Ambulance Services 24 Ltd

Thruxton Industrial Estate

Inspection report

Unit 12A Thruxton Industrial estate
Thruxton
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated it as requires improvement because:

- Staff did not keep accurate patient records.
- Staff did not always store and manage medicines safely. Storage of medical gases did not ensure the safety of people. There were out of date medicines in kitbags and in the medicine cupboard.
- The service could not demonstrate they always controlled infection risks and cleaned vehicles and equipment.
- Not all equipment was calibrated to ensure it was working effectively.
- Leaders did not use systems to manage performance and quality effectively. Policies did not always reflect the service provided.

However,

- The service had enough staff to care for patients and keep them safe. Most staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed incidents well and learned lessons from them.
- Staff provided good care. Managers took action to make sure staff were competent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs.
- The service planned care to meet the needs of local people and made it easy for people to give feedback.
- Leaders supported staff to develop their skills. The service had a vision and there was a strategy to realise the vision. The service had process for patients and clients to engage with them. Leaders demonstrated a commitment to improving the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Requires Improvement 	We rated it as requires improvement because: • Staff did not keep accurate patient records. • Storage of medical gases did not ensure the safety of people. • The service could not demonstrate they always controlled infection risks and cleaned vehicles and equipment. • Not all equipment was calibrated to ensure it was working effectively. • Leaders did not use systems to manage performance and quality effectively. Policies did not always reflect the service provided. However, • The service had enough staff to care for patients and keep them safe. Most staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed incidents well and learned lessons from them. • Staff provided good care and supported patients' drink requirements during patient journeys. Managers took action to make sure staff were competent. • Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. • The service planned care to meet the needs of local people and made it easy for people to give feedback. • Leaders supported staff to develop their skills. The service had a vision and there was a strategy to realise the vision. The service had process for patients and clients to engage with them. Leaders demonstrated a commitment to improving the service. We rated this service as requires improvement good because safety and leadership required improvement. Effective and responsive were good and there was insufficient evidence to rate caring.

Summary of findings

Emergency and urgent care

Requires Improvement

We rated it as requires improvement because:

- Storage of medical gases did not ensure the safety of people. There were out of date medicines in the medicine bags and the monitoring process failed to identify this.
- The service could not demonstrate they always controlled infection risks and cleaned vehicles and equipment.
- Not all equipment was calibrated to ensure it was working effectively.
- Leaders did not use systems to manage performance and quality effectively. Policies did not always reflect the service provided.

However,

- The service had enough staff to care for patients and keep them safe. Most staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed incidents well and learned lessons from them.
- Staff provided good care. Managers took action to make sure staff were competent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs.
- The service planned care to meet the needs of local people and made it easy for people to give feedback.
- Leaders supported staff to develop their skills. The service had a vision and there was a strategy to realise the vision. The service had process for patients and clients to engage with them. Leaders demonstrated a commitment to improving the service.

Emergency and urgent care is a small proportion of hospital activity. The main service was patient transport services. Where arrangements were the same, we have reported findings in the patient transport service section.
We rated this service as requires improvement good because safety and leadership required improvement. Effective and responsive were good and there was insufficient evidence to rate caring.

Summary of findings

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Summary of this inspection

Background to Thruxton Industrial Estate

Thruxton Industrial Estate is operated by Ambulance Services 24 Ltd. It is an independent ambulance service based in Andover, Hampshire.

The provider was registered with CQC on 19 February 2021 to carry out the regulated activities transport, triage and medical advice remotely and treatment of disease, disorder and injury form the location Thruxton Industrial Estate.

The service carried out patient transport services for a local NHS ambulance trust which included a dedicated patient transport ambulance for a local acute NHS trust to support the discharge of patients from hospital. The service also carried out some event work, which included transporting patients from event sites to local acute NHS hospitals if needed.

At time of the inspection the registered manager had left employment with the service in November 2021 but had not yet applied to cancel their registration with CQC. The service had, however, appointed a new manager, who had applied to CQC to be the registered manager.

The main service provided by this ambulance service was patient transport services. Where our findings on patient transport services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the patient transport service.

This was the first time the service had been inspected since registration in February 2021.

How we carried out this inspection

We carried out this short notice inspection using our comprehensive inspection methodology on 7 April 2022.

During the inspection process we:

- Looked at the quality of the environment; this included the office, staff kitchen, storage areas, and service vehicles. We interviewed the leaders of the service, reviewed patient and staff records and reviewed a variety of policies and policies. Ambulance crew staff were not available to speak with during the inspection.

The inspection team consisted of a CQC inspector and a specialist advisor with expertise in patient transport services.

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

Areas for improvement

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

Action the service MUST take to improve:

Summary of this inspection

Patient Transport Services

- The service must ensure that patient records are accurate. Regulation 17(2)
- The service must ensure the medical gases are stored safely, in line with national guidance and pose no health and safety risks. Regulation 12(2)
- The service must ensure governance processes provide assurance about the quality and performance of the service. Regulation 17(2)
- The service must ensure policies accurately reflect the service provided and current national guidance. Regulation 17(2)

Emergency and Urgent Care

- The service must ensure the medical gas storage area is in line with national guidance and does not pose a risk of harm to people. Regulation 12(2)
- The service must ensure all medicines are in date. Regulation 12(2)
- The service must ensure governance processes provide assurance about the quality and performance of the service. Regulation 17(2)
- The service must ensure policies accurately reflect the service provided. Regulation 17(2)

Action the service SHOULD take to improve:

Patient Transport Services

- The service should ensure that blood sugar monitoring devices are calibrated. Regulation 12(2)
- The service should ensure clinical waste is removed from ambulances at the end of staff shifts. Regulation 12(2)
- The service should consider providing training about learning disability and autism awareness for staff.
- The service should consider driving safety assessments for all staff who drive company vehicles.
- The service should consider continuing with their plans to introduce appraisals and supervision for staff.
- The service should consider using established translation systems and avoid using family members of patients as interpreters.

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- The service should consider continuing with their plans to introduce appraisals and supervision for staff.
- The service should consider not using family members of patients as interpreters.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires Improvement	Good	Insufficient evidence to rate	Good	Requires Improvement	Requires Improvement
Emergency and urgent care	Requires Improvement	Good	Insufficient evidence to rate	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Insufficient evidence to rate	Good	Requires Improvement	Requires Improvement

Requires Improvement

Patient transport services

Safe	Requires Improvement
Effective	Good
Caring	Insufficient evidence to rate
Responsive	Good
Well-led	Requires Improvement

Are Patient transport services safe?

Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff and monitored completion of mandatory training.

Most staff received and kept up to date with their mandatory training. Records showed most staff employed by the service were up to date with mandatory training. Some staff were recently appointed and still progressing through the training. Out of 31 staff who worked for the service and not newly employed, 25 had completed all elements of their mandatory training. The manager monitored training, alerted staff when they needed to update training and took relevant action when staff did not complete their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. The manager had developed a mandatory programme that had over 20 subjects. This included privacy and dignity, lone working, information governance, health and safety, moving and handling and fire safety.

Clinical staff completed training on recognising and responding to patients with mental health needs. Records showed that as part of mandatory training all staff were required to and most did complete training about dementia awareness, mental health act and conflict resolution. However, there was no evidence that staff completed training about learning disabilities or autism.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Records showed all staff completed level three safeguarding vulnerable adults training. Records showed all staff completed level three safeguarding children training. This met national guidance.

Requires Improvement

Patient transport services

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had an Adult safeguarding policy and a Children safeguarding policy which set out types of abuse and how they may be recognised. Staff had access to the policy electronically. The manager and director of the service demonstrated in conversation they understood how to identify people at risk of or being subject to abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding lead who staff reported safeguarding concerns to. The safeguarding lead coordinated safeguarding alerts to the local authority safeguarding teams. To aid timely referrals the service had contact details for the different local authority safeguarding teams in the areas they predominately worked in. Staff used the NHS ambulance trust's safeguarding processes when carrying out work for the NHS.

Cleanliness, infection control and hygiene

The service could not demonstrate they always controlled infection risks and routinely cleaned vehicles and equipment. Staff used equipment and control measures to protect patients, themselves and others from infection.

Most areas were clean and had suitable furnishings which were clean. The ambulance base was visibly clean, as were the fixtures and fittings. Our inspection of two ambulances showed the vehicle and fixtures and fitting were visually clean and free from dust. However, on one ambulance there was a used clinical waste bag that had not been disposed of. We escalated this to the manager who immediately removed the clinical waste bag and disposed of it in the designated clinical waste bin. Review of end of shift vehicle check forms identified there was no prompt for to remind staff to remove clinical waste from the vehicle.

The service could not demonstrate staff always cleaned equipment after patient contact. Staff entries on patient record forms could not demonstrate equipment in the ambulance was cleaned between each patient transfer.

Cleaning schedules for the ambulances were displayed in the ambulances. The schedule detailed what cleaning staff needed to complete between each patient journey and what cleaning they needed to complete at the end of their shift. Staff recorded completion of cleaning at the end of each shift. The service deep cleaned ambulances every six weeks, using a process, cleaning equipment and chemicals as recommended by a specialist cleaning company. The service was waiting for the delivery of specialist equipment to enable them to monitor the effectiveness of deep cleaning by swabbing the fixtures and fittings of the vehicle before and after the deep clean.

Leaders said staff followed infection control principles including the use of personal protective equipment (PPE). There was appropriate supply of PPE, including face masks to reduce the risk of transmission of COVID-19, at the ambulance base and on the vehicles we inspected. All staff were required to complete training about infection prevention and control as part of their mandatory training. Numbers of staff in each room at the ambulance base were limited to reduce the risk of transmission of COVID-19. The service carried out hand hygiene audits. These showed all staff washed their hands according to national guidance.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and most equipment kept people safe. Most staff managed clinical waste well.

The design of the environment met the needs of the service. There were dedicated areas inside the ambulance base for maintenance of vehicles, storage of equipment, storage of medicines, cleaning equipment and administrative areas.

Requires Improvement

Patient transport services

The outside areas of the ambulance base were monitored with security cameras. All keys for service vehicles were stored in a lockable wall mounted box. Equipment was accessible on the ambulances; cupboards were labelled to identify the equipment in them.

Staff carried out daily safety checks of specialist equipment. Records demonstrated that staff checked equipment on the ambulances was in working order at the beginning of each shift.

The service had enough suitable equipment to help them to safely care for patients. Vehicles contained emergency equipment including defibrillation equipment and manual handling aids. All equipment we saw was labelled to show it had been appropriately serviced and electrical testing undertaken.

However, the service could not demonstrate blood sugar monitoring equipment was working effectivity as they did not follow a process to calibrate the equipment.

Most staff disposed of clinical waste safely. Staff disposed of most clinical waste hospital sites. For clinical waste not disposed of at hospital sites, the ambulance base had a designated bin for the disposal of clinical waste, and these were locked. There was a contract for the regular removal of clinical waste by a third party.

Assessing and responding to patient risk

Staff followed guidance to identify and quickly respond to deterioration in patients' health.

Staff followed guidance to respond promptly to any sudden deterioration in a patient's health. Although the service did not have deteriorating patient policy, it did have a clinical memorandum accessible to staff about the identification and management of the deteriorating patient. This gave guidance to staff about what they needed to do in the event of patient deteriorating during transportation. When carrying out work for the NHS ambulance trust, staff were required to follow the trust's processes for managing a deteriorating patient, which involved requesting an emergency ambulance.

For both the NHS ambulance trust work and the acute hospital trust work, patients were screened and assessed by the NHS ambulance trust or the acute hospital trust prior to being allocated to Thruxton Industrial Estate ambulance staff.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers gave staff a full induction.

The service had enough staff to keep patients safe in line with service agreements. Staff who worked for the service on a part time or self-employed basis notified the service of their availability in a timely manner. Shifts were allocated according to the availability of staff and the required skill mix for the work carried out.

Managers made sure all staff had a full induction and understood the service. Records showed that all staff, including self-employed staff who worked for the service, had full recruitment checks completed on them and completed a full induction into the service.

Records

Staff kept some records of patients' care, but these were not always accurate. Records were stored securely.

Requires Improvement

Patient transport services

Patient notes were not always accurate. Of six patent records forms for patient transport we looked at, all had times recorded that could not have been accurate. All records detailed the time the crew was dispatched, arrived at pick up, and left with patient as being the same time. This did not allow for handover of the patient at the point of pick up, time to transfer the patient from the ward to the ambulance and no time to settle the patient for the journey.

All six records also detailed the time the ambulance crew finished taking the patient to their destination and time they were available for their next patient as the same time. This did not demonstrate the time to clean the ambulance between patients, despite the record detailing staff did clean the ambulance between patients. This evidence indicated the times recorded on the patient record forms was not accurate.

When the service undertook patient transport work on behalf of the NHS ambulance trust, they received all patient information on handheld devices, these were secure and when a job was completed the information would be removed automatically. This helped keep patient information secure.

We looked at one record for a patient conveyed from an event site to an acute NHS hospital. The record was detailed and had clear descriptions of the assessments, care and treatment provided to the patient.

Records were stored securely. Records were stored electronically, and password protected or in paper format in a locked safe.

Medicines

The service did not always follow best practice when administering, recording and storing medicines. Staff did not always store and manage all medicines safely.

The medical gas storage area was located outside and attached to the ambulance base. Following national guidance, used and unused medical gas cylinders were stored separately. However, the environment adjacent to where the medical gas cylinders were stored in posed a risk to people in the area. There was a metal fuel container standing next to the storage area and a fire extinguisher lying on the floor in front of the storage area. The manager did not know why either were there, who the items belonged to or what was in the metal container. Access to the medical gas storage area was cluttered and posed a trip hazard to staff accessing the area. We escalated our concerns about the medical gas storage area to the manager, who took action to remove the metal fuel container and the fire extinguisher and improve safe access to the storage area.

Incidents

The service managed incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff had access to the incident management policy to guide them through the incident reporting process. This included what type of incidents to report, including near misses.

Staff understood the duty of candour. The service had a duty of candour policy that guided staff to be open and transparent and give patients and families a full explanation if things went wrong. However, since registration of the service there had been no incidents that the service had assessed as meeting the duty of candour threshold.

Requires Improvement

Patient transport services

Managers investigated incidents thoroughly. Records showed incidents were investigated and actions taken to reduce the likelihood of similar incidents reoccurring.

Staff received feedback from investigation of incidents. The manager and director shared findings and learning from incidents through conversations and email correspondence with staff.

There was evidence that changes had been made as a result of feedback. This included process to ensure patients with mental health problems were not assigned to the patient transport crew for transportation and process to enable ambulance crew to decline transporting patients who they felt they did not have the skills to convey safely. This was following an incident with a patient who had mental health issues.

Are Patient transport services effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. The service had 47 policies and procedures to support staff on the delivery of the service. Policies and procedures mainly reflected current national guidance and legislation.

However, the Dignity and Respect policy referenced current legislation of the Equality Act 2010, but also quoted legislation that has been superseded. In addition, five policies referenced staff titles of staff groups that did not exist in this service.

Staff protected the rights of patients subject to the Mental Health Act 1993 and followed the Code of Practice. The service did not convey patients detained under the Mental Health Act. However, all staff were required to complete training about the act to give them an awareness of patients' rights.

Nutrition and hydration

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

The service undertook transfers and discharges within the local area. Vehicles were stocked with bottles of water for patients.

Response times

The service recorded some response times, but did not monitor or review them.

There was limited opportunity for the service to monitor response times. The service did record response times for their work carried out for an NHS ambulance trust, although this was not reviewed and there were no key performance indicators to measure against. However, there was a process recently introduced to meet with the trust to review performance, including response times. This was a new agreement and the first meeting had not yet taken place.

Requires Improvement

Patient transport services

Leaders told us they had not received any concerns from the NHS ambulance service or hospital about response and transfer times since they had started carrying out work for them.

The service carried out very few conveyances from events. Response times were recorded on the patient record form, but these were not assessed against any key performance indicators and there was insufficient activity to give a picture of response times.

Competent staff

The service took some action to make sure staff were competent for their roles. The service had a process to appraise staff's work and performance to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had a recruitment process to ensure all staff who worked for the service had the right skills, experience, qualificators and knowledge. records showed the recruitment process was followed. The recruitment process included checking staff against their relevant professional governing bodies, such as the Health Care Professions Council (HCPC).

Staff were required to maintain a valid UK driving licence with no more than six penalty points. The registered manager documented this check during the recruitment process. Staff driving licenses were checked every six months.

At the time of the inspection leaders did not routinely carry out safe driving checks on all staff. Driving assessments were only carried out if concerns were identified about a member of staff's driving. However, the manager was in the process of recruiting a member of staff with the relevant qualifications to instruct and assess staff driving.

Managers gave all new staff a full induction tailored to their role before they started work. The recruitment process included an induction process. Records showed all staff completed the induction process before carrying out any work for the service.

The service had a process to supported staff to develop through yearly, constructive appraisals of their work. However, at the time of inspection no staff had undergone an appraisal. This was because staff had only recently transferred to being permanent employees and subject to the appraisal process.

At the time of the inspection staff did not receive any clinical supervision of their work. The manager had identified this as a gap in the management and development of their staff and was considering ways to introduce supervision and development of staff. [WJ3]

The manager demonstrated in conversation a commitment to developing staff. They described how they supported staff with informal development such as providing relevant clinical resources for staff to read. They described a commitment to developing staff into mentors and educators to support staff supervision and development across the service.

Managers made sure staff received any specialist training for their role. Records showed all staff completed non-emergency transport service (NEPTS) training. Records showed all staff completed first response emergency care (FREC) level 3 training and the manager expressed a commitment to support staff complete FREC level 4 training.

Managers identified poor staff performance promptly and supported staff to improve. The service had a capabilities and qualification policy. The manager described an example where he had supported staff who were not performing to the required standard to identify the cause and supported them to improve.

Requires Improvement

Patient transport services

Multidisciplinary working

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

The service coordinated all transport journeys with NHS hospital or ambulance service which used their patient transport service. They described how they had worked with the NHS ambulance trust to determine how many ambulances they could provide to the ambulance trust each day. Leaders explained how they had liaised with the NHS hospital bed managers to ensure only patients that staff had the skills to support were allocated to them for transport

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff had guidance about gaining consent and the Mental Capacity Act through in date policies and mandatory training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Leaders described that staff sought verbal consent from patients before transporting them

The service did not transport patients subject to the Mental Health Act 1983.

Are Patient transport services caring?

Insufficient evidence to rate

Compassionate care

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

Although we were not able to observe any activity during the inspection, review of client and patient feedback demonstrated staff took time to interact with patients and those close to them in a respectful and considerate way.

Leaders described how they treated patients with kindness in a friendly way. Examples were given of how privacy and dignity were maintained when caring for and transporting patients.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Although we were not able to observe any activity during the inspection, review of client and patient feedback demonstrated that staff supported patients with their emotional needs. This included comments about how staff demonstrated empathy and thought about the patient experience.

Requires Improvement

Patient transport services

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and the reason for being transported.

Although we were not able to observe any activity during the inspection, review of client and patient feedback demonstrated that staff spoke to patients and those close to them in a way they understood. The patient feedback form asked the questions, "did the ambulance personnel explain your care and treatment in terms you understood" and, "when you had questions were, they answered in terms you understood?" For the two patient feedback forms that the service had received since their registration with CQC in February 2021, the answer to both two questions were "strongly agree".

Are Patient transport services responsive?

Good

Service delivery to meet the needs of local people

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

Patient transport services was the main service offered by Thruxton Industrial Estate. Journeys included transportation to and from outpatient appointments and hospital discharges.

The service liaised with the local NHS ambulance trust and acute NHS hospital trust to plan and deliver patient transport services for local people.

The service undertook some private transport bookings but due to the workload from its NHS contracts this was less frequent.

Meeting people's individual needs

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

The service had an in-date dignity, equality and respect policy. This supported staff to meet people's individual needs. Leaders demonstrated in discussion their commitment to meeting people's individual needs and their understanding of their accountability towards the Equality Act.

The staff were equipped with skills to support patients living with dementia. Staff received training about dementia awareness to equip them with the skills to support people living with dementia in a kind and compassionate manner.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. Staff had access to language line, however there was no detail about how frequently this was accessed. Leaders said that patients' family members were sometimes used as interpreters. This is not best practice, as it does not protect patient confidentiality. The service did not have access to British sign language interpreters, instead they relied on pen and paper to communicate with people who were hard hearing, who lip read or whose first language was British sign language.

However, there was no evidence that staff completed training about the needs of people with a learning disability or autism.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

The service operated between 9am to 10pm seven days a week. Staff worked with the local NHS ambulance service to provide patient transport services and support discharges from a local NHS acute trust. The service told us they transported between twelve and fifteen patients per day and that since being registered with CQC in February 2021. They had undertaken around 1,900 patient transfers, all of which were for NHS services except for one private booking.

There were no systems or processes to formally monitor waiting or journey times. The NHS ambulance trust monitored the waiting and journey times of the work undertaken. The service had received no feedback from the NHS ambulance trust about waiting or journey times.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

There was a system in place for patients to give feedback, including complaints, about the service. Feedback forms were available on the ambulances for patients. Information about how to give feedback and make a complaint were on the provider's website.

Leaders told us they had not received any complaints or concerns in the 12 months prior to this inspection. There was a set process to follow if complaints were received that was supported by the Complaints, Concerns and Suggestions policy.

Are Patient transport services well-led?

Requires Improvement

Leadership

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

The leadership team included the two directors of the provider Ambulance Services Ltd, one of which was the operating director and the manager for Thruxton Industrial Estate and the other who was the managing director for Ambulance Services Ltd. Consultancy staff included the medical director and the human resources manager. The operations director had recently taken on the role as manager of the service and had applied to CQC to register as manager of the service.

Leaders understood their individual roles within the organisation. The company organisation structure was detailed in the company governance policy, which set out the responsibilities for each leadership role. Discussion with the leaders demonstrated they understood and carried out their roles.

Requires Improvement

Patient transport services

Leaders were visible and approachable in the service for staff. Leaders were available for staff 24 hours seven days a week. A manager on call system meant staff could access a leader for advice and support at any time. During the inspection we observed that staff contacted leaders by telephone to speak to them if needed. We observed leaders spoke to staff during the telephone calls with respect and courtesy.

Leaders planned to support staff to develop their skills and take on more senior roles. They had plans to develop staff through additional training and developing staff into supervision, practice educator roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of the service. Leaders understood and knew how to apply them and monitor progress.

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The strategy and vision were set around three priorities for the service. These were: “developing each member of our work force to improve overall care standard to our patients; continual improvements to our procedures and working environment; and perform all services at a safe and high standard.”

The strategy had three monthly targets to support the planning and development of the service. The targets could be easily measured to assess progress against the strategy. Leaders recognised that the business of independent ambulances was dynamic and that the plans and strategy may need revising depending on any business opportunities that arose.

Culture

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

During the inspection the manager spoke about actions which demonstrated how they valued and supported staff. This included the introducing opportunities for career development and supporting staff with both personal and work problems. They described the culture as an open-door culture and described how they supported staff with work and personal issues. The service provided staff with access to wellbeing and counselling services.

Leaders discussed their commitment to promote equality and diversity in all aspect of the service. The dignity and respect policy set out how staff and patients must be treated and how staff must take account of the Equality Act and peoples protected characteristics. They gave examples about how they had supported both patients and staff, respecting their protected characteristics.

Governance

Leaders did not operate effective governance processes. There was limited evidence of learning from performance of the service. Leaders were clear about their roles and accountabilities.

The service had a Company Governance Policy that set out the roles of the company senior leadership team, the purpose of governance and the responsibilities and accountabilities of the different members of staff who worked at the service. The policy described that the company governance was the system for continual improvement of the quality of the service and promoting high standards of care. The policy also described the reason for governance was to ensure safe high-quality care from all involved in the patient’s journey and to ensure patients were the focus and priority.

Requires Improvement

Patient transport services

A lack of quality auditing did not ensure high quality care for all patients. This included lack of auditing of patient record forms, lack of formal process to monitor the quality of the service provided by them in their contracts/ agreements with other providers and CCGs, lack of process to monitor/assess the routine daily cleaning of ambulances, lack of process to assess/audit the accurateness and detail of patient records and lack of process to assess the performance of staff carrying out the regulated activities did not ensure high quality care for all patients.

However, the service did assess and monitor other performance in other areas of their work. This included monitoring whether medicines were in date or out of date, monitoring staff completion of mandatory training, monitoring the availability and expiry dates of equipment, process to ensure vehicles were safe to use and seeking the views of people using the service and clients who contracted with the service.

There was no set timetable for leadership meetings, three meetings had been held since the service registered in February 2021 (August 2021, January and March 2022). Review of the meeting records showed these were business meetings and did not consider the quality or performance of the service.

Governance process did not ensure policies fully supported the performance and quality of the service. Our review of 30 policies identified several that had staff roles and functions that did not exist in the service. For example, the children's safeguarding policy detailed there was a company board. The attendance management policy detailed there was a front-line manager. The medicines management policy detailed there was a locality clinical lead and a controlled drugs accountable officer. The infection, prevention and emergency decontamination policy detailed there was a chief operating officer and an associate director of governance and compliance. None of these roles existed in this service.

We also identified one policy that had misleading information. The complaints policy detailed that if a complainant was not satisfied with the complaint response from Thruxton Industrial Estate, they should refer the complaint to the Care Quality Commission (CQC). This was incorrect guidance, as CQC does not have the legal powers to investigate individual complaints.

Management of risk, issues and performance

Leaders did not use systems to manage performance and quality effectively. However, they did identify relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Staff did not have guidance about the identification and management of risks. The service did not have a risk management policy to give guidance to staff how to manage, monitor and review risks.

However, the service did maintain a risk register that detailed risk and actions taken to lessen risks although there was no detail to demonstrate when risks were reviewed or who was accountable for the action to reduce the level of risk.

The service had a business continuity policy and the risk register gave detail about the actions to take in the event of unexpected events such as loss of power and IT systems.

Leaders had introduced some auditing processes to monitor and manage performance and quality. However, these did not cover all areas of the work carried out by the service. Lack of monitoring of the service increased the risk of not maintaining the quality and ensuring the effective performance of the service

Requires Improvement

Patient transport services

Information Management

The service did not collect reliable data for all areas of their work and analyse it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were submitted to external organisations as required.

The service did not have its own key performance indicators for all areas of their work to monitor against. Where the service undertook work for the NHS ambulance trust, it relied solely on them to monitor the quality and performance of the service.

The service did collect data on patient record forms for response times for work it carried out for the acute NHS trust. However, as detailed in the Safe section of this report, those times were not accurate, so could not be used to accurately monitor the performance of the service.

The service collected accurate data about staff training, analysed it and acted to ensure staff completed all required training. Staff could find information they needed. Policies and procedures were stored electronically which staff could easily access.

The service had arrangements to ensure data or notifications was sent to external bodies as required. Notifications, such as changes to the nominated individual and to the registered manager positions, were submitted to the Care Quality Commission.

Engagement

Leaders and staff engaged with patients and clients to get feedback about the service. There was no evidence patient and client feedback were used to plan and develop the service.

The service had taken action to try to engage with both patients and relatives of patients they conveyed. Feedback forms were available in the ambulances and there was information about how to feedback displayed in the ambulances and on the provider's website.

Feedback the service had received from clients they worked with described a high level of satisfaction with the service provided. However, at the time of the inspection, there was no evidence to show how the service used feedback to help develop the service.

The service did not have any formal process to gather feedback about the service from local community groups, equality groups or local organisations.

Leaders described the engagement they had with the NHS ambulance trust as a positive working relationship and described that monitoring meetings would be held by the ambulance trust to discuss performance and areas for improvement. However, as Thruxton Industrial Estate had only been working with the trust for two months, they had not yet had a monitoring meeting.

Learning, continuous improvement and innovation

Leaders were committed to improving services. However, they did not demonstrate quality improvement methods to support improvements.

The leadership team expressed a commitment to learning and improving the service provided by Thruxton Industrial Estate. They had identified some areas for improvement such as developing staff.

Requires Improvement

Patient transport services

They were investing in their ambulance fleet, to make the ambulances suitable for flexible use so the service could be more agile to meet the different needs of people effectively.

However, there was no evidence of the use of recognised quality improvement methods being used to support making improvements to the service.

Requires Improvement

Emergency and urgent care

Safe	Requires Improvement
Effective	Good
Caring	Insufficient evidence to rate
Responsive	Good
Well-led	Requires Improvement

Are Emergency and urgent care safe?

Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff and monitored completion of mandatory training.

The processes for managing mandatory training were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about mandatory training, please see the patient transport section of this report.

Safeguarding

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

The processes for safeguarding patients from abuse and improper treatment were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about safeguarding, please see the patient transport section of this report.

Cleanliness, infection control and hygiene

The service could not demonstrate they always controlled infection risks and cleaned vehicles and equipment. Staff used equipment and control measures to protect patients, themselves and others from infection.

The processes for managing cleanliness, infection control and hygiene were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about cleanliness, infection control and hygiene, please see the patient transport section of this report.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Most staff managed clinical waste well.

Requires Improvement

Emergency and urgent care

The processes for managing the environment and equipment were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about the environment and equipment, please see the patient transport section of this report.

Assessing and responding to patient risk

Staff completed a risk assessments for each patient and removed or minimised risks. Staff identified acted upon patients at risk of deterioration.

Staff followed guidance to respond promptly to any sudden deterioration in a patient's health. Although the service did not have deteriorating patient policy, it did have a clinical memorandom accessible to staff about the identification and management of the deteriorating patient. This gave guidance to staff about what they needed to do in the event of patient deteriorating during transportation, including the use of a nationally recognised tool to identify deteriorating patients.

The service required paramedics and emergency care technicians to follow national guidance set out in the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) to asses and respond to the risk of patients.

The patient record form we reviewed demonstrated that staff completed a set of risk assessments of the patient and responded according to the findings of the assessment.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers gave staff a full induction.

The processes for managing staffing were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about staffing, please see the patient transport section of this report.

Records

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

We looked at one record for a patient conveyed from an event site to an acute NHS hospital. The record was detailed and had clear descriptions of the assessments, care and treatment provided to the patient.

Records were stored securely. Records were stored electronically, and password protected or in paper format in a locked safe.

Medicines

The service did not always follow best practice when administering, recording and storing medicines.

Staff followed systems and processes to prescribe and administer medicines safely. The service had an in-date management of medicines policy. The policy gave guidance to staff on the use, administration and transportation of medicines. This included a requirement for staff to follow JRCALC guidelines for the administration of medicines.

However, the policy did not fully match the service provided. The policy referred to a Controlled Drugs Accountable Officer and locality clinical teams which the service did not have. The service did not hold any controlled drugs, so did not need a Controlled Drugs Accountable Officer.

Requires Improvement

Emergency and urgent care

Staff completed medicines records accurately and kept them up to date. The one record we reviewed for a patient who had been conveyed from an event to an acute NHS hospital demonstrated staff recorded the administration of medicines accurately.

Staff did not always store and manage all medicines safely. The process to monitor medicines in the medicine cupboards and the kit bags was not effective. We found that some medicines were out of date. There was out of date ipratropium bromide in the medicine cupboards and ambulance kit bags. There was out of date glucagon in the medicine fridge and ambulance kit bags. We escalated this finding with the manager of the service, who promptly took action to remove the out of date medicines and order new stock.

Following the inspection, the manager informed CQC that they had enhanced the monitoring of medicines to reduce the risk of a similar occurrence.

For further information about the management of medicines, please see the patient transport section of this report.

Incidents

The service managed incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Processes for managing patient safety incidents were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about incidents, please see the patient transport section of this report.

Are Emergency and urgent care effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Processes for ensuring patients received evidenced-based care and treatment were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about evidenced-based care and treatment, please see the patient transport section of this report.

Pain relief

Staff assessed and monitored patients to see if they were in pain and gave pain relief in a timely way.

Our review of one patient record form for a patient conveyed from an event site to an acute NHS hospital showed their pain was assessed and pain relief given in a timely manner.

Response times

The service recorded response times, but did not monitor them

Requires Improvement

Emergency and urgent care

The emergency and urgent care service was only provided as part of event work. Emergency and urgent care was only carried out if the event contract required Thruxton Industrial Estate to convey patients off the event site for to acute NHS Hospitals. Response times were recorded on the patient record form, but the service did not monitor or audit their response times at event work. The service did not carry out NHS 'front line' work, which meant they did not have to comply with the national standards for response times.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

The service had carried out limited emergency and urgent care work. Patient record forms detailed whether patients were conveyed or treated at the scene at events. However, there was no process to identify whether patients received effective care and treatment as the service did not review or audit the records.

Leaders were aware of national standards for conditions such as stroke but had not experienced patients with these conditions' whist working at events that had contracted them to transport patients to acute NHS hospitals.

Competent staff

The service took some action to make sure staff were competent for their roles. The service had a process to appraise staff's work and performance to provide support and development.

Processes for ensuring staff were competent for their role were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about competent staff, please see the patient transport section of this report.

Multidisciplinary working

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

Processes for supporting multidisciplinary working were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about multidisciplinary working, please see the patient transport section of this report.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Processes for ensuring staff had access to guidance about consent and the Mental Capacity Act 2005 were the same for both the patient transport service and the emergency and urgent care service.

For detailed findings about Consent, Mental Capacity Act and Deprivation of Liberty Safeguards, please see the patient transport section of this report.

Are Emergency and urgent care caring?

Requires Improvement

Emergency and urgent care

Insufficient evidence to rate

Compassionate care

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

Processes to ensure a staff treated patients with compassion and kindness, respected their privacy and dignity and took account their individual needs were the same for both the patient transport service and the emergency and urgent care service.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Processes to ensure a staff provided patients with emotional support were the same for both the patient transport service and the emergency and urgent care service.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and the reason for being transported.

Processes to ensure the involvement and understanding of patients were the same for both the patient transport service and the emergency and urgent care service.

Are Emergency and urgent care responsive?

Good

Service delivery to meet the needs of local people

The service planned and provided emergency an urgent care in line with the contracts agreed with for event work.

The emergency and urgent care service was only provided as part of event work. Emergency and urgent care was only carried out if the event contract required Thruxton Industrial Estate to convey patients off the event site for to acute NHS Hospitals.

Meeting people's individual needs

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

Processes for meeting people's individual needs were the same for both the patient transport service and the emergency and urgent care service. For detailed meeting individual needs, please see the patient transport section of this report.

Requires Improvement

Emergency and urgent care

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

The emergency and urgent care service was only provided as part of event work. Emergency and urgent care was only carried out if the event contract required Thruxton Industrial Estate to transport patients off the event site to acute NHS Hospitals. There had been only one patient transport from an event site to an acute hospital since registration with CQC. The patient record form demonstrated the patient received treatment and transport to hospital in a timely way. However, due to the low number of patient transfers to acute hospitals, there was insufficient evidence to make a judgement about access and flow**.**

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Processes for learning from complaints and concerns were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about learning from complaints and concerns, please see the patient transport section of this report.

Are Emergency and urgent care well-led?

Requires Improvement

Leadership

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

Leadership of the service was the same for both the patient transport service and the emergency and urgent care service. For detailed findings about leadership, please see the patient transport section of this report.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of the service. Leaders understood and knew how to apply them and monitor progress.

Vison and strategy were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about the vision and strategy, please see the patient transport section of this report.

Culture

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

Culture was the same for both the patient transport service and the emergency and urgent care service. For detailed findings about the culture, please see the patient transport section of this report.

Requires Improvement

Emergency and urgent care

Governance

Leaders did not operate effective governance processes. There was limited evidence of learning from performance of the service. Leaders were clear about their roles and accountabilities.

The governance process was the same for both the patient transport service and the emergency and urgent care service. For detailed findings about governance, please see the patient transport section of this report.

Management of risk, issues and performance

Leaders did not use systems to manage performance and quality effectively. However, they did identify relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Processes for management of risk, issues and performance were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about management of risk, issues and performance, please see the patient transport section of this report.

Information Management

The service did not collect reliable data for all areas of their work and analyse it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were submitted to external organisations as required.

Processes for management of information were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about information management, please see the patient transport section of this report.

Engagement

Leaders and staff engaged with patients and clients to get feedback about the service. There was no evidence patient and client feedback were used to plan and develop the service.

Processes for engaging with people were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about engagement, please see the patient transport section of this report.

Learning, continuous improvement and innovation

Leaders were committed to improving services. However, they did not demonstrate of quality improvement methods to support improvements.

Processes for continuous improvement were the same for both the patient transport service and the emergency and urgent care service. For detailed findings about learning, continuous improvement and innovation, please see the patient transport section of this report

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The medical gas storage area was not in line with national guidance and posed a risk of harm to people. Some medicines were out of date.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Governance processes did not provide assurance about the quality and performance of the service. Policies did not accurately reflect the service provided.