

Alpha Care Ambulance Service Limited

# Alpha Care Ambulance Service

## Quality Report

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Alpha Care Ambulance Service is an independent medical transport provider based in Moulsoford, Oxfordshire. The service provides a patient transport service and medical cover at events. Services are staffed by trained paramedics, emergency care technicians, ambulance care assistants and technicians.

We inspected this service as a follow-up, responsive inspection after our inspection of 14 March 2017 when the service was suspended until 16 May 2017.

We carried out the inspection on 10 May 2017 and our focus was to determine if improvements had been made against the areas of poor practice highlighted at the previous inspection.

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? We have not commented on caring in this report, as there were no concerns highlighted from the previous inspection.

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 provider did not have processes or practices in place to assess, monitor and improve quality and safety. There was not a robust system to ensure all incidents were recorded and monitored appropriately and no learning or outcomes were shared with staff.
- There were limited policies and guidelines to support staff to provide evidence based care and treatment.
- Managers did not have an understanding of risk and its management relating to the business and they did not demonstrate the necessary knowledge to lead effectively. The registered manager appeared to have very little understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and how these related to the business, or the consequences of not complying with them.
- There were no effective governance arrangements in place to monitor or evaluate the quality of the service and improve delivery. Audits were not undertaken and therefore learning did not take place from review of procedures and practice.
- There was no formal risk register in place at the service and therefore we had no assurances that risks were being tracked and managed to mitigate risks.
- There was limited provision on ambulance vehicles to support people who were unable to communicate verbally or for whom English was not their first language.

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. We also issued the provider with two requirement notices that affected the patient transport service. Details are at the end of the report.

# Summary of findings

Despite improvements that still needed to be made, as highlighted above and in this report, we determined that the significant concerns we previously had regarding the immediate risk to patients had been sufficiently mitigated. We were therefore satisfied that the registration of the service could resume on 16 May 2017 and we informed the provider of this on 12 May 2017.

**Professor Edward Baker**  
**Chief Inspector of Hospitals**

# Alpha Care Ambulance Service

## Detailed findings

### Services we looked at

Patient transport services (PTS)

# Detailed findings

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## Background to Alpha Care Ambulance Service

Alpha Care Ambulance Service is operated by Alpha Care Ambulance Service Limited. The service was registered on 27 July 2011. It is an independent ambulance service based in Moulsoford, Oxfordshire. The service provides non-emergency patient transport and medical cover at events to private organisations and some non-emergency patient transport to NHS trusts. The service also provides school transport for special needs children. Services are staffed by trained paramedics, ambulance technicians and ambulance care assistants. The service primarily serves the communities of Oxfordshire and Berkshire.

The service has had a registered manager in post since 27 July 2011.

Alpha Care Ambulance Service fleet consists of eleven vehicles: three front line ambulances, five patient transport ambulances, one wheelchair access vehicle, three response cars and a support lorry for events. Four of the patient transport ambulances are fitted with one stretcher and three seats. The service employs eight whole time equivalent employed staff and seven self-employed staff. The service provides cover seven days a week for its patient transport service.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist

advisor who had experience and knowledge of emergency ambulance services and non-emergency patient transport services. Leanne Wilson, Head of Hospital Inspection, oversaw the inspection team.

## How we carried out this inspection

We carried out a focused, unannounced inspection on 10 May 2017.

During the inspection we visited the station at Moulsoford, Oxfordshire and we spoke with staff including; registered paramedics, technicians and ambulance care assistants.

We did not speak with patients as part of this inspection because the service was suspended at the time our inspection.

# Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

## Information about the service

Alpha Care Ambulance Service is an independent ambulance service, which provides non-emergency patient transport services. They also supply first aid services to public events. The service is staffed by two registered paramedics, one technician, one emergency care technician and four ambulance care assistants, one of whom worked as a mechanic.

We inspected this service as a patient transport service as this was their primary work.

The journey types and categories of patient transported included outpatients appointments, admissions and discharges to hospital, nursing and residential home transfers, long distance road ambulance transfers, hospital to hospital and medical standby for public events. The service also provided school transport for children with special educational needs.

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury.

During the inspection, we visited the service base located in Moulsoford, Oxfordshire, and we spoke with five staff including; registered paramedics, patient transport drivers and management.

The service had been inspected twice in December 2013 and the most recent inspection took place on 14 March 2017, after which the service had its registration suspended due to significant concerns of the immediate risk to patients.

## Summary of findings

- The provider did not have processes or practices in place to assess, monitor and improve quality and safety. There was not a robust system to ensure all incidents were recorded and monitored appropriately and no learning or outcomes were shared with staff.
- There were limited policies and guidelines to support staff to provide evidence based care and treatment.
- Managers did not have an understanding of risk and its management relating to the business and they did not demonstrate the necessary knowledge to lead effectively. The registered manager appeared to have very little understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and how these related to the business, or the consequences of not complying with them.
- There were no effective governance arrangements in place to monitor or evaluate the quality of the service and improve delivery. Audits were not undertaken and therefore learning did not take place from review of procedures and practice.
- There was no formal risk register in place at the service and therefore we had no assurances that risks were being tracked and managed to mitigate risks.
- There was limited provision on ambulance vehicles to support people who were unable to communicate verbally or for whom English was not their first language.

# Patient transport services (PTS)

## Are patient transport services safe?

### Incidents

- At our inspection 14 March 2017, we found the service had a paper-based system in place for staff to report accidents, incidents and near misses. At the time, managers informed us there were no incidents recorded since January 2016. We were concerned that incidents or concerns were not being reported or investigated and we were not assured incident reporting was embedded in the culture of the service.
- The service had updated and re-organised the incident reporting folder. We were unable to test the process as the service had not been operating since the previous inspection. However, the service was unable to evidence that feedback for staff had been implemented, and that there was differentiation being made between serious incidents, near events, incidents, near misses, complaints or safeguarding concerns. This meant the service was unable to assess or analyse incidents, identify themes and trends or areas for improvement.

### Cleanliness, infection control and hygiene

- At our inspection of 14 March 2017, we were not confident in the service's infection control processes because we found there were no cleaning or deep cleaning schedules in place. There was no clearly defined process for deep cleaning or how this would be done, and using what products. There were also no audits on vehicle cleanliness present when we inspected.
- During this inspection, we found a deep cleaning process was in place including deep cleaning schedules. However, the schedules were not robust and outlined only cleaning which had taken place and did not have dates for future cleaning.
- No audits had been undertaken or planned to check the effectiveness of the cleaning of vehicles.
- At our previous inspection, we were informed the service did not complete infection, prevention and control audits or hand hygiene audits. This meant the service could not be assured they were compliant.

- During this inspection, we found that no infection, prevention and control audits or hand hygiene audits had been undertaken or planned.

### Environment and equipment

- On 14 March 2017, there were no records of equipment testing or records of equipment asset management available to view. We saw some equipment had been serviced, however, we found two defibrillators on ambulances that had been serviced but the batteries needed replacing. We also found that the safety testing for all the electrical equipment had expired.
- An asset register for all portable equipment had been put in place. We saw this detailed service dates for all items and showed, where appropriate, all equipment had now been serviced and safety tested.
- At our previous inspection there were no fire safety risk assessments or environmental risk assessments in place. Fire extinguishers in all the ambulances and onsite had never been serviced. This demonstrated a lack of ownership and oversight of the potential risks to patients, staff and visitors.
- During this inspection we found both fire safety and environmental risk assessments had been completed and were in place. In addition, with the exception of one, fire extinguishers in all the ambulances and onsite had been serviced.
- At our inspection on 14 March 2017 vehicles did not have current records detailing their maintenance, insurance and road tax records. We found that one vehicle's tax expired in October 2016. We received assurance that the vehicle had not been used since the tax had expired. This was raised with the management team and the tax was renewed immediately.
- A computerised record system was now in place for all vehicles. On review this system monitored and tracked each vehicle's journey. It also detailed maintenance, insurance and road tax information. In addition it provided the service with automated notifications regarding these areas, for example when insurance or road tax was due to renewal.

### Medicines

- At our previous inspection, we found examples of poor medicines management. The service was storing and

# Patient transport services (PTS)

administering medicines, which were out of date. Staff had not received any training on medicines management. We found, out of date morphine (2015) being stored awaiting destruction. There was no policy or risk assessment to support the need for the use of these medicines, storage or disposal.

- All out of date medicines had been removed. There were no controlled drugs on the premises and we saw confirmation that the controlled drugs had been safely removed and disposed of.
- We also saw evidence staff had been provided with medicines management training.
- At inspection on 14 March 2017 there were no recorded medicines audits or checking of expiry dates of medicines.
- A process for checking expiry dates of medicines had been implemented but we did not see evidence of a medicines audit or audit plan.
- At our previous inspection we found staff had not received training to administer a patient's own medicine for one of their regular transport patients should they deteriorate en route. An external provider had given all staff the appropriate training for this medicine.

## Safeguarding

- At our inspection in 14 March 2017 we found processes, training and policies did not keep vulnerable people safe. The service transported children, patients with learning disabilities and patients living with dementia, as well as persons otherwise vulnerable due to their age, mobility or illness. There were no systems or processes established or operated effectively to prevent abuse of service users, or to recognise and report concerns. There was no oversight or scrutiny of the safeguarding training.
- We saw evidence safeguarding eLearning was in place and all staff had completed the training. In addition all staff were booked to attend face-to-face training provided by the local safeguarding team. The service had identified a safeguarding lead and they had been booked to attend additional training for that role with the local safeguarding team.
- At our previous inspection staff did not demonstrate a clear understanding of safeguarding process. There

were no procedures for staff to follow in the event of them having a safeguarding concern, and no guidance documents to support staff in identifying a safeguarding concern.

- During this inspection the service was able to provide an example when a member of the public had called the service to request transport. However the managers were concerned about the details of the transport and raised a safeguarding concern with the local safeguarding team. This demonstrated an improved awareness of the safeguarding process within the service.

## Mandatory training

- At our previous inspection there was not clear evidence that staff had undertaken mandatory or induction training since employment with the service. There was no definition of what training was mandatory and must be undertaken by staff. The service did not have an up-to-date record of staff training.
- During this inspection we saw evidence staff had received mandatory and statutory training via eLearning packages. In addition staff had received face-to-face training for basic life support. Training records were in place and stored on the staff database held by the service.

## Are patient transport services effective?

### Evidence-based care and treatment

- At our inspection on 14 March 2017 we found staff had access to Joint Royal Colleges Ambulances Liaison Committee (JRCALC) clinical practice guidelines. However, there were no regular clinical audits to monitor adherence to these guidelines.
- In addition there were limited policies and guidelines to support staff to provide evidence based care and treatment.
- We saw no evidence of a clinical audit plan having being implemented or scheduled. The service remained unable to assure itself that transport was provided in line with local guidelines. It was also unable to assure itself that staff assessed patient needs against evidence based protocols to provide care and transport.



# Patient transport services (PTS)

## Response times and patient outcomes

- At our previous inspection there was no formal system in place to monitor the services performance to ensure they were delivering an effective patient transport service. The service did not benchmark itself against other providers.
- The service did not undertake audits, which would allow it to assess if it was meeting the needs of the patient groups it served. We found the service did not have a system in place to routinely collect or monitor information on how the service was performing.
- During this inspection we did not see any evidence a monitoring or audit system had been put in place or was planned.

## Competent staff

- At the inspection in March 2017 we could not be assured all staff employed by the service were of good character and had the competency to carry the role in which they were employed. We had found that relevant employment information such as references, reasons for the termination of previous employment, and health checks were not in place on staff files. This did not adhere to the service's own Recruitment Policy (September 2016).
- In addition staff had not received specific basic training and competencies in respect of their roles. There were no records of competencies for staff on how to use equipment such as chairs, defibrillators or oxygen. Neither did the service have an induction programme for new starters and senior management informed us that the staff had not received an appraisal.
- A computerised system had been purchased to enable the service to store staff records and employment information. We saw that this was being updated to reflect completed training and on-going human resource information.
- We saw that an induction policy and programme had been implemented.
- Managers and staff we spoke with confirmed that appraisals had commenced. We saw evidence of completed appraisals and dates for those that had been scheduled.

- However, staff had still not received specific competency based training in respect of their roles. Managers informed us that they had identified external training resource for this but had yet to implement the training due the unsure future of the service following its suspension. We saw evidence of the external training and records in respect of basic life support training that had been provided.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At our previous inspection we found vulnerable patients including children with learning disabilities and patients with mental health concerns were transported on a daily basis. There was no evidence staff had received any initial or continual training in understanding learning disability or mental health needs.
- We saw information demonstrating all staff were booked to attend a learning disability study day with the local safeguarding team.

## Are patient transport services caring?

We did not inspect caring as the service was suspended at the time of our inspection and so we were unable to observe any duties or patient interactions.

## Are patient transport services responsive to people's needs? (for example, to feedback?)

## Meeting people's individual needs

- At our inspection of 14 March 2017 there was no coordinated training for staff in dementia awareness, mental health or a learning disability. This meant services delivered might not take account of the needs of patients and callers living with dementia, mental health or a learning disability, although some staff gave us examples of how they would communicate with these patients.
- We saw that relevant training had been sourced by the service. All staff had either completed training or had been booked onto appropriate courses.

# Patient transport services (PTS)

- At our previous inspection we found the service did not have any communication aids, to support patients with communication difficulties for whom English was not their first language, who were visually or hearing impaired, who were unable to speak due to their medical condition or who had complex needs. There was a potential risk of patients not being able to explain what was wrong or understand staff.
- During this inspection we saw no evidence that the service had identified any additional communication aids to support both staff and patients. The potential risk remained of patients not being able to explain what was wrong or understand staff.
- At the last inspection on 14 March 2017 we found significant concerns regarding the governance and risk management processes of the service. Neither the managing director nor director of operations had good oversight of the quality of the business. There was no understanding or appreciation of wider quality assurance issues such as patients being properly safeguarded against harm
- In addition, the service did not hold a risk register or have other similar systems to identify and monitor or grade risks to the organisation, both clinical and non-clinical. There were no systems in place to identify and act on risks to people who used the service. There were potential risks to staff and patient safety, through lack of observation and monitoring of performance.

## Are patient transport services well-led?

### Leadership / culture of service related to this core service

- The day-to-day management team for the service comprised of the managing director, director of operations and an administrator who all worked full time. The managers looked after the welfare of the staff and were responsible for the planning of the day-to-day work. They also formed part of the operational staff.

### Vision and strategy for this this core service

- At the previous inspection we found that the service had a statement of purpose and a vision to “deliver a high quality, cost effective service that is patient centred with dignity and respect, by a skilled compassionate workforce who are open and honest and work as a team”.
- The service had seven strategic aims based on the word “mission”, motivation, inspire satisfaction, staff, and infrastructure, open and never stop listening. We observed that this was on the staff noticeboard.
- During this inspection staff we spoke with told us they did not know what the long-term vision and strategy for the service was. However, this was primarily due to the uncertainty following the suspension of the service. They expressed a hope that the service would continue and that they could continue to help their patients.

### Governance, risk management and quality measurement

- There was also no evidence of governance meetings taking place. The senior managers did not meet regularly or formally record any meetings. There was no system in place to disseminate learning from incidents, safeguarding and complaint outcomes.
- There was a lack of assessment of the environment and of fire safety matters, which contributed to the lack of monitoring the quality of the service, and safety risks that may be present.
- There was no audit strategy or plan in place for the service. The service did not carry out audits to measure the quality and effectiveness of the service delivered, such as cleanliness and infection control.
- There was no oversight of recruitment requirements regarding staff receiving appropriate support, training, professional development, supervision and appraisal.
- During this inspection we found limited progress with regard to governance within the service.
- We saw no evidence that an audit strategy or plan had been put in place or devised. This meant there remained limited opportunity for the service to measure its quality against set internal or external standards.
- Fire safety and environmental risk assessments had been completed and an action plan was seen.

# Patient transport services (PTS)

- There was no risk register in place that effectively identified and graded risks to the organisation. So there remained no formal process for identifying and prioritising risks and recording measures implemented to reduce the identified risks within the organisation.
- We spoke with three members of staff who told us they were all aware of the situation regarding the suspension of the service following the previous inspection. There was still no evidence of regular forums however they confirmed managers had been working with the staff to improve the service.

## **Public and staff engagement**

- At the inspection on 14 March 2017 staff reported to us there had not had any team meetings. There was no evidence of regular forums to engage all staff, update them on any developments and share any learning.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital MUST take to improve

- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to incident recording and reporting, and the governance of the service.
- Ensure robust governance and risk management systems are in place and understood by all staff. The provider must implement systems and processes to assess, monitor and improve the quality and safety of the services.
- That appropriate infection control and prevention methods are used to prevent the spread of infection. Whilst vehicles were seen to be clean, there were a number of concerns around the deep cleaning of vehicles.
- Ensure processes are in place so all staff employed have the experience and competence required for their role.
- A risk register is in place with describes risks to the services and what plans are in place to reduce the risks.

## 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 Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>How the regulation was not being met:</b></p> <p>The provider failed to ensure that safe care and treatment was provided at all times because:</p> <ul style="list-style-type: none"><li>Incidents that affected the health, safety and welfare of people using services were not always thoroughly investigated and actions were not taken to prevent recurrences</li><li>There were no infection prevention control audits conducted to ensure high standards of cleanliness were being maintained.</li></ul> <p>Regulation 12 (1)(2)(a)(b)(c)</p>
Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>How the regulation was not being met:</b></p> <ul style="list-style-type: none"><li>The quality of incidents reporting and investigation was not adequate.</li><li>There were no infection, prevention and control or hand hygiene audits.</li><li>There was no risk register to ensure risks were identified and managed to ensure appropriate actions were taken to mitigate risk.</li><li>The provider did not have systems or processes in place such as regular audits of the service provided or assess, monitor and improve the quality and safety of the service.</li></ul>

This section is primarily information for the provider

## Requirement notices

- There were insufficient quality and monitoring processes in place to review systems and procedures and to take learning to make improvements.

Regulation 17 (1)(2) (a)(b)(f)

## Enforcement actions

### 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  Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>Due to significant breaches of the above regulations, we issued a section 29 warning notice.</b></p> <p>The warning notice was in respect of patient transport services at Unit FT2 1-3, Greenlands Rural Business Centre</p> <p>Moulsford, Oxfordshire, OX10 9JT.</p> <p>The registered provider has to make necessary improvements and provide evidence of assurance on the following:</p> <ul style="list-style-type: none"><li>• Governance processes were improved in line with Regulation 17 (Good governance) of the Health and Social Care Act (2008). This included systems and processes to assess, monitor and improve the quality and safety of the services are established and operated effectively.</li></ul>