Ambu-Kare (Uk) Limited

Ambu Kare UK - Westwood Farm

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 know to CQC and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

Ambu Kare UK - Westwood Farm is operated by Ambu-Kare UK Ltd. The service provides a patient transport service to the local NHS hospitals and occasional private transfers.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on the 8 June 2017, along with an unannounced visit to the service on 26 June 2017.

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

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

Services we do not rate

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

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

- The incident reporting process was not embedded and staff had not received any training on incident reporting, investigation or learning.
- The service did not have a formal inclusion or exclusion criteria to thoroughly assess if the patient was eligible to safely use the service.
- There was a lack of risk assessment performed and no specific risk assessment or policy for transferring children.
- Patient identifiable data was taken to the provider's home address for transcribing which represented a data protection risk.
- The safeguarding adults and children lead had not received the level of training as recommended in best practice guidelines.
- There was a lack of oversight relating to the stocking and servicing of equipment.
- There was limited formal audit process in place to ensure all aspects of the service were continually monitored and the service did not benchmark itself against other providers either locally or nationally.
- There were guidance policies in place but they lacked version control and implementation and review dates. We were not assured all policies were in line with current guidelines or best practice.
- Staff were not knowledgeable about policies available for them to reference and there was no process to ensure that staff were up to date with current policies.
- The governance systems were weak and ineffective which meant that we were not assured that concerns would be identified and mitigated.
- The operational manager lacked clinical governance experience. This was reflected in the poorly adapted and out of date policies, and the lack of understanding of the need to measure quality and performance.
- The service risk register was in its infancy and there was a lack of understanding about what constituted a service risk.
- However, we also found the following areas of good practice:
- All staff had completed mandatory training within the last 12 months.
- Vehicles were well maintained and cleaned, and there were robust processes in place to monitor vehicle cleanliness.
- Staff were aware of their safeguarding responsibilities and had received the required training.
- Staffing was sufficient to meet the needs of patients.
- There was a clear induction programme and support for new staff members.
- Staff driving licence and Disclosure and Barring Service checks were performed yearly.

Summary of findings

- Patient and relative feedback was consistently positive and stated that the service provided compassionate care.
- Staff we spoke with demonstrated a caring attitude to patients and their relatives.
- There were systems in place to monitor vehicle servicing and maintenance, vehicle cleanliness and staff training compliance.
- Staff described the culture within the service as very positive with one member of staff describing it as "the best job since leaving school".
- Quarterly staff meetings were held and there was a communications book for regular staff messages.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Professor Edward Baker
Chief Inspector of Hospitals

Ambu Kare UK - Westwood Farm

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Background to Ambu Kare UK - Westwood Farm

Ambu Kare UK - Westwood Farm is operated by Ambu-Kare UK Ltd and has been providing services since 1984. It is an independent ambulance service in Peterborough, Cambridgeshire. The service primarily serves the communities of the Peterborough, Cambridgeshire and the surrounding counties, providing patient transport services to the public and private sector. This includes the picking up and dropping off of service users from their homes to local NHS trusts, and the transport of service users, to and from local NHS trusts and to other hospitals in the country.

The service has had the current registered manager, who also performs the operational manager role, in post since 2007.

The service was inspected on 8 June 2017 and a further unannounced inspection was carried out on 26 June 2017.

Our inspection team

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

How we carried out this inspection

During the inspection, we visited the operations base at Unit 1 Westwood Farm, Westwood, Peterborough, Cambridgeshire. We spoke with four staff including; the operational manager and patient transport drivers/crew. We accompanied the patient transport crew on two patient transfers.

We also spoke to the patient transport liaison at the local NHS trust. During our inspection, we reviewed four patient transport records and inspected two patient transport ambulances and one wheelchair suitable car. We observed care provided to two patients during their transportation.

Detailed findings

Facts and data about Ambu Kare UK - Westwood Farm

The service is registered to provide the following regulated activities:

Transport services, triage and medical advice provided remotely.

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

The service was last inspected on 30 April 2013, at that time the service did not meet three out of the seven standards of quality and safety it was inspected against. The three standards not met were;

People should get safe and appropriate care that meets their needs and supports their rights.

People should have their complaints listened to and acted on appropriately.

People's personal records, including medical records, should be accurate and safe and confidential.

Activity from April 2016 to May 2017

In the reporting period April 2016 to March 2017 the service undertook 2416 patient transport journeys. The service declined 12 transfers and 35 transfers were cancelled.

Three patient transport drivers, along with the operational manager worked at the service and another part time staff member joined during the inspection period. There were plans to increase the staff to include a deputy manager. The service did not employ any bank or agency staff.

Track record on safety

- No never events

- Clinical incidents were not reported or classified according to; no harm, low harm, moderate harm, severe harm, death

- No serious injuries

No complaints

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

Are services safe?

We do not currently have a legal duty to rate independent ambulance services.

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

- The incident reporting process was not embedded and staff had not received any training on incident reporting, investigation or learning.
- The service did not have a formal inclusion or exclusion criteria to thoroughly assess if the patient was eligible to safely use the service.
- Risk assessment forms were not routinely used and there was no specific risk assessment or protocol for transferring children.
- The safeguarding adults and children lead had not received the level of training as recommended in best practice guidelines.
- Patient identifiable data was taken to the operational manager's home address for transcribing which represented a data confidentiality risk.
- There was a lack of oversight relating to the stocking and servicing of equipment.

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

- All staff had completed mandatory training within the last 12 months.
- Vehicles were well maintained and cleaned, and there were processes in place to monitor vehicle cleanliness. Staff were aware of their safeguarding responsibilities and had received training.

Patient transport services (PTS)

Are services effective?

We do not currently have a legal duty to rate independent ambulance services.

- We found the following issues that the service provider needs to improve:
- There was no formal audit process in place to ensure all aspects of the service were continually monitored.
- The service did not benchmark itself against other providers either locally or nationally.
- There were guidance policies in place but they lacked version control and implementation and review dates. Some were not in line with current guidelines or best practice.
- Staff were not knowledgeable about policies available for them to reference and there was no process to ensure that staff were up to date with current policies.

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

- Staff consistently received six monthly appraisals which staff felt were meaningful.
- There was a clear induction programme and support for new staff members.
- Staff driving licence and Disclosure and Barring Service checks were performed yearly.

Are services caring?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Patient and relative feedback was consistently positive and stated that the service provided compassionate care.
- Feedback indicated that patients were treated with dignity and respect.
- Staff we spoke with demonstrated a caring attitude to patients and their relatives.
- Staffing was sufficient to meet the needs of patients.

Are services responsive?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice**:**

- The service was planned and delivered to meet the needs of local people and NHS providers. The service demonstrated flexibility and availability for booking, including out of hours on call bookings.
- The service managed capacity well and was able to meet patients' individual needs.
- The service received no complaints since 2012.

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

- Staff received no specific training for dealing with patients with complex needs, for example those with a learning difficulty, older patients, or patients living with dementia.
- There was no information available to patients or relatives on how to make a complaint.
- There was no translation service available for non-English speakers and no easily understood accessible information for patients with dementia or a learning difficulty.

Are services well-led?

We do not currently have a legal duty to rate independent ambulance services.

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

- Staff were unable to state the service vision and values indicating that they were not embedded.
- The governance systems were weak and ineffective. This was reflected in the poorly adapted and out of date policies, and the lack of understanding of the need to measure quality and performance, which meant that we were not assured that concerns would be identified and mitigated.
- The service risk register was in its infancy and there was a lack of understanding about what constituted a service risk.

However we also found the following areas of good practice:

- There were systems in place to monitor vehicle servicing and maintenance, vehicle cleanliness and staff training compliance.

Patient transport services (PTS)

- Staff described the culture within the service as very positive with one member of staff describing it as "the best job since leaving school".
- Quarterly staff meetings were held and there was a communications book for regular staff messages.

Are patient transport services safe?

Incidents

- The service had no formal incident reporting process in place, so no incidents, including never events, serious incidents, or near misses were reported between April 2016 and May 2017. This meant we were not assured that staff understood how to recognise report, escalate and categorise incidents. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Staff had not received training in incident reporting or investigating and there was no effective investigation or learning taking place to improve service provision and safety following incidents.
- There was no formal sharing of lessons learnt as a result of incidents but staff did participate in informal debrief meetings.
- There was an incident reporting policy (company policy no: 09) which described the type of incidents and the responsibilities of staff. The policy was not dated or version controlled and contained information that did not relate to the service and referenced appendices that were not available to the service. This had been reviewed by the operational manager and updated following the initial inspection.
- Incident forms were available, however these were not referenced in the policy and staff did not complete them. Two members of staff reported that they recorded incidents that occurred on the patient report forms.
- During our inspection the operational manager related transport episodes that fulfilled incident reporting criteria. Further discussion resulted in an appreciation that these episodes should have been reported.
- Following the announced inspection the service recorded three incidents on their reporting log and we saw incident forms were correctly completed at the unannounced inspection.
- The operational manager had not undertaken training in root cause analysis or incident investigation. They confirmed that should an incident occur that they would look to outside organisations to perform any investigation. However this meant that they may not

recognise an incident that required investigation. Following the inspection the operations manager booked themselves onto an NHS root cause analysis training course.
- The service had no duty of candour policy in place at the time of our inspection. The duty of candour is a regulatory duty that relates to openness and transparency and requires the providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The operational manager reported that they had difficulty accessing duty of candour training and the service was trying to organise this with the local NHS trust.
- The operational manager clearly articulated their responsibilities under duty of candour and although the patient transport drivers were unfamiliar with the term, they understood their responsibilities.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- Safety dashboard data was not collected for the service so we were unable to review.
- The service did not have any process or system in place to monitor the clinical quality of the service such as; whether they always met the 'meet and greet timings' for service users who were being met at a location by carers. This was a requirement from the local NHS referrer.

Cleanliness, infection control and hygiene

- We inspected two patient transport ambulances and one car that transported patients using wheelchairs. The vehicles were mostly visibly clean and tidy although there was a dirty mark on the back of one seat and both ambulance vehicles had a piece of oil stained towelling taped over the metal part of the strap holding the wheelchair in place. Staff removed this when pointed out and said they usually changed it weekly and used it to stop the metal rubbing on the wheelchair whilst in transit. On our unannounced inspection the straps had been replaced by webbing.
- One ambulance stretcher had a small tear in the mattress cover which meant that it could not be cleaned effectively and could pose an infection risk. Both ambulances contained a number of sliding sheets for patient transfers but these had dirty/dusty marks on them and one had small holes. Staff commented that they did not use these. The operational manager was informed and these were removed. On the unannounced inspection the service had swapped to using disposable sliding sheets in line with the local NHS trust.
- The ambulances contained, gloves, biohazard spill kits and decontamination wipes. In addition, staff carried personal hand decontamination gel although there was none available for service users.
- Staff told us it was their responsibility to clean vehicles after each patient had been transported and at the end of each shift and we observed staff wiping the stretcher with decontamination wipes between transfers.
- Vehicles were cleaned and washed down daily, and deep cleaned weekly (and/or after bodily fluids spilled or transporting a service user with a known infection) using a steam cleaner.
- There was a deep cleaning log for each vehicle which was consistently signed by staff (records seen dating back to 1 April 2017 as previous records archived) and audited by the operational manager. The service infection prevention and control policy referenced the National Patient Safety Agency specifications for cleaning ambulances and we saw a copy of that was available for staff to access. The daily vehicle cleaning logs were seen and the recent audit showed that vehicles were consistently cleaned daily.
- Staff washed their own uniforms and if a uniform became dirty during a shift they went home to change. There was no uniform policy in place to provide staff with guidance on how to wash and maintain uniform and no uniform audit to look at the general hygiene of staff and uniforms.
- Dirty linen was placed in bags and exchanged for clean linen daily at the local NHS hospital. This was via a local agreement.
- Staff were observed following good practice in hand washing prior to and following patient contact and used the appropriate personal protection equipment when transporting a patient with a known infection.

Environment and equipment

- There were multiple out of date consumable items with dirty or torn packaging. These included; oxygen tubing, masks and airways and dressings that were stored in two paramedic bags and overhead storage lockers on both ambulances. The operations manager removed

these as soon as they were identified and explained that these were left over from when the service employed an ambulance technician. The current staff did not use the items.

- There were blood pressure monitors and oxygen saturation monitors with no calibration, maintenance or electrical testing dates on both ambulances and in the storage cupboard. The operational manager explained that the current crews did not use these as they were left over from when the service provided a higher level of care. The operational manager immediately removed them from the ambulances and the storage cupboard.
- Six pieces of patient handling equipment including wheelchairs were overdue for maintenance/service due September 2016 (last dated September 2015) and the stretchers on the vehicles did not contain dated stickers indicating service/maintenance dates. When we returned for the unannounced inspection all equipment had been serviced and bore dated stickers to confirm date next service due.
- Ambulance stretchers had appropriate stretcher harnesses and seatbelts in place and vehicles contained clamping systems to enable the safe transportation of patients travelling in their own, or the service's wheelchairs.
- The ambulance station was located in a large garage space that was shared with a private individual. There was a clear demarcation of the space but no barriers. This meant that the private individual had access to the equipment, unlocked vehicles, and ambulance station office, should they attend when ambulance staff were not on the premises. The operational manager reported that the individual rarely attended their own part of the garage but we were concerned that this could represent a security risk.
- The ambulance garage space was mostly uncluttered and consisted of an office, coffee room and large open space (with a sink), which was used for parking vehicles, staff lockers, storage. There was an ambulance parked that had been decommissioned and was awaiting disposal, and an area at the back of the ambulance bay that contained shelves for storage of equipment that was no longer used by the service.
- The powder fire extinguisher on one ambulance was out of date for replacing (due February 2016) however it was replaced during the inspection before inspection staff raised it with the crew. Staff commented that the vehicle had been out when the new extinguisher arrived recently but this meant that the extinguisher was still out of date for more than 12 months before being replaced.
- There were separate bins for domestic and clinical waste.
- Clinical waste was disposed at the local NHS trust daily.
- The service leased their ambulance vehicles from an external company that also provided yearly servicing and maintenance of both the vehicles and the defibrillators and suction equipment. We saw evidence to demonstrate that the ambulance vehicles were less than two years old and did not require MOT certification and the wheelchair car owned by the service was within MOT and service date. There was also a schedule with an outside provider to perform monthly vehicle tyre checks. The operational manger oversaw the maintenance schedule.
- Vehicle keys were stored securely in a locked cupboard at the location office.
- The service did not provide specialist equipment for transporting children. If a child transport was undertaken the equipment was provided by the accompanying parent or organisation.

Medicines

- Patients own medicines were transported with the patient in sealed, named bags. The ambulance crew did not take any responsibility for controlled drugs (CDs) carried by patients. If CDs accompanied a patient they were the responsibility of the patient or carer.
- There was a medication policy (revised December 2016) but the service did not store or administer medicines, with the exception of prescribed medical gases on the vehicles, or at the base.
- The service told us that staff had received medical gases training. However there was no evidence of this in the staff personnel folders.
- There was no policy in place to provide guidance for the safe storage and transportation of medical gases. In both vehicles that we inspected, we found that the oxygen cylinder was stored in a safe and secure manner.
- Full and empty oxygen cylinders were stored safely in a wire crate, with a divider to separate them, attached to the wall at the station overnight, and securely on the ambulances. Crews exchanged cylinders when required.
- The service medicines management policy stated that 'HSE (Health and Safety Executive) approved Qualified

First Aiders may not administer any drug or oxygen – but may assist the patient to self-administer an inhaler for asthma and/or use glucose gel if a patient is unconscious and thought to be suffering from hypoglycaemia. The operational manager reported that the crew members were able to monitor oxygen therapy if it was set up at for the service user at the pick-up location and transferred by an appropriate person at the drop off location. They were not permitted to administer oxygen therapy otherwise. The medicines policy also stated that a signed copy of the policy should be place in the staff personnel records. These were not present in personnel records we reviewed.

Records

- Staff completed daily call sheets recording; collection point, (ward for example) service user name, mobility, arrival destination, NHS number, pick and drop off times, referral time and a comments section. They also recorded further information on a patient transfer record at point of contact for each service user. This included specific details such as; oxygen required, medical condition, do not attempt cardiopulmonary resuscitation orders and access concerns at arrival destination. The four forms we reviewed were comprehensively completed.
- The patient and daily call records were kept on clipboard in the vehicles until the end of a shift and then placed in a red file box in the office overnight. The operational manager collected the call sheets the following day and took them home to transcribe onto a spreadsheet and shredded them within 48 hours. During the inspection on 8 June 2017 we found two call sheets with patient identifiable information left (covered) on clipboards in the front cabins of both ambulances. One from April 2017 and one from May 2017. This was raised with the operational manager who immediately removed the information.
- The location office was not locked overnight and we were not assured that service user details were kept secure and confidential due to the availability of access by an individual not-employed by the service who also rented space in the same garage. On the unannounced inspection we saw that records containing patient identifiable data were locked in a cabinet overnight or when the office and station were unmanned.
- The operational manager scanned and transcribed information from the patient transport records service at their home address but did not carry out any audits or checks of completed patient report forms. Therefore, we could not gain assurances that records were accurate, complete, legible and up to date.
- The operational manager reported that they returned patient identifiable data back to the office for shredding. We were not assured of the disposal of confidential information as we did not inspect the process, disposal or recording of confidential information at the operational manager's home as it was not appropriate at the time of inspection.
- Special notes information, such as patients with infection or known aggression, were recorded on the risk assessment form and on the patient transfer record and text to staff if they were not at the base to receive the referral.
- Staff did not provide a copy of the patient report form to the receiving hospital or clinic therefore we could not gain assurances that patient records were shared with other healthcare professionals if required.

Safeguarding

- The safeguarding policy (company policy number 14) was out of date, with review overdue since October 2016. This had been updated when we returned for the unannounced inspection on 26 June 2017.
- Safeguarding children and adults level two was included as part of mandatory training and all staff including the operational manager had received safeguarding training level two for adults and children from an accredited trainer within the last 12 months and yearly prior to that. The certificates indicated the training was for adults only however the operational manger contacted the trainer during the inspection and we heard them confirm over the telephone that the training was also for children's level two and saw updated certificates at the unannounced inspection.
- There was no level three trained safeguarding lead as recommended in the NHS England Intercollegiate document, Safeguarding Adults. This meant the service was not working in line with national guidelines on safeguarding. However the operational manager did book this training between the initial and unannounced inspection although it had not yet been completed.
- The service referred to the level four safeguarding lead at the local NHS trust for any safeguarding concerns.

- Information about how to raise a safeguarding concern was available on the office and coffee room notice board as well as on a flow chart.
- Staff confirmed they would usually contact the operational manager first but if they were not available they would make a safeguarding referral themselves and knew who to contact.
- All staff discussed what constituted a safeguarding concern and gave of examples, including an assessment of a patient's home environment and possible warning signs of neglect that had been raised prior to the inspection.

Mandatory training

- Mandatory and statutory training was provided annually and included, but was not limited to; manual handling, infection control, first aid at work, mental health act and deprivation of liberty and constraint.
- Training was provided on a weekend and all staff had completed mandatory training within the previous 12 months and we saw evidence of this in personnel folders.
- There was no formalised driving assessment required during the course of employment, as a standard driving licence enabled crew to drive the ambulance vehicles, which were less than 3.5 tonnes.

Assessing and responding to patient risk

- The service did not have a formal inclusion or exclusion criteria but did have a policy excluding patients with intravenous infusions or cannula in situ unless accompanied by medical staff. Crew members were not aware of the policy and gave conflicting responses when asked if they transferred patients with cannulas or intravenous infusions. They did confirm that they would not transfer patients not wearing underwear/or inappropriately dressed and would not transport a child without a responsible adult accompanying them. We were not assured that all staff were aware how to thoroughly assess if the patient was eligible to safely use the service.
- There was no policy for managing a deteriorating patient and staff confirmed that they would call for assistance via making a 999 call.
- There was no policy or risk assessment for transferring children.
- The operational manager initially denied that they performed paediatric transfers; however staff reported that they did transport children, with the most recent transfer approximately one month previously. When we questioned the operational manager further, they clarified that they did transport children, but only when escorted by a responsible adult such as a parent or medical professional.
- Patient eligibility was assessed verbally over the telephone at the point of booking and for complicated transfers staff attended the pick-up location to assess the patient before accepting the transfer. Booking calls were taken by the operational manager when on duty and by the crew members at other times. There was a risk assessment form for assessing patients suitable for transport however this was not consistently used and did not log details such as a service user's cognitive ability or skin integrity for manual handling etc.
- Ambu-Kare UK Ltd occasionally transported patients detained under the mental health act. The service did not carry out formalised risk assessments in relation to transportation of patients with mental health conditions. Information about medical history and risk of violence was obtained at the time of booking and passed to staff either verbally, or via text message on the work mobile phone. Staff confirmed that if transporting a person with mental health problems who was likely to be aggressive, they would use three crew members rather than the usual two.

Staffing

- The service was small and employed three full time members of staff (and one new part time staff member who commenced employment between the announced and unannounced inspection) in addition to the operational manager. The staffing level was appropriate to meet the needs of the patients. The operational manager confirmed that the service did not experience any challenges with staffing levels, skill mix or recruitment and that bookings were never turned down due to lack of available staff. At the time of inspection the service was actively recruiting a deputy operational manager.
- The staff rota was usually worked out by the operational manager on a weekly basis and ambulance crews/ drivers generally worked two shifts on duty and two shifts off duty to cover the rota with weekends on

standby and flexibility to cover annual leave or extended hours. No bank or agency staff were used and if demand increased, the 'rest day' staff attended to crew the second vehicle.
- Out of usual operational hours, staff contacted the operational manager for support if required.
- Disclosure and Barring Service (DBS) checks were performed on staff at the time of commencing employment with the service and yearly afterwards. We saw copies of the DBS checks for all staff members employed to work in patient transfers.

Response to major incidents

- The service had a fire safety policy which outlined the responsibilities of all staff in the event of a fire at the station.
- There was a business continuity management policy to ensure that, in the event of a critical failure within the organisation for whatever reason, they could continue to deliver adequate levels of service to its clients and the public.

Are patient transport services effective?

Evidence-based care and treatment

- The service had 30 policies in place including training and development, incident reporting, infection prevention and control, safeguarding, care and welfare of the people who use the service, recruitment and selection, data protection and complaints. However the policies did not all have an implementation date, version control number and where there was a review due date (mostly June 2016) they were out of date so we could not be assured that they were up to date with current guidelines and best practice such as National Institute for Health and Care Excellence or Joint Royal Colleges Ambulance Liaison Committee guidelines.
- Staff could access only eight of the 30 policies at the base location as the rest were kept on the operation manager's computer at home and were not printed as hard copies. There was no electronic access at the base and staff were unable to access any policy information whilst out on a call. On the unannounced inspection we saw that the policy folder contained 18 updated policies.
- The operational manager reported that they found it difficult to ensure that staff took notice of policies. Staff were not knowledgeable about policies available for them to reference and there was no process to ensure that staff were up to date with current policies.

Assessment and planning of care

- The operational manager generally took the calls from the local NHS provider and completed an assessment form for patients with complex or additional needs. If staff were available at the base, the information was passed directly. If staff were away from the base, the information was passed via a text message on the service mobile telephone.
- The assessment form was not consistently completed for all patients and the assessment criteria mainly focused on the moving and handling needs and environment, and did not take any account of patient cognitive abilities, skin integrity or illness related risks. We were not assured that all risk assessments identified patient risks.
- For complicated transfer referrals, staff attended the referring location to assess transfer suitability and we observed this process. Referrals that were deemed not suitable were declined.

Response times and patient outcomes

- The service recorded pick-up and drop off times on the daily record form and the operational manager recorded these on their weekly spreadsheets which they shared with the referring NHS trust weekly. They did not measure or audit these outcomes or the timeliness of its service, which meant they had no way of measuring the quality of their performance.
- The service did not participate in any national audits or benchmarking itself against other organisations

Competent staff

- The service had an induction policy, but this was not adapted to the size of the service as it referenced a human resources department, departmental handbook, and a copy of the job description which were not available at the time of inspection. However the attendance of induction and shadowing assessments were recorded and details were available in the staff personnel files.
- Staff confirmed they received an induction programme on the commencement of their role which included

training in but not exclusive to; first aid at work, and manual handling. Staff also confirmed they received six weekly meetings to address any training needs or concerns.

- The operational manager performed appraisals every six months and we saw evidence to support this in the personnel files. At the time of inspection one crew member had been in post less than one year, one two months and the other over three years.
- Driving licences were checked on a yearly basis, via an online system. We reviewed all three personnel files for the staff, which showed that all had a driving licence check within the 12 months prior to our inspection.
- The service encouraged staff training and development and we saw evidence that previous members of staff had been supported to undertake training to ambulance technician level.
- The operational manager had an external mentor which they used to discuss and reflect on the service and any concerns.

Coordination with other providers and multi-disciplinary working

- There was a service level agreement with the local NHS trust to provide an ad hoc non-emergency patient transport service for patients requiring transport to and from hospital or home as well as transfers to other hospitals.
- We spoke to the transport liaison at the local NHS trust. They confirmed that they held monthly meetings with the service and that the service was efficient, responsive and that they had never had a complaint about them. They commented that 'they did as they were asked' and that 'they raised a concern if they felt that they could not complete a transport episode and that the reasons given, were valid'.
- Staff confirmed that they would contact the initial provider if they felt that there were concerns regarding a transport and gave an example of when there was a safeguarding concern at a patient's home address. They liaised with the discharge ward to ensure the appropriate action was taken in the patient's best interests.

Access to information

- Staff completed a patient record form for transfers. We saw that this included a section to indicate whether or not the patient had a 'do not attempt resuscitation' order and that the crew had been given paperwork to reflect this order.
- The referring organisation provided information via telephone at the point of transport request and staff received a verbal handover at the point of patient pick up. This ensured that staff were made aware of any specific requirements a patient may have and enabled them to ask questions regarding any concerns.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not provide any treatment requiring formal consent other than for manual handling, and staff had a good understanding of what constituted consent.
- The service provided staff with Mental Capacity Act training and deprivation of liberty as part of their mandatory training. They also received training in consent and constraint.
- Staff had a good understanding of their role in regard to deprivation of liberty and lawful and unlawful restraint. They described their responsibilities for keeping service users safe with the minimal restraint necessary.

Are patient transport services caring?

Compassionate care

- Staff we spoke with demonstrated a caring, compassionate attitude when talking about patients and their relatives. One crew member described visiting an elderly service user, they had previously transferred to a local care home, whenever they attended that location.
- Staff made sure that curtains were closed when transferring patients to ambulance stretchers or chairs to protect their dignity. Staff described how they would maintain their patient's dignity by ensuring that they were always suitably covered for example with the use of blankets and this was seen on the patient transfers we observed.
- The service encouraged relatives or carers to accompany service users in the ambulance to offer support.
- The operational manager informed us that they performed patient feedback audits every three months.

The crew gave patient feedback forms (with prepaid addressed envelopes) to patients to complete. The forms asked service users or relatives/carers to comment on a range of subjects including; cleanliness of vehicles, comfort, appearance of staff, treatment, and overall experience.

- The manager showed us several completed forms and the audit results, however the number of forms issued or returned was not recorded so the consistently 100% positive responses recorded, could not be matched against the number of transfers undertaken. We accompanied two patient transfers and saw that patient satisfaction forms were not issued.
- The feedback forms we saw complimented the service. Comments such as "polite and courteous", "exemplary in their care", excellent service is one thing but way beyond that is the genuine kindness and empathy shown", "staff a credit to the service", "could not have wished for a more professional service".

Understanding and involvement of patients and those close to them

- We observed the crew members providing explanations for their activities to service users and saw that feedback forms also commented positively about explanations given at all stages of the transport episode.

Emotional support

- Crew members were respectful of patients and chatted to them in a friendly way throughout the transfer process and journey to make them more comfortable. One patient was anxious when they arrived home and we observed the crew member doing their best to allay their concerns.
- Staff commented that they felt it was 'important to explain everything they did so that it allayed the fears and concerns of the people they transferred.' They showed a depth of understanding of the needs of patients who might be stressed or frightened especially if they suffered from dementia.
- One crew member described how they sometimes sat next to patients in the ambulance and held their hand during transfers to provide some comfort.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- Ambu-Kare UK provided an ad hoc non- emergency patient transport service, around the Peterborough area, to fill requests that larger commissioned services were unable to complete. This was usually due to; lack of capacity, time constraints or because a single patient journey was required.
- The service's contracted availability to the local NHS trust was between the hours of 11.30am and 5pm Monday to Friday, although staff regularly worked beyond 5pm, sometimes up to 9pm and could start at 9am if prior notice was given. An on-call day time service was also offered at weekends. Outside of these hours, the operational manager was contactable by mobile phone to take bookings but it was rare for referrals to occur at weekends.
- The service offered patient transport services for patients conveyed to and from the local hospital, as well as country wide hospital-to-hospital transfers as requested.
- Due to the low number of journeys undertaken, which averaged between 15 and 30 journeys per week, the service was able to manage capacity well. The operational manager and crew told us that if they were unable to fulfil a booking they would advise the referrer at the time the transfer was requested and this was confirmed by the transport liaison at the local NHS trust. Declined bookings happened rarely with only 12 transfers declined during the period April 2016 to March 2017.
- The operational manager met informally with the transport liaison from the local NHS trust on a monthly basis to discuss any issues or concerns.

Meeting people's individual needs

- There were no arrangements in place for accessing translation services if required. The operational manager told us that staff were encouraged to use an internet search engine to translate however staff said they would usually use relatives to translate.
- There was no pictorial or easy to read information available on ambulances for those patients with dementia or a learning difficulty.

Patient transport services (PTS)

- Staff received no specific training for dealing with patients with complex needs, for example those with a learning difficulty, older patients, or patients living with dementia. However we saw patient feedback forms with very positive comments on the crew's patience and understanding when dealing with the transfer of a relative with dementia.
- One crew member explained that they let 'patients tell their own story' and gave a good example. They displayed empathy and understanding on how to deal with patients with complex needs.
- There was bottled water and cups available for service users during transport on the vehicles.

Access and flow

- Bookings were made on a daily ad hoc basis from the local NHS trust. The operational manager contacted the trust in the mornings to find out the current situation at the trust and to try and ascertain when and how many referrals they were likely to receive.
- The operational manager had a telephone briefing with the local trust on a daily basis to anticipate staffing requirements and was able to manage capacity and resources as required.
- The service logged on-scene and turnaround times on their daily record sheets and these were recorded but not formally monitored by the operational manager.

Learning from complaints and concerns

- The service received no complaints for the period April 2016 to March 2017 and their last recorded complaint was in 2012. We were unable to ascertain any learning from complaints as the service had not received any in the last five years.
- The service had a complaints policy which set out their responsibilities and staff confirmed that they knew how to report a complaint, however there was no information routinely available on the ambulance vehicles to patients and carers on how to complain.
- There was no process in place for joint investigations with other providers that work was contracted from.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The service was led by the operational manager who was also the registered manager. They were responsible for overseeing all aspects of the service including training, clinical matters, the risk register, and policy setting.
- We spoke with three staff who described the manager as very approachable, and supportive.
- The operational manager worked from the location office daily and staff had good contact with them via mobile phone if they were off site.
- Staff appeared very relaxed and one commented that "this was the best job since leaving school".
- The service operational manager was aware of the limitations of their service and contracts. They shared this with staff via verbal and via the communications folder.

Vision and strategy for this this core service

- The service launched a new mission and set of values in September 2016. The vision was 'Positive experiences, safe and effective care' and the set of values focused on patient safety, clinical effectiveness and patient experience.
- Staff were not aware of the vision and values and could not relate them when prompted. This meant that they were not embedded; however we observed that they displayed the values through their commitment and conduct with patients.

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

- There was no effective governance framework in place. The operational manager did record performance data but there was no evidence of it being used to improve performance and quality or sharing of outcomes.
- There were staff meetings but the minutes did not show discussions around risk, monitoring of the service and performance or audit data.
- Working arrangements with the main contractor (the local NHS hospital) were by contract renewed on a six monthly basis. There was daily telephone contact with the hospital transport liaison manager at the hospital and informal monthly discussions
- There was no systematic programme of clinical or internal audit, used to monitor quality and systems to identify where action should be taken.

- The operational manager did not have good oversight of policies and procedures. Policies lacked implementation and review dates and were not embedded. For example the incident reporting policy was not being followed as incidents were not reported, investigated or learning shared. The service did not have an inclusion/exclusion policy or a policy for the management of the deteriorating patient. These policies were required to enable staff to carry out their role safely and effectively.
- The service had a risk register but there were no entries. The operational manager had indicated that repeated short term contracts of one year or less, with the local NHS trust prohibited them from developing long term development plans.
- When we returned for the unannounced inspection there were five entries on the risk register with some dating back to February 2017. The risks related to service level agreements ending for the ambulances, loss of deputy manager and a recent no fault road traffic accident requiring a vehicle to be off the road. The operational manager confirmed that they had reviewed the concerns and realised that they should have been recorded. We saw the risks were dated, rated and there were mitigating actions and ownership shown, but there was a lack of understanding about what constituted a service risk.

Public and staff engagement (local and service level if this is the main core service)

- The service held regular three monthly meetings with staff and we saw evidence of the minutes in the communications folder in the staff rest room.
- Engagement with the public was limited to the patient feedback cards.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The service did not engage in any innovation, service improvement or sustainability plans.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that appropriate inclusion/ exclusion guidance for patient eligibility to use the service is produced and adhered to.
- The provider must ensure that all patients are appropriately risk assessed prior to being transferred by the service.
- The provider must ensure that transfers involving children are appropriately risk assessed and develop a procedural policy.
- The provider must ensure that there is a level 3 children's and adult's safeguarding lead.
- The provider must ensure that equipment is serviced and maintained appropriately.
- The provider must ensure that incidents are identified, reported, investigated, and learning shared and that appropriate guidance and support is available to staff.
- The provider must ensure that there is a system of auditing and service improvement in place to ensure the effectiveness of the service.
- The provider must ensure that policies and processes are up to date, contain current guidance and that staff use the policy recommendations.
- The provider must ensure that an effective governance framework is in place.
- The provider must ensure that service user identifiable data is protected at all times.

Action the hospital SHOULD take to improve

- The provider should ensure that staff receive training in incident reporting, duty of candour, dementia and learning disability.
- The provider should ensure that staff are able to access translation services when needed and not use relatives to translate for non-English speaking service users.
- The provider should consider providing easy to read or pictorial reference information for those people with dementia or a learning difficulty.

This section is primarily information for the provider

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met; The provider had no inclusion/exclusion criteria which meant staff did not have clear guidance on whether a patient was suitable to accept for transport. Incidents were not identified, reported or investigated. There was an incident reporting procedure policy but this was not being followed. There was no formal training in place for the reporting of incidents. There was a lack of oversight regarding when equipment maintenance was due and some equipment was out of date for maintenance and servicing. Regulation 12 (2) (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks: (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met;

This section is primarily information for the provider

Requirement notices

Risk assessments were not consistently undertaken prior to transfers and there was no process for risk assessing child transfer

The provider did not audit service outcomes and there was no evidence of recorded information being used to improve performance and quality to ensure the effectiveness of the service.

The provider did not assess, monitor and improve the quality and safety of the services provided to identify and mitigate risk. The service risk register did not detail any risks known to the service for business continuity.

The service policies were out of date, poorly adapted and were not consistently followed by staff.

The service did not securely maintain patient identifiable data with records being removed off site in a private vehicle for transcribing elsewhere on a private computer.

This meant that they were failing to operate good governance through effective systems and process because risk was not being identified and therefore not being adequately monitored or managed.

Regulation 17,

(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part

(2) (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

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

This section is primarily information for the provider

Requirement notices

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

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