A B Medical Services (UK) Limited

AB Medical Services

Quality Report

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

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

AB Medical Services is operated by AB Medical Services (UK) Limited. The independent ambulance service provides event medical cover, patient transport services and patient repatriation services.

We inspected this service using our comprehensive inspection methodology. We carried out this announced inspection on 26 September 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 service understood and complied with the Mental Capacity Act 2005.

Services we do not rate

The main facility provided by this service was event medical cover. However, CQC does not currently have the power to regulate event medical cover. A small proportion of the activity provided by the service were patient transport services and self-funded repatriations. These activities are regulated by CQC.

We regulate independent ambulance services but we did not have a legal duty to rate them at the time of this inspection. We highlight good practice and issues that services need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Staff showed an understanding of the incident reporting system and the importance of reporting incidents.
- The service was very well equipped with equipment and consumable medical supplies that were appropriately sealed and in date.
- There were systems to ensure vehicles were checked and maintained regularly. We saw certificates reflecting that all vehicles complied with MOT testing, were insured and had been taxed.
- The service had good medicines management and good security for medicines and supplies.
- We saw evidence that both equipment on the ambulance and auxiliary equipment had comprehensive annual testing and servicing by an engineer. The engineer's feedback sheet from the most recent tests in March 2017 reflected that all equipment passed inspection.
- The service was prepared to respond to a major incident with trained staff and a well-equipped ambulance.
- Staff had access to evidence-based guidance.
- The service ensured staff had base line competency before offering employment and supported ongoing staff competency through regular auditing, training and appraisals.
- Staff worked with other medical staff from other services to share care and information.
- Patient feedback was positive.
- Staff ensured dignity in public places for vulnerable patients.
- Staff were prepared to meet the needs of individual patients, for instance children and young people and those with communication and learning difficulties.

Summary of findings

- The service reported that they had received no written or verbal service user complaints during the twelve-month reporting period prior to the inspection.
- Staff we spoke to understood the service's mission and readily told us the service was led by these values.
- Staff were proud to work for the service and felt they gave patients a high standard of service and care.
- The senior managers were very visible and accessible. They performed operational duties and were regularly at events working with staff as a senior team member or team leader.

However, we also found the following issues that the service should improve:

- Senior staff were not familiar with the duty of candour, although they were all able to discuss the importance of open and transparent communications with patients and family members.
- The service's training tracker reflected that only four out of eight staff members (50%) had completed their infection control training. This meant staff might not have up to date knowledge regarding infection control to protect patients.
- The service used a system of policies and audit to ensure the delivery of strategy and care, but did not have a robust system to manage risks or a system to ensure policies were regularly reviewed.

At the inspection, we reported to the service that the following issues needed to improve:

- The safeguarding lead was not trained to adult and child safeguarding level 3 in line with intercollegiate guidance.
- Bag valve masks (BVMs) were out of date having expired in 2015.
- Children under age two could not be transported safely as the service did not have equipment to safely transport this group.

The provider took steps immediately and provided evidence that they had improved these issues within ten working days of the day of inspection, these are outlined within the report. Details of steps we are still asking the provider to take are at the end of the report.

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We found areas of good practice at our inspection. • We saw that ambulances were well equipped with many supplies that were appropriately sealed and in date. • The service had a good appraisal system, which included audit of staff paperwork and on-the-job review of working practice. • The service had a good medicines management system that included security for medicines and supplies. • The service had a clear mission and worked within its established values. We also found areas for improvement. • The service used a system of policies and audit to ensure the delivery of strategy and care, but did not have a robust system to manage risks or a system to ensure policies were regularly reviewed. • The safeguarding lead was not trained to adult and child safeguarding level three at the time of inspection. This was not in line with intercollegiate guidance. • Bag valve masks (BVMs) expired in 2015. • Children under age two could not be transported safely as the service did not have equipment to safely transport this group. However, during the ten-day post inspection period, the service submitted evidence that they had addressed most of these issues by completing safeguarding level three training, replacing the BVMs and purchasing equipment to safely transport children under age two.

AB Medical Services

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Detailed findings

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Background to AB Medical Services

AB Medical Services is operated by AB Medical Services (UK) Limited. The service was first registered with CQC in 2014. It is an independent ambulance service in Sittingbourne, Kent. The service primarily serves the communities of Kent and the South East.

The main service provided by AB Medical is event medical cover. However, the CQC does not currently have the power to regulate event medical cover; this service is regulated by the Health and Safety Executive. A small proportion of the services performed by AB Medical were patient transport services, including two patient transfers to hospital and two self-funded patient repatriations (during the 12 month reporting period). The patient transport services are regulated by the CQC. This means CQC only have the power and duty to inspect the patient transport service and repatriation part of AB Medical Services.

The service employed one registered paramedic, two technicians, and five first responders on zero hour contracts. The service also used a subcontractor paramedic as necessary.

The service had a fleet that included one fully equipped ambulance and two ambulance cars.

The service has had a registered manager in post since 10 November 2014.

Our inspection team

The team that inspected the service comprised a CQC inspection manager (Elizabeth Kershaw), two CQC team inspectors, and a specialist advisor with expertise as a paramedic. The inspection team was overseen by Amanda Stanford, Deputy Chief Inspector of Hospitals.

How we carried out this inspection

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 AB Medical Services' only registered location in Sittingbourne, Kent. We spoke with the Managing Director (a registered paramedic). After the inspection we spoke by telephone to the Operations Manager (a first responder) and a paramedic who provided services to AB Medical as a subcontractor. During our inspection, we reviewed four sets of patient records, two sets of employee records, policies, the employer's e-portal (used for staff resources, auditing, training and staffing), one ambulance and the service's stock of medicines and supplies.

Detailed findings

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity during the reporting period (August 2016 to July 2017):

- The service undertook four patient transport journeys, two transfers to hospital and two repatriations.
- The service reported there were no never events.
- The service reported there were no clinical incidents.
- The service reported there were no serious injuries.
- The service reported there were no complaints.

Other providers do not operate within the service.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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Summary of findings

We found areas of good practice at our inspection.

- We saw that ambulances were well equipped with many supplies that were appropriately sealed and in date.
- The service had a good appraisal system, which included audit of staff paperwork and on-the-job review of working practice.
- The service had a good medicines management system that included security for medicines and supplies.
- The service had a clear mission and worked within its established values.

We also found areas for improvement.

- The service used a system of policies and audit to ensure the delivery of strategy and care, but did not have a robust system to manage risks or a system to ensure policies were regularly reviewed.
- The safeguarding lead was not trained to adult and child safeguarding level three at the time of inspection. This was not in line with intercollegiate guidance.
- Bag valve masks (BVMs) expired in 2015.
- Children under age two could not be transported safely as the service did not have equipment to safely transport this group.

Patient transport services (PTS)

However, during the ten-day post inspection period, the service submitted evidence that they had addressed most of these issues by completing safeguarding level three training, replacing the BVMs and purchasing equipment to safely transport children under age two.

Are patient transport services safe?

Incidents

- The service had an Incident Policy, which was last updated in May 2014. The policy addressed incidents including: health and safety, violence, abuse, clinical near misses and non-clinical near misses. The policy included objectives, staff roles, and the incident reporting process. However, the policy did not include a review date. This meant staff could not be assured the policy was current and accurate.
- The service had an electronic incident reporting system, which staff could access through the staff portal. All staff we spoke to reflected an understanding of how and when to report an incident. Incident reporting systems are important because they provide assurance that incidents are managed and opportunities to learn from incidents, even when they cause no harm.
- However, staff reported no incidents for the twelve months prior to inspection. This could mean there were no incidents or it could mean that "near miss" incidents were not being reported so the services could not learn from them and make improvements.
- The service had no never events in the twelve-month period prior to inspection. 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 services. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- The duty of candour, Regulation 20 of the Health and Social Care Act 2008, relates to openness and transparency. This duty requires health and social care service providers to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff told us they had never applied the duty of candour, as there had been no incidents.
- However, when we asked senior staff to describe their duty under the duty of candour, staff were not familiar

with this term. However, they were all able to discuss the importance of open and transparent communications with patients and family members. Further, the duty of candour was not discussed in the service's incident policy or any other policies we reviewed. This meant that if there were a 'notifiable safety incident' the service might not be fully aware of its regulatory duty with regard to the patient and/or their family.

Cleanliness, infection control and hygiene

- During the inspection, we reviewed the one ambulance used by the service for patient transport. The ambulance had last been used three days earlier. The vehicle was clean and tidy, supplies and equipment were appropriately stored and the ambulance was clear of clutter.
- Reusable equipment was visibly clean, intact and in good working order.
- The trolley and mattress were clean and intact and there was a supply of sealed disposable mattress covers on the ambulance.
- Decontamination wipes for cleaning equipment were available on the ambulance.
- We saw that there was a full container of hand cleansing gel available on the ambulance. We were not able to observe patient care so could not observe staff hand hygiene in practice.
- Senior staff told us they observed staff infection control procedures during observational appraisals. Performance reviews showed infection control procedures were observed and documented as part of the performance review template including the use of personal protection equipment (PPE) and bare below the elbow compliance. The template did not specifically address hand hygiene but senior staff told us this was part of the infection control observations.
- Performance review reports we reviewed showed staff complied with infection control policies and procedures.
- We saw there was personal protective equipment (PPE) available including disposable gloves in three sizes, helmets and high visibility jackets.
- The ambulance included an infection control cupboard that was fully kitted with stock such as bodily fluids spillage kit, wipes and absorbent roll.
- Staff were responsible for cleaning their own uniforms. If a uniform was contaminated it would be disposed of in the medical waste bin and replaced by the company. Staff had multiple sets of uniforms so they would have a clean uniform every day if they were working multiple days in a row. We saw the service had a stock of new uniforms so that if a staff member needed a new uniform, they were available.
- We saw the ambulance was cleaned after every use and deep cleaned by staff every three to six months. We saw the service kept a cleaning log, which reflected the most recent deep cleaning in September 2017. Senior staff said they used staff input and information from the 'known infections' box on the patient report form (PRF) to determine when a responsive deep clean was required.
- We saw a mop and disposable heads, clearly labelled for cleaning the ambulance, with appropriate cleaning solutions. We saw that the service used a cleaning fog machine when deep cleaning the ambulances to ensure all surfaces were disinfected and provide a longer-term protective film. All cleaning supplies were labelled and kept in a locked garage.
- We saw there were two waste bins on the ambulance, one for clinical waste and one for general waste. This allowed staff to segregate waste safely in line with Health Technical Memorandum 07-01: Safe Management of Healthcare Waste, Clinical waste was double bagged and disposed of in the service's locked clinical waste bin. However, the bin was not affixed to a wall or the ground, which meant it could have been at risk of theft.
- We saw that the service had a contract with a third party supplier to remove clinical waste and that the waste removal service supplied a certificate of removal reflecting that the waste had been disposed of appropriately.
- Staff told us that if they needed additional clinical waste pickup, the third party contractor would arrange an early or extra pick up, but that this had not been necessary. This meant clinical waste was not likely to be stored or disposed of inappropriately.

- We saw that there were sharps bins on the ambulance and storage facility. We saw that the bins were clean, not filled above the fill line and were closed in line with directions. Staff told us that full bins would be closed and disposed of in the clinical waste bin for disposal by the third party supplier.
- However, the service's training tracker reflected that only four out of eight staff members (50%) had completed their infection control training. This meant staff might not all have up to date knowledge regarding infection control to protect patients.

Environment and equipment

- The service did not have an ambulance station. The business was run from a private residence where vehicles could be parked overnight. Supplies were stored in a locked and alarmed facility. Staff told us vehicles were kept in a locked facility when they were not in regular use or could be parked at staff residences when they were to be used the next day.
- The service has three vehicles including two cars and one ambulance. We saw certificates reflecting that all vehicles complied with MOT testing, were insured and had been taxed. We inspected the ambulance, as this was the only vehicle used for patient transport.
- There were systems in place to ensure vehicles were checked and maintained regularly. Senior staff kept a spreadsheet with actions and calendared advanced notifications when a vehicle was due for regular maintenance, checks or insurance renewal.
- We saw evidence that the vehicles received yearly maintenance and were serviced at a nearby garage when concerns or defects were raised. Staff said there was an agreement with the garage that the garage would prioritise their vehicles. We saw that in September a defect with a blue light had been raised. The defect was addressed and we saw that it was working during our inspection.
- The vehicle we inspected was clean with working lights, doors and seatbelts.
- We saw that the ambulance did not have appropriate seatbelts or safety equipment to transport children under the age of two. The service stated that they had never transported children under the age of two and did not expect to. However, after receiving CQC feedback at the inspection, the service submitted evidence to show they had purchased an infant harness that fit onto their stretcher to ensure safety if they did need to transport an infant or very young child.
- The radios on the ambulance were working and batteries were charged.
- The ambulance had emergency equipment including a defibrillator, oxygen and suction, which were in working order. We saw regular equipment checks that had been recorded. This meant the ambulance was kitted out to respond to a range of patient needs.
- Staff reported there had been only one issue with faulty equipment, the concern was with battery life. Concerns about batteries had been addressed by keeping an extra set of batteries on the ambulance for each piece of equipment. Further staff explained that equipment could be plugged into the ambulance and powered through the vehicle if required, although this had never been necessary.
- We saw the service kept back-up monitors and defibrillators as a contingency in case of equipment failure.
- We saw that the ambulance was stocked with a device for sustaining chest compressions in a cardiac arrest. However, it was not secured in the vehicle, which meant it could be dislodged, and hit someone while in transit. The registered manager showed us there were belts to secure the device and provided assurances that it would be secured in the future and staff would be reminded.
- We saw evidence that both equipment on the ambulance and auxiliary equipment had a comprehensive annual safety testing, including electrical testing and servicing by an engineer. The engineer's feedback sheet from the most recent tests in March 2017 reflected that all equipment passed inspection.
- Senior staff told us that the three vehicles were currently in working order, but they were monitoring the vehicles and they would have to be replaced in the future. They told us they were currently reviewing options for replacement. They were talking to staff about requirements and considering testing vehicles. This meant that when they do purchase new vehicles, staff requirements can be considered.

- We saw that the ambulance was stocked with equipment for children and adults. This was important because the service served at events where there were children and adults and they might need to transport either patient group to hospital. The service had transported two children or young people in the past year.
- The ambulance included a paediatric kit, major trauma kit, dressings kit, first responder kit, obstetrics kit and burns kit. All kits were fully stocked. We reviewed all supplies in all kits and found them to be sealed and in date.
- However, we saw that there were two adult bag valve masks (BVMs) on the ambulance and two kept in the stock area that had expired in 2015. BVMs are important pieces of emergency equipment used for airway management and ventilation. There were no expiry dates on the children's BVMs. This risk of using an out of date BVM is that the valve could erode causing the BVM to malfunction. We raised this concern with the service. The day following the inspection, the service submitted receipts to show they had ordered five new adult's BVMs and five new children's BVMs.
- We saw that the Incident Reporting Policy required staff to remove any piece of faulty equipment from use immediately and to document the equipment fault. Staff told us that, no equipment had ever been faulty or needed to be removed from use. They noted the batteries discussed above were not faulty equipment and thus did not require removal.

Medicines

- We saw that the service had a Safe Handling and Administration of Medicines Policy, last updated in May 2014. The policy included information about supply, storage, disposal, monitoring, prescribing and administration of medicines. However, the policy did not include a review date. This meant staff could not be assured the policy was current and accurate.
- We saw that the service complied with this policy and medicines were ordered, stored, administered and disposed of in a safe and secure manner.
- Medicines were not stored in the ambulance overnight.
- We saw the service ordered medicines from one of two licenced pharmacy wholesalers depending on the circumstances and medicine ordered. The service had an account with both pharmacies and only one staff member was authorised to order any medicines or controlled drugs. By ordering from a wholesaler, the service was assured that they were receiving medicines from a reliable source and would receive information about recalls if they affected any medicine they had obtained. The service told us they had never received recall information but were reassured to know they would if it were necessary.
- Paramedics are authorised under a Home Office Group Authority to requisition and hold their own supply of certain prescription only medicines for use in their practice. There was one paramedic employed by the service. We saw that they obtained, held and administered medicines under this authority.
- The service also subcontracted with another paramedic. The subcontracted paramedic managed and supplied their own controlled drugs under their own authority.
- We saw that controlled drugs were stored in an affixed, locked safe within an alarmed, locked facility. Only the paramedic knew the code to open the safe so it could not be accessed by anyone who did not have authority to hold controlled drugs. This meant controlled drugs were protected from theft or misuse.
- We saw that other medicines, which were not controlled drugs, were held in a locked alarmed facility in a locked cabinet individually or in medicine bags. We saw records reflecting that staff signed a record to reflect each time they took or returned a medicines bag.
- We reviewed all controlled drugs and other medicines held by the service and saw that they were all in date.
- We saw that the service disposed of outdated medicines and all controlled drugs using a local pharmacy. We saw a log of medicines disposed of at the pharmacy. The log showed that, where required (disposal of diazepam and morphine), the pharmacist signed a document reflecting the controlled drugs had been disposed of by the pharmacy.
- Staff told us opened medicines that were not controlled drugs could be disposed of in the sharps bin, which would be emptied into the clinical waste bin. The clinical waste company was happy with this system as there were no cytotoxins disposed.

- We saw medical gases were in date and stored securely on the ambulance. They were not stored on site. We saw the service had an agreement with a third party service to supply medical gases and dispose of associated equipment appropriately.

Records

- We saw that the service kept patient records in paper format. The records were stored securely in a locked cabinet in the office, which was in a locked and alarmed building.
- Staff held records on the ambulance during patient care and transportation. After the event, staff delivered the records to the service for review and storage on site.
- We reviewed all four sets of records relevant to patient transport. All notes were dated, signed, and printed clearly. Three sets of records were complete. One set of records lacked a pain score for a person with an injured limb, although the notes stated the patient was in pain. Staff explained that there was a rationale for not taking the score. However, this was not documented and meant that clinicians receiving a hand over at the hospital might not have complete information.

Safeguarding

- The service had a Safeguarding Vulnerable Adults and Children Policy, last updated in May 2014. The policy had no review date. The policy set out the service's responsibilities, principles and practices regarding safeguarding.
- All staff were required to complete safeguarding training level two and renew it yearly. The service's training tracker reflected safeguarding level two training was up to date for all staff (100%).
- Intercollegiate guidance recommends paramedics and safeguarding leads be trained to safeguarding level three. At the time of inspection the safeguarding lead had not completed safeguarding level three training, although the subcontracting paramedic had.The safeguarding lead completed the safeguarding level three training shortly after we raised the matter at inspection. We saw certificates showing the safeguarding lead and subcontracting paramedic had completed level three training. This meant the safeguarding lead and paramedic should have the training and knowledge to make safeguarding decisions and guide other staff in safeguarding matters.
- We saw certificates showing both paramedics involved in patient transport had current safeguarding level three training. This meant that all paramedics treating adults and children during patient transport had the correct level of training and should have the skills and knowledge to manage and escalate safeguarding concerns.
- The safeguarding lead explained that they had an agreement with one county council that the service could make any vulnerable adult or child referral to that council, no matter where the patient was seen and refer any questions to the county council's safeguarding team. The safeguarding lead had not had to make any referrals or request direction from the county council.
- Staff could make safeguarding referrals using the county council's safeguarding forms. We saw that these forms were located in a box containing document templates in the ambulance. Staff would submit the form to the lead, who would escalate the matter to the county council.

Mandatory training

- The service demonstrated that they were able to monitor staff training using the company's on-line staff portal. The service submitted a training tracker reflecting staff compliance with mandatory and additional training.
- The mandatory training included inductions to the company, kit and vehicles and annual training including e-learning and an in-person core skills training day.
- The training tracker reflected that 100% of staff had completed the company, kit and vehicle inductions. This meant staff had reviewed relevant policies and were prepared to use the service's equipment and supplies.
- There were five mandatory training areas with varying levels of compliance: safeguarding (100%), capacity (87%), infection control (50%), moving and handling (75%; two staff members training was outstanding but this was planned), core skills refresher (0%). The service explained all staff had an annual in-person core skills refresher day where the trainer provided a core skills

update and introduced new relevant material. All staff were overdue for the training day; however staff told us that it was being arranged for January when all staff were available.

- The service did not have a training rate target; which meant if the provider were to grow, they might not be able to measure whether staff had sufficient skills and knowledge to perform their roles.

Assessing and responding to patient risk

- We saw that staff responded to patient risk at the point of booking planned transport by collecting detailed information about the patient and their needs. Senior staff evaluated patient requirements and only accepted jobs they could safely staff. Staff provided examples of situations when they had referred patient transport jobs to a more appropriate service, for instance when there were mental health requirements or insufficient staff available.
- Staff told us that they prepared for identified risks. For instance, for repatriation from Europe, they had prepared for any unexpected emergencies by providing the staff involved with a map of all of the emergency departments on the route.
- The clinical lead, a paramedic, was available by telephone or in person to provide clinical advice during patient transport. If the clinical lead was not able to provide advice, staff could access an NHS ambulance advice line. Staff told us that if there were a patient emergency in England, they would transfer to the emergency department or call 999 based on a risk review.
- Staff reported there had not been any incidents with violent patients. Staff were offered conflict resolution training, but not required to take it. We saw specific advice about responding to violence was not included in the incident policy, which meant staff might not all know how to react when a violent incident arose.
- Staff told us they managed risk around violent patients by reviewing transport patients' needs and only accepting patients they could manage. Senior staff discussed patient needs with patients, family and medical care services to determine whether staff had the skills to manage individual patients. This meant the risk of exposure to violent patients during transfers was managed.

Staffing

- The service employed eight staff members on zero hour contracts. These included a paramedic, first responders and technicians. The service also subcontracted a second paramedic to provide services.
- The service carried out pre-employment checks to assess the suitability of new staff. We saw that the service performed Disclosure and Barring Service (DBS) and reference checks before employing staff. This ensured staff had the experience they claimed and limited risk to patients from staff members.
- The service used client input, staff expertise and the Purple Guide (guidance published by the Events Industry Forum) to establish staffing numbers at events. This meant there were sufficient staff present for the service to transfer patients from events when necessary.
- Repatriation and transfer patients' needs were assessed by the paramedic/ managing director and only experienced and competent staff were assigned to these jobs. Patient records showed there was a paramedic and second experienced staff member assigned to each medical repatriation or transfer.
- The service did not use bank or agency staff. They had a small pool of first responders and technicians who covered for each other when necessary. There was a system for keeping a member of staff on "standby" to ensure safe staffing. For additional paramedic cover, they used a paramedic subcontractor. Senior staff told us that they had agreements with other CQC registered independent ambulance services and could contact them for support if needed. If this occurred the other service would take over the job, not subcontract it. However, whilst they had referred new work to other services, they had not ever needed to have another service take over any contracted patient transport work.

Response to major incidents

- The service had a Major Incident Policy, which was last updated in March 2015. The policy outlined the objectives and process for responding to major incidents and provided information about triaging, care,

conveyance and chain of command at the incident. It also provided information about debriefing and post-traumatic support for staff. However, the policy did not include a review date. This meant staff could not be assured the policy was current and accurate.

- The service was prepared to respond to a major incident. One senior staff member had completed a major incident command course. This meant the staff member had the training required for management of a major incident. The staff member explained that they could manage a site until NHS staff arrived and were prepared to assist the NHS ambulance service.
- There was no specific mandatory training practice for major incidents. We saw that one staff member whose training record we reviewed had taken major incident training courses independently.
- We saw that the ambulance was stocked with equipment and supplies to provide support in the event of a major incident. The ambulance had National Ambulance Resilience Unit (NARU) action cards to provide staff with direction in the event of a major incident and supplies such as tourniquets, major trauma kit and burns kit.
- This meant if a major incident occurred, senior staff had the appropriate training and kit to respond to and manage the site until NHS staff arrived.

Are patient transport services effective?

Evidence-based care and treatment

- We saw that the service's policies, for instance the Safe Handling and Administration of Medicines Policy and The Safeguarding Adult and Children Policy referenced national guidance from The Department of Health, Royal Pharmaceutical Society and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- The service relied primarily on JRCALC for evidence-based guidance in patient assessment and care. JRCALC provides recognised guidance to ambulance personnel including general clinical guidance and detailed guidance about a wide variety of areas for instance, medicine calculations and paediatrics.

Assessment and planning of care

- The service did not have written eligibility criteria for transport patients. Senior staff discussed the patient needs with patients, family and medical care services to determine if they could provide appropriate transport on an individual case-by-case basis.
- Staff members explained that if the service was not able to provide adequate care, they would assist patients in finding an appropriate ambulance service.
- For planned repatriations, staff told us they liaised with treating doctors, patients and family to assess patient requirements and plan care. When transferring a patient between facilities, there was a clinician-to-clinician handover to ensure relevant information was communicated when the patient was collected and transferred. This was verified by patient records we reviewed. This meant staff understood patient requirements before transport and could prepare accordingly.
- The service had transported two patients from events where they were injured in the past twelve months. Staff involved told us that in both incidences, they relied on patient and family to provide patient information. They relied on their own knowledge and experience to assess patients. The patient records verified this giving a clear description of the patient injury and situation.
- In most instances, the service did not have to transport patients to the hospital as they could be treated on site. Staff told us, when they did consider transporting a patient, they assessed the patient's condition and staffing on site to decide whether to transport a patient to hospital.
- Staff described monitoring pain by observing patients and asking patients to rate their pain on a one to ten scale. We saw on three out of four sets of records that pain scores were recorded. On the fourth record, we saw that a pain score was not recorded, although the notes reflected that the patient was in pain and pain would have been expected for the underlying injury. Staff told us they believed the pain score had not been taken because the young patient was upset and they felt further questioning would distress them further.
- Staff described responding to a distressed patient who was in pain. As the young patient was highly distressed,

they evaluated the pain based on observations and parent input and then provided pain medicine. After the patient received the medicine, he was more able to communicate.

- Staff told us that patients received food and hydration during repatriations but not during short patient transfers. During repatriation, staff took information about food and hydration needs at hand over and patients were provided food and drink in line with their needs.

Response times and patient outcomes

- The service did not provide emergency response services and therefore did not monitor response times. It did not monitor pick up or travel times given the number and type of transfers provided.
- The ambulance was fitted with a 3G tracking device and all radios were on a 3G/ 4G system, which linked to the service's monitoring system. The service demonstrated how they could use this system to see when an ambulance left a site, its progression, and when the ambulance arrived at its destination. This meant the service could monitor the ambulance in real time and had the capability to monitor, record and audit response times should they want or need to do so.

Competent staff

- Prior to employment, the service interviewed candidates, checked employment references, observed patient care and obtained enhanced DBS checks. This ensured new staff members all had a baseline competency.
- The training tracker showed 100% of staff had received inductions to the company, which included policies, uniforms, portal access, ID, observations, kit and vehicles. Staff told us sub-contractors received the same inductions. Staff told us that the inductions were valuable. Staff explained that when the service purchased new equipment, they also received training on the equipment before they could use it. We saw that when the company purchased new paediatric safety equipment, training was planned.
- The service worked with the local council training team to offer staff compulsory safeguarding training. It subscribed to a service to provide mandatory and optional online healthcare training and continuing professional development (CPD). We saw that there was a broad variety of courses, which staff could access. This allowed staff to be current, effective and knowledgeable.
- There were procedures to ensure that staff maintained their competencies. The service demonstrated that 100% of employees had received appraisals in the past year. Staff received appraisals two times per year (January and June) and appraisal information about 11 performance indicators was accessible on the staff portal. Some of these indicators included creativity and innovation, understanding and knowledge, teamwork and paperwork. The manager and staff could access their appraisal information on the staff portal.
- All staff who drove the ambulance were required to have C1 driver training, certifying them to drive a vehicle over 7.5 tonnes, and blue light training. The service did not provide this training. We saw training records reflecting the service had verified relevant staff had had the appropriate, up-to-date, driving training.
- Other staff members drove the ambulance cars, which required a standard UK driver's licence. We saw that the licence was checked upon employment and senior staff told us drivers licences were checked every six months at a minimum. A senior member of staff had advanced driver certification, which allowed him to assess driving as part of the appraisals process. This provided assurances all staff were competent to drive the service's vehicles safely.

Coordination with other services and multi-disciplinary working

- Staff told us they had good communication with patients' treating physicians when repatriating patients. Senior staff spoke to treating physicians before the transport and received full clinical handovers.
- Staff described the working relationship with other care services at events. They explained that they worked with physiotherapists, school nurses and doctors at events to share information about patients when appropriate. This meant that if they needed to transport a patient from an event they could, in some cases, rely on care services who knew the patients for relevant information.

Access to information

Patient transport services (PTS)

- Staff had access to evidence-based guidance. They could access JRCALC through the service e-portal, which they could access on their mobile phones or tablets. Staff also carried "pocketbooks", which aresmall paper versions of the guidance.
- Staff had access to full medical information about their repatriation patients. We saw information on the file including doctors' letters, correspondence from family and other information about the patient's history.
- Staff told us this information included access to Do Not Attempt Cardiopulmonary Resuscitation DNACPR information and relevant documents for their information. DNACPR is a document outlining patients plans regarding CPR, this document may now be augmented or replaced by Recommended Summary Plan for Emergency Care and Treatment (RESPECT).
- While we saw doctors' letters and other information, we did not see any evidence of DNACPR or RESPECT documentation on the patient files. When we asked staff about this we were advised that neither of the repatriation patients from the past 12 months had DNACPRs.
- Staff had access to 3G satellite navigation systems on the ambulance. As part of the service's deployment system, each job allocation was automatically sent to the ambulance's navigation system. This meant staff had navigation information to hand when they needed it.
- On the vehicle staff had access to paper copies of documents such as blank templates for records, capacity reviews and safeguarding referrals. They also had access to the e-portal on tablets and mobiles phones which provided electronic access to blank templates, guidance, policies and all other information on the portal.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a Mental Capacity and Deprivation of Liberty Policy, which was last updated in May 2017 and had no review date. However, the policy did state the clinical governance and senior management team would review the policy in accordance with updates or changes to the Mental Capacity Act (MCA). The policy outlined objectives, responsibilities and MCA principles and processes. However, without a review date staff could not be assured the policy was current and accurate.
- We saw that staff had noted that they considered capacity on all of the patient records we reviewed. Staff showed an understanding of the MCA. They explained that if they had concerns about capacity the team leader or senior staff member would perform a competency review and complete the appropriate paperwork. They explained that they had not needed to perform a competency review or best interest decision for any transport patient in the past 12 months.
- We saw the capacity forms located in the ambulance and on the staff e-portal.
- Staff told us that when caring for children and young people they would usually gain the consent of both the child and parent or responsible adult. Staff were able to describe Gillick competency (a test of whether a person under the age of 15 is able to consent to treatment) although they stated that they had not had to apply the test.
- Staff told us that they gained consent for each individual element of care, for instance when touching or moving a patient.

Are patient transport services caring?

Compassionate care

- We saw that written feedback for one patient-transport patient was sent directly to the service (by a family member). The feedback was positive. The family member of a repatriation patient noted that the senior staff member was very helpful and provided reassurance. They stated that they would thoroughly recommend the service to anyone needing repatriation services.
- CQC provided comment cards for feedback prior to inspection; we saw these were placed in the ambulance. However, the service did not provide any patient transport during that period and patients did not complete any cards.

Patient transport services (PTS)

- Staff ensured dignity in public places for vulnerable patients. For instance, staff described parking and covering ambulance windows when an immobile repatriation patient needed to urinate into a receptacle inside the ambulance.
- Staff told us about caring for a patient who had injured a leg during a competition. They described performing observations by cutting the patient's trouser leg to expose a minimum amount of the leg necessary for observations in the public area. Staff only exposed the entire leg after the patient was transferred into the ambulance away from public view.
- Another staff member told us about spending two to three hours during a repatriation talking to a patient's family member while the patient was asleep to provide reassurance and emotional support.

Understanding and involvement of patients and those close to them

- Staff described communicating directly with patients and, in some cases, family members about care. Staff told us they understood the importance of involving patients in care decisions so that patients fully understood what was happening to them. Staff told us when they cared for children, they made sure to use child friendly language and ensure the child understood what was happening.
- Staff told us about one young person who was unable or unwilling to communicate with them when they first began caring for them. By the time they reached hospital, the patient had calmed and thanked them for their good care.

Emotional support

- Staff described using their communication skills and experience to provide emotional support to a young patient and their parent who were upset by the patient's injury. Staff communicated with the patient and parent respectfully outlining the injury and discussing care before it was provided. Staff assessed the situation and decided to transport the patient to hospital, because they believed it would be the most supportive response for the young person.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The service was primarily an event company. Patient transport services and repatriation made up a very small portion of the service's work. The service did not provide any commissioned service, and all services were self-funded.
- We saw that the ambulance was fully stocked and enabled to deliver patient repatriation services. For instance, the ambulance was supplied with equipment to support a patient during transport and to respond in the event of a medical emergency. It was equipped with navigation and monitoring equipment so that staff on the ambulance had necessary information and senior staff could monitor the progression of the vehicle.

Meeting people's individual needs

- Staff had access to telephone translation services. Staff could find necessary information about the translation service on the staff portal and were encouraged to keep this information on their mobile phones. Senior staff told us the service had not yet needed to use this service.
- Staff told us that they offered optional training for meeting patients' individual needs on their e-learning site. For instance, staff could access an optional dementia awareness class and "breaking bad news" communication training.
- Staff described working with a young patient who might have had learning difficulties. They described addressing information directly to him, ensuring they were understood and gathering information from adults who were present and knew the child.
- Staff told us they did not have facilities to provide bariatric care. Therefore, they would not book any repatriation for a bariatric patient. They told us that if a bariatric patient needed to be transported from an event, they would call the NHS for assistance making it clear that they would need a bariatric ambulance.

Patient transport services (PTS)

- The service had performed two patient transfers from events to hospital in the past 12 months; both were transfers of children. We saw that the ambulance had a complete paediatric kit, which included equipment for taking observations and treating paediatric patients.
- Staff told us they had the knowledge and experience to treat children. They described communicating with children in age-appropriate language and using a smiley face pain-scoring card to help children assess their pain.
- The service described working closely with schools and clubs they contracted with to understand the needs of the children they were caring for.

Access and flow

- The service primarily provided medical cover at events. They held contracts to provide regular cover for some clients and provided event cover for individual events. The service's patient transport work came from either transferring patients from events to hospital emergency departments or pre-arranged repatriation. As such, the service had control over the scheduling and flow of their work.
- Patients could use a web form or call the service directly to discuss their medical transport or event requirements. Senior staff were familiar with the service's capacity. They were able to arrange services in advance so that they could be staffed appropriately.
- The patient records reflected no delays to patient transport patients.

Learning from complaints and concerns

- The service had a complaints policy last updated April 2015. The document outlined how the service would review, manage and respond to complaints. The Managing Director had overall responsibility for managing and resolving complaints. However, the policy did not include a review date. This meant staff could not be assured the policy was current and accurate.
- The service reported that they had received no written or verbal patient complaints during the twelve-month reporting period prior to the inspection. This meant we could not review how complaints were managed or whether learning was taken from them.
- The service told us that when they received positive feedback about an individual staff member, this was fed back to the staff member and put in their performance review. We did not see this in the reviews we observed, however we only observed a small sample of reviews.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The service's managing director managed the day-to-day running of the service. They engaged with suppliers, clients and members of the public seeking patient transport. They managed staff, performed audits, and managed equipment, vehicles and medicines.
- The operations manager supported the managing director in fulfilling these responsibilities.
- The service had one member of staff who provided support by managing supplies.
- The senior managers were very visible and accessible. They performed operational duties and were regularly at events working with staff as a senior team member or team leader.
- Staff reported that the team was a small close group. Because the team was small, staff often worked together and knew each other. Staff often had down time and took the opportunity to share experiences and best practices.

Vision and strategy for this this core service

- The service stated that its mission was to provide an outstanding service with the highest levels of patient care, cleanliness and clinical excellence while being professional, safe and compliant with motivated, qualified and caring staff.
- Staff we spoke with understood the service's mission and readily told us the service was led by these values. This was supported by observations on the inspection of cleanliness, records and equipment.
- The strategy was to continue to grow at a steady pace gaining work, vehicles and staff.

- Staff told us they liked working for the service. They appreciated having all equipment and supplies they needed and felt they could communicate with senior staff whenever they needed or wanted to.
- We saw that management engaged with staff to find out what equipment and supplies they needed to best do their jobs.
- Staff were proud to work for the service and felt they gave patients a high standard of service and care.

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

- The service was a small company primarily run by the managing director and supported by the operations manager and other staff. The service used a system of policies and audit to ensure the delivery of strategy and care. The service did not have a more robust governance structure because senior staff were able to monitor and support the small number of staff using the existing system.
- All contracts for services and with third party contractors were agreed and managed by the managing director.
- We saw that the service monitored risk using an audit system. Audits were performed on vehicles, paperwork and staff. Staff audits included semi-annual observations of staff competence and compliance with policy. The audits were managed using the e-portal so that outcomes could be managed.
- Senior staff told us the largest risk to the service was staff failing to follow guidance. They told us they addressed this risk by ensuring staff understood their roles and were working within their competencies, providing evidence based guidance such as JRCALC and using appraisals and reviews to ensure compliance.
- Senior management was able to outline current relevant risks and how they were managed, even though this was not formally documented.However, the service did not have risk registers or any robust system to monitor risk. If the business grows, lack of a risk management system could mean managers were not aware of or able to manage risks.
- Additionally the provider's policies did not include review dates. This meant policies could become outdated and give dated or inaccurate direction to staff.

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

- We saw that the service engaged with their community. For instance, they told us they volunteered at charity events and we saw a thank you letter from a local children's rugby club thanking the service for donating an event gazebo for matches and festivals.
- We saw that the service engaged with staff. Staff told us management asked them for input before purchasing equipment and were open to requests from staff for necessary supplies.
- Senior staff told us they were engaging with staff about what they wanted in new ambulances when they are purchased.
- The service offered emotional support to staff directly at review sessions and through MIND to provide support to "blue light" staff after distressing incidents.

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

- Senior staff described how they worked with the team to create an A5 sized vehicle logbook after a staff member raised the idea. The service had previously used individual A4 sheets to log vehicle cleaning, checks and issues. These sheets were held in a folder in the office and required regular management. The new book was the right size, could be kept in the vehicle and kept all of the information conveniently in one place. Senior staff told us they were very happy with the book and they would incorporate staff ideas for improving the book further the following year.

Outstanding practice and areas for improvement

Outstanding practice

- The service had a strong vision and values which directed the way staff ran the business, worked together and provided patient care.
- The service was prepared to respond to a major incident and manage the major incident site until NHS staff arrived.

Areas for improvement

Action the hospital SHOULD take to improve

- The service should provide support to ensure all staff are up-to-date with their mandatory training including infection control training.
- The service should provide policies and training to ensure all staff understand the Duty of Candour.
- The service should implement a risk management system and update policies to include meaningful review dates.