the provider was not formally able to evidence the effectiveness of its systems and processes. This also had an impact on the providers ability to undertake routine audits to improve the service.

The providers medicine management policy was inaccurate. For example, the medicine management policy was not specific about the remit that staff had in relation to administering medications. Managers told us that staff did not administer medicines and only assisted with self-administration of medical gases. However, sections of the policy were about staff administration of medicines and the competencies required to do this which provided an unclear picture on the current remit of staff for both PTS and HDU services. Despite this, we had assurance from staff we spoke with that they understood their remit for medicines and that they were only offering support for self-administration. We did not find evidence the provider had a formal policy review cycle.

The service web site had not been updated recently. During our inspection, we found one example of misleading information relating to the provision of private critical care transfers which the service was unable to provide. The provider was advised that some language does require clarification so that the remit of the service is clear. However, all other information reviewed was accurate at the time of our inspection.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They could not always demonstrate that they identified risk. But escalated relevant risks and issues and identified actions to reduce their impact when they were known.

Managers had systems and processes to capture risk, however not all aspects of these processes were formally captured or evidenced. For example, triage oversight arrangements with their clients were not evidenced or underlined by suitable policies, processes, or service level agreements at location level that explained how the service mitigated the risk associated with not conducting triage processes.

We found through our review of the service policies and patient journey records that risk identification systems were working but they lacked evidence to fully mitigate all risks around the provider's processes. Clients of the provider had

the primary responsibility of triaging patients. The provider did not have a documented monitoring process for triaging and monitoring key patient information as part of the triage process. Managers received a summary of the journeys they conducted from their clients that showed some patient information, but this lacked detail on why patients were considered suitable for the service and how the patients met the safety parameters agreed with their clients.

This raised concerns in risk associated with some High Dependency transfers where the medical history of patients could mean that initial triage information became inaccurate. The system heavily relied upon staff reporting this to the client's duty manager which was then shared with the provider by staff using their issued tablets.

Managers conducted an audit programme that covered IPC, hand washing hygiene, staff areas, and clean areas. Performance audits were managed with the clients, however there was limited evidence of performance data being used to improve the service. Managers were committed to using data collected to improve patient care alongside their client partners.

Managers had a paper-based form system which collected information and kept records for potential risks in safeguarding, accidents, incidents and patient's medical conditions which staff were expected to fill out if an event occurred during a journey. Managers felt this process would become even easier for staff with the introduction of the electronic tablets.

Managers had a suitable number of vehicles for the services being provided and a suitable level of ambulance personnel who were available to meet the demand for their service. Managers told us that if unexpected events did occur or that staff felt uncomfortable then they could call the client's duty manager at once and suitable alternative arrangements would be made. Meeting minutes showed that staff were not raising concerns about risk oversight processes and staff told us that they had the confidence to call managers directly if they had concerns.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service collected journey data and used it to measure their performance and service quality. Managers could query individual patient journeys proposed by the contractor by telephone if required.

Managers provided staff with training in General Data Protection Regulation (GDPR). Staff showed an understanding of how to manage information and ensured all data remained confidential and was kept securely. Confidential information was disposed in a secure manner using shredding machines.

Staff were conscious of data security at their computer terminals and ensured their desktops were logged off if they were away from the area. All computers had password protected access platforms.

Engagement

Leaders and staff actively and openly engaged with staff and patients to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Requires Improvement

Patient transport services

Leaders engaged with staff. Duty managers sent updates to the team day to day through electronic messaging applications and telephone. Leaders held staff meetings. This included the distribution of meeting minutes for staff unable to attend.

Leaders and staff engaged with patients. Patients were requested to provide feedback on the service which included fixed questions and a box to allow for free writing to express any thoughts they had about the service. Leaders told us they used this information where possible to improve their service for patients and we saw examples of positive feedback for the service following the inspection.

Leaders and staff engaged with partner organisations to help improve services for patients. Managers spoke with partner organisations and provided them with information to help improve services, including their response times to feed into the client holders overall performance monitoring.

Managers showed a proactive approach to staff engagement. This included encouraging staff to meet on a frequent basis through both work meetings and social events. Managers had good arrangements with their client partners and met often. Managers more widely contributed to the local community through sponsored a children's football team, donating to local charities and collecting for local food banks.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Managers communicated often with their partners and were keen to contribute to any improvement projects. Managers were keen to promote environmentally friendly vehicles and had been provisionally looking at this with a view to upgrading their vehicle fleet. Managers told us they were receptive to feedback and open to making improvements because of it.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not operate effective systems and processes to make sure they assessed and monitored their service when conducting regulated activities. Regulation 17 (1).