Lifestar Medical Limited

Quality Report

35 Penair View
Truro
Cornwall
TR1 1XR
Tel: 01872 264842
Website: lifestarmedicalltd@virginmedia.com

Date of inspection visit: 09 January 2020
Date of publication: 07/05/2020

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Lifestar Medical Limited is operated by Lifestar Medical Limited. They provide a patient transport service. The details of the service included several different contracts/arrangements:

- a service to a nearby acute trust. This included transport for patients who were being discharged from the hospital plus internal transfers from the emergency department and the acute medical unit to the wards.
- a contract with an independent ambulance service provider.
- a service to the local authority or NHS transporting very ill patients to special places they chose as their 'last wishes'."
- private transfers arranged directly with paying customers.
- repatriation of patients to anywhere in the UK. These contracts were won on an individual basis.

The service also provided first aid at events. They did not transport patients off site from events therefore this aspect of their work did not come under the regulations and did not form part of this inspection.

We inspected this service using our comprehensive inspection methodology. We visited the service headquarters to carry out the short notice announced part of the inspection on 9 January 2020. We completed a telephone interview with the lead paramedic and spoke with patients and staff on the telephone on 16 and 17 January 2020.

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

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

We rated the service as Good overall.

Following this inspection, we told the provider it must take some actions to comply with the regulations and it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected patient transport services. Details are at the end of the report.

We found areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed most aspects of medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients and had access to good information. Key services were available seven days a week.
- Patients' relatives told us staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. Staff provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs.
- Staff felt respected, supported and valued. Leaders were visible and approachable. All staff were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Leaders looked for ways to sustain and develop the service.

Summary of findings

However, we also found areas for improvement in relation to patient transport:

- Many of the recommendations from our previous inspection had not been resolved. Managers did not use information systems to monitor the quality of the service. Managers did not collect data to show if people could access the service when they needed it and in a timely way. Records of audits did not contain enough detail to provide assurance of safety on an ongoing basis. The service did not have a documented vision or strategy.
- There were gaps in the process and records of recruitment of new employees. Managers did not arrange governance meetings. At the time of our inspection, managers had not used patient feedback to improve the service.

Nigel Acheson

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

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good 	Patient transport services was the only service provided by this independent ambulance provider. The service included patient transport for admissions/ discharges and hospital appointments, long distance repatriation, organ and surgical team support, holiday transport for clients with mobility issues, neonatal transfers, high dependency/ITU transfers, specialist bariatric transfers and event cover. The service was provided mostly to adults, with a small number of children.

Summary of findings

Contents

Good

Lifestar Medical Limited

Services we looked at:
Patient transport services

Summary of this inspection

Background to Lifestar Medical Limited

Lifestar Medical Limited is operated by Lifestar Medical Limited. The service opened in 2004. It is an independent ambulance service in Truro, Cornwall. The service primarily serves the communities of Cornwall but also provides some services out of the county.

The service provided patient transport for admissions/ discharges and hospital appointments, long distance repatriation, organ and surgical team support, holiday transport for clients with mobility issues, neonatal transfers, high dependency and critical care transfers, specialist bariatric transfers and event cover.

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

Our inspection team

The team that inspected the service comprised a CQC lead inspector and another CQC inspector. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

Information about Lifestar Medical Limited

During the inspection, we visited 35 Penair View, Truro. This was the headquarters of the service. We visited the nearby car park where the vehicles used to transport patients were stored. We spoke with six staff, including registered paramedics, a registered nurse, ambulance care assistants and management. We spoke with five relatives of patients and a member of staff at the local acute trust to gain feedback on the service provided. During our inspection, we reviewed two sets of patient records.

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 has been inspected twice, and the most recent inspection took place in July 2017. At that inspection the service was not rated, and we found some areas of good practice and areas where improvements were needed.

The service is registered to provide the following regulated activities:

- Patient transport services and triage and medical advice provided remotely
- Treatment of disease, disorder or injury

Activity (January to December 2019):

- In the reporting period 1 January to 31 December 2019, there were 1,873 patient transport journeys undertaken.
- There were seven registered paramedics, one emergency nurse practitioner, one ambulance technician, and 22 ambulance care assistants who worked at the service.
- There was no accountable officer for controlled drugs (CDs) because the service did not provide controlled drugs. However, the service supported individual clinicians to maintain safe custody of their own supply of controlled drugs.
- The service had five ambulances, plus three pool cars. In addition, a new ambulance had just been purchased which was not operational at the time of our inspection.

Track record on safety:

- No never events.
- No clinical incidents
- No complaints.

Good

Patient transport services

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

Information about the service

The main service provided by this ambulance service was patient transport services. The service provides patient transport for admissions/discharges and hospital appointments, long distance repatriation, organ and surgical team support, holiday transport for clients with mobility issues, neonatal transfers, high dependency transfers, specialist bariatric transfers and event cover. The service primarily serves the communities of Cornwall but also provides some services out of the county.

The service had five ambulances, plus three pool cars. In addition, a new ambulance had just been purchased which was not operational at the time of our inspection. There were 31 staff employed at this location.

Summary of findings

We found areas of good practice in relation to patient transport services:

- The service had enough staff to care for patients and keep them safe. Staff controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed most aspects of medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients and had access to good information. Key services were available seven days a week.
- Patients' relatives told us staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people and took account of patients' individual needs.
- Staff felt respected, supported and valued. Leaders were visible and approachable. All staff were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Leaders looked for ways to sustain and develop the service.

However, we also found areas for improvement in relation to patient transport:

Good

Patient transport services

- Managers did not use information systems to monitor the quality of the service. Managers did not collect data to show if people could access the service when they needed it and in a timely way. Records of audits did not contain enough detail to provide assurance of safety on an ongoing basis. There were gaps in the process and records of recruitment of new employees.The documented patient group directives used by staff to administer medicines were incomplete.
- The service did not have a documented vision or strategy. Managers did not arrange governance meetings. At the time of our inspection, managers were in the process of proactively collecting feedback using a patient questionnaire and this data had not yet been analysed.

Are patient transport services safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff. Some staff experienced a delay in accessing the face to face elements of this training. This was partially mitigated because staff completed competencies training at the start of their employment.

An external contractor provided a face to face mandatory training day once a year. This day included moving and handling plus refresher training for infection protection and control, health and safety and all equipment used. At the time of our inspection, 14 of the 31 staff were up to date with this training. Many of the current staff had started employment after the most recent training day in February 2019.

If new staff started after this mandatory training day, they had to wait until the next day was planned as it was not cost effective to put on the day for a small number of staff. At the time of this inspection, this applied to six of the 31 staff employed. During this delay, staff did not work alone. However, staff were expected to complete moving and handling tasks and to contribute to risk assessment of moving and handling situations. To partially mitigate this risk, staff participated in a comprehensive induction to learn how to use essential safety equipment. Managers discussed important policies during the staff induction to ensure staff were aware of safe practice in between training days. Where staff were employed by other providers the service asked staff for evidence of their mandatory training for their records.

Staff completed other mandatory training online using an e-learning training package. This learning included: safeguarding adults' levels one and two; safeguarding children levels one and two; equality, diversity and human rights; infection prevention and control; awareness of mental health; awareness of dementia; health, safety and welfare; information governance. At the time of our inspection, 24 of the 31 staff were up to date with this training.

Safeguarding

Good

Patient transport services

Staff we spoke with understood how to protect patients from abuse. Not all staff had completed training on how to recognise and report abuse. No staff received advanced safeguarding training as recommended for care and treatment of children. Staff we spoke with knew how to apply the training they had received.

Safeguarding training did not meet the recommendations in the intercollegiate document "Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Fourth edition: January 2019".

At our last inspection, we found there were no staff trained higher than level two safeguarding. At the time of this inspection, this had not improved. The safeguarding policy did not refer to required training for staff. The provider could not demonstrate they had considered the roles of different members or groups of staff to determine which members of staff were required to have which level of children's safeguarding training. The manager told us all staff were required to complete e-learning training for level two safeguarding children and adults. At the time of our inspection, 77% of staff were compliant with this training.

There had been no safeguarding incidents reported by the service during the 12 months preceding our inspection.

Managers obtained Disclosure and Barring Service (DBS) checks for all staff. However, there was no documented evidence they were returned before the member of staff started work at the service.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.

The service made sure vehicles and equipment were safely cleaned and ready for use. The vehicles and equipment we saw were all visibly clean. Staff told us they cleaned vehicles before the start of their shift and dealt with spillages in accordance with the policy for infection prevention and control. Cleaning schedules were documented. Deep cleans were planned and recorded when they had been completed. If a vehicle needed a deep clean following a transfer due to infection risk, the vehicle would be removed from use until this was completed. Staff used a 'fogging' machine to deep clean vehicles and recorded when this was completed.

Each crew was responsible for the cleaning of their vehicles at the end and beginning of each shift. Staff kept records to show this was completed consistently. Specialist cleaning wipes were provided for staff to use. Every month the registered manager checked to make sure cleaning records were completed. There was no designated lead for infection prevention and control.

The registered manager told us crews were made aware of specific infection and hygiene risks associated with individual patients when they collected them for transfer. Staff had access to some personal protective equipment (PPE). Gloves were available on the vehicles and staff could collect aprons from the storage facility when they anticipated spillages. Hand gel was available on the vehicles.

Managers provided all operational staff with a uniform. Staff were expected to ensure their uniform was clean and maintained to a high standard. The provider's infection prevention and control policy gave instructions to staff for laundering their uniform.

There was no service level agreement in place for the management of laundry. Staff used linen from the local NHS trust. Staff stowed soiled linen in special bags. Staff took these bags to the local NHS trust for laundering.

There was a system for the safe disposal of sharp bins. This required staff to seal and routinely dispose of sharps bins at least monthly. Staff brought the sharps bins back to the office and licensed transporters of clinical waste collected the sharps bins from the office. The safe management of sharps was detailed in the provider's infection prevention and control policy.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Good

Patient transport services

There was no ambulance station or garage. The service had an arrangement with a local sports club where they stored the ambulances in the club car park a two-minute drive from the office. Vehicle keys were stored securely at the headquarters in a safe accessed via key pad.

The service ensured all vehicles had a current ministry of transport (MOT) test, were serviced and insured. Records demonstrated all vehicles were safe to use on the road. Staff had access to a breakdown system for all vehicles if needed.

Staff reported all faulty equipment to the registered manager or provider. If this was minor it was dealt with by a member of staff. However, if it was more serious and had an impact on how safe the vehicle or equipment was, this was withdrawn from use immediately. Action was taken to repair the vehicle or equipment as a matter of urgency.

There were up to date records of equipment maintenance. Equipment and medical devices were maintained and serviced annually by an external contractor.

There was suitable equipment available. Staff had access to up to date satellite navigation systems. Staff could access appropriate moving and handling equipment. Stretchers were height adjustable. One vehicle had a powered tail-lift. Equipment was designed to meet the needs of specific patient groups, for example there was a wheelchair for bariatric patients and stretchers could accommodate the needs of these patients. This equipment was not standardised as staff needed access to different equipment for specific purposes.

Seatbelts were available in all vehicles. For children, parents provided their own car seat. When children required use of a stretcher, the staff used a special seatbelt designed for children to be used on a standard stretcher. Staff did not use vehicles to transport patients detained under the mental health act.

At our previous inspection, some first aid items were found to have exceeded their expiry date. All consumables we checked at this inspection were in date.

Assessing and responding to patient risk

When transporting patients, staff removed or minimised risks according to the changing needs of the patient and their surroundings. Staff identified and quickly acted upon patients at risk of deterioration.

Staff were trained and supported to dynamically risk assess patient journeys. This meant staff took account of all the variables at any given time and adjusted their assessment of the risks accordingly. For example, staff frequently encountered moving and handling situations which posed a risk to patient safety. If a patient's mobility status varied, staff selected appropriate moving and handling equipment and techniques accordingly. At the time of our inspection, the service did not transport patients detained under the Mental Health Act.

Managers supported staff who identified risks to patients. For example, a member of staff terminated a journey and returned a patient to hospital because they deemed the patient to be at risk of harm during the transfer. The member of staff was able to rearrange a suitable vehicle to safely transfer the patient to their destination.

When patients unexpectedly required emergency care during a routine journey, staff called 999 to request assistance from the NHS ambulance service. All staff we spoke with had a good awareness and understanding of when it would be appropriate to call for an NHS ambulance and when a patient should be transported to an emergency department.

Staffing

The service had enough staff with the right qualifications and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels.

There were seven registered paramedics, one emergency nurse practitioner, one paramedic technician, and 22 patient transport drivers who worked at the service. None of the staff were employed by other ambulance providers. All staff except for the directors and lead paramedic held zero hours contracts. This arrangement gave managers the flexibility to adjust staffing levels. Managers allocated shifts to staff according to the workload on any given day. Referrers indicated what skill level of staff was required to meet the needs of the patient to be transported. Managers

reviewed this along with the rest of the referral information and allocated suitably qualified staff accordingly. For complex patients, such as neonatal transfers between hospitals, staff were accompanied by suitably trained hospital personnel, for example doctors and nurses employed by the commissioning hospital.

In the event of staff sickness, managers called upon other staff members at short notice to cover. The service did not use bank or agency staff. Staff told us they were not pressurised to work. Staff were responsible for scheduling their own breaks during working hours. Rosters were organised to allow time for rest between shifts.

The service transported a small number of children (five children over 30 journeys during the 12 months preceding our inspection). Children were always accompanied by a member of their family or a member of staff from the commissioning hospital. Managers recognised the infrequency of this work meant staff had limited opportunity to keep their skills up to date for this client group. Managers planned to introduce refresher training.

Records

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

Staff recorded all patient transfer jobs on a paper job sheet, including work completed at the local acute trust. This was a list which included brief information about patients' pre-existing conditions, for example high blood pressure, and any other relevant factors, for example steps to the front door. Staff checked patients' treatment escalation plans and do not attempt cardiopulmonary resuscitation (DNACPR) orders prior to transporting patients.

When staff gave patients any treatment during a journey, they completed a patient report form. This was a carbon copy paper record where staff recorded all relevant details of interventions completed. For example, if a member of staff had administered a medicine they would record this on the patient care record. One copy of this record went with the patient to the receiving organisation. This meant all relevant information was handed over to staff providing ongoing care.

During our inspection, we looked at two patient report forms. These were clear and up to date. Managers did not complete formal audits of documentation. However, managers reviewed all patient records when staff brought them to the office for filing. All records were stored securely in locked cabinets for the legally required length of time. Confidential waste was shredded or bagged up and collected by an external provider.

When patients were transferred between hospitals, staff transported their healthcare records in an orange zipped bag and handed these records directly to the nurse in charge of the patient.

Medicines

The service used systems and processes to prescribe, administer, record and store medicines. Not all of these systems were fully developed.

No medicines were stored in vehicles except oxygen and pain-relieving gas. Staff administered these gases only if they were trained to do so. The lead paramedic told us most patients who used oxygen were transfers from the NHS and staff would administer oxygen as directed by the doctor.

At our last inspection, the exterior of the storage facility for stock medical gases did not have appropriate warning signs. The storage facility was very hot and not secured. During this inspection we found the cylinders were stored in a secure facility with appropriate warning signs. However, managers did not monitor the temperature of this storage facility. Following our inspection, managers planned to review the temperature recommendations for pain-relieving gas with senior staff to ensure safe use.

Medicines were stored securely. Paramedics stored medicines bags at the office in a locked medicines cupboard. These bags were securely tagged and did not contain controlled drugs. A senior member of staff explained how they audited their use. On the exterior of each bag, there was a list of medicines contained inside. This included stock numbers and expiry date. Each paramedic signed the bag out at the start of their shift and back in again at the end of their shift. If a medicine had been used from the bag the expectation was for the paramedic to re-stock this, change the list and re-tag the bag. Records of this were maintained.

The lead paramedic monitored the expiry dates of medicines in the paramedic bags. The lead paramedic completed a monthly stock check of each paramedic bag

and we saw records to demonstrate this. This included opening the bags, checking the required medicines were present and within expiry dates. The lead paramedic then re-tagged and secured each bag ready for use.

At our last inspection, the service did not have patient group directions (PGDs) for administration of unlisted parenteral medicines and non-parenteral prescription only medicines. At the time of this inspection, the provider was in the process of signing off PGDs for salbutamol, ipratropium, and water for injections. The PGDs stated staff wishing to use the protocols must be named on the central register held by the company. The purpose of the register was to list those staff who were deemed to be trained and competent and were authorised to administer the medicines. This register did not exist at the time of our inspection. Managers told us staff were not administering these medicines at the time of our inspection. Staff recorded all use of medicines on the patient report form. Managers checked these forms to gain oversight of medicines administration.

At our last inspection, the provider was holding controlled drugs and did not have an accountable officer for controlled drugs. During this inspection, we saw the service was no longer providing or storing controlled drugs. Registered paramedics now sourced and stored their own supply of controlled drugs. The provider gave these staff an individual lockable safe for secure storage of these medicines and a pouch to carry these when on duty.

The service had an up to date medicines policy. This included information about procurement, receiving, disposal and storage of medicines, approved formulary, medical gases, controlled drugs, record keeping and audit. This policy included a brief summary of the definition and scope of patient group directions and how these would be developed and authorised. There was an up to date policy for the management of patients' own medicines. Brief guidance for staff was also accessible in the staff handbook.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and partner organisations. Managers ensured that actions from patient safety alerts were implemented and monitored.

There was a paper system for reporting incidents. Staff knew the process for reporting incidents and felt confident these would be investigated. There were incident forms available inside vehicles which staff could complete.

The management team investigated all incidents. The registered manager told us there had been eight incidents reported in the last 12 months, none of which were serious incidents. Some of these were vehicle issues. Managers were investigating a trend of incidents related to poor communication in referrals and were looking into ways to resolve this, including liaison with the nearby acute trust. Managers posted information about patient safety alerts in the staff online storage system. This was accessible by all staff using their personal smartphones.

The provider reported no never events in the last 12 months. Never events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened for that incident to be categorised as a never event.

Are patient transport services effective?
(for example, treatment is effective)

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers carried out informal observations of practice and checked to make sure staff followed guidance.

The service provided care and treatment which was based on national guidance. Policies, procedures and guidelines were based guidance from National Institute for Health and Care Excellence (NICE). Staff had access to the Joint Royal

Good

Patient transport services

College Ambulance Liaison Committee (JRCALC) guidance in the office. Staff were able to take these away to use and would ensure care and treatment they provided was in line with this. Managers produced new guidance in response to changes in the type of work undertaken by staff. For example, managers had recently written a protocol as guidance for staff who worked in the emergency department at the local acute trust.

Staff had access to the provider's policies and procedures via a computerised system which they could log onto via a computer device. Managers informed staff via e-mail when a new policy or updated policy was available. Staff also had a staff handbook, which contained guidance that could be quickly accessed. The staff handbook included references to key information needed for day to day operations, for example how to report incidents, or what to do in the case of vehicle breakdown.

Managers checked to make sure staff followed guidance. Managers took time to get to know their staff and informally observed their practice when working alongside them. Managers completed a monthly audit of safety processes. However, records of this audit were insufficiently detailed to provide evidence of ongoing compliance with key policies.

Managers assessed patients' eligibility for the service on an individual, case by case basis. They did not transport patients detained under the Mental Health Act 1983. Managers made staff aware of any individual patient needs by including these details on the job list, for example mental health needs.

Nutrition and hydration

Staff ensured patients' food and drink requirements were met during a journey.

Staff carried drinking water on board vehicles to give to patients when required. The service did not provide food for patients but encouraged patients to bring food with them if they anticipated a long journey. If necessary, staff were permitted to stop during a long journey for patients to purchase their own food. For NHS patient transfers on long distances, patients were provided with food by the NHS location to meet their individual needs.

Response times/Patient outcomes

The service did not monitor response times or patient outcomes. The service did not use data to make improvements.

The service collected some information about patient journeys. This information did not include any indicators of the timeliness of journeys. The data was not recorded in an easy to manipulate electronic format. Managers could not analyse this data to measure performance.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and supported them to develop.

Managers provided new staff with an induction programme. Copies of the induction form were signed off by a senior member of staff and stored in staff files. Staff told us they worked in a supernumerary capacity for one shift and were given time to become familiar with the vehicles and equipment prior to working as part of a crew.

Managers checked the professional qualifications of registered staff. Only staff who were held an existing emergency driving qualification were permitted to drive the vehicles with emergency lights and sirens on.

Managers provided a training update day to help staff maintain their professional qualifications. This was theory and practice based. Other non-registered staff were able to join in the practical part of the day. This training included clinical skills, for example advanced life support.

There was a framework to check on staff competencies. Managers assessed staff at the start of their employment and at three months undertook a probationary review and appraisal. We did not see the grading system, but the registered manager said it was in place to help them review their staff members and identify whether they needed additional support.

There was no formal recorded process of staff supervision. Staff and managers raised concerns on an informal, adhoc basis and staff told us managers were always willing to listen. At the time of our inspection, all staff had participated in an annual appraisal.

Managers provided training and competency assessments for the use of oxygen and pain-relieving gas. Only staff with extended qualifications or a registered professional were permitted to administer pain-relieving gas, following

training. Staff had participated in a recent refresher training day in relation to use of gases. The registered manager said they were assured staff who administered these gases were competent to do so and they had records to demonstrate this.

Leaders organised annual training days. These were mandatory for the paramedic staff and other grades of staff were invited. The most recent of these training days covered advanced life support, immobilisation, patient assessment, trauma assessment and intraosseous devices. An intraosseous device enables a member of staff to inject a medicine directly into the bone marrow. Thirteen staff attended, including all six paramedics employed at the time. Staff were involved in planning the content of these training days.

Staff completed e-learning training on awareness of mental health and dementia. Managers had planned training for staff on restrictive practice, due to take place in February 2020. This was to provide staff with extended skills and knowledge on how to safely transfer patients with mental health needs.

Multidisciplinary working

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

Staff worked at the local acute trust under the direction of staff there. Staff were frequently booked to form part of a multidisciplinary team transporting high dependency patients between hospital sites. Feedback from the local acute trust indicated staff worked well as a team in these situations.

Staff checked all relevant patient details prior to the journey to ensure patients' needs were met. This included looking at the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)record and the advanced care plans where applicable. Any special notes were communicated to staff on the booking form.

Staff told us they frequently liaised with care providers to check home care visits were arranged for patients on their return home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff completed online training regarding the Mental Capacity Act. Staff could refer to the 'Capacity to Consent' policy for advice and guidance. When staff transported patients from the local acute trust, the expectation was for the ward or department to gain consent prior to the transfer. However, staff always checked consent with the patient on arrival at the ward or department. This was documented in their policy. Staff recorded consent on the booking forms. The registered manager told us they would transport a patient who was under a Deprivation of Liberty Safeguard if they had an escort from that provider with them.

The registered manager told us they sometimes transported children. However, none of the staff we spoke with were aware of the Gillick competencies. Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) can consent to his or her own medical treatment, without the need for parental permission or knowledge.

Are patient transport services caring?

We did not have enough evidence to rate this service.

Compassionate care

Relatives told us staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff told us and gave examples of situations where they made sure patients' needs were met. For example, when end of life patients needed items for care at home that had not been delivered, staff drove to a nearby community hospital to acquire supplies for the patient.

Patients relatives told us that staff always remembered personal preferences that mattered to them, this made patients and relatives feel that staff cared about their experience. Relatives told us that staff took time to make sure patients were comfortable.

Emotional support

Good

Patient transport services

Relatives and staff told us staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff told us they always made sure patients were comfortable before leaving them. This included putting the heating on, checking there was food in the refrigerator, and making a hot drink for the patient.

Relatives told us staff were reassuring and helped to relieve their anxiety. One relative said, "we felt calm from the moment they walked in through the door".

Understanding and involvement of patients and those close to them

Relatives told us staff supported and involved patients, families and carers to make decisions about their care.

Patients' relatives who booked the service for private transfers told us staff gave them opportunities to make choices about their care. This helped them to feel in control and autonomous. For example, patients could decide when they would like to be collected from appointments.

Relatives told us staff took time to talk with them as well as with patients. When patients could not communicate, staff still spoke with them and involved them in their care. Relatives told us staff remembered to ask about things that were important to the patient.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

Service delivery to meet the needs of local people

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

Lifestar Medical Limited provided NHS transfers and ad-hoc private work. Bookings were undertaken either through a direct contract with the trust or via a second ambulance provider. People were able to contact the service directly for private transfers. The service also provided out of area and out-of-hours patient transport as required.

The provider worked with a local NHS trust seven days a week to help transfer patients quickly within the hospital or to their home or other locations. This helped the local trust to manage the demand for their services. Lifestar Medical Limited were able to generate additional crews at short notice to meet the fluctuating demand for services at the local acute trust. Feedback received form the local acute trust indicated this service was reliable and flexible.

When existing providers at the local acute trust could not meet the transport needs of patients due to limited capacity or due to patients' complex moving and handling requirements, Lifestar Medical Limited provided a flexible and responsive service to meet those needs at short notice.

The service met the needs of patients with learning disability who required sedation to travel. Hospital staff intubated these patients in their home environment and staff from Lifestar Medical Limited transported the patient, accompanied by members of the hospital team.

The service worked flexibly to meet the demands of the local population. The service had purchased stair climbing equipment. Nearby there was a local beach that could only be accessed via several steep steps. Staff used the specialist moving and handling equipment to assist patients to access the beach to attend events, for example weddings.

Meeting people's individual needs

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

Staff we spoke with showed an awareness of the needs of patients with dementia. Wherever possible, staff limited the time these patients were required to be in the vehicle and allowed extra time for collection. Patients with dementia were never left alone on the vehicle.

Staff we spoke with showed an awareness of the needs of patients with autism. For example, a member of staff recognised when a patent with autism became unsettled

during a journey. To resolve this, the crew returned the patient to the hospital and then successfully transferred the patient in a smaller vehicle with an additional member of staff.

Managers gave staff permission to take time to ensure the patient's needs were met. Staff told us this included settling them back into their home environment, making them a hot drink, and making sure they had food available.

Staff tried where possible to meet the needs of patients with communication difficulties. On the vehicles there was a communication guide which contained pictures and short sentences for staff to use with patients who needed help with communication. This included space for the patient or relative to record information about themselves, for example allergies, mobility, and dietary requirements.

At the time of our inspection, all patients transported by the service either spoke English as their first language or were accompanied by an interpreter provided by the client. If a patient was part of the NHS contract, the ward or department would usually provide an escort who was able to offer this service.

Access and flow

There was no data available to assess whether people could access the service when they needed it, in line with national standards. There was no data available to assess whether people received the right care in a timely way.

The provider did not monitor the time taken to access care, the number or length of delays experienced or whether patients were kept informed about any disruptions.

Bookings were not cancelled. Managers only accepted bookings if they had suitably qualified staff available to meet the patient's needs. We spoke with five patients' relatives. They told us they could access the service at short notice, that staff arrived on time and they did not experience delays.

The bookings process was straightforward. For private bookings, the customer telephoned the office and managers took all necessary details over the telephone. If necessary, managers visited the customer face to face to gain further information. Managers ensured that patients with urgent needs were attended to within the customers requested time-frame. Staff did not manage bookings at the local acute trust, these were managed and triaged by staff employed at that facility and allocated to staff in order of priority.

Learning from complaints and concerns

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

Information about making complaints and sharing patient experiences was displayed within the vehicles we viewed. There were no complaints received in the 12 months leading up to this inspection.

The service had a complaints policy which covered how patients, or their relatives/friends could make a complaint. This policy included how complainants would proceed if the complaint involved another provider, and sign-posted to the Patient Advice and Liaison service (PALS) at the local acute trust for complaints related to the NHS contract. However, the policy did not mention how they would proceed if the complainant was not happy at the end of their process.

Are patient transport services well-led?

Requires improvement

Leadership

Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Staff told us leaders were visible and approachable. Operational road staff saw their manager most shifts and told us they could easily contact them for advice. Patients' relatives knew the leaders' names and referred to them as 'friends'. They told us leaders were approachable regarding any aspect of care.

Leaders clearly articulated the pressures experienced by the service and the challenges to good quality care. Leaders were focussed on managing the day to day issues experienced by teams and looked for ways to sustain and develop the service.

Staff were supported to develop their skills and take on more senior roles.

Good

Patient transport services

Opportunities for career progression were limited by the small size of the company. However, one member of staff was offered further training to obtain a more advanced qualification. Leaders were supporting a senior paramedic to develop the clinical leadership role as part of an ongoing strategy to ensure a sustainable leadership for the service.

Vision and strategy

The service did not have a documented vision or strategy for what it wanted to achieve. The management team were focused on sustainability of services.

The vision of the service was not written down in a formal document. Leaders described the vision which was to continue to develop in a sustainable way whilst maintaining the 'family' culture of the business. This involved training up a new leadership team to take a more active role in the management of the service. An experienced paramedic was recruited 13 months prior to our inspection and was developing the role of clinical lead. In this way the service was preparing to fill the gap in skills that may result from the future retirement of the managing director.

The strategy was not written down in a formal document. However, leaders had a clear understanding of the future direction of the service.

The values of the service were not formally documented. However, we saw the service was focussed on doing the right thing for patients and their families and we frequently heard reference to a sense of family values within the service. Relatives told us staff treated patients like members of their family and likewise, staff told us their managers treated them like members of their family.

Culture

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

There was a policy for 'Being Open and the Duty of Candour'. The duty of candour is a regulatory duty that relates to openness and transparency and requires 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 policy included clear instructions as to how to proceed in the event of a patient safety incident and outlined staff responsibilities in relation to the duty of candour. However, staff did not receive training in duty of candour and only one of the four staff we spoke with demonstrated an awareness and understanding of this responsibility.

There was a strong emphasis on staff well-being. Staff normally worked in pairs and occasionally they would work alone. Staff working outside normal working hours could access support from the director and managing director by calling a mobile telephone, and managers tracked the location of team members using the satellite navigation system. All staff told us they felt comfortable to raise concerns and ask for help at any time of the day or night. Staff all agreed managers listened to them.

Managers valued their staff and showed appreciation of their work. The management team described their staff as "like a family". Staff told us they were encouraged to develop their skills. For example, managers had discussed with an ambulance care assistant the possibility of training to become an emergency care assistant.

The service had an up to date equal opportunities and diversity policy.

When staff received positive feedback from patients or external organisations managers shared the feedback with staff, included it in the staff personnel file and displayed it on the notice board.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff did not have regular opportunities to meet as a group to discuss and learn from the performance of the service. However, staff at all levels were clear about their roles and accountabilities.

Staff we spoke with understood the scope of their job role and were aware of the limitations of their remit.

Good

Patient transport services

As part of the terms of their contract, the provider was not required to meet externally set key performance indicators around quality. Managers had not set internal standards to inform systems of accountability to support the delivery of good quality sustainable services.

At our last inspection, we identified the provider was not completing adequate checks to ensure safety processes were being completed. During this inspection, we saw managers completed a monthly check of safety processes, for example vehicle deep cleans completed. However, records of monthly management checks did not include data regarding percentage compliance with safety protocols and did not contain enough detail to provide assurance the provider had an ongoing awareness of safety performance from month to month.

We were not assured policies were being followed. For example, managers did not follow the recruitment, selection and retention policy, which required the interview panel to provide written evidence of interviews and the decision-making process, and to obtain references from the most recent employer.

Managers did not complete adequate checks to give assurance of the integrity and credibility of new staff employed. Managers did not explore and document reasons for gaps in employment records or document why staff had left employment with children or vulnerable adults. This was a breach of a regulation.

Managers reviewed incidents and other safety information promptly and made changes where necessary. These changes were disseminated to staff using the group online 'drop-box' and discussed informally on an adhoc basis. Managers met regularly with the local acute trust to discuss the service provided under that service level agreement. Managers received subjective feedback from the local acute trust about the quality of the work provided.

However, staff did not meet regularly as a group to learn from the performance of the service. There were no governance meetings during the 12 months preceding our inspection.

Management of risks, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not document how they identified and escalated relevant risks and issues and identified actions to reduce their impact.

At our last inspection, inspectors found managers did not record how risks were measured and monitored and there were no risk registers. At this inspection, minimal progress had been made to address these concerns. The provider had mechanisms to complete risk assessments. Risks were immediately escalated and discussed within the small management team. The service had responded proactively to risks to service delivery. For example, to resolve the risk related to an ageing fleet of vehicles, managers sourced and purchased a new vehicle delivered the day before our inspection.

However, there was no documentation of how ongoing risks were managed and mitigated. Risk-related policies were out of date. For example, the complex manual handling policy for managing risk and the business continuity policy was due for renewal in March 2019.

Information management

The service collected information about service delivery in paper format. This information was securely stored. However, staff could not access data in easily accessible formats, to understand performance and to make improvements.

At our last inspection, the service was collecting data but not using this to measure the quality of the service. There were no audit outcomes of key performance indicators such as times of collection of patients and the monitoring of delays and aborted journeys. The provider did not undertake audits to identify the strengths and weaknesses of the service.

During this inspection, we found the provider had not made progress to rectify this. Managers had made unsuccessful attempts to find a suitable data management system. The provider manually recorded patient journeys and did not have a system to collate this information into manageable data for the purposes of understanding or analysing performance. The provider did not collect the data in a format which easily identified different patient groups or responsiveness of the service. The service was unable to benchmark its service against other providers, it was unable to confirm whether patients spent more time than expected on vehicles, whether the patients arrived at their appointments on time or whether the patient spent more than the expected time waiting for collection**.**

Good

Patient transport services

Notifications were consistently submitted to external organisations as required. For example, the week after our inspection, the service submitted a notification to the Care Quality Commission for the death of a patient. The service was not required to submit data to the commissioners of the service.

Public and staff engagement

Leaders and staff did not use formal engagement mechanisms to engage with patients, staff, equality groups, the public and local organisations to plan and manage services. Leaders regularly spoke with staff and patients on an informal basis.

Staff told us they felt listened to and managers acted on any concerns they raised**.** For example, staff had commented that some frequently used items were inconveniently located in the paramedic kit bag. This led to the kit bag being rearranged to facilitate ease of retrieval of these items.

The service provided social events for staff to encourage team building. Senior staff told us they saw most staff when they were working, and the registered manager was always contactable in the office. However, no formal staff meeting had taken place in the last 12 months to enable formal feedback from staff.

Managers had conducted a staff survey. Managers had made improvements as a result of feedback from the staff survey. For example, managers had changed the format of the induction to include more time for new staff to observe crews before becoming operational.

Managers reviewed all feedback provided to them by patients. At the time of our inspection, none of this had been negative. Managers were in the process of proactively collecting feedback using a patient questionnaire. At the time of our inspection, and this data had not yet been analysed.

Innovation, improvement and sustainability

Managers were receptive to improving the sustainability of the service.

Managers continually strived to make the service more useful to the wider health economy. For example, the local acute trust needed to be able to transport more than one stretcher patient at a time. In response to this request, the provider purchased a vehicle that had capacity for two stretchers and was in the process of discussing with the local acute trust how this could be utilised to meet patient demand.

However, progress made to improve the service did not include several recommendations from the previous CQC report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Introduce a robust staff recruitment process, including maintaining adequate records.
- Ensure there are mechanisms to measure and monitor the quality of the service on an ongoing basis.

Action the provider SHOULD take to improve

- Provide training for safeguarding children in accordance with the intercollegiate guidance “Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019".
- Make plans to comply with the intercollegiate guidance “Adult Safeguarding: Roles and Competencies for Healthcare Staff. First Edition: August 2018
- Have readily available a list of approved signatories authorised to administer medicines under each of the patient group directions.
- Provide evidence of staff competencies to drive using emergency warning equipment (blue lights and sirens).
- Take steps to increase staff compliance with mandatory training.
- Take action to minimise the delay for face to face mandatory training
- Amend the complaints policy to include information on how a patient should proceed if they are not happy at the end of the internal complaints process.
- Introduce staff meetings so staff can give feedback regarding the quality of the service and to discuss service developments.
- Improve staff awareness and understanding of Gillick competencies.
- Arrange a service level agreement for the management of laundry items
- Improve staff awareness and understanding of the duty of candour.
- Record the identification, assessment and mitigation of risks to the service using a risk register or equivalent.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19(3)** The provider was not taking adequate steps to check the integrity and credibility of new staff employed. Records of the recruitment process were insufficiently detailed.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1)** The provider was not monitoring the quality of the service provided and did not have adequate oversight of responsiveness and safety on an ongoing basis. There was no documentation of how ongoing risks were managed and mitigated. Risk-related policies were out of date.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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