PTS-247 Limited

PTS-247 Limited

Inspection report

Unit 65
Basepoint Business & Innovation Centre, Metcalf Way
Crawley
RH11 7XX
Tel: 03450040504

Date of inspection visit: 5th April 2022
Date of publication: 01/08/2022

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 effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this service went down. We rated it as requires improvement because:

- Managers did not always monitor the effectiveness of the service or ensured staff received a proper induction.
- Leaders did not have the skills and abilities to run the service. They did not always understand or manage the priorities and issues the service faced. Leaders did not operate effective governance processes and did not use systems to manage performance effectively. The recruitment process was not robust. Staff were not clear about their roles and accountabilities. Leaders did not always identify or escalate relevant risks or take action to reduce their impact. The service did not collect or analyse reliable data. Leaders did not actively engage with staff or patients.

However:

- The service had enough staff to care for patients and keep them safe. Staff 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.
- Staff provided good care and assessed patients' food and drink requirements. The service met agreed response times. Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Page

Background to PTS-247 Limited 5

Information about PTS-247 Limited 5

Our findings from this inspection

Overview of ratings 7

Our findings by main service 8

Summary of this inspection

Background to PTS-247 Limited

PTS-247 Ltd is an independent ambulance service based in Crawley, West Sussex and is part of a group of small companies providing patient transport services in the local area. The service is sub-contracted to a large NHS ambulance provider and primarily serves the communities of Surrey and Sussex. Vehicles have been adapted to convey patients in wheelchairs. The service does not convey patients requiring stretchers. The service is managed from one office location with vehicles being based at the home address of each driver.

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?

The service is registered to provide the following regulated activities:

• Transport services, triage and medical advice provided remotely

We inspected this location twice between April and June 2022. During the first inspection in April 2022 the registered manager changed. We found significant gaps in records which meant we required the provider to show us further evidence as assurance that the service was being managed safely. We returned to the service in June 2022 to review documents we had been unable to see on the first inspection along with assessing improvements that the service had made since the new registered manager had taken up their post. Registered managers have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

We last inspected the service in February 2020 and rated it as good overall.

How we carried out this inspection

The team that inspected the service comprised of two CQC inspectors, a CQC inspection manager and a specialist advisor with experience in ambulance services. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

During this inspection, we visited the main office and two of the local hospitals which the service conveyed patients to. We spoke with three drivers, the service manager, service consultant, team leader and one patient. The service did not hold patient records because they were sub-contracted by the NHS ambulance trust who provided information on a need to know basis in line with the General Data Protection Regulations (2018).

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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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.

Summary of this inspection

Action the service MUST take to improve:

- The provider must ensure they identify a suitable person of good character, with the necessary qualifications, skills, and experiences to act as the nominated individual to supervise and manage the regulated activities of the service. Regulation 6 (3) (a,b,)
- The provider must ensure they carry out effective governance processes that assess, monitor, and improve the quality and safety of the service. Regulation 17(2)(a)
- The provider must ensure they introduce risk management systems to identify and mitigate risks to safety. Regulation 17(1)(b)

Action the service SHOULD take to improve:

- The service should ensure it continues to monitor recruitment references and make sure any gaps in employment history are discussed with the employee and a reason documented. Regulation 17
- The service should ensure that all staff have a signed job description, which details their role and responsibilities. Regulation 17
- The service should ensure they continue to update their policies, so they reflect national guidance. Regulation 17
- The service should ensure they continue to review their audit program and complete regular audits to make sure staff follow policy. Regulation 17
- The service should consider improving the layout of the staff handbook so that information is easy to find.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Patient transport services

Safe	Good
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Patient transport services safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

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

Staff received or keep up-to-date with their mandatory training. Mandatory training was provided to all staff. Training was ongoing and reviewed regularly and aligned to the CQC key lines of enquiry. Staff training included, moving, and supporting people, infection control, communication skills, equality and diversity, oxygen therapy training and mental health awareness and records confirmed this.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service manager used a spreadsheet to record staff training. Many staff had training booked for future dates, but it was not clear when training had last taken place.

During our first visit in April 2022, we looked at the training records of six members of staff and found two had not received training since November 2020. There were no records of fire safety training for any staff, and we were unable to find evidence of driving competency assessments.

After the inspection, we highlighted our concerns to the service manager who responded quickly. The service had employed a third-party organisation to deliver fire safety training. At our second visit in June 2022, records confirmed that 33% of staff had completed this training as well as fire extinguisher training. The service also submitted evidence to demonstrate all drivers had received a competency assessment with a suitably qualified member of staff.

As a response to staff feedback the provider had introduced epilepsy awareness training and 13 staff had completed this to date. Training was on going and managers had planned for all staff to receive this training.

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. All drivers had completed level two training for adult and children safeguarding. The registered manager had completed level five training, and this was an improvement since our previous inspection in 2020.

Leaders protected patients by carrying out the required pre-employment checks. We looked at five staff records which included all required checks under Schedule 3 of Regulation 19(3)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014. These included checking the disclosure and barring service which confirms that their staff have not been barred from working with vulnerable adults or children.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns. The contract with the NHS ambulance trust meant that all concerns had to be reported to the NHS duty safeguarding lead. We saw records of two of these referrals. The service manager told us they were sometimes sent feedback from the NHS following the investigation which was shared with staff.

If staff had safeguarding concerns about people who were not patients of the NHS ambulance service (for example, children in a patient's home) they would raise a safeguarding alert with the appropriate team at the local authority. Contact details were available via the service's computer system.

The service did not report any safeguarding concerns to the CQC within the last year.

Cleanliness, infection control and hygiene

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

The service had introduced updated infection control guidance during the COVID-19 pandemic. Although, it did not contain specific guidance for staff about COVID-19 testing, staff completed twice weekly lateral flow tests. These were reported to the registered manager via the staff social media communication portal. The service reported no work-related acquired infections during the pandemic.

All staff completed a COVID-19 risk assessment which was stored in their staff files and included information relating to their ethnicity. This is because evidence recognised that people from minority ethnic groups are at higher risk of poor outcomes from COVID-19 infection. This ensured that staff from minority ethnic backgrounds knew the risks and used the correct PPE and infection control measures.

Staff had access to a list of the most common acquired infectious diseases, how they are spread, how they are controlled and what to do if people are exposed to them. This information was stored in the main office and the service was in the process of implementing flashcards in the vehicles for ease of use.

Vehicles and equipment were visibly clean. Staff followed internal guidance to clean vehicles and wheelchairs between each patient. Staff used appropriate cleaning products and antimicrobial wipes.

Cleaning records were up-to-date and demonstrated all vehicles were cleaned regularly. Drivers told us they did daily cleanliness checks which they recorded on hand-held electronic device. These records were uploaded to the NHS ambulance trusts internal system so they could monitor cleaning on a regular basis. Evidence showed the service performed well for cleaning checks.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff used PPE, for example, disposable aprons, face masks and gloves. Hand sanitiser, clinical wipes and PPE was available on all the vehicles and included in daily checks.

Following our inspection in April 2022, we asked the service manager to submit further evidence, because there was lack of clarity about the suitability of the cleaning materials used by the service. For example, during our first visit one driver showed us a spill kit for the safe disposal of bodily fluids which expired in 2020 and the driver had not been shown how to use it. Two other vehicles that we inspected did not have spill kits.

The service responded promptly and submitted evidence that assured us that their infection control systems kept people safe and that cleaning materials used by the service complied with health and safety standards for business use.

During our second visit the services consultant provided evidence that they had implemented staff training on how to use the spill kits and records confirmed that 33% of staff had completed this and the remaining staff had booked training dates.

Environment and equipment

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

Staff completed daily vehicle checks prior to starting their shift. The information was uploaded on to their handheld device. Team leaders also completed ad-hoc spot checks on vehicles. Vehicle checks were also photographed and uploaded to the staff social media portal, and we were shown evidence of this.

The service had a stock of 29 vehicles. Leaders made sure that vehicles were serviced every twelve thousand miles. If vehicle's were not functioning correctly then staff could take them to one of three garages used by the service so they could be assessed and repaired. The service had access to four back up vehicles.

During both of our visits we looked at equipment kept in a storeroom next to the main office. This was because during our first visit we found a child safety seat for use in vehicles which had a broken locking mechanism. We brought this to the attention of the service manager who disposed of it immediately. On our return visit, we found a new child seat was available for use and could be adjusted to the size of the child.

All vehicles were fitted with a suitable fire extinguisher but during our first visit we noted that three of these expired in February 2022. Staff were unaware of this and could not tell us when the extinguishers were due to be replaced. We drew this to the attention of the service manager who took immediate action. During our second visit, we checked six fire extinguishers in the office and one on a vehicle. These were all in date. Fire extinguisher checks were now included in the daily vehicle checks.

Staff mostly disposed of clinical waste safely. Each vehicle had a supply of orange clinical waste bags and drivers were aware of how to use them. This had improved since our last inspection, but we did find used disposable gloves in a door recess in one of the vehicles. Drivers disposed clinical waste bags safely. The provider had a service level agreement with the local NHS trusts and disposed of this at local hospitals at the end of their shift.

Staff used standardised wheelchairs designed to convey patients. The wheelchairs conformed to national guidance for general use and complied to the requirements of the NHS ambulance trust. The wheelchairs were wipe clean and had recent safety checks.

Requires Improvement

Patient transport services

Assessing and responding to patient risk

Staff updated risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any deterioration in a patient's health. Staff knew how to identify deteriorating patients. They could describe examples of deterioration of a patient's health which they raised with the relevant healthcare provider.

Staff knew about and dealt with specific risk issues. The NHS ambulance trust risk assessed all patients before allocating them to PTS-247 Limited. The service level agreement that existed between the two organisations was to convey low risk patients who could walk independently or use a wheelchair. Staff told us this arrangement usually worked well. If staff felt patients were not appropriately risk assessed, for example they had a very high body mass index they would immediately raise this with the NHS ambulance trust or third party organisation and complete an incident form. They would make sure the journey was re-booked with a service that had specialist equipment. We saw one of these incident forms and the action taken as a result.

The service had recently seen an increase in the conveyance of patients suffering from epilepsy and knew how to respond to immediate risk. Because of this staff received additional training. Staff told us they would pull over, stop the engine, ensure the patient was not at risk of harm and call the emergency services for help.

Staff shared key information to keep patients safe when handing over their care to others. Staff told us that when taking patients to healthcare providers they would always verbally handover any concerns or significant information.

The service manager supported staff out of hours and could be contacted for telephone advice.

Staffing

The service had enough staff with the 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.

The service had enough drivers to keep patients safe. The service employed 33 drivers. Patients were allocated to a driver and vehicle according to the time needed for each journey. Once a driver's time was allocated no further patients were accepted.

The manager could adjust staffing levels daily according to the needs of patients. If a journey took longer than expected, for example, unexpected traffic jams, the service manager would review the remaining journeys for that driver. If necessary, other drivers or a team leader would be allocated to later patient journeys.

The service had high staff turnover rates. At our last inspection in February 2020, the turnover rate was 19%. The service manager told us this had stabilised during 2021. Since January 2022, six drivers had left the service, however six new drivers were recently recruited but were awaiting pre-employment checks before they started work.

The service had low sickness rates. The service manager told us that staff sickness was low. However, in the last two months an increasing number of drivers had tested positive for COVID-19 and had to stay away from work.

Records

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

Requires Improvement

Patient transport services

The service itself did not hold patient records. This was because they did not provide treatment. Instead, the NHS ambulance trust downloaded the required records to a personal digital assistant (PDA) held by each driver which complied with the General Data Protection Act 2018. When the driver logged onto their PDA at the start of their shift, they could see how many journeys they were due to undertake, the name and address of the patients, any risk factors, and the addresses of each location.

Records were stored securely. All drivers were allocated a PDA with a unique sign on number. They carried these with them for the duration of their shift. Personal information about the journeys they had undertaken was deleted at the end of each working day, but records were held by the NHS ambulance trust. In the event of incidents or complaints the service liaised with the trust for the information required to complete investigations Computer systems used by the service were secure and password protected.

MEDICINES

The service did not prescribe or administer medicines.

Oxygen was prescribed by third party clinicians and conveyed with patients.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents but did not share lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns and reported incidents and near misses in line with the provider's policy. They followed clear guidelines and could describe the process for reporting incidents. Records showed that the cause of incidents was investigated, and action taken to prevent similar incidents occurring.

Staff understood the duty of candour. They were able to describe the importance of being open and honest with patients and their families.

Staff did not always receive feedback from investigations of incidents. Although staff received feedback from incidents, they had reported themselves, they told us that learning from other incidents was not shared with them.

There was a clear process for responding to patient safety alerts. Relevant alerts were sent to the service by the local NHS ambulance service. Records showed alerts were reviewed, and any applicable changes were made.

Are Patient transport services effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Requires Improvement

Patient transport services

Evidence-based care and treatment

The service provided care based on national guidance and evidence-based practice. However, managers did not always check to make sure staff followed guidance.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. This was because some of the policies used were not up to date. We raised this with the provider following our first visit. On our second visit, evidence showed policies were being updated and there was a plan to update all policies by September 2022.

Staff working remotely did not have access to protocols and policies. Staff told us if they needed to check a policy, they rang their operations manager and the contract holder's operations manager. Staff were required to follow the service's policy as well as working in line with the policies of the contract holder that was subcontracting work to them. Managers told us all policies and procedures were emailed to staff when they started with the service. Because of this the provider was in the process of creating 'flash cards' to be stored in each vehicle for protocols that were used on a regular basis.

The service did not provide clinical treatment for patients and so opportunities for the monitoring of evidence-based practice were limited.

The governance policy was out of date and did not follow national guidance. For example, there were no risk assessments for the control of substances hazardous to health. We raised this with the provider following our first visit, and they immediately introduced Control of Substances Hazardous to Health (COSHH) training for staff. Records confirmed that so far four staff had completed this training and the remainder were booked to complete this training.

The staff handbook contained an out-of-date standard operating procedure for communicating with ambulance control. It had not been reviewed since 2018.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients. We saw drivers addressing the psychological needs of patients and reporting these to care workers and clinical staff.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey.

Staff made sure patients had enough to eat and drink. Drivers called ahead to patients who were about to have a long journey. They advised them to have something to eat before the journey or to bring a snack with them. All vehicles carried bottled water and disposable cups.

Response times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients.

Response times were monitored for five different categories of patients: renal patients being taken to and from dialysis units, non-renal outpatients, pre-planned ward discharges, unplanned ward discharges and accident and emergency discharges. Between October 2021 and January 2022, the service met all agreed response times.

Staff contacted the service manager in the event of delays that could make them late collecting patients for their journey. These delays included heavy traffic and road closures.

Requires Improvement

Patient transport services

Competent staff

The service did not always ensure staff were competent for their roles as staff performance was not regularly reviewed. Managers had not appraised all staff's work or performance to provide them with support and development.

Managers did not give all new staff a formal induction tailored to their role before they started work. The service manager told us that new drivers worked with a more experienced member of staff for up to three weeks before they worked on their own. At the first visit, the service manager could not tell us the content of the induction training and confirmed that no records were kept of it. They were unable to provide evidence of a competency assessment at the end of the induction period to confirm that a new driver had the skills and knowledge to carry out their work effectively.

However, after the inspection the manager submitted a detailed competency checklist which was signed by team leaders to confirm drivers had completed their induction period. This was filed within their staff records.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, there were recent gaps in the appraisal process. We looked at the records of five staff who had been in post for more than a year. Two had had no appraisal and the other three had not had an appraisal since November 2020. However, at our second visit, evidence confirmed five drivers had recently completed their yearly appraisal and managers had planned to complete all appraisals by September 2022.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service manager had noticed that's an increasing number of the patients they were transporting had been diagnosed with epilepsy. Staff had expressed concern that they did not know what to do if a patient had an epileptic fit. Therefore, additional training had been arranged to improve the knowledge and skills of all drivers. We saw records of this additional training in staff files and 11 staff had completed this.

Managers identified poor staff performance promptly and supported staff to improve. This was because team leaders completed regular spot checks on staff and vehicles. The service manager described the process that would be followed in the event of poor staff performance.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff described good teamwork between different groups of staff. Records showed that drivers communicated effectively with other healthcare providers to deliver good patient care. Managers held quarterly meetings with the local NHS ambulance trust to share information about the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Records confirmed that staff had received training in mental health awareness which included subjects such as living with dementia, informed decision making and gaining consent. Staff were informed in advance if a patient was likely to be confused because of mental ill health. Staff supported the conveyance of a patient's escort or carer where this would help reduce distress or confusion. We saw staff gain patients' consent before helping them into a vehicle.

Requires Improvement

Patient transport services

The service did not transport patients who were subject to the Mental Health Act or a deprivation of liberty authorisation.

Are Patient transport services caring?

Good

Our rating for caring remained the same We rated caring as good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. They took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. We saw staff care for patients in a gentle and considerate manner. They asked patients if they were comfortable before starting a journey. We were shown an email from a recent patient who said, “The driver’s kindness made a real difference”.

Staff were aware of the need to support privacy and dignity when transporting patients. For example, they offered patients a choice of male or female crew and worked to meet individual requests that would help people feel more at ease.

Staff followed policy to keep patient care and treatment confidential. They understood the principles of patient confidentiality and knew that personal details should not be shared with unauthorised persons.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We saw the care of patient who was confused because of a mental health condition. The driver involved the patient’s carer in explaining what was going to happen. They calmly repeated information when the patient had difficulty understanding.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff could describe some of the needs of people from differing cultures, for example fasting during Ramadan, and Diwali. The workforce was diverse, which meant that many staff were bilingual.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. They understood the impact that patients’ care, transfers, and condition had on the patient’s wellbeing. Staff discussed the importance of treating patients as individuals with different needs. They showed us a communication from a regular patient. This said “I have been transported five days a week, for the last six weeks to and from radiotherapy. I would like to thank the crews for their friendliness and good organisation”.

Requires Improvement

Patient transport services

Understanding and involvement of patients and those close to them

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary.

Staff had access to online or telephone language translation services.

Patients and their families could give feedback on the service and staff supported them to do this. Staff encouraged feedback in any means convenient for the individual, including e-mail, telephone, or letter.

Patients gave positive feedback about the service. We saw several examples of consistently positive feedback from patients and their loved ones. One said “A really lovely lady collected me today and took me to the hospital for an appointment. She assisted me into a wheelchair and helped me to the clinic. It was so nice to see her for the return journey”.

Are Patient transport services responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, to meet the needs of the local population. The service provided non-emergency transfers between a range of locations, including care homes and hospitals. Journeys could be booked in advance or on an ad-hoc basis. The service worked closely with the local NHS ambulance trust to help with the discharge of patients from local emergency departments. They looked carefully at the locations involved and re-deployed nearby drivers if this did not delay other patients.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff established each patient’s needs in advance. This included patients own oxygen therapy or if they needed specific support or equipment during a journey. Patients were given a choice to use their own wheelchair, or one provided by the service. Drivers ensured patients could make requests during longer journeys, including stops at service stations for refreshments and to use the toilet. Long journeys would be planned to ensure there were sufficient service stations en route.

Ambulances had different points of entry, including sliding doors with steps and tailgates so that people who were mobile or in wheelchairs could enter safely.

Staff built supportive relationships with patients who used the service regularly, such as those who were transported for renal treatment. Staff said they tried to book the same crews for the same patients, which helped build trust and understanding of individual preferences.

Requires Improvement

Patient transport services

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. They worked closely with carers to explain what was happening in terms the patient could understand. Extra time was allowed for people who needed it such as those with learning disabilities or suffering with confusion. Staff made sure they conveyed carers with patients when required.

The service did not have information leaflets available in languages spoken by the patients and local community. Staff were told in advance of the journey if English was not the patients first language. Staff used an online or phone-based translation service to support communication with patients.

Access and flow

People could access the service between 7am and 11pm at night 365 days a year.

Managers worked to keep the number of cancelled journeys to a minimum. Managers told us if a vehicle had a breakdown or was held up with a previous job they would locate and send another crew and vehicle to reduce the number of patients unable to be transported.

The service manager monitored wait times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Between October 2021 and January 2022, expected response times varied from 94% for pre-planned ward discharges and 99% for patients being collected from renal dialysis units. The local NHS ambulance service had told the service manager that these response times were better than most other services.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients, relatives, and carers did not always know how to complain or raise concerns. During our first visit, there was no information in the vehicles informing patients on how to raise concerns or give feedback. The service did not always provide feedback forms for people to complete. This was because the NHS Ambulance trust has a service level agreement to supply their own feedback forms and stock ran low at times.

Managers investigated complaints and identified themes. Complaints were occasionally received via the local NHS ambulance service. We looked at the two most recent complaints and found they were investigated carefully and methodically. A clear explanation and apology was given to the complainant and action was identified to prevent similar problems happening in the future. For example, managers reviewed data stored on vehicle trackers to investigate complaints about drivers speeding. Drivers found speeding were interviewed by managers. The local NHS ambulance service was involved in all stages of the investigation.

Are Patient transport services well-led?

Requires Improvement

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

Requires Improvement

Patient transport services

Leadership

Leaders did not establish the skills and abilities to run the service. They did not always understand or manage the priorities and issues the service faced. Local leaders were visible and approachable for staff.

Leaders were not always visible and approachable in the service for patients and staff. The current owners had managed services from abroad until two years ago. Staff told us the owners were supportive but were often abroad and not involved in the organisation of the service until recently.

At the time of the inspection, the service did not have a nominated individual. The nominated individual is responsible for supervising the management of the regulated activity provided. The impact of this was that the owners lacked oversight of the requirements of the Health and Social Care Act (2008) and the governance processes required to ensure robust management and recruitment processes had been implemented and monitored.

During our first visit, the registered manager was working remotely part-time and was not available. A registered manager is the person responsible for meeting legal requirements under the Health and Social Care Act (2008) (Regulated Activities). We were told the registered manager was leaving the service. Due to their working arrangements, the registered manager had limited oversight of the day to day running of the service. This had led to a lack of governance processes required to ensure robust management and recruitment processes had been implemented and monitored.

The current service manager had applied to become the CQC registered manager and was awaiting their interview. At our first visit, there had not yet been a handover between the two managers. The service manager had not been issued with a job description or a list of roles and responsibilities. They did not know who they reported to although they said that directors of sister companies were always happy to give advice when needed. There was no staff file for the registered manager, although the CQC had received a completed disclosure and barring check which was dated April 2022.

The new registered manager was supported by one administrator who worked remotely on staff rosters and a consultant who had completed a review of services and highlighted gaps, implemented change and was in the process of reviewing all the policies and procedures. We saw evidence that their experience had made improvements to the service.

The service had two team leaders who did not have job descriptions or a list or roles and responsibilities which meant there was lack of clarity about their role. They frequently covered gaps in the rotas and had little time to carry out their leadership role. This meant they had less time to manage and review staff inductions, safety checks and governance.

We saw the service manager talking to drivers by telephone. It was clear that they knew the drivers well and understood their roles. Drivers told us that the service manager was approachable and easy to contact.

Vision and Strategy

The service had a vision for what it wanted to achieve but there was not a clear strategy to turn it into action.

The vision for the service was to provide a timely, safe, high quality, customer focused transport service to low risk patients. Staff did not know whether the owners shared this vision and the strategy for achieving it had not been explained to them. The service did not monitor its progress towards its vision.

The vision depended on gaining contracts with NHS ambulance providers. Although an informal agreement existed with the local NHS ambulance service, there was no formal contract. Managers had tried to agree a contract but, to date, this had not proved possible.

Culture

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

Staff we spoke with were proud of the work that they carried out. They enjoyed working for the service and were enthusiastic about the care and services they provided for patients. They described the service as a good place to work and described opportunities for promotion.

Staff said they felt that their concerns were addressed, and they could easily talk with the service manager. They described positive working relationship with each other. One told us about a "get together" that had taken place the previous weekend. Several staff brought their families to the main office so that children could play together, and families could exchange experiences. It had not been possible to do this during most of the COVID-19 pandemic and staff told us that they appreciated the opportunity to meet each other.

When patients raised concerns, they were addressed in a timely and courteous manner.

Governance

Leaders did not operate effective governance processes although it did co-operate with the governance processes of partner organisations. Staff were not clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.

Although the service had a governance policy it was not dated or signed. It was not clear who was responsible for compliance with quality assurance systems and there were no roles or responsibilities described within it. It stated that it would maintain a quality service "by way of regular audit and review of standards of performance across the service". However, there were no descriptions of the audits or reviews. During our second visit, we saw evidence that showed the service was in the process of reviewing the governance policy.

There were no effective systems, such as audits and risk assessments, to monitor the quality and safety of the service. For example, there were no audits to assess whether safe recruitment practices were being used. This meant the senior team was unaware of the gaps we found in recruitment records. We asked to see safety audits for the previous year, including fire safety audits and infection control audits. The service was not able to provide these. Since our second visit, the service had developed an audit program based on the needs of the service.

Staff at all levels were not clear about their roles and accountabilities. The staff handbook provided information about some of the drivers' responsibilities, their staff files did not contain a job description which set out the details of their role and accountabilities. One driver was self-employed. Their contract with PTS-247 contained many spelling mistakes and was illegible in places. This meant drivers were not clear about their roles and accountabilities. This did not conform to Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers did not hold any meetings to discuss themes in incidents, complaint, risks, or patient feedback. As a result, opportunities to look for gaps in compliance and to identify improvements were missed. However, it did co-operate with the local NHS ambulance service when they carried out their yearly private provider assurance visit.

Requires Improvement

Patient transport services

At our last inspection in February 2020, we told the provider they should review and improve their governance processes in particular the recruitment process because it was unsafe. However, we found the same issue during this inspection and asked the provider to submit evidence that all staff had two written references. The service responded within two weeks of our request. The manager was unable to provide full references for one staff and was taking action to rectify this but there was a delay because they were awaiting checks from overseas.

The service ran enhanced checks with the disclosure and barring service before drivers were allowed to transport patients.

Management of risk, issues, and performance

Leaders did not use systems to manage performance effectively. They did not always identify or escalate relevant risks and issues. Actions identified to reduce their impact were not always carried out. They had plans to cope with unexpected events.

The service had a risk management policy, but it was not signed or dated. It stated that "all activities of the organisation have been subject to a generic risk assessment". However, when we asked to see risk assessments for the vehicles used to transport patients, they could not be provided.

In accordance with the risk management policy, there was a risk register. It contained 19 risks which were given a score depending on the degree and likelihood of harm that the risk could produce. However, 17 of the 19 risks had not been reviewed since March 2019. The risks reflected concerns raised by staff and some of the issues we found during our inspection. Managers told us that their top risk was that several vehicles had been recalled by the manufacturer, but they were still waiting for them to be repaired. This risk was not on the risk register, when we raised this with the provider it was added to the risk register immediately.

There were action plans to reduce these risks, but many were not being carried out and there were no times frames for completion. For example, actions described to reduce the risk of an accident while driving patients included all drivers being given driver awareness training, driving licenses checked every six months and head office undertaking monthly inspection of all vehicles. There were no records of these actions being carried out and therefore the risk to patients and staff remained.

Managers completed employee compliance checks which were carried out by team leaders to monitor operational performance. For example, the cleaning of equipment, the use of PPE and safe driving. Checks were completed on the vehicle equipment such as fire extinguishers, first aid kits and wheelchairs. It also included the cleanliness of the vehicle and correct uniform for drivers.

Managers did not always record compliance checks. Records we viewed found gaps in January, February, and March 2022. However, the local NHS trust did complete regular checks at hospital locations and the information was used by the NHS provider to monitor the service for safety purposes.

The service manager met monthly with one of the directors of the company to discuss performance. The meetings did not have a standard agenda. There were notes of agreed actions, but it was not clear which issues were being addressed. We looked at the notes of meetings held from January to March 2022. Items such as recruitment and vehicle replacement were discussed but there was no mention of risks or safety issues.

There was a business continuity plan which gave guidance to staff should unexpected events such as power cuts or floods take place.

Requires Improvement

Patient transport services

Information Management

The service did not collect reliable data or analyse it. Staff could not always find the data they needed to understand performance, make decisions and improvements. The information systems were not always integrated. Data or notifications were not consistently submitted to external organisations as required.

The service collected limited data. Information systems were electronic. Patient information was sent directly by the local NHS ambulance service to personal digital assistants held by each driver. The information was removed at the end of each day. The information was owned by the NHS service and so could not be used or analysed by PTS-247 Limited this was because the provider complied with General Data Protection Regulations (2018) and only kept records on a need to know basis. In the event of an incident, the provider would apply to the NHS trust for the relevant patient journey record and review information stored on the vehicle trackers.

The service manager had daily communication with the NHS ambulance trust who employed their patient transport services. This was because the personal digital assistants used by drivers were provided by the NHS ambulance service so that they could communicate directly with them.

Drivers were given a staff handbook which consisted of 46 pages. However, an incorrect index made it difficult to find information to help drivers make the right decisions. For example, information for stopping at incidents was on page three, not page seven. Health and safety information was on page 12, not page 10. After the first inspection we raised this issue with the registered manager, when we returned, we was told the service was in the process of reviewing and updating the document and expected the review to be completed by October 2022.

Comprehensive information about each vehicle was available on the patients internal digital system. However, the recording of daily mileage was not consistent, and records were not easy to review. This was because drivers sent the information via their social media group, but it was not always recorded onto the digital system.

Engagement

Leaders did not actively engage with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, this information was not shared with staff.

The provider did not have its own patient feedback forms. This was because the service level agreement with the NHS ambulance trust meant the trust provided the leaflets which were placed within vehicles and returned to the NHS trust for monitoring purposes. However, during our first visit there were none available in the vehicles we checked, although stock had been replaced when we returned.

Staff did not attend formal staff meetings. This was because staff were on the road conveying patients, and it was hard to bring staff together for formal meetings. the service manager did communicate daily via the staff social media group and was available when needed.

Managers held quarterly meetings with the local NHS ambulance trust, but the information discussed at the meetings was not shared with other staff.

The providers website was not easy to access, when we raised this with the manager, they showed us evidence that this issue had been reported.

Requires Improvement

Patient transport services

Leaders and staff did not fully engage with the public and equality groups. Staff completed equality and diversity training. However, the service had no formal engagement with equality groups.

Learning, continuous improvement and innovation

The service was not committed to continually learning and improving services. The service did not understand quality improvement methods. Leaders did not encourage innovation.

Staff were not aware of any quality improvement initiatives within the service and managers were unable to demonstrate how they used quality improvement tools to drive improvement. Some of the issues that we raised at our February 2020 inspection had not been improved when we inspected in April 2022. For example, recruitment practices and governance processes. However, we were able to see that the service was now making improvements, but we were unable to assess whether the improvements being made were sustainable.

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
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must ensure they carry out effective governance processes that assess, monitor, and improve the quality and safety of the service. Regulation 17(2)(a) • The provider must ensure they introduce risk management systems to identify and mitigate risks to safety. Regulation 17(1)(b) • The provider must ensure they identify a suitable person of good character, with the necessary qualifications, skills, and experiences to act as the nominated individual to supervise and manage the regulated activities of the service. Regulation 6 (3) (a,b,)