Akcess Medical Limited

Akcess Medical Control Centre

Quality Report

Unit 2265
Dunbeath Road
Swindon
Wiltshire
SN2 8EA
Tel:01793855550
www.akcessmedical.co.uk

Date of inspection visit: 25 January 2018
Date of publication: 12/03/2018

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Akcess Medical Control Centre is operated by Akcess Medical Limited. The service provides non-emergency patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 25 January 2018 and spoke with staff and patients over the telephone during the following 10 days.

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

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

Services we do not rate

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

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

- Governance processes were weak and did not provide assurance of quality and safety.
- Policies and procedures provided guidance in a number of areas but some appeared to be plagiarised from other services and did not always reflect current practice.Management oversight of compliance with policies procedures and safety systems was poor.
- There was no evidence that incidents, complaints or other patient feedback were properly investigated or that these events were used to improve safety and drive improvement.
- Staff employment records were not well organised and did not provide assurance that the service's recruitment policy had been fully complied with.
- Not all staff were up to date with mandatory training, which was not refreshed frequently enough. There was no formal system of staff supervision and no evidence that this took place.Staff appraisals were overdue.
- There was a lack of assurance with regard to the security of confidential patient information.
- Information about patients' transport needs, including important information about their medical condition or safety risks was not always complete or up to date. We also found instances where information had been overlooked or ignored when allocating transport resources.
- There was no guidance in place for staff to follow in the event that a patient in their care deteriorated. This was despite a number of incidents where patients had collapsed and emergency services had been called.
- Staff had received no training in respect of the specific needs of patients with complex needs and associated risks, for example patients receiving renal dialysis treatment and patients at the end of their lives.
- There was no policy or guidance in place with regard to the transport of patients who are sedated or patients who require oxygen therapy. We could not be assured that staff were suitably trained in this regard.
- Staff did not comply with requirements in relation to the carriage of patients' own medicines and reported varying practice.
- The service had taken no steps to support patients living with dementia or patients with learning difficulties. There were no communication tools available to support patients with communication difficulties.

Summary of findings

- There was no service level agreement in place with commissioners of the service. Key performance measures had not been agreed and were not monitored by the provider. There was little engagement or joint working with the commissioning ambulance service or receiving hospitals in relation to the quality of the service provided.

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

- Staff understood how to protect patients from abuse and there were systems in place to ensure other agencies were informed.
- The service had suitable premises and equipment and vehicles were well maintained and clean.
- The provider undertook regular Disclosure and Barring Service (DBS) and driving licence checks.
- Patients and hospital staff were very pleased with the service. They told us the service was reliable and staff communicated any delays.
- The service telephoned new patients to discuss their transport requirements and expectations.
- Patients described staff as helpful and caring.Staff described how they were flexible to meet patients' needs, for example accommodating an escort who had not been pre-arranged or waiting for a patient who was delayed at the hospital to ensure they got home.
- Staff enjoyed working for the service and felt well supported.
- Managers were respected, visible and accessible.
- There were regular staff meetings and communication channels were good.

Full information about our regulatory response to the concerns we have described can be found at the end of this report.

Amanda Stanford
Deputy Chief Inspector of Hospitals (south) on behalf of Chief Inspector of Hospitals

Akcess Medical Control Centre

Detailed findings

Services we looked at: Patient transport services (PTS)

Detailed findings

Contents

Background to Akcess Medical Control Centre

Akcess Medical Control Centre is operated by Akcess Medical Limited. The service opened in 2015. It is an independent ambulance service based in Swindon. The service provides patient transport to patients attending hospitals in Swindon, Bath and Gloucestershire.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

Facts and data about Akcess Medical Control Centre

The service provides non-emergency ambulance transport to patients attending renal dialysis centres in Swindon and Bath and to patients discharged from hospitals in Gloucestershire. Services are operated from a depot in Swindon, where vehicles and equipment are stored. These premises also provide office accommodation, where records are stored, and a training room.

The service is registered to provide the following regulated activities:

Transport services, triage and medical advice provided remotely.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has not been inspected since its registration with CQC in 2015.

Activity:

In the reporting period January to December 2017 the service undertook 22,380 patient journeys.

The service employed eight ambulance care assistants and eight drivers.

Track record on safety:

- No never events
- One patient death
- No serious injuries
- The service was unable to confirm the number of complaints received as no records could be found.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The service was registered by CQC in July 2015 to provide the regulated activity, transport services, triage and medical advice provided remotely. The service has not been inspected since its registration.

The service provides non-emergency ambulance transport to patients attending renal dialysis centres at NHS hospitals in Swindon and Bath. These patients attend hospital regularly, usually two or three times a week. The service also provides transport home for patients discharged from NHS hospitals in Gloucester and Cheltenham. This includes patients who are at the end of their lives. The service provided is sub-contracted work commissioned by another independent ambulance service. This is referred to as the commissioning ambulance service throughout this report.

The service has six ambulances and employs 16 (11.96 whole time equivalent) staff.

We visited the ambulance station on 25 January 2018. This was an announced inspection. We looked at records, including staff records and documentation relating to vehicles and equipment. We inspected premises, vehicles and equipment and spoke with office staff. We accompanied one staff member on an ambulance and spoke with them, their patients and staff at the receiving hospital. Following the inspection we spoke with a further four staff over the telephone. We spoke with transport coordinators and two nursing staff at receiving hospitals. We spoke with two further patients over the telephone.

Summary of findings

We found that governance processes were weak and did not provide assurance of quality and safety.

However, patients and hospital staff were very pleased with the service, telling us that the service was reliable and staff were kind and helpful.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- The service did not manage safety incidents well and missed opportunities to use these events to mitigate risk and improve safety.
- The registered manager told us that staff were encouraged to report incidents. Incident report forms were held on ambulances and staff we spoke with understood their responsibility to report concerns and knew how to do this.
- Completed incident report forms were held on a file at the provider's headquarters. There had been 12 incidents reported in the period July 2015 to date (January 2018). These included four patient falls and four occasions where patients had collapsed or fainted. One of these patients subsequently died. Four incidents resulted in an emergency ambulance being called. These did not prompt any analysis or review of the circumstances which may require change in practice, guidance or staff training in regard to managing deteriorating patients.
- Incident reports were poorly completed and did not always clearly describe what had happened. The manager's review did not demonstrate that a full investigation had been carried out, including consideration of the causes of incidents and remedial actions arising from the incidents. The manager review was often a simple statement to confirm they were happy with the actions taken by the staff member involved. Of the 12 incident forms, only one had been counter signed by the managing director, in accordance with the provider's policy.
- There was no evidence of learning from incidents or feedback to the wider workforce. We were concerned that there was no evidence of support provided to the staff member involved in the incident where a patient had died.
- The provider told us that any safety alerts or changes to policy would be notified to staff at regular staff meetings. These meetings were not always recorded and we saw no evidence of any such notifications.
- The provider had produced guidance for staff on Duty of Candour. This was contained in a pack of laminated guidance sheets held on each ambulance. The Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. 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. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. There were letter templates to be used in the event that Duty of Candour was applied.

Mandatory training

- The service provided comprehensive staff induction training on employment; however, training in safe systems and processes was not frequently refreshed.
- Staff were provided with mandatory training in safe systems and processes; however there was no policy in place which outlined what training was considered mandatory for each staff role. The training matrix identified that all mandatory subjects should be refreshed every three years, with the exception of safeguarding training which was refreshed every four years. We did not consider the frequency of refresher training to be sufficient to ensure staff remained appropriately skilled and up to date. When we requested to see the training policy we were sent a policy entitled Selecting a training provider. Staff had received driver training, moving and handling, first aid and infection prevention and control training. Safeguarding adults training had been introduced in the weeks prior to our inspection; however, staff had not completed safeguarding children training.
- Compliance with mandatory training was monitored using a training matrix, which was shared with us.There were some unexplained gaps on the training matrix, which did not provide assurance that all staff were up to date. This also raised concerns that there was not sufficient oversight of training.
- All staff were required to sign a declaration of care which confirmed they had read an understood policies and procedures and their responsibilities towards patients.

Patient transport services (PTS)

Safeguarding

- Staff understood how to protect patients from abuse and there were systems in place to ensure other agencies were informed. There was a Safeguarding Adults Policy (May 2017) and a Safeguarding Children Policy (May 2017). The policies identified that all employees were to complete mandatory safeguarding training. This had only been provided very recently. Training included how to recognise signs and symptoms of abuse, including behaviours, and the overarching legislation. At the time of our inspection, 13 out of 16 staff had completed this training. The training matrix identified that safeguarding training was to be refreshed every four years. We did not consider that this was frequent enough.
- There was a laminated safeguarding flow chart which was held in the guidance pack held on each ambulance. Staff we spoke to confirmed they understood their responsibility to report concerns and knew how to do this. They were required to report concerns using and incident report form to the operations manager, who was identified and the service's safeguarding lead. The operations manager confirmed that this responsibility had only recently been allocated to them and they had received no training to support them in this role.They understood however, their responsibility to report concerns to the relevant local authority and to notify the Care Quality Commission.

Cleanliness, infection control and hygiene

- There were systems in place to prevent and protect people from the risk of infection; however, these were not consistently applied and there was no audit system in place to provide assurance that infection risks were effectively managed.
- There was an Infection prevention control procedure (May 2017). This included guidance on hand hygiene, personal protective clothing and equipment, exposure to blood and body fluids, cleaning, waste management and uniform. A summary of this guidance had been produced on a laminated sheet held on each ambulance.
- Staff received mandatory training in infection control, which they were required to update every three years. However, training records provided showed five out of 16 staff had not completed this training. There was summary guidance on infection control held in staff guidance packs held on each ambulance.
- There was a cleaning schedule which set out cleaning methods and frequency of cleans, and there were checklists for daily and weekly cleaning tasks. There was no documentary evidence that these forms were checked to provide assurance that the policy was complied with and no audits or spots checks of vehicle and equipment cleanliness. There was a whiteboard which displayed the vehicle deep cleaning schedule. We were told that managers periodically monitored the board. There were 'deep cleaned' discs which are affixed to vehicles showing the date they were last deep cleaned (should be at least 6 monthly). On the three ambulances we inspected, the discs were either missing or had not been filled in.
- There was a vehicle cleaning checklist completed daily by staff. Daily cleaning tasks included mopping the floor of the vehicle and wiping visible surfaces. There was a designated area at the provider's ambulance depot where cleaning took place.
- Ambulances were equipped with anti-bacterial wipes and spray and we observed staff cleaning seats and equipment after patient transfers. Seat covers on one ambulance were vinyl and could be wiped clean. On the other two ambulances, seat covering was soft fabric and we queried how this would be decontaminated in the event of a spillage. The registered manager undertook to investigate this. There was no information in the Infection Control Procedure to explain this.
- We inspected three ambulances and found they were mostly clean and tidy. However on one ambulance there was dust visible on shelving and on the automatic defibrillator (a medical device used in the event of a cardiac arrest).On one ambulance the interior fabric was ripped, exposing foam filling; making this surface difficult to keep clean.
- We checked a range of medical devices on ambulances and found these were clean and ready for use.
- Personal protective equipment (PPE), such as gloves, aprons and masks were available on the ambulances. A supply of PPE was held at the depot for staff to replenish stocks as required.

Patient transport services (PTS)

- There were appropriate systems in place for segregating and disposing of waste. Staff were required to dispose of segregated waste in appropriate bins at hospitals or at the ambulance depot. However, we found one clinical waste bag, which contained a soiled item, had been left on an ambulance.
- Linen was exchanged at hospitals or if heavily contaminated it was disposed of. Staff were responsible for laundering their uniforms and guidance was provided on the disposal of heavily soiled items.
- The infection control policy did not provide guidance on transporting infectious patients but the operations manager told us that they would transport patients with Methicillin-resistant Staphylococcus aureus (MRSA). They would be transported individually and the ambulance would subsequently be deep cleaned. Information regarding patients' infection status was included on the electronic booking system; where there was the facility to include special instructions (bookings were taken by the commissioning ambulance service). We reviewed the bookings screen during our inspection and saw that a patient who was identified in the notes as MRSA positive was booked to travel with other patients.The operations manager had not taken the notes into account when allocating this patient because they believed the notes to be out of date. At our request they contacted the organisation which placed the booking and it was confirmed that the information was no longer valid and it was removed. However, we remained concerned that the provider had failed to identify the infection risk and shared our concerns with them.

Environment and equipment

- The service had suitable premises and equipment and vehicles were well maintained. However, not all equipment was tested to ensure it was safe to use.
- Premises comprised two buildings and a vehicle compound. One building housed a mechanical workshop and office; the other contained a training office and vehicle cleaning area. The premises were monitored by an external company who alerted the registered manager of any unexpected activity. Overnight, vehicles were stored within buildings or a secured compound. If a vehicle was returned outside of normal working hours, staff could access the compound and deposit keys.
- There was a Vehicle Maintenance Policy (May 2017) which outlined roles and responsibilities for ensuring the safety of vehicles.
- The service used an electronic vehicle maintenance management and storage system. This software alerted the provider when inspections, servicing, and testing were due. The vehicle inspections and testing were conducted by another company owned by the registered manager and located at the depot.
- We reviewed the paper and electronic vehicle records for the six ambulances used by Akcess Medical Control Centre. All vehicles had correct registration and up to date servicing and MOT.
- All vehicles were regularly serviced and maintained. There were safety checks for wear and tear documented using a vehicle safety checklist. However, some paper records were incomplete, for example dates, registration numbers and signatures were missing. We found one document which contained information relating to two different vehicles, which we highlighted at the time of our inspection.
- There was a checklist which staff were required to complete to show that daily and weekly checks of vehicles and equipment had been undertaken and any defects reported. Staff we spoke with could describe the process for reporting defects.
- We inspected three ambulances. The exterior of vehicles were clean and in good condition, with no visible damage.
- Ambulances were well equipped and equipment was mostly safely stored. There were seatbelts and harnesses for securing wheelchairs. There was essential emergency equipment, including an automated external defibrillator and oxygen cylinders. Oxygen cylinders were appropriately secured in vehicles and safely stored at the depot.
- Not all equipment had undergone appropriate checks to ensure it was safe to use. We found no evidence that a defibrillator had been tested for electrical safety.

- There was a first aid bag order form which listed the contents of this bag and staff were responsible for replenishing used items and checking that contents were in date and intact. On one ambulance we found there were items missing from the first aid kit and there was a dressing which had passed its expiry date.
- During our inspection of one ambulance we found two leather belts and some latex resistance strips. We asked the registered manager to explain why these items were on the ambulance because we were concerned that they may have been used to restrain a patient. The registered manager spoke with the staff member who usually used this ambulance and told us that they could provide no explanation.We later spoke with the staff member, over the telephone. They told us that the leather belts had been used as a temporary measure to prevent oxygen cylinders banging together, as the packaging had split. They told us the latex strips were lost property belonging to a patient. The staff member had completed an incident form to this effect. The actions arising from this incident were to review the deep cleaning process (as these had not been identified during this process) and to remind staff of the lost property procedure.

Medicines

- Medicines were not managed safely.
- The service did not prescribe medicines, and administered only oxygen. There was a policy for the storage of medicines which described the requirement for ambulance staff to securely store patients' own medicines, including controlled drugs handed to them by hospital staff and to sign these medicines in and out. Staff we spoke with described different practices in relation to storage and recording in relation to patients' own medicines and we could not be assured the policy was complied with.
- There was guidance on the safe storage of oxygen cylinders and we saw this was complied with. However, there was no guidance on the administration of oxygen to patients during transport. Within the context of non-emergency patient transport, the administration of oxygen is permitted following a prescription from an appropriate healthcare professional. Staff we spoke with confirmed that sometimes hospital staff connected the oxygen supply and other times they connected it. They told us they had received training to administer oxygen as part of their ambulance care assistant training. We saw no guidance on checking the prescription of oxygen and documenting flow during the patient's journey.

Records

- The service did not manage care records in a way to keep patients safe. Patient information was not always complete and there were insufficient safeguards to ensure confidential information was kept secure.
- The service received confidential patient information from the commissioning ambulance service via a secure electronic portal, which was password protected. However, not all staff accessing the system had individual passwords; this meant there was no audit trail as to who was accessing this information.
- Patient information was transmitted to ambulance staff by two different systems. Staff working in Bath and Gloucestershire area accessed the electronic portal directly to review their allocated workload. This included notes to alert them to patients with, for example, pre-existing conditions or safety risks.Staff did not have individual log in details and used those allocated to the registered manager. Staff working in the Swindon area received a downloaded copy of the patient information directly to their personal email accounts, via their personal smart phones. This did not include notes and staff told us they were not aware of any particular needs of the patient until they arrived. There was an expectation that staff would delete the record from their e-mail account; however, there was no assurance in place that this occurred.There was no written guidance which set out staff responsibilities in respect of protecting patients' confidential information. However, there had been no data protection breaches reported.

Assessing and responding to patient risk

- There were not effective systems in place to assess and manage risks to patients.
- Patients' eligibility and suitability for ambulance transport and type of conveyance was assessed by hospital staff and information was provided to the commissioning ambulance service and then transmitted to Akcess Medical Control Centre. Information was provided in respect of patients'

mobility to enable the service to assess what support they required during transport. Notes to alert staff to patients' pre-existing medical conditions or safety risks were recorded; however we found two examples where this information had been overlooked or ignored. One patient, who had been identified a requiring a two person crew had been transported by a driver only. The operations manager was not able explain why their information had been overlooked and it had not been queried. Another patient, who was identified as being infected with MRSA was booked to travel with other patients. On investigation, the information was found to be out of date; however we were concerned that this had not been investigated until we queried it.

- Staff told us that important information about patients' transport requirements was not always provided, or the information was incorrect or out of date. All of the staff we spoke with told us this was a regular and frequent occurrence. They told us that they undertook dynamic risk assessments and discussed patients' needs with hospital staff to assure themselves that it was safe to convey patients.
- There was no documented escalation process for staff to follow in the event that a patient became seriously ill. This was despite three incidents where a patient had collapsed and emergency services had been called. Staff told us they would administer emergency first aid and call an emergency ambulance.
- There was no guidance on managing challenging behaviours, despite the fact that staff were on occasions asked to transport patients exhibiting challenging behaviour. Two staff told us that they transported patients who had been sedated. There was no guidance for staff and they had not received training to support patients under sedation.

Staffing

- The service did always ensure that staff with appropriate training were deployed to meet patients' transport needs.
- The number of staff required for a journey was planned approximately one week in advance and every attempt was made to ensure continuity so that staff were familiar with regular patients' needs. There was no algorithm used to determine the number of staff required, this was based on staff judgement and experience.Staff told us that in the event of staff sickness or other unplanned absence, staffing cover was found from within the current workforce.
- Staff employment records were incomplete and did not provide assurance of the suitability, skills and experience staff on employment or on an ongoing basis.
- There was a Recruitment and Selection Policy (July 2015) which set out guidance and principles in relation to recruitment and selection. All applicants were required to complete an application form and attend an interview. There was guidance on producing a job description, person specification and interviewing against criteria set out in the person specification. We saw no job descriptions, person specifications or interview notes. Two records did not contain an application form and there was no evidence that their employment history had been checked. The policy set out that offers of employment were to be made subject to:
  - Confirmation of eligibility to work in UK
  - Receipt of satisfactory references and explanation of employment gaps
  - Satisfactory medical clearance
  - Disclosure and Barring Service (DBS) clearance. The DBS is a government organisation which runs background checks on applicants to prevent unsuitable people from working with vulnerable people.
  - Successful completion of the company training courses
  - Confirmation of relevant qualifications.
- We checked four staff records. Files were disorganised and did not facilitate easy monitoring. All records contained evidence of a recent DBS check, driving licence check and confirmation of the staff members' home address. There was a checklist to be completed every three months to complete these checks.Only one record had been checked in the last three months but all had been checked within the last six months. All applicants had one reference from a previous employer,

none had medical clearance.There were various training certificates, some of which were very out of date but no clear training history was apparent.We found two incomplete driver assessment forms.

Response to major incidents

- The service did not have a role in major incidents.
- There is a Business Continuity Plan (May 2017) which set out procedures in the event of vehicle breakdowns, road traffic incidents, staff shortage, severe weather conditions, telephone/power failure and major incidents where they may provide urgent assistance to their client (commissioning ambulance service).

Are patient transport services effective?

Evidence-based care and treatment

- The service had no written specification or service level agreement with the commissioning ambulance service and did not measure its performance against any standards.

Assessment and planning of care

- Patients 'eligibility for patient transport and their needs were assessed by the requesting hospital and screened by the commissioning ambulance service and sent to Akcess Medical Control Centre via an electric booking system. Any special requirements or information which transporting crews needed to be aware of was recorded in a notes field. This information was used to ensure the most appropriate resource was allocated to meet patients' individual needs. However, during our inspection we noted that a patient who was identified as having limited mobility and needing a two person crew had been booked to travel with a driver only. When we queried this the operations manager could not explain why the notes field had been disregarded.

Response times and patient outcomes

- The service was required to record key outcome data for monitoring by the commissioning ambulance service. This was to measure the timeliness of the service and included arrival and pick up times and the time that patients spent on the vehicle. The service did not produce any information in order to monitor its own performance and did not seek or receive feedback, either from the commissioning ambulance service or the hospital departments receiving the service.

Competent staff

- Staff were supported to ensure they had the necessary skills and knowledge on employment; however, there was little evidence that they were managed on an on-going basis to identify and support their training and development needs.
- Staff received a comprehensive induction which included familiarity with the ambulance depot, ambulance vehicles and driver checks, driver training and breakdown and emergency procedures. They also received training in infection control, manual handling and emergency first aid.
- Staff told us they felt supported in their roles, although access to training was limited to mandatory training. Staff had received no training to support them in respect of the particular needs of the patient groups they transported, that is to say, patients receiving renal dialysis, patients who were at the end of their lives or patients with mental health needs.
- The recruitment and selection policy stated that staff would receive annual appraisals. We saw records to show that staff had been appraised in the spring and summer of 2016 and appraisals were now overdue. The registered manager acknowledged that appraisals had been "neglected". The operations manager confirmed that appraisal forms had been sent to staff and meetings would be scheduled in the near future. There was no formal system to ensure on-going supervision of staff. There was a team leader but they worked solely in the Gloucestershire 'team' and, when asked, they could not clearly explain any supervisory responsibility. The registered manager explained that they employed an external trainer/advisor, who periodically provided training and supervision/assessment by accompanying staff on ambulance journeys and conducting spot checks at hospitals. We were told that this took place approximately three times in 2017, but we found no records to support this. The registered manager told us there were plans to formalise this process and undertake it monthly.

Patient transport services (PTS)

- We were told that any poor practice identified, for example as a result of a complaint, would result in assessment of training needs. An example of this was a complaint, which was received about a staff member driving too fast. The staff member concerned underwent a driving assessment to ensure their competence.

Multi-disciplinary working

- The service worked closely with the commissioning ambulance service and receiving hospital departments and transport coordinators on day to day operational issues.
- Information in relation to patients' transport needs, including their mobility, was captured by the commissioning ambulance service and this information was transmitted electronically to Akcess Medical Control Centre. This information was then conveyed via text or email to the relevant staff. As detailed above, information relevant to individual patients' needs was not always conveyed to ambulance staff. Three staff members told us that information was frequently unreliable or out of date and this was a regular and frequent occurrence.
- Staff told us they frequently provided transport home for patients who were at the end of their lives. They told us that they were alerted to the patient's status/ condition by the transport coordinator at the hospital and this information was contained in the notes field on the electronic portal. Staff were also alerted when a 'Do not Attempt Cardiopulmonary Resuscitation' (DNACPR) order was in place, although they told us they always checked this with patients. They told us they worked in accordance with the commissioning ambulance service's DNACPR policy, which we saw a copy of. This required that they inspected the relevant paperwork before transporting the patient.

Access to information

- Staff told us that they accessed their work schedule via an electronic portal. This contained patients' names, collection and destination addresses, appointment, times collection times, category of transport and mode of conveyance (wheelchair, stretcher, for example). Special notes were included to alert staff to specific patient needs such as pre-existing medical conditions or safety risks, including accessibility of patients' homes. Staff were also alerted via special notes if a patient had a 'Do not Attempt Cardiopulmonary Resuscitation' form in place. Where this was not evident and the staff were uncertain, they told us they would speak with hospital staff or patients directly. Staff confirmed their practice in relation to DNACPR was in accordance with the commissioning ambulance service's Resuscitation and DNAR Policy (November 2015). This required staff to satisfy themselves a valid DNAR form was in place.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a Consent and Capacity Policy (July 2017) which described best practice; however the policy did not clearly describe how this could be put into practice.
- Staff had not received specific training in consent and the Mental Capacity Act 2005, although they told us this was covered in first aid training and training for the ambulance care assistant role. Staff told us that where a patient lacked capacity, this had been assessed by the hospital staff making a transport booking. All decisions in relation to transport and care while being transported were discussed with hospital staff before a patient was conveyed.

Are patient transport services caring?

- Staff provided compassionate care and respected patients' dignity.
- The service periodically collected patient feedback using a questionnaire. We saw 19 completed feedback forms; however these were not dated and staff could not confirm how recent this feedback was. Nevertheless, feedback was mostly very positive. Comments included: "Your drivers are very helpful and courteous; they always do everything to help" and "My driver is a pleasant caring person. She stands out as a driver who is always careful to make sure the journey is as comfortable as possible and is considerate of all of our needs".
- We spoke with one patient over the telephone. They described the staff who had transported them home from hospital as "marvellous". They told us the crew had taken them into to their living room, helped them into a chair and wrapped them in a blanket as it was a cold night.

Patient transport services (PTS)

- We spent some time on an ambulance with patients. The staff member interacted in a friendly and courteous manner with patients and constantly checked that they were comfortable.
- Staff at the receiving/discharging hospitals also commented positively about the service provided by Akcess Medical. They told us staff took the time to get to know their patients and interacted with them in a respectful and considerate manner. One nurse told us that a number of patients attending their unit had learning difficulties and were initially booked to travel to and from hospital with an escort to support them. They told us the patients had built up a relationship of trust with their regular drivers and were now comfortable to travel without an escort.
- Staff respected patients' dignity. It was recorded in the minutes of a recent staff meeting that staff were concerned about transporting patients who were not appropriately dressed to maintain their dignity. Staff told us they would challenge hospital staff if this occurred.
- Staff at receiving hospitals told us that they observed staff taking steps to preserve patients' dignity.

Understanding and involvement of patients and those close to them

- Staff at receiving hospitals were complimentary about the relationships which staff had formed with their regular patients and told us that patients were very appreciative of this.
- The journeys undertaken by Akcess Medical Control Centre were organised by the commissioning ambulance service; therefore this is was no direct contact with patients or those close to them prior to their collection. Should the patient have additional requirements, for example the need for a family member or carer to travel with them, this would be pre-arranged. Staff told us that on occasions they would encounter a situation where an escort wished to travel but this had not been booked. They told they would happily accommodate this if they had the room to do this safely (and the booking was amended for insurance purposes). They also told us that they were as flexible as possible to meet people's needs, for example waiting for patients who were delayed or accommodating luggage if they could do so safely.

Emotional support

- Staff supported patients during distressing events. A staff member described a recent event where a patient, who was living with dementia, was exhibiting challenging behaviour and refusing to travel to a care home. The staff member took time to introduce themselves, and reassure and calm them. On arrival at the care home, they ensured that that the patient was immediately attended to by a staff member and given a cup of tea.

Are patient transport services responsive to people's needs?

- Services provided by Akcess Medical have been commissioned by NHS services in Swindon and Bath, via another independent ambulance service for specific patient transport contracts to support renal dialysis patients. The service also provided a dedicated discharge service from hospitals in Gloucester and Cheltenham which included the transport of patients who were at the end of their lives. There was no service specification or written agreement between these services and no specific needs had been identified but largely, the transport of these identified patient groups was time critical.
- Resources (staff and ambulances) were based in both Gloucester and Swindon in order to meet the demand in both localities.

Meeting people's individual needs

- The service had not taken any formal steps to identify and support the needs of vulnerable groups and patients with complex needs, although staff were able to describe the emotional support and reassurance they would provide to, for example, patients living with dementia, patients with learning difficulties or patients who were at the end of their lives.
- Transport of patients at the end of their lives was given priority and in most cases, these patents would be transported individually.
- Staff had received no specific training to support patients with complex needs and there were no communication tools available to support patients with communication difficulties or patients whose first

language was not English. The registered manager told us they had recently purchased multilingual phrasebooks; however this was not available on the ambulances we inspected.

Access and flow

- The service was unable to provide us with any information to demonstrate its efficiency or timeliness.
- Staff were required to log patient collection and arrival times but this information was not complied or analysed. However, staff at receiving hospitals and the commissioning ambulance service told us they were very pleased with the service by provided by Akcess Medical and felt it was responsive. Hospital staff told us if there were any delays, they were kept informed. The registered manager told us that when new patients were allocated to them, they telephoned them in advance of their first journey to discuss their journey requirements and expectations. Regular patients generally travelled alongside the same travel companions; however, in some cases, the order in which they were collected and returned home was alternated so that the time patients spent on vehicles varied.

Learning from complaints and concerns

- We found no evidence that the service treated complaints seriously, investigated them and shared learning from them.
- There was a Customer Complaints Procedure (undated) which outlined guidance on the management of complaints, whether they were made verbally or in writing. Staff were instructed to record verbal complaints using an incident report form. Complaints were investigated by the registered manager. He was able to describe a recent complaint about a staff member driving too quickly and the action taken in response to this complaint, which was a requirement for the staff member to undertake a driving assessment.
- The registered manager estimated that five complaints had been received in the last year. He told us about several similar complaints about travel time for patients who lived outside of Swindon. In response to these complaints, the order in which patients were collected and returned home was alternated so the frequency of long journeys for individual patients was reduced.
- We checked the incident report records and found that no complaints had been recorded. This came as a surprise to the registered manager. We could not be assured therefore that staff reported concerns and that these has been investigated, resolved and learning taken from them. There was no evidence that complaints were reported to the commissioning ambulance service or receiving hospitals or any evidence of joint investigation and learning.
- Patients we spoke with while out on an ambulance told us, when asked, that they did not know how to make a formal complaint. However, they told us they felt comfortable to raise any concerns with their driver and they were confident that the driver would respond to and resolve their concerns.

Are patient transport services well-led?

Leadership of the service

- The registered manager is the company director. He is supported by an Operations Manager and a Compliance Manager/office manager and a human resources administrator. Staff described managers as accessible and supportive.

Vision and strategy for this this core service

- The service had produced a mission statement, which was published on their website.It stated: “Your wellbeing is important to us, we understand that life can be difficult enough. We care about people, and want to help as much as we can.It is important to us that you feel; safe, respected and comfortable when travelling whilst with us and your waiting time is minimised." Staff, while not able to articulate this statement, could relate to it and demonstrated in their conversations with us that they worked in accordance with the values and sentiments expressed in this statement.

Governance, risk management and quality measurement

- There was not an effective governance or quality assurance framework. The service was not able to assure itself or its commissioners of the safety and quality of the services it provided. There was a range of policies but these were often statements of good

practice, which were not supported by more relevant local processes. It was clear that some policies had be plagiarised from others services and needed to be made more relevant and useful to this service.

- Where safety systems and processes were in place, there was little evidence that compliance with these systems and processes was monitored. The registered manager told us that he took assurance from systems to ensure safe recruitment and training but he did not have proper oversight of these systems. Records were poor and did not provide assurance. Recruitment records were disorganised and did not facilitate monitoring of the process. Records did not provide evidence that the Recruitment Policy had been consistently complied with in full. A training matrix had been produced but there were unexplained gaps, no training plan and no evidence of regular oversight of staff compliance with training. Mandatory training was refreshed every three to four years and we questioned whether this was frequent enough. The service had not clearly identified training requirements, including the timescale in which training should be refreshed, for each role. Safeguarding adults training had only just been introduced and staff had not completed training in safeguarding children. The registered manager told us the service had recognised that first aid training should be refreshed annually, rather than every three years as was currently the case. There was no formal or regular system of staff supervision and staff appraisals were overdue.
- There were systems in place to ensure vehicles were properly equipped and cleaned but no oversight and no audits to ensure these checks were carried out consistently. There were good systems in respect of vehicle maintenance and safety.
- Performance data, although captured on a day to day basis in relation to the timeliness of the service, was not available to us and was not monitored by the service.
- Data in respect of incidents, complaints and other patient was not monitored or used to mitigate risks or drive improvement. Records were poor and did not provide evidence that incidents were appropriately reported, recorded or investigated. The service did not maintain a risk register which identified risks and control measure to mitigate those risks.
- The service did not engage with receiving hospitals to ensure there was an understanding of their requirements and the specific needs of different patient groups and did not seek feedback from these services.

Culture within the service

- Akcess Medical Central Centre was a family-run service and the registered manager told us they employed "people from the same cloth". He told us that patients' needs came before profit.
- Staff felt well supported, enjoyed working for the company, which they described as like a big family. There were good channels of communication; fortnightly meetings were held, where information was disseminated and experiences were shared. Staff felt these meetings provided opportunities to raise any concerns and they felt their concerns were listened to. There were also breakfast meetings held every few months, which were more sociable events where staff got together.
- There was a Whistleblowing and Public Disclosure Policy (undated), which appeared to be plagiarised from another organisation and not wholly relevant to this service.

Public and staff engagement

- The service did not have an effective system to capture and monitor patient feedback or to act on any areas of concern identified through this route.
- The service invited service users to provide feedback via their website. The Registered Manager told us that about a year ago the service conducted a patient feedback campaign. Staff were encouraged to give out feedback questionnaires to patients and certificates of recognition and vouchers were awarded to staff who received a certain number of positive feedback forms. Business cards had been produced, to be displayed in card holders on ambulances, which asked patients "How did you find our service?" We did not see these displayed on the vehicles we inspected, although there were some in the glove compartment in one vehicle and several staff we spoke with over the phone confirmed they were aware of them.
- We were shown a file containing 19 patient feedback forms. These were not dated and staff could not confirm how recent they were. There were a small number of

forms where patients, who had provided their names, had provided negative feedback about arriving home late. There was no evidence that these comments had been followed up with the patients concerned.

- During our inspection we spoke with transport coordinators in the receiving hospitals. They were very complimentary about the service provided by Akcess Medical Control Centre but there was no established method for them to pass on this positive feedback and the service did not routinely engage with them.

Innovation, improvement and sustainability

- The registered manager was keen to grow the service but was unable to invest in the business because there was no guarantee that work would continue to be sub-contracted by the commissioning ambulance service.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance There is not an effective governance and quality assurance framework. The service is unable to assure itself or its commissioners of the safety and quality of services provided.