

G4S Health Services (UK) Limited

G4S Patient Transport Services - Kent & Medway

Quality Report

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

Ratings

Overall rating for this
ambulance location

Requires improvement



Patient transport services (PTS)

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

NHS non-emergency patient transport services help people access healthcare in England. They are free at the point of use for patients who meet certain medical criteria and are unable to use public or other means of transport.

In Kent the patient transport service is managed by a lead clinical commissioning group. To help meet demand for transport requests, the group subcontracts to independent providers such as G4S.

G4S Patient Transport Services - Kent & Medway was operated by G4S Health Services (UK) Limited.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 24 April 2019, along with staff telephone interviews on 25 April 2019.

This was the service's first inspection since registration.

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

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

We rated it as **Requires improvement** overall because:

- Some staff did not understand when they could raise a safeguarding concern without the consent of the individual.
- At Gillingham depot the premises needed cleaning. The vehicle park, vehicle "make-ready" area and bulk storage facilities were insufficient for an operation of this size and complexity. Some aspects were not fit for purpose.
- We observed the unsafe use of an electrical cable by a contractor in the vehicle park. However, this was corrected by managers as soon as we raised our concern.
- Appraisal rates for some staff groups did not meet their target of 85%. However, managers and ambulance care assistants were meeting this target.
- We found that staff followed the service's procedure for staff to report incidents relating to abuse of risk of abuse but that five incidents that should have been reported to CQC were not. Also, the services procedure did not help staff identify when incidents should be reported to CQC.
- Some staff did not feel supported by their managers and felt they could not speak about their complaints.

However,

- The service had high compliance rates for staff mandatory training and had met most of their targets.
- The service had clear processes and systems to help keep vehicles and equipment ready for use. This included yearly MOTs, regular servicing and maintenance.
- Vehicle interiors were visibly clean, and we saw they were deep-cleaned every eight weeks or sooner if needed.
- Staff demonstrated clear understanding of their daily duties about cleanliness and infection prevention and control in line with the provider's infection prevention and control policy. The service was piloting a portable computer system which significantly improved the way in which vehicle preparation checks and post-use cleaning was monitored. This system provided an excellent level of assurance and was due to be cascaded to all depots.
- Staff demonstrated a willingness to report incidents and raise concerns. Staff received feedback and any relevant extra training to ensure the service learned from incidents to improve patient safety.

Summary of findings

- All staff had undertaken in-house induction and mandatory training in key areas to provide them with the knowledge and skills they needed to do their jobs safely.
- The service had up to date policies and guidance to support staff.
- Staff treated patients with compassion. One patient told us crews went above and beyond to ensure their safety and wellbeing.
- The service acted to meet patients' individual needs. This included patients for whom English was not a first language.
- The service met the needs of children that travelled with them. Staff ensured that children had their favourite toy for comfort before they started on their journey.
- The service had company wide and local risk registers that assessed, reviewed, and mitigated risks.
- The leadership looked for innovation and improvements.
- Most managers supported their staff.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (South East), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Patient transport services (PTS)

Requires improvement



Rating

Why have we given this rating?

We rated this core service as **Requires improvement** overall because:

- Some staff did not understand when they could raise a safeguarding concern without the consent of the individual.
- At Gillingham depot the premises needed cleaning. The vehicle park, vehicle “make-ready” area and bulk storage facilities were insufficient for an operation of this size and complexity. Some aspects were not fit for purpose.
- We observed the unsafe use of an electrical cable by a contractor in the vehicle park. However, this was corrected by managers as soon as we raised our concern.
- Appraisal rates for some staff groups did not meet their target of 85%. However, managers and ambulance care assistants were meeting this target.
- We found that staff followed the service’s procedure for staff to report incidents relating to abuse of risk of abuse but that five incidents that should have been reported to CQC were not. Also, the services procedure did not help staff identify when incidents should be reported to CQC.
- Some staff did not feel supported by their managers and felt they could not speak about their complaints.

However, we also found the following areas of good practice:

- The service had high compliance rates for staff mandatory training and had met most of their targets.
- The service had clear processes and systems to help keep vehicles and equipment ready for use. This included yearly MOTs, regular servicing and maintenance.

Summary of findings

- Vehicle interiors were visibly clean, and we saw they were deep-cleaned every eight weeks or sooner if needed.
- Staff demonstrated clear understanding of their daily duties about cleanliness and infection prevention and control in line with the provider's infection prevention and control policy. The service was piloting a portable computer system which significantly improved the way in which vehicle preparation checks and post-use cleaning was monitored. This system provided an excellent level of assurance and was due to be cascaded to all depots.
- Staff demonstrated a willingness to report incidents and raise concerns. Staff received feedback and any relevant extra training to ensure the service learned from incidents to improve patient safety.
- All staff had undertaken in-house induction and mandatory training in key areas to provide them with the knowledge and skills they needed to do their jobs safely.
- The service had up to date policies and guidance to support staff.
- Staff treated patients with compassion. One patient told us crews went above and beyond to ensure their safety and wellbeing.
- The service acted to meet patients' individual needs. This included patients for whom English was not a first language.
- The service met the needs of children that travelled with them. Staff ensured that children had their favourite toy for comfort before they started on their journey.
- The service had company wide and local risk registers that assessed, reviewed, and mitigated risks.
- The leadership looked for innovation and improvements.
- Most managers supported their staff.

G4S Patient Transport Services - Kent & Medway

Detailed findings

Services we looked at

Patient transport services (PTS)

Detailed findings

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Detailed findings from this inspection

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Background to G4S Patient Transport Services - Kent & Medway

G4S Patient Transport Services - Kent & Medway was operated by G4S Health Services (UK) Limited. The service opened in 2018 and was an independent ambulance service based in Chatham, Kent.

This service was contracted by the clinical commissioning groups of Kent, Medway, Bexley and Bromley to help people access healthcare in their respective areas. The provider employed 453 staff and had 200 vehicles operating from seven depots in; Tonbridge, Margate, Maidstone, Gillingham, Dartford, Canterbury, and

Ashford. They offered transport services for people attending outpatient appointments and renal dialysis clinics as well as admissions or discharges from hospitals and inter-hospital transfers. The service transported adults and children of any age as long as they did not need an incubator to travel.

The service has had a registered manager in post since 2018.

We had not inspected this service before.

Our inspection team

The team that inspected the service comprised a CQC lead inspector; three CQC inspectors, one assistant inspector and two specialist advisors with experience in patient transport services.

The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection (South East).

How we carried out this inspection

During the inspection we visited three sites and accompanied three crews on duty. We observed handovers and care provided, checked vehicles and equipment and spoke with patients and relatives. Eight vehicles of differing makes' and models were inspected. We looked at six patients records.

We spoke with 30 staff in various roles including senior managers, depot managers and ambulance care

assistants along with administrative and cleaning staff. We looked at policies and procedures, staff training and appraisal records along with meeting notes, audit reports, the environment and equipment used.

We also received feedback from four staff from stakeholder hospitals and clinics. We spoke to nine patients that had travelled with the service.

Detailed findings

Facts and data about G4S Patient Transport Services - Kent & Medway

The service was registered with the CQC to provide the regulated activity of transport services, triage and medical advice provided remotely.

The service had 200 vehicles at the time of this inspection; this was a mix of cars and ambulances that were either adapted for patient transport or designed for this purpose.

The service was organised locally from an office location in Chatham, Kent. They also had a head office in London that organised companywide issues. The service had a call centre in Wath upon Dearne. They also had a call centre in Chelmsford that handled calls at busy periods. Also based at their Chelmsford site was their head of operations, safeguarding line, incident management, business intelligence, and complaints management. The service had logistics specialists in their Chelmsford office that organised out of area journeys.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Activity

- In the reporting period from March 2018 to February 2019 there were 331,670 patient transport journeys undertaken.
- 409 ambulance care assistants were employed by the service, which also had a bank of temporary staff that it could use.
- The service did not use controlled drugs.

Track record on safety







- No never events in the reporting period from March 2018 to February 2019
- 103 incident reports in the past year, of which 10 were rated as severe incidents, 33 moderate incidents and 51 mild incidents.
- Three serious injuries were reported, and six incidents related to deaths occurring during transport. These deaths were related to either patients that had died in their homes which were found when the crew arrived or patients receiving end of life care.
- The service had received 892 complaints in the past 12 months.

Our ratings for this service

Our ratings for this service are:

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

Patient transport services (PTS)

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

The only service provided by this ambulance service was patient transport services.

The service was registered with the CQC to provide the regulated activity of transport services, triage and medical advice provided remotely.

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In the reporting period from March 2018 to February 2019 there were 331,670 patient transport journeys undertaken. There were 409 ambulance care assistants employed by the service. There was also a bank of temporary staff that were used.

The service was organised locally from an office location in Chatham, Kent. They also had a head office in London that organises companywide issues. The service had a call centre in Wath upon Dearne. They also had a call centre in Chelmsford that handled calls at busy periods. Also based at their Chelmsford site was their head of operations, safeguarding line, incident management, business intelligence, and complaints management. The service had logistics specialists in their Chelmsford office that organised out of area journeys.

Summary of findings

We found the following areas of good practice:

- The service had high compliance rates for staff mandatory training and had met most of their targets.
- Staff showed a willingness to report incidents and raise concerns. Staff received feedback and any relevant extra training to ensure the service learned from incidents to improve patient safety.
- Crews had identified and provided detailed reports of safeguarding concerns.
- Vehicle interiors were visibly clean, and we saw they were deep-cleaned every eight weeks or sooner if needed.
- Staff demonstrated clear understanding of their daily duties about cleanliness and infection prevention and control in line with the provider's infection prevention and control policy. The service was piloting a portable computer system which significantly improved the way in which vehicle preparation checks and post use cleaning was monitored. This system provided an excellent level of assurance and was due to be cascaded to all depots.
- The service had clear processes and systems to help keep vehicles and equipment ready for use. This included yearly MOTs, regular servicing and maintenance.

Patient transport services (PTS)

- All staff had undertaken in-house induction and mandatory training in key areas to provide them with the knowledge and skills they needed to do their jobs safely.
- The service had up to date policies and guidance to support staff.
- Staff treated patients with compassion. One patient told us “crews went above and beyond to ensure their safety and wellbeing.”
- The service acted to meet patients’ individual needs. This included patients for whom English was not a first language.
- The service met the needs of children that travelled with them. Staff ensured that children had their favourite toy for comfort before they started on their journey.
- The service had company wide and local risk registers that were used to assess, review, and mitigate risks.
- The leadership looked for innovation and improvements.
- Most managers supported their staff.

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

- At Gillingham depot the premises were dirty. The vehicle park, vehicle “make-ready” area and bulk storage facilities were insufficient for an operation of this size and complexity. Some aspects were not fit for purpose.
- We observed the unsafe use of an electrical cable by a contractor in the vehicle park. However, this was dealt with by managers as soon as we raised our concern.
- Some staff did not understand when they could raise a safeguarding concern without the consent of an individual.
- Appraisal rates for some staff groups did not meet their target of 85%. However, managers and ambulance care assistants were meeting this target.

- We found that staff followed the service’s procedure for staff to report incidents relating to abuse of risk of abuse but that five incidents that should have been reported to CQC were not. Also, the services procedure did not help staff identify when incidents should be reported to CQC.

Patient transport services (PTS)

Are patient transport services safe?

Requires improvement



We had not inspected this service before and therefore has not been rated before. We rated it as **requires improvement** because we found that staff did not all understand when they could raise a safeguarding concern without consent. Also, there were not suitable areas to make vehicles ready at the Gillingham site. However, the service met 15 out of 20 of their targets for mandatory training rates.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and reported them. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

- The service recorded incidents in four categories which were; death, severe, moderate and mild. Incidents reported in the past 12 months included; six death incidents, 10 severe incidents, 33 moderate incidents and 51 mild incidents. Serious incidents are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified
- The service reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Never events relevant to patient transport services include chest or neck entrapment in trolley (or bedside) rails.
- We reviewed the service's guidance for reporting and investigating incidents. This was clear on what would qualify for each of the above categories with examples to help staff categorise incidents correctly.
- Staff knew how to report safety incidents. We spoke with 11 staff that all knew how to report incidents. Some staff

were using an intranet tool to report incidents and others used paper forms that were then transferred to the intranet system. This then triggered the incident investigation process.

- The service had systems to investigate incidents that kept people safe. We reviewed the root cause analysis for five different incidents. These contained an incident overview, timeline of events, interviews with staff or statements from staff, immediate actions taken, follow up actions, consideration for duty of candour, involvement of the patient and/or relatives, and action plans. These also showed that there had been consideration of what investigation methodology was used for the incident.
- Staff were involved in the investigation of incidents. We saw interview records in investigations performed to gain understanding from staff that were involved in incidents. These records clearly showed that staff were reassured that the purpose of the investigation was to improve the service and not to blame staff.
- The service shared lessons learnt from incidents. We reviewed four lessons learnt leaflets that were then displayed in depots for staff to view. These included an overview of the incident, any learning outcomes, and extracts from related policies to serve as a reminder to staff.
- The service had systems to feedback learning from incidents to staff although this may not always have been effective. We saw posters in the depots that identified learning from incidents. Managers told us that the incident reporter would also receive feedback about learning from the incident. Three staff we spoke with told us that they had seen the lessons learnt posters. However, four staff we spoke with about incident reporting said that they had not received feedback.
- The service investigated incidents and applied duty of candour in line with their policy. The service had an up to date policy about duty of candour. We reviewed three duty of candour incidents which were handled in line with their policy. The service provided e-learning for all staff on duty of candour with a compliance of 97%. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

Patient transport services (PTS)

health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure most staff completed it.**
- The service offered a range of mandatory training both face to face and via e-learning. The service had considered the frequency needed for these modules which ranged from yearly to five yearly. Modules covered every year were; basic life support, first aid, infection control, manual handling, oxygen therapy, dementia awareness, and patient consent. Other modules were repeated from every two years to every five years
- The service had identified staff roles and which training courses they needed to complete. They had a skill matrix that clearly showed which roles needed to complete which training course. This also showed which extra training courses may be relevant to extend their understanding but were not needed for their roles.
- The service had mandatory training modules for staff and met most of their targets. The service was meeting their target of 85% compliance for 15 out of their 20 modules. With nine of these modules being above 95% compliance. The modules that they met targets for included; Basic life support, first aid at work, oxygen therapy, prevent radicalisation, G4S values, anti-bribery, conflict resolution, duty of candour, equality and diversity, fire safety, health and safety, mental capacity act, safeguarding adult level 2, and safeguarding child level 2.
- The service had systems to monitor compliance with mandatory training. The services overall compliance was within their target. However, there were five modules that fell below their target of 85%. These modules were manual handling, dementia awareness, information governance, infection control, and patient consent. Manual handling compliance was 84% so was close to the services target of 85%. Dementia awareness training compliance was 81% so was also close to the services target of 85%. The service had plans to improve their training compliance.

- We reviewed eight staff records and found that they contained certificates that showed completion of training modules. We also saw the records of three senior managers contained certificates from mandatory training courses. Managers explained that the information governance module had a low completion rate as it had been redesigned to take account of the introduction of general data protection regulation (GDPR) in November 2018. This compliance was worse than the target as they made two courses into one which resulted in compliance showing as 58%. However, compliance for the completion of the old course in December 2018 was 94%.
- Managers told us the reason for compliance in infection control training being worse than the target was because many staff were due to complete their training in December. This meant that compliance drops after this and then returns towards their target in the following months. We reviewed training records that showed these trends. These records showed that in December the compliance with infection control training was 95%.
- The service introduced a new training module focused on dementia awareness and within four months had achieved 92% compliance in this module.

Safeguarding

- **Most 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 most staff knew how to apply it.**
- The service had identified leaders to support effective safeguarding. The service had a level 5 trained safeguarding lead, but they were on extended leave at the time of the inspection. In their absence the service had given responsibility for safeguarding to their chief nurse and this was overseen by the services clinical director both of whom were trained to safeguarding level 4 for adult and child.
- The service had access to an independent service to help them review safeguarding policy. We reviewed records that showed a service agreement describing this arrangement.
- The service provided training for their staff in safeguarding. All staff were trained to at least level two

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child and adult safeguarding. The service had 96% compliance with level 2 safeguarding adults and 97% compliance with level 2 safeguarding children. Training was in line with national guidance.

- The service had a system to process safeguarding concerns raised by their staff. The service had an up to date policy for safeguarding children and adults. This covered areas such as descriptions of the type of abuse and the role of the safeguarding lead. We reviewed a flow chart that explained the way a concern would be processed. This included; what to do if there was an immediate danger, what to do if no immediate danger, and how the concern would be reported to social services. The risks about this incident were also included in this flowchart for consideration by the service's managers.
- Staff had access to a 24-hour safeguarding line to the control centre. Details of this call line was seen on vehicles and in depots. The control centre then passed on these concerns to the relevant local authority safeguarding team or the governance team to review.
- The service was identifying and referring concerns of abuse or risk of abuse. We reviewed 21 incidents of concerns relating to abuse or risk of abuse raised by the service's staff. We found that these showed a range of issues were being highlighted by their crews. This included physical abuse, neglect, self-neglect, poor caring agencies, absences of suitable care arrangements and mental ill health concerns. The service had reported all of these to the local safeguarding authority in line with their policy and national guidance.
- Patient facing staff did not always understand when they were responsible for raising a safeguarding concern without consent from the patient. The services flow chart to support staff completing safeguarding reports did not include advice about the requirements regarding consent. Four staff based at the Maidstone depot we spoke with could not tell us when they would be able to raise a concern without consent. Seven other patient facing staff we spoke with across the service did understand when they would be able to raise a concern without consent. In seven safeguarding records we reviewed we saw that consent had not been obtained for the referral but the reasoning for the concern still being reported had been recorded in line with national guidance.

- Crews had ready access to guidance and information when they had safeguarding concerns. At the Gillingham depot, we saw each vehicle had a "blue folder" which contained laminated copies of key documents, including a safeguarding prompt sheet. We were told by managers that these were in all vehicles.
- The service had an up to date policy on the government initiative called Prevent. This is to; protect vulnerable people, challenge the ideology that supports terrorism, and support action against radicalisation.

Cleanliness, infection control and hygiene

- **Infection risks were controlled. Staff kept themselves, and vehicle equipment visibly clean. They used satisfactory control measures to prevent the spread of infection.**
- The service had new systems for ensuring high standards of cleaning were always done. Crews were using a new software package that would have them take pictures of the cleaning they had achieved. This was then seen by managers and the following crew to ensure high levels of cleaning had been completed. At the Gillingham depot, managers demonstrated the use of a commercially-available software package that had been modified to include a record of end-of-day vehicle cleaning. G4S were piloting the application before spreading the technology to other bases. The pilot was regarded as successful. Managers explained the package was designed for use with a portable digital assistant (PDA) issued to each crew at the start of their shift. Crews could not close the record for the day until the final cleaning task was marked completed and shown by a photograph taken using the PDA.
- Vehicles and equipment were cleaned and decontaminated to ensure patients and staff were protected from acquiring infections during their journey. We saw staff using wipes to disinfect equipment between uses. At both depots we saw unmarked spray bottles which staff said carried an approved cleaning agent. Although staff told us this was not a harmful product it is still good practice to label spray bottles.
- The four vehicles we checked at Gillingham had visibly clean interiors. The exterior paintwork appeared to be covered by a layer of road grime or salt spray. But windows and mirrors appeared clean.

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- The four vehicles we checked at Maidstone had visibly clean interiors. These had visibly clean exteriors including windows and mirrors.
- Vehicles were rotated through deep cleaning every eight weeks and we saw records confirming this. The deep cleaning was performed by a specialist contractor who provided a mobile service.
- When vehicles were contaminated and needed extra cleaning the service had a guide to help crews decide what level of cleaning was needed. This was based on the type of contamination. If the vehicle needed an extra deep clean, then this was done by the specialist contractor.
- Staff decontaminated their hands in between each patient interaction. We saw antibacterial hand gel dispensers fitted to each ambulance and these were full and working. We saw staff using the gel correctly. Disposable gloves in different sizes were also available for staff to use. However, there were no aprons on the vehicles so if crews needed these during a journey they would have to wait until getting to a hospital or depot.
- Staff had uniform lockers in the depot office. Staff told us they cleaned their own uniforms and kept a spare set available at their base station should their uniform become soiled or contaminated. We noted that all staff wore uniforms that appeared to be clean and serviceable. They had short-sleeved tops that ensured they remained “bare below the elbows”. We saw crews wearing watches attached to accessory pouches or belt loops. The removal of items of jewellery from hands and wrists improved the effectiveness of hand washing or wiping.
- Staff had a good understanding of infection prevention and control. We spoke with five patient facing members of staff who followed national guidance on infection control and described infection control issues to us.
- In the Maidstone depot we saw four different coloured mop buckets and mop handles in line with national guidance. The mop heads used were disposable.
- We saw clinical and non-clinical waste was segregated correctly into different coloured bags. Clinical waste was stored securely in locked bins while awaiting collection for disposal.
- **The service had suitable equipment and looked after them well. The service had some suitable premises.**
- The service had a contract for annual equipment testing. While some items we checked did not have service labels, we saw equipment records that showed all the items had been tested and serviced in line with manufacturers’ specifications.
- Records showed the equipment in the ambulances was checked and tested daily and supplies replenished as needed.
- We found several concerns at Gillingham depot. Managers described the depot as one of the busier stations in the region. Over 90 staff operated 33 vehicles from the depot, covering shifts from 5am to 11pm with a two-person crew working overnight. The depot was based in a factory site, comprising office accommodation and a separate vehicle park with various outbuildings. These facilities were shared between a number of co-tenants offering steel fabrication, heavy goods transport and automotive repair services. While the office block and staff car park were sited in a gated compound, the vehicle park was open to a public road.
- The office accommodation and staff toilets looked dirty. Managers explained that the cleaner had left. Depot team leaders took it in turns to clean facilities while a new cleaner was recruited. Based on our observations, the cleaning was not sufficient to meet the demand arising from the number of staff using the offices and the extended operating hours.
- Vehicle facilities were also insufficient to meet the needs of a busy depot. Parking bays appeared to contain a mix of ambulance vehicles and private cars belonging to G4S staff and other workers. In one corner of the vehicle park we saw that two shipping containers (in single file) had been positioned next to small metal “garden shed” and security lights atop two or three lampposts. We noted the shipping containers were used for consumable supplies such as gloves and other items such as wheelchairs and stretchers awaiting repair. The shed contained cages of full and empty oxygen cylinders. Three bulk waste containers were located next to a shipping container

Environment and equipment

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- Ambulance stations or depots commonly have a facility called a “vehicle make-ready” area. This usually includes all-weather provision for vehicle safety checks (such as tyre pressure, oil and water); vehicle maintenance; cleaning, equipment stores and waste handling. There were no spaces reserved for vehicle preparation and cleaning. Staff working in the area were exposed to the elements. Inspectors had to pause their own vehicle checks during a period of rain. Staff told us that working in the vehicle park was particularly challenging during winter months.
- Managers stated that vehicle washing was not permitted on the site as the property overlooked the River Medway and there was insufficient provision for trade effluent (run-off from vehicle cleansing). Water was not supplied to the vehicle park.
- We observed a vehicle being cleaned during our visit. We saw that the deep clean was augmented by a steam generator and industrial vacuum cleaner. We noted the use of a 240v electric extension cable, which was laid out some 25m across the tarmac park. The contractor explained that another ambulance had been moved into the bay adjacent to the shipping container and nearest power point. This ambulance had developed a fault and had been towed in for repair. It could not be moved. This caused a trip hazard as cleaning of vehicles then had to be done in spare spaces across the car park. This was also not compliant with guidance leaflet INDG231 (2012) from the Health and Safety Executive as there was no reduction in voltage and no residual current device in use. The guidance says portable tools that run from a 110 volt supply are readily available and that a reduction in voltage is one of the best ways of reducing the risk of injury when using electrical equipment.
- When we pointed out our safety concern about the extension cable to managers, it was rectified. We were also told that traffic cones had been ordered that day to help control parking in future.
- Each station had colour coded general waste bins and clinical waste bins for disposal of waste. All bins were collected fortnightly by a private contractor. However, at the Gillingham depot we saw that there was not a secure area for bin storage. Although the clinical waste bin was locked the overall standard did not meet guidelines because the area was accessible by unauthorised staff and the area was not well drained to allow for washing down the bins. “Management and disposal of healthcare waste (HTM 07-01 Section 5.98)” states that bulk storage areas, regardless of location, should be totally enclosed and secure; sited on a well-drained, impervious hardstanding; readily accessible but only to authorised people; kept locked when not in use; provided with wash-down facilities and clearly marked with warning signs.
- At the Maidstone site keys were stored in a locked key safe. This prevented unauthorised staff from accessing the vehicles.
- The service had a contract with a specialist service provider to do vehicle maintenance. This included servicing and yearly department of transport (MOT) certificates. We reviewed records that showed a countdown to when that vehicle was due to be serviced. The fleet manager told us that they reviewed this daily and would not allow any vehicles on the road if they were out of date. The records we reviewed showed that all vehicles they had in use had in date MOT and servicing.
- The service considered the fire risks at their sites. We reviewed a fire risk assessment at the Maidstone depot that was up to date. We also saw that on both the local risk registers for the depots that we visited fire risks had been considered.

Assessing and responding to patient risk

- **The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.**
- The service had effective measures to alert vehicle crews to patient risks. We were told by three bookings staff that they would ask patients on booking about mobility and medical history. They also told us that if patient needed a relative or carer to travel with them due to a medical condition then they would give the caller a reminder that this may be a good idea. These risks were recorded on the journey record and then highlighted to the ambulance care assistants that collected the patient. The three ambulance care assistants we asked about this in interview confirmed that they received information about patient risks via their digital tablet.

Patient transport services (PTS)

- The service had an up to date policy based on national guidance for deteriorating patients. This said that if a patient deteriorated during a journey the ambulance crew were to find a safe place to pull over and call 999 for emergency treatment. We were also told about this by one manager and two crew. This was also confirmed by one manager and two crew when discussing management of a deteriorating patient.
- All ambulance care assistants completed several mandatory training courses including a three-day first aid course and a basic life support course. These allowed staff to provide patients with basic life support, airway management and support patients with first aid.
- The service prepared their staff to manage aggressive or agitated patients. The service had a policy of not restraining patients and instead provided de-escalation training. The training manager told us this included advice about coming down to the level of the patient and reasoning with them. On double crew vehicles they also suggested that the crew could try switching the ambulance care assistants around as this may help alleviate the problem and both crews were trained to carry out both roles.
- The service also had patient transport liaison officers that were based in the large hospitals across the region. Managers told us these staff were responsible for carrying out extra checks on patients' needs after the hospital booked transport. This was to ensure the correct type of booking has been made to meet the patient's mobility and medical needs.

Staffing

- **The service had enough staff with the right skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**
- The service reviewed staffing levels and demands placed on the service. The service calculated staffing levels during the tender process for the Kent and Medway contracts. We were told by managers within the service and within the clinical commissioning group that the service had reviewed the calculation of staffing levels in relation to the demand for the service.
- The service had cover arrangements for sickness and leave. We saw records that showed the service had a sickness rate of 6%. The service had two senior ambulance care assistants at each of their bases. We were told by staff these staff would cover for ambulance care assistants that were off sick at short notice. We were also told by managers that if they had notice of leave or that someone was going to be off sick for an extended period these shifts would be put out for bank cover. The service operated each of their contracts with an extra 18% resilience level above the establishment figure. This allows cover for sickness, annual leave and training.
- The service had processes to meet the staffing levels agreed with their commissioners. We saw records to show that in February 2019 the service had 383 full time equivalent (FTE) of the agreed 399 FTE. They also had 8 FTE waiting for vetting clearance and another 7 FTE scheduled to start induction training. They also had 8 FTE staff leave in February. Managers told us that agency staff who worked with the service for 13 weeks were offered permanent posts and that over the past three months 13 ambulance care assistants had joined their permanent staff in this way.
- The services arrangements for using bank and agency staff kept people safe. Managers and crews told us that agency and bank staff completed the same induction training as permanent staff.
- In April 2019 the service used 62,085 hours of substantive staff, 4,313 hours of bank staff, 1,793 hours of overtime and 1,500 hours of agency staff. The service had no unfilled shifts.
- We reviewed eight staff records which showed that they had enhanced disclosure and barring service checks done within the past three years. The service has a policy to repeat the enhanced disclosure and barring service checks every three years. The review date had been recorded in these records. Four records we checked had references for the past five years of employment. The remaining four records were for staff that had been transferred from another provider as part of a contract transfer. We saw records to confirm this for these other four staff. The service did not repeat reference checks for these staff as they assessed the previous provider's vetting process and found it was in line with their own. The service did, however, repeat the disclosure and barring service checks.

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Records

- **Staff kept records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.**
- The service managed peoples' records in a way that kept people safe. The service did not use paper records. We saw staff used hand held digital tablets to recall people's records. We saw in patients' records there were notes made about extra support that may be needed or preferences the patient had asked for.
- Staff had timely and straightforward access to information that they needed to deliver safe care. The service had electronic records that contained key information that were accessible by booking staff, control room staff, and vehicle crews. We saw in these records there were tick boxes for common conditions, a section for mobility, a notes section for this journey and a notes section for the patient that would record previous issues. We saw in the four records we reviewed these were completed as expected. We also saw in one record an alert to crews that the patient was epileptic and a description of how this presented in this patient. Booking staff told us that when they record a note then there was a box to tick that alerts the crews to read the notes section.
- The service had clear process to identify and record patients that had a do not attempt cardio pulmonary resuscitation (DNACPR) order and the vehicle crew felt confident in their understanding of this process. This was recorded at the booking stage and then crews were alerted to this via their digital tablets. The crews would then ensure they had a valid DNACPR order. We reviewed an incident report that described how a patient that become unresponsive on going to leave a ward advised hospital staff of the DNACPR order.

Medicines

- The service did not hold any medicines or medical gasses apart from oxygen.
- The service stored medical gases safely. We saw "in date" cylinders of oxygen securely stored on vehicles and in purpose-built cages at the both sites. Cylinders on vehicles were positioned so the fill gauges could be

seen. Cylinders and regulators appeared to be clean (dust and oil free) and immediately usable. The medical gas cylinder storage cages were compliant with The Department of Health Technical Memorandum 02-0.

- We saw clear, marked segregation of full and empty cylinders to help prevent crews' accidentally taking an empty cylinder onto a vehicle.
- At the Gillingham depot the oxygen was stored in a small shed. It was correctly marked with suitable hazard labels. We noted eight empty cylinders next to one of the cages. A staff member told us that the oxygen delivery service driver was expected, and these would be removed. The shed was locked.
- The service had an up to date medicine policy that described the use of oxygen. We reviewed records that showed the service had an agreement with a private supplier to restock their oxygen supply when needed.

Major incident response planning

- **The service planned for emergencies and some staff understood their roles if one should happen.**
- We saw the service had a plan to support hospitals in the event of a mass casualty incident. This had been shared with control staff and the managers. This plan had not been shared with vehicle crews yet as the plan had only been made recently.
- The service had plans to allow them cope with adverse weather. We reviewed the services heat wave and cold weather business continuity plan. This had details of supplying patients and staff with water and extra blankets.
- The service had a general business continuity plan for emergencies. We review this and found it was up to date with details of how to prioritise patients by groups. This put the patient with the highest clinical need first; for example, renal patients were in the highest priority category. Both these plans included consideration to their staff welfare in these situations of extra stress.

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Are patient transport services effective?

Good



We had not inspected this service before and therefore has not been rated before. We rated it as **good** because the service had up to date policies based on national guidance. They also had an in-house induction program taught over ten days face to face. However, appraisal rates were below the services target.

Evidence-based care and treatment

- **The service provided care based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- The service had policies and guidance documents to support staff to provide evidence-based care. We reviewed their policies for; infection prevention and control, serious incidents, medicines management, do not attempt cardio pulmonary resuscitation orders, open and honest care policy, and mental capacity. These policies were up to date and based on current national guidance. These policies all clearly recorded when they were to be reviewed which ranged from yearly to three-yearly.
- The service monitored crews' adherences to guidance. We were told by managers that they did supervision of vehicle crews by coming on vehicles as observers. We were also told by crew and managers that all managers took part in "back to greens" program that involves managers going out on vehicles acting as a second crew member of double crew vehicles. This was called "back to greens" as the vehicle crews wear green uniforms. This allowed managers to keep up to date with current issues about implementing their policies.
- The service ensured that staff had access to the policies and guidance. We saw that office staff could access these on a shared drive. Vehicle crews showed us that they could access the policies and guidance via hard copies at each base station and there was also a folder on each vehicle that contained guidance information.

Response times / Patient outcomes

- **The service monitored the effectiveness of care and used the findings to improve them. They compared local results with those of other services to learn from them.**
- The service collected booking time, departure time and arrival times. This was monitored against their key performance indicators. These indicators were set by the commissioners of this service. We reviewed these and found the service had 29 indicators and of these 17 were exceeding their targets, three were not applicable and nine were below their target. The records that we reviewed showed that five of the six targets that were not meeting their targets were within 5% of the target. Details of the six targets they did not meet are below.
- The first of these targets not met were outpatient journeys booked on the day of travel. The required standard was for the service to have patients arrive on time and no more than 75 minutes prior to their appointment time. The service required two hours' notice for these journeys. The target was 80% and the service achieved 77%, although this had improved through the last 12 months.
- The second of these targets not met was outpatient journeys booked on the day of travel for time bound patients. The required standard for these patients' journeys to arrive no later than 15 minutes before their appointment. The service required two hours' notice for these journeys. The target was 80% and the service achieved 29% in February 2019. However, this had been higher during the past 12 months but not above their target.
- The third of these targets not met was patients booked in advance for discharge from hospital. The required standard was for the service to collect all patients within 75 minutes of the booked time. The target was 80% and the service achieved 76% in February 2019.
- The fourth of these targets not met was for renal patients not to spend more than 60 minutes in a vehicle. The service had a limit of 20% but was at 22%, this had increased over the past six months. Managers told us that this increase had been due to capacity in renal units causing patients to need to travel long distances for renal treatment.
- The fifth of these targets not met was for patients traveling due to a transfer of care from one hospital to

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another hospital where the destination was within Kent and Medway. The required standard was for patients to be transported within two hours of the booked ready time. The target was 80% or above but the service achieved 77%.

- The sixth of these targets not met was transfers of patients booked in advance for travel from a hospital to another hospital. The required standard was for the service to collect all patients within 75 minutes of the booked ready time. The target was 80% and the service achieved 79%.
- The last three targets not met were also related to waiting times for patient transfers from hospital to hospital. These three targets were sometimes not met and sometimes met. They were also in some months not applicable due to not having any patients that related to these targets. The target for these were 80% and the service achievement varied from 0% to 100%.
- The details of the seventeen targets that the service met. Three of these were related to arrival times of patients to outpatients' appointments. These had a target of 80% and the service achieved 84% for two and 100% for the third.
- The next target met was for patients returning from outpatients' appointments. The required standard was for all patient to be collected within 75 minutes of the booked or made ready time. The target for this was 80% and the service achieved 90%.
- The fifth target met was for patients booked on the day returning from outpatients' appointments. The required standard was for all patient to be collected within 75 minutes of the booked or made ready time with two hours' notice. The target for this was 80% and the service achieved 98%.
- The sixth and seventh targets met also related to patients returning from outpatients' appointments. The required standard for these two targets was for no more than 1% of patients to wait over 4 hours. The service had achieved 0% for these. There are two standards for this that are split into patient booked on the day and those booked in advance.
- The next two targets met related to renal patient's outpatient appointments arrival and return journeys. The standards for these were for patients to arrive on time but not more than 15 minutes before their appointment and to be collected for their return journey within 30 minutes of their booked ready time. The target for both was 80% and the service achieved 86% and 93%.
- The tenth target that was met related to patients booked on the day of travel for transfer from another hospital for outpatient appointments. The standard for this was for patients to be collected within 15 minutes of booked ready time with two hours' notice. The target was 80% and the service achieved 90%.
- The next three targets met related to patient being discharged from hospital. The first standard was to collect all patients within two hours of being booked ready. The target for this was 80% and the service achieved 80%. The other two targets had a standard of not more than 1% of patients to wait more than four hours to be collected and the service achieved 0% and 1% for these. These two targets were separated for patients booked on the day and in advance.
- The next target met was for the service to not abort or cancel journeys as the result of the services provision. The target for this was 0% and the service achieved this.
- The last three targets that were met related to time spent in the vehicles by patients. The standards for these related to distance to travel and maximum time for that distance. The target for these three was for not more than 20% of patients to exceed the times and the service achieved 1%, 3% and 4%. Although this excluded renal patient that had their own target.
- The service recorded their performance monthly and over the past 12 months there had been improvements in most of these indicators. The commissioners gave us positive feedback about the service and their culture to provide continuous improvements. However, we had also been contacted by other stakeholders with concerns about long waiting times for collection after appointments, on discharge from hospital and for transfers from one hospital to another.
- The service had satellite navigation systems in every vehicle. They had geofenced their main pick up locations. This meant that when vehicles left one of these locations the control team would be automatically notified of this. Vehicle crews when arriving or leaving any other locations had to press a

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button on their digital tablets to record their location and the time. This allowed the service to monitor their performance. This system also monitored the speed of vehicles and notified managers of any breaches of speed limits.

Competent staff

Coordination with other providers and multi-disciplinary working

- **The service made sure staff were competent for their roles.**
- The service provided appraisals for staff but completion of these was not consistent across different job roles. This varied from ambulance care assistants with 85% having completed an appraisal to managers with 87% having had an appraisal. The other job roles were between 52% and 66%. The managers and ambulance care assistants appraisal completion rate met the services target of 85% but other roles were below the services target of 85%. We were told by managers that this year they had switched to a new appraisal year only allowing them eight months to complete a year's appraisals. This was to align their appraisal year with the rest of the G4S group.
- Appraisals were used to look for positives as well as areas for development. Managers told us that staff if staff had development needs then training would be offered that was tailored for their individual needs.
- The service supported staff to improve their understanding of how to support their patients. We saw in appraisal records that the service had career development planner. Managers told us this was targeted at ambulance care assistants and allowed them to choose a pathway to structure their development.
- The service had a training program for new staff. Managers told us this was a ten-day face to face training. This included two days to cover the e-learning topics with support. The next three days were for manual handling training. They then spent one day getting familiar with vehicle checks and with the trainers they practiced using the equipment. They then completed a three-day first aid at work course. On the final day they did a day of assessments with the trainers on everything they had learnt. If new starters needed to then they could repeat the sections that they had not understood.
- If new starters were sick during this training, then they re-join the next course at the start of the section that they were sick for and then complete the remaining days. New starters would not be allowed to act as crew before completing the full ten days. The service has plans to increase this ten-day training to 15 days. After the ten-day face to face training they had a week of shadowing other crews. The service introduced a buddy system to give extra support to new starters. However, we had received concerns from patients, staff and stakeholders about the services training of new staff.
- The service had systems to support staff that worked remotely or alone. We were told by ambulance care assistants that they did at least one week of shadowing after their induction training. Managers told us about this as well and we saw records that confirmed that this had been completed. Ambulance care assistants also told us that they had supervision as part of their appraisals. This would be one of their managers coming on a journey with them to review their development needs.
- The service had a plan to improve their monitoring of adherence to training. The training manager told us that at the time of the inspection the trainers were only trained to assess staff in a simulated environment, but the plan was to train the trainers so that they could assess staff with patients. This would allow them to provide supervision for ambulance care assistants to assess their continued competence.
- The service had a system to monitor their ambulance care assistants driving licences. Licences were checked on recruitment and then repeated yearly. The fleet team carried out yearly checks of online driving licences and then any issues were reported to the depot manager. We saw in the eight staff records we reviewed diving licences checks had been completed.
- New ambulance care assistants undertook a driving training session where their driving skill would be assessed. Extra training was given if any concerns about staff driving were identified by this process or via complaints. The training manager told us that this extra training would be tailored to the needs identified.
- The service monitored their staffs' driving performance. Driving skill was monitored via a digital system that recorded aspects of driving such as; acceleration,

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breaking, collisions, and cornering speed. This system then reports driving quality to the driver's manager. Managers and crew told us this system was also used to award the best driver of the month.

- As a non-emergency service, no vehicles were fitted with blue lights or sirens so there was no requirement for emergency response driver training.
- The service coordinated with local stakeholders to provide effective care. Managers at the service and commissioners from the local clinical commissioning groups told us that they had regular meetings. These meetings were to discuss performance data, for example transport times, incident, risks and complaints.
- The service had patient transport liaison officers that were based within local hospitals. These were to help facilitate discharges and transport arrangements. Managers told us that the local trusts had found these to be helpful.
- The service had improved their handover process with healthcare professionals. There had been a recent incident that identified a lesson to be learnt about handover processes. This had been shared via the services lessons learnt leaflets. This included asking staff to record what was handed over by who and to who.
- The service used a third-party independent ambulance services to provide support on both ad-hoc and pre-planned basis, to meet its contractual obligations with the commissioners.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.**
- The service had support for staff to understand how to help patients that lacked capacity to make a decision. We looked at their mental capacity act policy that had been reviewed in April 2019. The service provided mental capacity act training for all staff and 95% of staff were up to date with this training.

- The service sought patients consent in line with national guidance. We observed three ambulance care assistants that acted inline with the service's policy when they asked patients for consent. However, we did not observe any patients that lacked capacity so were unable to see what crews would do if patient lacked capacity in practice.

Are patient transport services caring?

Good



We had not inspected this service before and therefore has not been rated before. We rated it as **good** because patient told us the crews treated them with compassion and provided support when needed.

Compassionate care

- **Staff cared for patients with compassion and kindness.**
- During our inspection, we observed patient transfers and saw that staff treated patients with dignity and respect. Staff interacted well with patients in a friendly way and with good humour. We noted that staff were always courteous and professional.
- Feedback from patients and stakeholders was positive. One staff member from the trust said the service was wonderful and the drivers were superb and worked to time. One patient said that crews went above and beyond to ensure their safety and wellbeing.
- We were not able to talk to patients on the day of inspection. However, the service provided us with telephone numbers of patients that had consented to be contacted for feedback.
- Following our inspection, we spoke to nine patients and the feedback was positive. Patients told us, and we had observed, that staff were attentive and paid due regard to their needs.
- Patients' privacy was respected at all times and crew members addressed patients in the way they wished to be addressed. Patients told us they were now used to many of the staff, and staff were polite. Staff rang patients to inform them they were on their way about 30 minutes before pickup, so they had ample time to

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prepare. However, patients told us the new staff did not always introduce themselves, although they wore their identification badges with their name and photograph on display.

- There were paper-based patient feedback questionnaires in the vehicles and in transport lounges for patients to fill out. The service carried out patient satisfaction surveys where paper questionnaires were sent to random patients each month for feedback about their experiences with the service. However, during our inspection, we saw crew did not always offer patients the feedback questionnaires. Patient satisfaction results for February 2019 showed that of the 796 patients feedback sampled, 78% would recommend the service to family and friends. Also 99% of respondents said “yes” they felt staff were friendly and helpful and offered assistance when needed.

Emotional support

- **Staff provided emotional support to patients to minimize their stress.**
- Staff understood the impact a patients’ condition, care and treatment had on their wellbeing. We saw that staff were sensitive towards patients and treated them with empathy. Staff were considerate, reassuring and patients were allowed to do things at a comfortable pace.
- Patients we spoke to told us staff took time to check on their wellbeing, in terms of discomfort and wellness. One patient told us staff always sensed when they were not feeling well. Another patient, who suffered from anxiety, also said staff seemed to sense when they were in a low mood. Patients told us staff always found a way to lift their mood and “by the end of the journey they were smiling”.
- The service supported the emotional needs of children well. When children were being transported, the service usually sent two crew members. Staff ensured children had their favourite toy for comfort. Patients were accompanied by a carer, parent or responsible adult for reassurance.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in their care and treatment.**
- Staff told us patients and relatives were given clear information over the telephone at the time of booking transportation. Patients and relatives were informed about times they would be picked up before and after their appointments by the booking team or the crew staff. Patients could discuss any concerns or raise objections at any time. Although one patient told us they were picked up too early before their appointments and they often had to wait up to one hour at the place of appointment which could be a long wait.
- Staff communicated with patients and their relatives in a way they understood. Patients were given enough time to ask questions and staff took time to explain how they were going to be transported and cared for in a calm, friendly and respectful manner. Patients could attend appointments with a carer or relative if they wished and could be accommodated safely.
- During our inspection, we saw that staff encouraged people to take part in their care and treatment. Staff were supportive of patients to manage their own health, care and wellbeing and maximise their independence but were there to help when needed.
- Staff discussed patients’ care and treatment with them and took time to address all questions and concerns, such as whether they would make their appointments on time and who would be picking them up after their appointments.
- Crews double checked to ensure that patients were fit to travel. Staff reminded patients to check they had everything they needed such as care plans, appointment letters and mobile phones. Staff ensured doors were locked and patients were in possession of their home keys before departing to ensure patients did not have cause to be distressed.

Are patient transport services responsive to people’s needs?

Good



We had not inspected this service before and therefore has not been rated before. We rated it as **good** because the

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service had staff within hospitals to assist in the patient flow. Also the service had a system to identify patients with extra needs and this alerted the crews that were assisting these patients during transport.

Service delivery to meet the needs of local people

- **Patient transport services were planned and delivered in a way that met the needs of local people.**
- Service delivery was a contractual arrangement between G4S forensics and medical services limited and Kent and Medway clinical commissioning groups (CCGs), coordinated by the NHS West Kent CCG for the commissioners.
- The main service was a non-emergency transport for patients who were unable to use public or other means of transport due to their medical condition. Patient transport services were mostly provided to patients attending hospitals, diagnostics, renal and outpatient clinics and those being discharged from hospital wards. The service was also commissioned to transfer mental health patients between inpatient services across Kent and Medway, where such transfers posed no significant risk to the service and crew. Risk level was assessed by booking clinicians along with the call handler going through a mental health pathway to determine if the patient could travel with them.
- The service had a booking system for patients attending medical appointments. The majority of patient transport bookings were pre-planned and in some cases the service scheduled patient transport on “ad hoc” on the day services to meet the needs of patients. On the day, bookings were responded to quickly via telephone. We observed effective communication between a manager and a crew member as part of service planning.
- All patient transport bookings were coordinated by managers throughout the day. The service operated a 24-hour, seven days a week service to meet the needs of people who needed transport. Crew staff worked individual rotas and rotas were planned to ensure there was cover at all times. Staff were not forced to work outside of their planned hours.

- The service monitored their call handling. We reviewed records that showed waiting times on calling to book a journey had improved over the last 12 months.

Meeting people's individual needs

- **The service took account of peoples' individual needs.**
- Staff had completed an equality and diversity and dementia awareness course as part of their mandatory training every year. Staff we spoke with had a sound understanding of the cultural, social and religious needs of patients, and staff practiced this in their work.
- Patient's condition and individual needs were identified at the booking stage for transportation. The service used a flagging system to identify patients with complex needs such as people living with dementia, learning disability and those with a physical disability. The service also had staff attached to each trust known as patient transport liaison officers (PTLO) who assessed and identified patients with complex needs. The service made all reasonable adjustments to accommodate and transport patients such as providing a mobility assistive equipment like wheelchairs or ensured patients had an escort.
- Crew staff were made aware of patients with complex needs including those living with dementia, learning disability and mobility difficulties via a booking form and on a handheld electronic device. Staff ensured patients who had a package of care were not left at home on their own without being safe, supported and cared for.
- Patients who had out-of-area and long-distance appointments were well cared for. Crews stopped at services to allow them to stretch their legs and to get refreshments. Patients told us that staff always asked if they would like a five-minute toilet break throughout the journey.
- Crew staff sought consent from patients before carrying out any manual handling. Patients were moved with consideration to the outside temperature and staff ensured patients were comfortable. Staff ensured patients wore adequate clothing, vehicle heating was turned on and patients were offered blankets when they felt cold during transfers. Patients told us staff turned on the air conditioning during hot summer months.

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- All ambulance vehicles we inspected were wheelchair accessible with ramps. There were carry chairs and stretchers available to help patients who had mobility problems or walking difficulties.
- The service had bariatric trolleys which were used to safely transport patients with body weights of up to 300kgs and could accommodate their associated body mass.
- Patients whose first language was not English were encouraged to bring a friend or relative who could act as an interpreter for basic communication. In cases where this was not possible or appropriate due to the nature of the conversation, the service had a contract with an external interpreting and translation service who could provide verbal translation in 257 languages. The service also provided patients with written material in different languages as needed. These included picture cards for simple communication of patient needs and feelings like pain, toilet, and happy.
- The service ensured that children and young people were always transported by at least two members of crew staff. Children were always escorted by a carer or a parent, and staff ensured they were safe and comfortable at all times.
- The ambulance service did not transport deceased patients. However, the service had a care pathway for patients who were an end of life transfer with significant risk of an unplanned death. As part of the pathway, the booking team ensured they captured the do not attempt cardiopulmonary resuscitation (DNACPR) and all related requirements. All spiritual, cultural and religious needs of the patients were discussed before commencement of their journey. Ambulance staff were made aware of the information via their handheld device, and staff told us they respected and made all attempts to fulfil patients' wishes.

Access and flow

- **Patients had timely access to care and treatment.**
- The service had a contractual key performance indicator (KPI) with the Kent and Medway clinical commissioning groups (CCGs). The service had regular meetings with the commissioners to discuss their performance. Performance results from April 2018 to February 2019 indicated that the service mostly met its targets.

However, outpatients' arrivals for journeys booked on the day were below the target. For more detail on the service performance against these targets see the above section "patient outcomes/response times".

- The service was designed to ensure patients had timely access to care and treatment and to increase flow. The patient transport service operated a 24-hour, seven days a week service at four of their stations. Four of the other five stations operated a twenty-four-hour service Monday to Friday, and one station operated from 6am to 8pm.
- All journey times were calculated at the time of booking, and patients were given an appointment time. The service ensured that at the time of booking, they had the resources to complete all patient journeys, such as the correct number of staff, type of vehicle and equipment to avoid delays.
- Potential delays were discussed with patients, carers and hospital staff by telephone. When there was a delay or cancellation due to unforeseen circumstances such as an accident or vehicle breakdown, other crew teams were quickly redeployed to complete the journeys. Staff told us base team and managers were also available to carry out patient transport journeys when needed.
- There was a patient transport liaison officer (PTLO), employed by the provider, at the host trust to facilitate communication between the hospital and crew staff. The PTLO ensured crews had the right equipment and vehicle, which helped reduce delays and expedite patient discharges from hospitals.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**
- The service had a complaints policy which was developed using the NHS complaints procedure and was easily accessible to all staff.
- Complaints were acknowledged within three working days and responded to within 25 working days. Complaints were acknowledged, investigated and responded to by a complaint resolution officer (CRO) with support from administrative staff.

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- Operational managers and the clinical governance team reviewed all complaints. Themes and trends, and lessons learnt from the complaint were discussed at the local and central senior management team meetings monthly. Lessons learned were sent to all staff via a weekly newsletter. We saw information about outcomes of complaints investigation and lessons learnt on display at the ambulance sites we visited. We spoke to staff that had seen these displayed.
- There were patient feedback forms available in the vehicles with information on how to make a complaint. Patients made a complaint by contacting the complaint team on telephone or they could make a complaint on the website. The service carried out a patient survey to determine if patients knew how to make a complaint. Results for February 2019 indicated that of the 711 patients who completed the survey, 77.5% of them knew how to make a complaint.
- The service had received 132 complaints between December 2018 and February 2019. The main themes of the complaints were long wait for transport and missed appointments. The service had a system that monitored vehicles that were going to be late and had controller phone clinics to try and arrange for patients to still be seen.
- We reviewed five patients' complaints and saw that responses were provided in a timely way, were clear and the process was thorough. Although the service did not have data to show how many complaints were upheld or not upheld, there was learning from complaints which led to a change in practice. For example, following previous complaints about call handling times, the service had separated the call centres to streamline and improve the service. We were made aware of a high-profile complaint. The service quickly provided an apology to the patient and acted to protect patient safety. The service also started an investigation into the incident.

Are patient transport services well-led?

Requires improvement



We had not inspected this service before and therefore has not been rated before. We rated it as **requires**

improvement because some staff told us they did not feel supported by their managers. Also, we found the service had a procedure relating to concerns of abuse or risk of abuse that was not fit for purpose. However, the service had oversight of their risks and sought out improvements.

Leadership of service

- **The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.**
- A managing director was the strategic lead for this service they were also the registered manager. They reported to an executive management for the region within the wider company. The service also has a nominated individual that led on quality improvement and compliance. At the time of the inspection the nominated individual was on extended leave. The service had identified another member of staff to fill this role in their absence.
- The service had a senior management team that ran the patient transport services. This was led by the managing director. The service had a governance team to maintain and manage improvement to the service which reported to the senior management team.
- The day to day operations were run by two general managers who each managed half of the service. Each of these managers was supported by an operations manager. They then each had several depot managers. These depot managers were responsible for managing the patient facing staff. The patient facing staff included ambulance care assistants and senior ambulance care assistants.
- Most leaders were visible and approachable. We were told by most staff that they felt supported by their line manager but that they did not often see the senior leadership team. There were also some staff that told us they did not feel supported by any managers.
- The service had a program to develop junior managers to give them skills to progress. We heard from three junior managers that were being supported through an advanced management course. This course included training on the wider operations within the G4S group.

Vision and strategy for this service

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- **The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff. However, patients were not included in the development of this vision and strategy.**
- The services vision was to provide a safe, caring, specialist transport service which actively supported those in their care. They aimed to achieve this through a multi-skilled workforce using up to date technology to be effective in supporting people with complex requirements. We saw posters with this vision displayed in depots.
- Managers we spoke with were able to explain the services vision. The patient facing staff we interviewed could explain the principles of the vision to provide good care however, they could not recall the service's vision.
- The service had a strategy to focus on delivering the basics to support patient centred care. Alongside this their strategy was to invest in growth which included improving efficiency and care.
- We saw the service had plans to expand to cover other areas of specialist transport. Managers told us they were working with vehicle provider to develop new vehicles customised for this new area of transport.

Culture within the service

- **Most managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Most staff felt supported valued and respected by their managers. Nine staff we interviewed told us they were supported and valued by their line managers. We heard about a staff member being supported by their manager with an emotional situation. However, some staff reported not feeling they could talk openly to their line manager.
- The service had a system to report issues without talking to their line manager. This was called the speak out program. This was an independent and confidential whistleblowing system. However, we heard from two staff that felt they had no way to report their concerns.
- Call centre staff told us that they felt well supported by their managers. They reported seeing their head of

support services regularly. They also reported that the managing director had visited to talk to staff last month which they appreciated as they were on the other side of the country and this made them feel included in the service.

- Staff felt proud to work for the service. All managers and staff we spoke with told us that they felt proud to work for the service as they were helping people every day. One ambulance care assistant reported that they had retired but wanted to do something to help people so joined the service. Another ambulance care assistant told us that they enjoyed helping their patients get to their appointments as some of them felt isolated so enjoy the conversation.
- Staff were passionate about their roles and were dedicated in providing excellent care to patients. Staff told us the highlight of their day was getting patients to their appointments and back in good time and seeing the smiles on their faces.

Governance

- **The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in care would flourish. However, not all their procedures supported this high standard.**
- The service had clear governance processes overseen by the managing director. At the time of the inspection the head of governance was on extended leave, so the service had appointed an interim head of governance for this period.
- The service had a clear governance structure and staff understood who investigated incidents. We saw posters in staff rooms that displayed lessons learnt from incidents. Managers told us that the member of staff that had reported an incident would also receive feedback about the incident. However, some staff told us they did not receive this feedback.
- The service had systems to monitor the quality of their subcontractors. Managers told us that they performed audits on their subcontractors to hold these providers to the quality and principles of G4S Patient Transport Services - Kent & Medway (G4S). These audits included areas such as checking staff files, training records,

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policies, CQC certificate of registration, cleaning procedures, clinical waste systems, vehicle maintenance, and driving license checks. These audits are completed twice a year.

- The service subcontracted services to six providers. We reviewed five audits for these providers covering the areas listed above and showed that they were compliant with the standards that G4S set for them. They included a judgement about each question that was required to be answered and the evidence that supports this judgement. For example, staff training has recorded that five staff file were checked for certificates and attached to the audit file is the providers training log. The sixth service was a taxis service that is out of scope of regulated activity, but they did audit staff files at this service and set standards for training required. This training required included; basic first aid, infection control, patient dignity, care and safety, manual handling, equality and diversity, safeguarding adults' level 2, and confidentiality and data protection. We also reviewed one audit of a service that did not meet G4S standards, so the audit was stopped, and the subcontract was withdrawn from this service.
- The service had a governance and procurement team. We reviewed this teams standard operating procedures that list the areas they required to be covered in the audit before work could be subcontracted to these services. This included CQC registration number, confirmation of disclosure and barring service checks, vehicle age inline with G4S policy, date and summary of last CQC inspection, any improvements recommended by CQC and actions taken to address these and a completed audit of the service.
- We reviewed two sets of senior management meeting minutes and these included discussion on risks, incidents, safeguarding and improvements. These meetings occurred once a month.
- The service had audit programs that were carried out each year. The services governance team carried out yearly CQC style audits once a year for each site. They also completed health and safety audits yearly for each site. We found the service were not sending notifications of safeguarding incidents in line with legal requirements.

- We found that the service had a procedure for staff to follow when dealing with incidents relating to abuse or risk of abuse relating to their regulated activity. We found that staff followed the service's procedure for reporting incidents relating to abuse of risk of abuse but that five incidents that should have been reported to CQC were not. The service's procedure did not help staff identify when incidents should be reported to CQC. We alerted the service to this and they immediately reviewed their practice and started a retrospective review of their incidents log against their updated procedure.

Management of risk, issues and performance

- **The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**
- The service has a corporate risk register and local risk registers for sites. We reviewed one corporate risk register and two local risk registers. These risks, mitigating actions taken, a plan for reducing each risk and who was responsible for these actions.

Information Management

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- The service had integrated computer-based business management systems to support the business and operations. These systems were setup with individual password protected access for each person which allowed access to systems they needed to fulfil their role. This also allowed the service to restrict access to systems people did not need. They had an information security system to protect all private and confidential data. This included password protection on staff's digital tablets.
- The service used information technology systems to monitor and improve the quality of care. The service used a secure system to store patient information. This system was updated live so as soon as call handlers recorded information crews could assess this. The service also had a system to record the movements of their vehicles, so they could audit performance and look for areas to improve efficiency.

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- The service has clear and robust performance measures which were reported on monthly. Some of these were set by their commissioners but others were set by their managers. For example, we saw records showing managers were monitoring sickness rates were working on ways to improve them.

Public and staff engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage services, and collaborated with partner organisations effectively.**
- The service engaged with patients that used their service and those close to them. The service carried out patient feedback surveys which were offered to patients with every journey. The service used the results of these surveys to produce monthly reports. We reviewed two of these reports. In these reports' trends were highlighted and negative feedback quotes were recorded. These reports were reviewed by the service's managers.
- The service held engagement meetings with renal patients. Managers told us they had received feedback from these patients that they did not wish to fill in a journey feedback survey for every journey as they travel six times a week with the service. The service had their relationship manager attend the renal units in person to receive feedback from these patients. We reviewed records that showed they had spoken with 136 patients to gain their feedback. From this they picked up a trend that patients felt the vehicles were uncomfortable, so the service has worked with their vehicle provider to improve the comfort in the vehicles.
- The service carried out a yearly global staff survey. The results are reviewed for trends. The service also had a local staff health and wellbeing survey that was completed yearly. This showed that there had been an improvement in staff saying the service takes action to support their wellbeing; in 2017 this was 19% but in the 2018 this was 79%. This local survey also identified that 37% of staff report that they had felt unwell due to stress in the past 12 months. The service had produced a mental health awareness guidebook and leaflet for tips to reduce stress.
- The service produced a monthly staff newsletter. We reviewed a staff newsletter that included; congratulations to the employee of the month, issues

that had been reported by staff and what had been done about these, and information about staff engagement days. One of these incidents related to crews being able to refuse to accept patient that are unsuitable for the transport that was booked for them. The leaflet reminded staff that they are to risk assess each patient and the service support them in their decision to refuse when needed. The staff engagement meetings were advertised to alert staff when there will be one at their site. There was a reminder about the G4S global employee engagement survey. However, two staff reported that at their site a suggestion box had been removed with an explanation from their managers.

- The service had counselling and stress support service available to all staff.
- The service had awards for employee of the month, employee of the year and best driver of the month. Employees that were given these awards were given a gift and any staff nominated for these awards were invited to a gala dinner. Staff could be nominated for these awards by managers or their colleagues.
- The service had meetings with their commissioners. We received positive feedback from the services commissioners about the services focus on improvements. They also highlighted that the service had improved over the past year increasing their engagement with the commissioners and driving improvements in some of their performance indicators beyond the targets.
- We received positive feedback from some other stakeholders reporting that the service had increased their engagement with them over the past year. However, we also received negative feedback from some stakeholders saying the service did not always attend engagement meeting they had agreed to attend.

Innovation, improvement and sustainability

- **The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.**
- The service has introduced a new geofencing system to notify the control room when a vehicle arrives or leaves one of the large hospitals in the region. This reduced the input needed from the vehicle crews. The fleet team

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were also looking at a way to make the system automatically identify when vehicles arrive at patients' addresses and smaller sites that were not included in this system.

- The service had a trial running of a new way to complete the vehicle checks. This system monitored the crew's performance while they input the checks that were needed. This included using the sensors in the digital tablet when checking a vehicle's tyre treads to ensure that the crew were moving around the vehicle.
- The fleet team had improved their defect reporting system. This now allowed crews to take pictures of defects in vehicles to be added to the report. This allowed the subcontractor that carried out repairs to more accurately assess the repair needed. This in turn allowed them to send out staff suitable for the repair with the correct equipment more efficiently.
- The service had identified that for their renal patients that travelled with them six times a week may not want to complete a journey feedback form for each journey. The service had introduced a patient relationship manager that goes out to renal units to gather feedback from these patients in person.
- The service reviewed feedback from patients asking to be able to travel in their own wheelchairs. This was not possible at that time. The service had then worked with their vehicle provider to modify new vehicles to have restraints to allow patients to safely travel in their own wheelchairs.
- The service had introduced the role of patient transport liaison officer. These staff were based in large hospitals and performed extra checks to make sure that the control room had correct information so that the crew and vehicle sent to transport the patient was suitable. These staff also went to wards to identify patients that could be transported home earlier in the day to reduce the peak in demand for transport at the end of the day.

Outstanding practice and areas for improvement

Outstanding practice

- The service was running a trial of a new vehicle checking application. This used the crews' digital tablet to record the information and ensure adherences to the guidance. For example, crews had to take a photo after cleaning had been done to show the result.
- We saw records from when staff had been in difficult and distressing situations but still identified signs of abuse and reported their concerns.
- Incident investigation was completed in a positive way by managers looking for improvement not to blame staff. Then learning was shared via leaflets produced for staff.
- Patients gave positive feedback about the way staff went above and beyond to care for them.

Areas for improvement

Action the hospital **MUST** take to improve

- The provider must take prompt action to address concern identified during the inspection in relation to the governance of the service. The service must ensure that all required statutory notification to CQC are completed.

Action the hospital **SHOULD** take to improve

- The service should check understanding of when staff can raise a safeguarding concern without consent from the individual.
- The service should take action to improve the facilities at their Gillingham site.
- The service should improve their appraisal rates.
- The service should give all staff feedback about incidents they report.
- The service should remind all their staff of the importance of introducing themselves to patients and check this.
- The service should offer all patients a satisfaction survey.
- The service should improve the way they share the service's vision with staff.
- The service should consider how its managers could be more approachable and reassure staff they can approach them for support.
- The service should consider how all staff can provide feedback about the service.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>17.- (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.</p> <p>(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to — (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (d) maintain securely such other records as are necessary to be kept in relation to— (ii) the management of the regulated activity;</p> <p>The service had a procedure for staff to follow when dealing with incidents relating to abuse or risk of abuse relating to the regulated activity. This did not ensure notifications for all incidents that should be notified to CQC were completed.</p> <p>Regulation 17 (1)(2)(b)(d)(ii)</p>