Medicar Limited

Medicar Limited (Clacton on Sea)

Quality Report

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

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection visit of Medicar Limited (Clacton on Sea) on 7 November 2016 and an unannounced inspection on 21 November 2016.

We were not committed to rating independent providers of ambulance services at the time of this inspection. However, we highlight good practice and issues that service providers need to improve.

We found the following areas of good practice:

- Staffing was sufficient to meet patient need.
- All staff were up-to-date with appraisals and mandatory training.
- Staff had access to the information, support and supervision they needed to carry out their roles effectively.
- Staff worked closely with each other and external providers to best meet the patient's needs.
- Staff were caring in their approach and had a highly patient-centred attitude, and patient feedback about the service was consistently positive.
- Staff reported the working culture was positive and they felt engaged with the service.
- The service was proud of the fact that a registered nurse escorted every patient during transfer.
- The service was responsive to the concerns we raised and we found that much improvement had been made in relation to these concerns by the time of our unannounced inspection. For example, we raised safety concerns about the equipment, because the stretcher did not have all of the manufacturer's recommended straps in place to secure patients during transport, and there were no handle grips or foot restraints on the carry chair. These had been addressed by the time of our unannounced inspection.

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

- There was a lack of clear systems or procedures to ensure, if an incident occurred, that lessons would be learnt.
- There was no risk register for the service. However, by the time of our unannounced inspection one had been developed, though this was not yet embedded.
- There was a lack of formal or documented risk assessments for the vehicles and for patients being transported.
- There was a lack of formal, clear record keeping. For example, daily vehicle checks, deep cleaning of vehicles, patient transfer forms, and driver competencies were not always well recorded.
- There was no flagging system to clearly indicate if a patient was living with dementia or learning disabilities.
- There was no system in place to indicate if a patient had been assessed as lacking capacity and how best to meet their needs.
- The governance systems were not effective, which meant we were not assured that concerns issues would be identified and mitigated. The risks identified during our inspection had not been identified as issues by the management team.

Information on our key findings and action we have asked the provider to take are listed at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Overall we have not rated patient transport services at Medicar Limited (Clacton on Sea) because we were not committed to rating independent providers of ambulance services at the time of this inspection. Incident reporting and learning procedures were not embedded in the organisation. If an incident occurred, we were not assured lessons would be learnt. There was a lack of formal or documented risk assessments for the vehicles and for patients being transported; a lack of specialised, adequate and recorded deep cleaning of vehicles to prevent the spread of infection; and vehicle checks were not documented. There was a lack of a safe safeguarding process due to the safeguarding lead not being trained to level three in safeguarding adults as recommended in best practice guidelines. The governance systems were weak and ineffective which meant that we were not assured that concerns would be identified and mitigated. The risks identified during our inspection had not been identified as issues by the management team. The service was not continuously monitoring and evaluating its performance. However, by the time of our unannounced inspection the service had introduced and implemented a record-keeping process which was an improvement. However, staffing was sufficient to meet patient need and local demand. All staff were up-to-date with appraisals and mandatory training. Staff had access to the information, support and supervision they needed to carry out their roles effectively. Staff worked closely with each other and external providers to best meet the patient's needs. Staff were caring in their approach and had a patient-centred attitude. Patient feedback about the service was consistently positive. The working culture was positive and staff felt engaged with the service. The service was proud of the fact that a registered nurse escorted every patient during transfer.

Medicar Limited (Clacton on Sea)

Detailed findings

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Detailed findings

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Background to Medicar Limited (Clacton on Sea)

Medicar Limited (Clacton on Sea) is a family-run business through Medicar Limited, which is located in Little Clacton, North East Essex.

Medicar Limited (Clacton on Sea) provides patient transport services to both public and private sector services including acute trusts, clinical commissioning groups (CCGs), private hospitals, social services, care homes and personal customers.

The current owner has owned the service since 2007, and established it as a limited company in 2009. From 2009 to 2014 over 97% of service activity was driven through their working agreements with the large, local acute hospital trust. The remaining 3% of activity was split between the local hospice, private patient bookings, and working arrangements with local, private hospitals. In August 2014 the acute trust tendered the contract and the service did not submit a tender to be considered for the contract. In the last year the service has focused on its private client base.

We inspected this service as part of our comprehensive independent health services inspection schedule.

Our inspection team

The team included three CQC inspectors including a specialist with experience as a registered paramedic.

How we carried out this inspection

This inspection was a scheduled inspection carried out as part of our routine schedule of inspections. The announced inspection took place on 7 November 2016 and the unannounced inspection took place on 21 November 2016.

We spoke with three members of staff, the registered manager and the operational lead. We also reviewed a range of information and documents provided by the service before, during, and after the inspection.

We did not rate the service as we did not have a legal duty to rate independent providers of ambulance service at the time of this inspection.

Detailed findings

Facts and data about Medicar Limited (Clacton on Sea)

There are 12 staff comprising the managing director, clinical lead (who is also the registered manager for the service), three ambulance drivers and seven registered escort nurses. There are two vehicles used by the service which are kept at the business address.

The service carried out a total of 1539 transport activities between April 2015 and March 2016.These were all carried out within six of these months as the service was inactive between September 2015 and February 2016 following the ceasing of the working agreement with the local acute trust.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Patient transport services (PTS) were the only service carried out by Medicar Limited (Clacton on Sea).

The business was run from the business address and this is where the two vehicles were kept that were used to deliver the patient transport service.

The service employed 12 members of staff in total, comprising three drivers and seven registered nurses. All staff were employed on a casual, zero-hours basis and would be called to carry out patient journeys as and when bookings came in.

The service carried out a total of 1539 transport activities between April 2015 and March 2016. These were all carried out within six of these months as the service was inactive between September 2015 and February 2016 following the ceasing of the working agreement with the local acute trust.

Medicar Limited (Clacton on Sea) offered the facility for transfers requiring medical transportation, for example to and from hospital or consultancy appointments. If required the service had links with medical insurance agencies to repatriate patient and family members home.

At the time of our inspection, Medicar Limited (Clacton on Sea) offered private transport services to personal customers; acute hospitals; clinical commissioning groups; private hospitals; social services; and care homes. The service did not have any formal contracts in place with external providers to provide PTS.

Summary of findings

Overall we have not rated patient transport services at this service.

Patient transport services (PTS)

Are patient transport services safe?

We did not rate the service for safety.

Incidents

- The service reported no clinical or non-clinical incidents between August 2015 and July 2016. However, the service had been inactive for six of those months.
- There was an up-to-date incident reporting policy in place which specified that an incident report form should be completed within 48 hours of the event and submitted to the registered manager. Incident forms were kept in the vehicles.
- Three members of staff we spoke with were aware of the process of how to report incidents.
- By the time of our unannounced inspection, the service had introduced an incident reporting log to improve incident monitoring and management.
- In the event of an incident the registered manager, who was qualified as a trainer in root cause analysis (RCA) would carry out the RCA. They were able to give examples of incidents that would need reporting such as patient falls or vehicle collisions.

Mandatory training

- Data provided by the service prior to inspection showed that all 12 members of staff were up-to-date with mandatory training, except for one registered nurse who had not yet shared her transferrable record with the service. We were not able to see this staff member's record at the time of inspection.
- Mandatory training included, but was not limited to, full first aid (for drivers), infection control and medical gases. Mandatory training involved a mixture of both e-learning and face-to-face training.
- Staff whose primary job was with the NHS were able to transfer their training record if evidenced by the employing NHS body. Staff who had retired from the NHS were enrolled onto training provided by a local community trust. This training was not specific to ambulance provision. Training was also carried out via e-learning modules and a Health and Safety Group.
- New drivers were accompanied by the operational lead for their first month to assess driving competence and attitude towards patients and families. However, there was no formalised driver training and the initial supervisory period was not documented so this was not possible to verify.

Safeguarding

- Safeguarding adults levels one and two were included in mandatory eLearning training. Data provided by the service showed that all 12 staff members were up-to-date with this training. This was in line with national guidelines on safeguarding adults (NHS England Intercollegiate document 2016, Safeguarding Adults: Roles and competences for health care staff
- Safeguarding children training was not included as the service did not transport children nor did the service transport adult patients travelling with children.
- The safeguarding lead for the service was the registered manager. However, this person wastrained to level one and not trained to level three safeguarding adults as recommended. This meant the service was not working in line with national guidelines on safeguarding adults. The NHS England Intercollegiate document, Safeguarding Adults: Roles and competences for health care staff All staff who regularly contribute in the investigation of adults at risk of harm or abuse and/or their families / carers, (through the multiagency safeguarding procedures, and assessing, planning, intervening and evaluating the needs of an adult that there are safeguarding concerns about)." There was also no agreement to refer safeguarding concerns to a level three trained external lead. However, after the inspection the safeguarding lead completed level three training, bringing the service in line with national guidelines on safeguarding adults.
- Information provided prior to inspection stated that the service would make a referral to the relevant local safeguarding authority if a patient did not appear to be safe alone without carer support.
- The operational director and clinical lead gave examples of potential safeguarding situations, including risks presented by the patient's home environment that become apparent at the time of drop off, such as hoarding.

- The nurse and driver we spoke with were able to give examples of potential safeguarding situations and knew how to escalate any concerns.

Cleanliness, infection control and hygiene

- As of September 2016, all staff were up to date with infection control training. This was refreshed on a three-yearly basis.
- There was a box stored in each vehicle with waste disposal bags, spill cleaning kits and information for staff on Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.difficile).
- Waste disposal bags would be taken back to the hospital to be disposed of. In addition, staff would return used laundry in appropriate linen bags, back to the hospital where the laundry originated from.
- Personal protective equipment (PPE) and hand-cleansing gel were available in the vehicles.
- The service had not undertaken an infection control audit.
- We were told that if a member of staff had transferred a patient who presented an infection risk they would have to clean and change their uniform immediately after.
- Deep cleaning of the vehicles was carried out by a local valet service which included steam cleaning the carpets inside the vehicles. We were told this was done once a week as standard, and immediately after transporting a patient who posed an infection risk such as a patient with diarrhoea. However no formal risk assessment was done for the deep cleaning of these vehicles and no formal records were kept to show that deep cleans had been undertaken. Therefore we were concerned about the cleaning processes as there was no evidence the service was cleaning the vehicles to a sufficient standard.
- However, by the time of the unannounced inspection the registered manager had contacted a specialist deep cleaning service and was making arrangements to have the vehicles deep cleaned there in the future as well as recording when this was carried out.

Environment and equipment

- All vehicle checks and servicing were undertaken by a local registered car centre and MOTs for both vehicles were in date.
- The service had produced a daily vehicle dashboard form to assess the vehicles and equipment before they were used each day, which we saw during our inspection. However these had not been completed although we were told that the daily checks were being carried out by the operational lead. When we asked the registered manager about this they told us they needed to start using it to document equipment and vehicle checks more thoroughly. When we returned for our unannounced inspection we saw that these checks were being completed and recorded on a daily basis.
- One of the two patient transport vehicles was equipped with a stretcher that converted to a chair. This was the only piece of technical/specialist equipment used by the service and only three members of staff were authorised to use it. We saw evidence that the stretcher had been serviced within the last 12 months.
- However, the carry chair did not have grips on the handles and the foot restraints were missing. These could present a potential safety risk for patients being transported and to staff when using this equipment. We raised this to the registered manager, and by the time of our unannounced inspection two new carry chairs had been purchased, and the damaged ones removed from use.
- There were no straps on the stretcher to secure the shoulders, head and neck area of a patient being transported in a supine position. We were concerned that this presented a potential safety risk to the patient, especially if the vehicle was involved in an accident during transport.We reviewed the manufacturer's instructions in relation to safety straps and noted that these were recommended for use. We raised this concern with the registered manager at the time. When we returned for our unannounced inspection we found that the correct four point shoulder harness, chest and leg straps were in place on the stretcher.
- There was space in each vehicle for an escort or family member to accompany the patient when travelling, as well as the registered nurse.
- The vehicles did not carry resuscitation equipment or oxygen cylinders. However, on occasion the service

would transport medical gases from another care provider that were for the patient. There were appropriate badges on the vehicle to state that there may be gases being transported.

- However, three members of staff we spoke with each told us a different way of transporting any oxygen cylinder and we were concerned they may not be transported securely or have the appropriate risk assessments done. According to a guidance note issued by the Department of Transport, cylinders should be secured during transportation. We raised this with the registered manager, who confirmed that they would send out a safety alert to all members of staff regarding this, and that, at present, they should be transported in the foot well to prevent forward motion in an impact. We saw evidence after our inspection that this had been done. The registered manager also stated that a risk assessment would be carried out and they would seek advice from a health and safety expert. They confirmed competency in this would be added staff induction checklist so we were satisfied this would no longer present a concern.
- The service did not have a medical gases policy. The registered manager informed us that one would be developed following our inspection.
- There were first aid boxes in each of the vehicles which drivers were trained to use.
- When vehicles were not in use, all keys were secured safely. The service had purchased a key safe to put on the property so staff could access the ambulance keys if required without the registered manager having to be present.

Medicines

- The service did not carry out any clinical activity so no medicines were administered or stored.

Records

- Patient details were recorded on the patient transfer form and were shredded after use for privacy and confidentiality reasons so there was no documented evidence of previous patient journeys. The provider informed us that they maintained diary sheets for patient transport; however we did not see these and they were not provided to us as evidence for this inspection.
- The service carried out transfers for patients who had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place and we saw a policy to advise staff on this. We were told this information would be recorded on the form; however as transfer forms were destroyed after use we were unable to verify this.
- The service had an up-to-date resuscitation policy requiring all staff to 'ensure DNAR are recorded and acted upon as necessary, ensuring they are in date and signed' and there was a section where this could be recorded on the patient referral form.

Assessing and responding to patient risk

- The service reported they carried out a "risk assessment" on patients prior to accepting them for transfer to assess their eligibility for the service. Information from this assessment would be noted down on the patient transfer request forms and in the daily diary kept by the operational director. However there were no records kept of this assessment as the transfer request forms and any records kept in the daily diary were shredded after use. Therefore, the service was not able to demonstrate how they were meeting their own eligibility criteria, nor did they monitor or audit this.
- We were told that the risk assessment process was carried out informally over the phone in most cases and the registered manager acknowledged that this process needed to be stronger in order to appropriately assess and respond to patient risk.
- If a patient's condition was potentially more complex we were told that the operational manager would visit the patient to carry out a face-to-face assessment prior to the transfer. However, we were unable to verify this as no documented records of these visits had been kept.
- The vehicles did not carry emergency medications or monitoring equipment or provide urgent and emergency care because all patients they transported were considered "medically fit for discharge". If a patient's condition worsened during transfer it would be the responsibility of the nurse on board to assess the situation and decide whether to return to hospital or call 999. The nurse we spoke with confirmed this.
- We asked how staff would manage a patient who was vomiting as they were being transported lying flat and we were told that "the head can be raised slightly" and

that they would ensure the patient were reminded or encouraged to take anti-sickness medication prior to transfer. We were concerned that there was a lack of sufficient measures in place to manage patients presenting this risk, particularly if a patient was travelling for the first time from a home address without anti sickness medication in place.

- There was no formal environmental risk assessment for the secure transport vehicles for patients who may have mental health problems. This is recommended in accordance with evidence based best practice from the National Institute for Health and Care Excellence (NICE), quality standard QS34 published in June 2013 specifically Quality statement 5: Safe physical environments.
- There was no violence and aggression policy in place so we were concerned that staff may not be sufficiently equipped to respond to these risks or protect themselves and patients from harm.
- Staff told us they never restrained patients. However, the registered manager told us that "sometimes" patients displayed aggressive behaviour. The registered manager informed us that on occasion a person's mental health condition only became apparent after pick up. There were no risk assessments in place for assessing the risk of aggression, and staff were not trained in restraint. Therefore we were concerned that staff may not be sufficiently equipped to respond to these risks or protect themselves and patients from harm, although no such incidents had occurred at the time of our inspection.

Staffing

- The service was small it employed 12 members of staff on a 'casual' basis. The staffing level was appropriate to meet the needs of the patients and the manager told us that the service was not experiencing any challenges with staffing levels, skill mix or recruitment.
- There were seven registered nurses (RGNs) who accompanied every patient on their journey but did not carry out any clinical roles. They were responsible for making the appropriate decision should there be a change in the patient's condition during transfer. They were also responsible for liaising with the patient during transfer; taking and documenting any new referrals; and giving estimated arrival times and accurate information to ensure continuity of service.
- The clinical lead told us, and nursing staff confirmed, that sometimes they would provide additional assistance on arrival at a patient's home, for example by making their bed or helping them get changed.
- The service did not employ any agency or bank staff.
- There were no fixed rotas or shift patterns for staff; when a booking was made staff would be contacted to see who was available to carry out the individual journey. This meant there was no risk of staff not receiving enough time off or becoming fatigued.
- Disclosure and barring service (DBS) checks were only carried out on staff at the time of commencing employment with the service. For example, five members of staff had undergone a DBS check in 2010. However, during our unannounced the registered manager informed us that they would be using an update service for DBS checks to ensure all staff were routinely monitored. The registered manager had undergone a DBS check in another organisation in 2014. This was updated in December 2016 following our inspection.
- All new staff were required to complete an induction checklist in their first week of employment. This included vehicle orientation, health and safety and reporting procedures for incidents and complaints.

Anticipated resource and capacity risks

- There was no business continuity plan or policy in place.
- Unexpected or fluctuating demand was not an issue for the service because bookings were made as and when they were required and the director would contact staff to carry out the journey or do it themselves.
- If there was an unexpected increase in service demand from same-day bookings, we were told that the service would use the two vehicles to cover separate bookings. Demand did not exceed this capacity as there were no contracts in place so the service met demand through a combination of ad-hoc, planned and repeat bookings**.**

Response to major incidents

Patient transport services (PTS)

- There were no major incident plans or arrangements due to the nature of the service. The service was not a first or emergency responder.

Are patient transport services effective?

We did not rate the service for effectiveness.

Evidence-based care and treatment

- The registered manager told us they were aware many of their policies such as the mental capacity policy were NHS-focused and needed updating to make them more applicable to the service they were providing.
- We were told that the service had sought external advice in areas such as infection prevention and control and employment law, when establishing or amending their policies to ensure they included the most relevant information for the specific service they were providing.
- There were exclusion criteria specified in the staff handbook to help staff assess a patient's eligibility for the service. A patient would not be eligible if they were under 18 or travelling with children; required medication administration during transportation; weighed 18 stone or greater; posed a high risk to themselves or staff; or did not pass the service's assessment (completed for each patient).
- There was no formal audit process in place to ensure all aspects of the service were continually monitored. The only audit undertaken related to consent. The registered manager recognised this was an area where the service could improve.

Assessment and planning of care

- There was an up-to-date policy on responding to the needs of service users with a disability or requiring re-adjustment. The purpose of this was "to ensure all staff are provided with information regarding the minimum requirements needed to respond to the needs of service users presenting with disabilities" or other individual requirements, for example religious, social or language needs.
- The patient referral form included a section to highlight any specific requirements for staff to plan transport appropriately and according to individual needs.
- If a person with a mental health condition required transport these details would be included in the transfer form. However the registered manager told us, and the nurse we spoke with confirmed, that on occasion the acuity or extent of the patient's mental health condition would only become apparent after the pick-up. The registered manager acknowledged that this could present an unexpected risk.

Nutrition and hydration

- The service advised patients and families to bring their own snacks and drinks if the journey was likely to take a long time.

Response times and patient outcomes

- The service did not benchmark itself against other PTS providers locally or nationally.
- The service was not monitoring and recording response times at the time of the inspection. The manager told us they aimed to pick up patients within one hour of the ad-hoc booking being made and that this was rarely a problem to achieve. However, there were no records to monitor these outcomes.
- We raised this to the registered manager, and at the unannounced inspection, we saw that the patient transfer form had been amended to include this information. The registered manager confirmed there were plans to audit this information and to check activity sheets to ensure that cancellations or delays were monitored and captured.

Competent staff

- Data provided by the service prior to inspection showed that 100% of staff were up-to-date with appraisals for the past year.
- The three members of staff we spoke with were happy with their level of supervision and the feedback they had received from appraisals. They reported that they felt they had all the support, resources and training required to carry out their roles effectively.
- Registered nurses were supported by the manager through revalidation with the Nursing and Midwifery Council (NMC).

- However, there were no formal driver training or ongoing competency checks aside from the one-month informal supervisory period for drivers upon joining the business.
- There was limited guidance and refresher training to prepare staff for supporting a patient with a mental health condition, or people with multiple or complex needs, which may become apparent during transfer. However, the nurse we spoke with was able to give an example of how she had accompanied a person with a mental health condition during transfer and calmed them down when they became agitated.
- We saw records of drivers' licence checks. Both had been verified in September 2016 in accordance with policy. One other driver was not working as of August 2016 and this was documented in the licence check records.
- The service was providing transport for patients to a local hospice. Staff working for the service undertaking this transport had not received any training or competencies in end of life care.

Coordination with other providers

- Prior to inspection the service told us that they would 'on occasion' return patients to hospital and reported that receiving hospitals coordinated well with them in this event.
- The registered manager told us they frequently had phone calls with the providers they had regular links with such as care homes and hospitals to keep them updated on their activity, although we did not see any documented evidence of this.
- The nurse we spoke with confirmed they had a full handover from the relevant hospital or other care provider.

Multidisciplinary working

- Internal multidisciplinary team (MDT) working was not a major point of focus for the service because apart from the three drivers, the staff were all registered nurses responsible for providing support during the patient journey. They did not provide clinical treatment.
- However, staff reported working closely with each other to best meet the patient's needs.
- The service reported having good support and input from external providers; for example, the operational lead told us they had weekly phone calls with the services from which they received regular and frequent work, to share any updates.

Access to information

- There was a 'special notes' section on the patient referral form to provide staff with information about particular patient needs that became apparent from the assessment of the patient.
- We were told that staff were made aware of patients who had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place via a note on the transfer form and we saw a policy to advise staff on this. However, as transfer forms were destroyed after use we were unable to verify this.
- Drivers and nurses used mobile phones provided to them by the service to communicate with the operational lead or with receiving care providers if required.
- The nurse we spoke with said she felt able to competently carry out her role with the information available to her. However, this nurse and the registered manager told us that, on some occasions, accurate and detailed patient information was not given by the referring provider such as the hospital or care home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- It was the responsibility of the registered nurse on each patient journey to obtain consent. This was specified in the staff handbook following the consent principles set out by the Nursing and Midwifery Council (NMC).
- There was an up-to-date consent policy, which was next due for review in March 2017. This included a consent flowchart to support staff to obtain consent.
- The service conducted a consent audit for the period April 2015 to March 2016 and found that 89.6% of transfers had consent recorded. However, no actions were identified in the audit to improve the consent process.
- There was an up-to-date policy on the Mental Capacity Act (MCA); however it was not included in staff

mandatory training and there were no specific MCA forms in place. We were told that the service did transfer patients who had been assessed by another provider as lacking capacity.

- The nurse we spoke with was aware of the MCA and Deprivation of Liberty Safeguards (DoLS) and was able to explain capacity. They said if there were any concerns, when picking up a patient from their home or a non-care location, in relation to capacity they would highlight this to medical staff at the relevant hospital or care provider prior to transfer.

Are patient transport services caring?

We did not rate the service for caring.

Compassionate care

- The service regularly transferred palliative care patients home to ensure they were able to achieve their preferred place of care supported by their families. Palliative care patient needs were prioritised by the service due to the nature of patient conditions.
- Although we were unable to see any patient journeys being carried out as no transport was taking place that day, staff gave examples of when they had 'gone the extra mile' for a patient. For example one elderly patient had mentioned to staff that they "hadn't had fish and chips for years" so staff brought them fish and chips once the transfer had been done.
- Staff were focused on maintaining and respecting patients' privacy and dignity. The nurse we spoke with told us that staff always introduced themselves prior to transport and ensured their personal needs were met and that they were covered with blankets if required.
- The service had regular patients they transported so staff would get to know the patients and their families and would have conversations with them during the journey. This helped ensure continuity of care for these patients.
- We reviewed patient feedback forms from the previous 12 months and saw the comments were positive in relation to the service provided and the staff.
- The service conducted an internal patient experience audit in August 2016 where they sent letters to all patients who had used the service within the previous six months, or their families. All responses were positive except one where a relative telephoned to say they did not want to be contacted.
- However, there were only eleven completed forms for the period February 2015 to October 2016. This was low considering the service had carried out 1539 transfers between April 2015 and March 2016. This was despite the registered manager and operational lead stating that all patients were given a feedback form unless it was inappropriate to do so, for example if the service was transporting a patient to a preferred place of death.

Understanding and involvement of patients and those close to them

- Patients' eligibility for the service would be communicated to them and their families either over the phone during the initial booking, or face-to-face in cases where the operational lead thought it more appropriate to conduct the service's informal risk assessment in this way.
- We saw a letter from September 2016 from a relative of a person living with dementia who had recently used the service. The relative had praised the staff for ensuring the patient and their family were involved at all stages of the transfer and said that the patient had started to sing during the journey which was a sign they were happy.

Emotional support

- No patient to date had died during transfer carried out by the service. Owing to the service's eligibility criteria and the low risk of patients they transported the likelihood of this was low.
- There was no policy setting out what to do if a patient died during transfer.

Supporting people to manage their own health

- Staff showed recognition of the importance of empowering patients and their families or carers, to manage their own health and supported their individual needs to achieve this. For example, two members of staff said they would ask patients what they could do to help them over the course of the journey and ensure their toilet, nutrition and hydration needs were met before commencing the transfer.

Patient transport services (PTS)

- The service liaised with relevant care providers to ensure patients' health was managed during and after transfer.

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

We did not rate the service for responsiveness.

Service planning and delivery to meet the needs of local people

- The service was open to take bookings from 8.30am to 10pm, seven days a week. They did not carry out transfers during the night or at weekends.
- The manager told us that sometimes a discharge from hospital would be processed very quickly meaning the service had to plan at short notice to meet the patient's transfer requirements.
- The non-stretcher bearing vehicle was able to transport a maximum of three patients plus one registered nurse at any one time; however, we were told this rarely happened and usually patients were transported one at a time.

Meeting people's individual needs

- The manager gave an example of when the lift had broken at a local private residential home. The service went there every day for a week to help transport patients up and down the stairs using the lift chair. We were told that these patients had learning disabilities and their routine was to come downstairs every day to the living area so this service met their individual needs by allowing them to maintain their daily routine and avoid becoming agitated.
- The nurse we spoke with gave an example of how she had accompanied a person with a mental health condition and kept them calm when they became agitated during the transfer. The clinical lead also confirmed this example in a separate conversation.
- The service had a section in the staff handbook on what to do if a patient had limited or no English language. This directed them to an interpretation service, although there had been no instances where staff had needed to use it at the time of our inspection.
- There was no flagging system to point out to staff cases where a person was living with dementia or a learning disability. This meant that staff may not have had all the information available to best respond to individual needs in the event of transporting a patient living with dementia.
- There was no training for staff in the service specifically related to Dementia. The registered manager recognised that this could be improved as many of their patients were elderly and "around five per cent" were living with dementia. However, by the time of our unannounced inspection the registered manager had looked into including dementia awareness in staff training. They confirmed one member of staff was currently undertaking the training, which would then be rolled out to all staff if it was considered sufficiently in-depth and relevant for the service provided.

Access and flow

- Bookings were mainly made on an ad-hoc basis on the same day they were required, although some transfers were planned one to four weeks ahead, for example in the case of a long journey. The service was not monitoring the exact proportion of same-day bookings.
- When a booking came through and the eligibility assessment had been completed, the operational lead would call in one of their drivers or carry out the transfer themselves. They would also call round and check the availability of the nursing staff to ensure an escort could be provided. Bookings came from other care providers, patients themselves or their families or carers.
- The service aimed to pick patients up within one hour of the booking being made (unless it had been made in advance for a specific time and day). On the transfer request form there were boxes to include the pick-up and drop off times; however these forms were shredded after use. This meant the service was not monitoring response times so it was not possible to verify whether they were achieving their target of one hour.
- When we returned for our unannounced inspection we saw that the patient transfer form had been amended to include this information. The registered manager confirmed there were plans to audit this information and to check activity sheets to ensure that cancellations or delays were monitored.

Patient transport services (PTS)

Learning from complaints and concerns

- Between October 2015 and September 2016 the service had not received any formal complaints from patients or families who had used the service.
- The service had no systems in place to benchmark its performance compared to other PTS providers locally or nationally in respect of complaints.
- There were no formal measures in place to gain feedback from providers in the community that regularly used the service.
- We were told that patients could make a complaint on the feedback card available on vehicles, through the website, or directly to staff.
- By the time of our unannounced inspection, the service had introduced a complaints log to monitor patient feedback.

Are patient transport services well-led?

We did not rate the service for well-led.

Vision and strategy for this service

- The service had a list of key aims and objectives, which were also displayed on the company website. These included, but were not limited to, the following: to ensure a high standard of patient experience and always offer a friendly face and an understanding attitude that puts patients, families and carers at their ease; to ensure that all journeys protect a person's dignity, privacy and vulnerability by ensuring their needs and wants are met by one to one support from a registered nurse; to maintain a professional customer focused approach; and to ensure that staff are appropriately prepared and trained.
- In August 2015, work ceased with a local hospital following the release of a tender for the service Medicar Limited (Clacton on Sea) were delivering. This followed a discussion between all staff where it was decided that the service would not apply for the contract because the hours required did not suit them and they did not wish to transfer patients in the early hours of the morning, particularly in the case of elderly or vulnerable patients. As a result, the offer of work to staff was limited, so casual staff were asked if they wished to continue, and those that did not resigned. This had a major impact on the activity carried out by the service as previously over 97% of its work had been through the working agreement with the local NHS trust.
- Since then the service had focused on building up its private client base and responding to specific patient needs.
- The service was also focusing on increasing its contribution to a 'last wish' scheme in conjunction with a local hospice, to help mobilise and transport patients who were approaching the end of life to carry out activities or go to chosen places.

Governance, risk management and quality measurement

- There was an up-to-date lone working policy in place. However, we were informed that staff never worked alone, which staff confirmed
- The governance systems were not effective which meant that we were not assured that concerns issues would be identified and mitigated. The risks identified during our inspection had not been identified as issues by the management team.
- There was a lack of record-keeping systems, for example with the daily vehicle checks and the patient transfer forms. This meant it was impossible to verify aspects of the service and also that the service would not be able to go back through patient transfer records if an issue later arose.
- There was no risk register for the service at the time of our announced inspection, but by the time of our unannounced inspection, one had been developed. However, this was not yet embedded.
- There was a lack of risk assessments undertaken in the service, specifically around violence and aggression, transport of people with complex needs or mental health conditions, or infection control. This did not demonstrate good risk management systems.
- By the time of our unannounced inspection, the service had also introduced an incident reporting log and a complaints log to improving monitoring or risks and quality.

Patient transport services (PTS)

- The service did not monitor performance or have any key performance indicators (KPIs) in place to effectively measure the quality and delivery of the service.
- The service was not meeting best practice requirements for the safeguarding of vulnerable adults. The service was not meeting the Safeguarding Adults: Roles and competences for health care staff (2016) intercollegiate document. This created a risk to the service and potentially to patients, carers and families.
- The service was not proactively undertaking audits or bench marking itself against other similar PTS providers locally or national. This meant that measurement of quality within the service was not being undertaken at a higher level.
- The provider was not meeting the requirements of the Fit and Proper Persons regulations in relation to directors. This was because files of both directors were not being maintained, there was no CV, DBS or other expected items present. There was also no policy for Fit and Proper Persons, though both managers were aware of the regulations. By the time of our unannounced inspection, processes to comply with these regulations were in place.
- However, the registered manager was implementing quality measures, introducing risk management systems and assessments and assured us that they would undertake these in future.

Leadership of service

- There was an operational manager who was responsible for overseeing the work of all drivers and nurses in the service.
- The clinical lead who was also a registered nurse was responsible for overseeing the governance of the service.
- The three staff we spoke with were happy with the leadership of the business and said they regularly saw their manager and would feel comfortable raising a concern if required.

Culture within the service

- We spoke with three members of staff who all spoke highly of the culture, team and management. The nurse we spoke with said she was proud of the work they carried out and liked the service's "patient-centred" approach. The driver we spoke with said they "wouldn't change anything" about their working environment.
- The patient-centred approach of the service was clear during our inspection and the manager told us they were proud of the fact they did not only carry out the PTS but went the 'extra mile', for example by making a cup of tea, making the patient's bed or going out to buy the patient a particular food they wanted. Staff felt the service benefited patients because it was not "target-led".
- The Duty of Candour is a legal duty on providers to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers. The provider did not have any examples of where Duty of Candour was required by the service.
- The service had not reported incidents or complaints. However, we were concerned that the operational director was not familiar with the term duty of candour when we asked them.
- Duty of candour was not specifically included in staff training although the nurse we spoke with was aware of it. Data provided by the service stated that the 'Being Open and Duty of Candour' Policy was currently under review and the registered manager was responsible for ensuring compliance with the duty of candour in all incidents.
- The clinical lead told us they were currently in the process of reviewing the duty of candour policy to make it more appropriate for the service they were carrying out. The service did not undertake any audits around duty of candour.

Public and staff engagement

- Staff meetings reportedly took place; however there were no meeting minutes we could review to confirm this.
- The operational and clinical leads were focused on ensuring staff felt involved in and engaged with the service they were carrying out. For instance, we were

told that all staff were involved in the consideration of whether to bid for the PTS contract with the local NHS acute trust after the previous arrangement ceased in 2015. However, this was not minuted.

- The manager had changed some elements of the staff handbook following feedback from staff, for instance by condensing the section on data protection and making it more specific to the PTS the service was carrying out.
- We reviewed staff feedback completed in September 2016, which was also included within the service's annual activity report for 2015-16. The feedback was consistently positive with comments such as, "There is nothing I would change as I feel Medicar is the most patient-centred company I have worked for".
- One driver was "dormant" because the service was not carrying out enough work at the time of our inspection. However, we were told that the operational director had weekly phone calls with them to ensure they were up-to-date and remained engaged with the service
- However, systems for engaging the public were limited, aside from the feedback cards that patients and families could fill in.
- After the arrangement with the local NHS trust had ceased, the service developed a marketing strategy whereby they sent leaflets to local GP surgeries, hospices and care homes; however the secretary and the operational lead both told us this had not been effective in engaging potential providers. The operational lead said they relied on "word of mouth".

Innovation, improvement and sustainability

- The service had recently introduced an app which was accessible to all staff on their work phones. The app provided access to all the service's policies as well as NHS guide to safeguarding and the Resuscitation Council guide to resuscitation. The app gave alerts when a policy had been updated so staff could keep up-to-date at their own convenience.
- The service was proud of their use of registered nurses to accompany every patient despite providing no clinical intervention and staff told us they had received positive feedback from patients and families about this aspect of the service because they felt well cared-for.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The service must assess, monitor and improve the quality and safety of the services provided to identify and mitigate risks.
- The service must implement and maintain record-keeping systems.
- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service users transport outcome.
- The service must evaluate and improve their practice through audits, benchmarking, performance and outcomes.
- The service must ensure the named safeguarding lead is trained to level three safeguarding adults so the service complies with national guidance on safeguarding training and competence.

Action the hospital SHOULD take to improve

- The service should ensure there is an adequate and regular specialist deep-cleaning service for the vehicles and record this to prevent the spread of infection.
- The service should ensure that staff are competent in supporting and caring for people living with dementia or learning disabilities.
- The service should ensure there is an identification system to point out to staff cases where a person was living with dementia or a learning disability so that their individual needs can be supported.
- The service should ensure that staff receive training on mental health awareness and end of life care.
- The service should ensure that there are processes in place for the fit and proper persons for directors and fit and proper persons employed.
- The service should minute meetings to provide an accurate record of the service activities.
- The service should seek and act on feedback from relevant persons and other persons on the services provided.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not assess, monitor and improve the quality and safety of the services provided to identify and mitigate risks. There was a lack of record-keeping systems with daily vehicle checks and patient transfer forms. There was a lack of risk assessments undertaken in the service for infection control, violence and aggression, transport of people with complex needs or mental health conditions. . The service did not monitor performance, or have any key performance indicators (KPIs) set to determine how the service was delivering against its contracted work. The service was not proactively undertaking audits or bench marking itself against other similar PTS providers locally or national. There were no records to monitor performance outcomes, meeting minutes, initial assessments for eligibility to use the service, or risk assessments for patients and staff. Regulation 17 (1) and (2) (a), (b), (c) and (e)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The named safeguarding lead was not trained to level three safeguarding adults so the service not complying with national guidance on safeguarding training and competence.

This section is primarily information for the provider

Requirement notices

Regulation 13 (2) and (3)