

# Elite Medical and Ambulance Services Limited

# Elite Medical and Ambulance Services Ltd Headquarters

## Quality Report

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

## Ratings

Overall rating for this  
ambulance location

Good



Patient transport services (PTS)

Good



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Elite Medical and Ambulance Service Ltd (Elite) is operated by Elite Medical and Ambulance Service Limited. The service provides a patient transport service.

We inspected this service using our comprehensive inspection methodology in response to concerns raised by whistle-blowers. We carried out an unannounced inspection on 30 January 2019.

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

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

We found the following areas of good practice:

- The provider had recently changed their process for reviewing incidents, and all incidents were now reviewed by the registered manager, as well as being reviewed by the contracting NHS ambulance service.
- Staff had training to the correct levels of safeguarding in line with best practice and national guidance. Staff understood their responsibilities in the event of identifying concerns.
- All the vehicles we looked at appeared visibly clean and tidy. All vehicles had a MOT and tax certificate and were free of any obvious damage and defects such as dents and worn tyres.
- Patient data was securely held by the contracting provider, and Elite staff could access the information they needed to complete their transfers through their secure personal digital assistants.
- Feedback from users of the service was positive.
- There were processes in place to ensure the needs of individuals were met.

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

- Not all staff had completed their mandatory training modules and only 20% of staff had completed their medical gases training.
- The service's safeguarding policies for adults and children did not reflect the process that staff followed when identifying a safeguarding concern. Systems and processes were not in place to ensure data and notifications were submitted to external bodies as required. The service was not meeting its' statutory obligation for notifying the CQC of safeguarding concerns. However, following the inspection, the service submitted notifications to the CQC and were in the process of updating their policy to reflect this.
- There was business continuity plan however this had some gaps where further information was required. The registered manager could describe practical steps taken in situations such as inclement weather.
- Less than 10% of staff had an appraisal within the last 12 months.
- Some policies including the safeguarding policy did not contain the most up to date guidance or best practice.
- There was an induction process for new staff, but there were no signed induction forms or checklists, in the staff files that we reviewed, to confirm that inductions were carried-out.

# Summary of findings

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

## **Dr Nigel Acheson**

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

# Summary of findings

## Our judgements about each of the main services

### Service

#### Patient transport services (PTS)

### Rating

Good



### Why have we given this rating?

The main service was patient transport services.

We rated the service as good for safe, caring and responsive because there were systems in place to ensure safe care of patients, patient feedback was consistently positive and there were processes in place to meet individual needs.

We did not rate the service for effective as there was not sufficient evidence to rate this domain.

We rated the service as requires improvement for well-led. This was because there was limited quality monitoring and risk management for the service.

We gave the service two requirement notices regarding competent staff and governance.

# Elite Medical and Ambulance Services Ltd Headquarters

## Detailed findings

### Services we looked at

Patient transport services (PTS).

# Detailed findings

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### Detailed findings from this inspection

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## Background to Elite Medical and Ambulance Services Ltd Headquarters

There have been no previous inspections of this location. The service was previously registered at a different address.

Elite Medical and Ambulance Service Ltd is operated by Elite Medical and Ambulance Service Limited. It is an independent ambulance service in Hellingly, East Sussex. The service primarily serves the communities of East and West Sussex.

Elite Medical and Ambulance Service Ltd provides non-emergency ambulance transfers. They provide patient transport services as a subcontractor for one main contractor (identified as the contracting NHS ambulance provider in this report).

The service has had a registered manager in post at the current location since November 2017.

## Our inspection team

The team that inspected the service comprised of two CQC inspectors and a specialist advisor with expertise in ambulance services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection, South East.

## How we carried out this inspection

Elite Medical and Ambulance Service has one location, which is their head office in Hellingly, East Sussex. The main service is patient transport services. The service did not provide urgent and emergency transport services such as responding to 999 calls. The service did provide support at events but this is outside the scope of this inspection. Whilst the service could provide repatriation,

no repatriations were carried out in the 12 months leading up to our inspection. The service was focussed on fulfilling its contractual obligations as a patient transport service for the contracting NHS ambulance provider.

The service is registered to provide the following regulated activities:

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

# Detailed findings

The fleet consists of 22 vehicles. Between January 2018 and February 2019, the service carried out 29,344 patient transport journeys on behalf of the contracting NHS ambulance service.

We spoke to eight members of staff including; a registered paramedic, ambulance care assistants, make-ready staff and the management team.

We spoke with six patients who had used the service within the last 12 months about the care they had received. We reviewed five sets of staff records and 50 feedback forms that service users had given regarding the service.

The contracting NHS ambulance service provided feedback on the service with regards to specific aspects such as safeguarding, complaints and incident reporting.

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

## Facts and data about Elite Medical and Ambulance Services Ltd Headquarters

Activity (February 2018 to January 2019)

- In the reporting period there were 29,344 patient transport journeys undertaken.

Three registered paramedics, 61 Ambulance Care Assistants, and two make-ready staff worked at the service.

Track record on safety:

- No reported never events;
- 74 incidents reported;
- No serious injuries;
- Two notifications of expected deaths during transfer; and
- Seven complaints.

## Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Not rated	Good	Good	Requires improvement	Good
Overall	Good	Not rated	Good	Good	Requires improvement	Good

# Patient transport services (PTS)

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Requires improvement	
Overall	Good	

## Information about the service

## Summary of findings

We found the following areas of good practice:

- The provider had recently changed their process for reviewing incidents, and all incidents were now reviewed by the registered manager, as well as being reviewed by the contracting NHS ambulance service.
- Staff had training to the correct levels of safeguarding in line with best practice and national guidance. Staff we spoke to had a good understanding of safeguarding and were confident in identifying areas of concern.
- All the vehicles we reviewed appeared clean and tidy. All vehicles had a MoT and tax certificate and were free of any obvious damage and defects such as dents and worn tyres.
- Patient data was securely held by the contracting provider, and Elite staff could access the information they needed to complete their transfers through their secure personal digital assistants (PDA).
- All staff could access all policies and procedures via an application on their mobile phones.
- Feedback from patients and service users was positive. We saw a range of compliments from patients and relatives who had contacted the service by letter or email.
- The eligibility for the transport service was decided by the contracting NHS ambulance provider.



# Patient transport services (PTS)

However, 13% of journeys involved an escort, either for medical reasons or to provide continuity of care to a patient which ensured that patients had the right support available to them when they travelled.

- The service was not responsible for planning the service to meet the needs of the local people as it was contracted by an NHS ambulance organisation. However, the service made sure it had the right staff and resources to meet the demand set by the contracting NHS organisation.
- The service had informal processes in place to ensure patient needs were met.
- There were a low level of complaints made about the service.
- There was a clear management structure for the organisation and leaders were visible and approachable.

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

- The service provided mandatory training in key skills to all staff; however, not all staff were up to date with their training, however, not all staff were up to date with their mandatory training modules and only 20% of staff had completed their medical gases training.
- The service safeguarding policies for adults and children did not reflect the process that staff followed when identifying a safeguarding concern and the service had not been notifying the CQC when a safeguarding concern was raised which was not in line with their own policy or the CQC statutory notifications guidance. However, following the inspection, the service was submitting notifications to the CQC and was in the process of updating their policy to reflect this.
- The service made efforts to ensure staff were competent for their roles but did not always ensure staff had the right training to undertake their roles. Staff did not receive a yearly appraisal. Induction plans were in place, but there was no record that staff had completed these.

- Some policies such as the safeguarding policies and duty of candour policy did not contain the most up to date guidance or best practice.
- There was limited auditing of the service.
- Complaints were jointly investigated and managed by the contracting NHS organisation. The sub-contracting organisation reported a low level of complaints raised regarding the service over a 12 month period. However, the service did not monitor or keep a record of the complaints made. Following the inspection the service told us they could access the contracting NHS organisations system to view these complaints.
- The service had systems for identifying corporate level risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However operational risks were not included in this.
- There was no vision or strategy in place for the service.

# Patient transport services (PTS)

## Are patient transport services safe?

Good



### Incidents

- **Patient safety incidents were reported and feedback had been introduced.** Between July and December 2018, the service reported 74 incidents. The majority of these incidents (12), were related to non-patient incidents, such as members of the public who have injured themselves. Other commonly reported incidents included patient injury or fall during transfers (11) and communication issues (11).
- There was a policy on clinical adverse incidents and non-clinical adverse incidents. This encouraged staff to report incidents and how to do so. The policy referenced a 'challenge culture' whereby staff should feel empowered to challenge poor practice from fellow colleagues or third-party staff.
- When reviewing the incident forms for the service, we saw that none of these had manager feedback or actions listed. We discussed this with the registered manager who advised that previously they had left any investigation to the contracting NHS ambulance. They had realised that this was not sufficient and they had since begun investigating the incidents locally, in addition to sharing these with the contracting NHS ambulance. We reviewed the incident forms from January and saw that they had started providing comments and feedback on the form.
- The service reported two deaths to the CQC in the last 12 months. In both cases the patient was in the end stages of their life and one died in the ambulance whilst stationary with a nurse supporting, and the second was transferred back to the hospital bed after the nurse in charge felt the patient was not fit enough to travel and sadly died following this.
- We spoke to the registered manager about the duty of candour legislation. They were aware of the legislation and advised it had never been applied for the service. There was a policy on the Duty of Candour, but it required updating at the time of the inspection.

### Mandatory training

- **The service provided mandatory training in key skills to all staff; however, not all staff were up to date with their training.**
- The service used an online system for e-learning and had oversight of staff compliance via a data spreadsheet held by the service. Mandatory training included infection control, information governance, equality and diversity, fire safety and manual handling.
- Prior to the inspection the provider sent us data showing which staff had completed which training and when. However, the spreadsheet also contained future dates booked and therefore it was not possible to work out the overall compliance. We raised this with the registered manager who told us that the HR manager was spending time to overhaul this database to make it clearer.
- There was no mandatory training compliance target set by the service. The updated data sheet showed that 33 of the 61 staff were up to date with all aspects of their mandatory training scoring 100% for all of their training. The remaining staff varied between 29% compliance and 86%. In the staff files we reviewed, we saw evidence that staff received reminder emails when they needed to complete their training or training was overdue. The registered manager told us they felt the only way to ensure compliance with training was to take crews off the road to complete the training at the office base.

### Safeguarding

- The provider mainly transported adults but did occasionally transfer children. Patient details were held by the contracting NHS ambulance provider so we were unable to see the exact numbers of adults and children transferred. We spoke to three members of staff who all had a good understanding of safeguarding.
- The registered manager told us that staff completed safeguarding adults training, and level two
- safeguarding children training, with the team leader completing level three safeguarding children training. We looked at the certificates of five members of staff and saw that certificates were in date for both safeguarding adults, and safeguarding children level one and two. The Team Leader held a safeguarding level three qualification and we saw the certificate for this. This was in line with the intercollegiate guidance document "Safeguarding Children and Young People:

# Patient transport services (PTS)

roles and competencies for health care staff” (2014) states, “All non-clinical and clinical staff who have contact with children, young people and/or parents/ carers” require safeguarding children level two training. It is also best practice for a nominated individual within the provider to act as a safeguarding lead, and would require level three safeguarding training.

- There were separate policies for protecting vulnerable children and adults, which was in line with best practice. However, the Child Protection policy quoted out of date references such as the Working Together 1999 document which has since been superseded.
- The safeguarding policies did not reflect the process that staff were taking when reporting a safeguarding concern. The Child Protection policy instructed staff upon recognising a safeguarding concern to contact the duty manager immediately, who would then contact the Local Children’s Safeguarding Board, and notify the CQC. However, this was not the procedure that was happening. When we spoke to the registered manager about the process, we were told that staff report directly to the contracting NHS ambulance organisation who then escalated the concerns to the local authority. This meant that the service policy was not accurate and required updating. We contacted the NHS organisation for clarification on this and for confirmation of how many safeguarding notifications had been raised by the service. They told us that 15 notifications had been raised by the service between March 2018 and January 2019.
- The protection of adults at risk policy advised staff to contact the duty manager or the police on the recognition of a safeguarding concern – again this was not what the process was on the ground as staff were escalating all concerns to the contracting NHS ambulance provider.
- Following the inspection, the service sent us a standard operating procedure that was from the contracting NHS ambulance. This specified that safeguarding concerns should be escalated through the contracting NHS ambulance provider and their safeguarding team. This meant that the service policies were not reflective of the practice on the ground.
- **Systems and processes were not in place to ensure data and notifications were submitted to external bodies as required.** Both the child protection and adverse incidents policies instructed that all abuse or allegations of abuse must be reported to the CQC,

however there had been no notification to the CQC in the last 12 months, even though safeguarding concerns had been raised. We spoke to the registered manager regarding this, and there had been a misunderstanding over reporting duties between the contracting organisation and the CQC. Following clarification, the service acknowledged that they would notify the CQC of all safeguarding concerns raised in the future and we received notifications following this.

- We saw data kept by the provider detailing all members of staff disclosure and barring service (DBS) reference numbers and when they were due to expire. According to the data, all the DBS checks were in date at the time of our inspection. We reviewed five staff files on site and saw that DBS checks had been completed.

## Cleanliness, infection control and hygiene

- The responsibility of cleaning the vehicles was with the make-ready staff employed by the service. All staff received infection control training provided by a third-party provider and we saw that the make-ready team had received this training along with 54 out of the 61 ambulance care assistants.
- The service had introduced a ‘swab test’, after the cleaning of vehicles to confirm the clean had been effective. A third-party provider completed monthly spot check audits using an adenosine triphosphate (ATP) cleaning check system. This system uses a swab which was passed over various different areas of the vehicle and then tested to check for bacteria growth following cleaning. Depending on the number of bacteria detected on the swab, the area would be awarded a pass (a score under 50), caution (a score between 51-99) or fail (a score of 99+). We reviewed spot checks of five vehicles between December 2018 and January 2019 and saw that these had passed the checks with some scores coming back as low as ‘zero’, indicating the cleaning that had taken place prior to the ATP had been effective.
- However, we did not see any cleaning checklists or schedules on the vehicles we reviewed. Whilst all vehicles we reviewed appeared visibly clean, it was not clear what the frequency of cleaning was for each vehicle and how this was being monitored, other than with the monthly spot checks with the ATP testing.
- The service was also trialling an alternative type of cleaning system. This included an ultra-violet (UV) light treatment, which is a type of light that can be applied to surfaces and will kill microorganisms or bugs that could

# Patient transport services (PTS)

potentially spread germs. The UV lamp would be placed in a vehicle for 15 minutes for a routine monthly clean or for 30 minutes post contamination. However as this was a trial there was no policy or protocol for this.

- We saw hand hygiene audits that had been completed during January 2019. The audit included whether staff were bare below the elbows, if the correct hand washing technique was used and whether paper towels were disposed of without touching the waste bin lid. We saw that for the 17 staff members audited over a three month period, 100% complied.
- Staff uniforms appeared clean. Whilst in the winter or during colder periods it was not possible for staff to remain bare below the elbows, we saw that the uniform policy advised staff to roll their sleeves up when required or when delivering patient care. Staff were responsible for washing their own uniform at home. The policy directed staff to consider when their uniform was contaminated with infectious waste whether they could safely clean it, or to simply place it in clinical waste to be destroyed.
- We saw one used clinical waste bag on an ambulance that had been left overnight. When we spoke to staff about this we were told that they were taking it to the hospital for disposal prior to their patient pickup.

## Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The station had been purpose built for the service. There was a dedicated make-ready team who were responsible for ensuring the vehicles were cleaned and prepared on-site prior to their journeys. There was a covered area that vehicles could be cleaned in.
- The provider had 22 vehicles including cars, 4x4s and mini buses. All vehicles had valid MOTs and tax in place. We saw the service had an overview of when servicing was due on the vehicles indicating that all vehicles had been serviced within the last 12 months.
- We inspected three vehicles that were ready for use whilst we were on site. These were visibly clean and tidy, and the condition of the exterior of the vehicle was good, with no obvious damage or dents. The exterior of the vehicles appeared clean. The exterior of vehicles should be kept clean, as clean vehicles will help staff keep their hands clean when opening and shutting doors.

- There was a vehicle maintenance policy which outlined the procedures for repairing minor and major faults. Staff reported all faults to the team leader or duty manager and we saw a spreadsheet detailing all faults and what fixes had been made between October and December 2018. The service had access to a mechanic on the same site as the location, which meant most faults could be repaired quickly.
- Equipment checklists were managed by an application on a smart tablet. This allowed the provider to create checklists that staff could complete daily prior to using their vehicle. All emergency equipment such as the defibrillator had been checked on the electronic tablet on the three vehicles we looked at. All the equipment on board the vehicles we checked had been serviced, electrical safety tested and was visibly clean. We found one fire extinguisher that was past its expiry date – this was raised with staff on site who replaced it.
- There were vehicle harnesses and chairs available for safely transporting children.
- We checked sterile supplies on the vehicles and found that these were stored correctly with the packages intact and they were all in date.
- We saw that there were no sharps boxes available on the vehicles which was not in line with the services 'disposal of sharps' policy. Whilst staff would not administer any intravenous medicines or provide injections, passengers who had long term conditions such as diabetes may need to use a sharps bin whilst travelling. We told the registered manager and we saw that following the inspection, sharps bins for vehicles had been purchased.
- Two of the vehicles had blue lights fitted to them. We spoke to the registered manager who advised that none of the vehicles had been driven under blue lights in the last 12 months. The only occasion where they may be used on a patient transport services (PTS) journey was if a crew had stopped to provide first aid at a road traffic collision to warn other road users of an incident. None of the PTS drivers were blue light trained as they would not need to use this.

## Medicines

- The service did not use any medicines for PTS journeys. Nitrous oxide with oxygen (a pain reliever) was available but this was for event use only (outside of scope of CQC

# Patient transport services (PTS)

regulation) and we were told that this had not been used for any PTS journeys. The service did however keep oxygen on site which we saw was stored correctly and securely.

- Not all staff were trained in the use of medical gases. There was a training session on medical gases, entonox and oxygen but we saw that only 20 members of staff out of 61 had completed this training.

## Records

- The service did not hold any patient records as the contracting NHS ambulance trust that sub contracted the work retained all patient data. Drivers used personal digital assistants (PDA) which were small, hand held devices similar to a smart mobile phone. These devices allowed the secure transfer of data between drivers and the contracting NHS ambulance provider. When the driver logged into their PDA at the start of their shift, they would have an overview of how many transfers they were doing, the name and address of the patients and the pick-up times set for these. As soon as the transfer was complete, the data was wiped from the PDA remotely. All drivers were allocated a PDA with a unique sign-on number and carried these with them for the duration of their shift.
- The service had an electronic fleet tracking system that meant all vehicles could be tracked to a GPS point on a map and their speed and braking could be seen. The data from these journeys was held for 185 days after the journey.

## Assessing and responding to patient risk

- If a patient became unwell on route, drivers were expected to safely pull over, call 999 and perform basic first aid until emergency services arrived. This was in line with the Illness policy which stated: “for major illness, which is life threatening or potentially life changing, we will arrange immediate transfer to definitive care”.
- The service had an unplanned treatment policy. This stated that: “reasonable efforts to provide appropriate unplanned treatment to individuals not covered by any contract with Elite, whilst actively working to minimise the impact of any incident on duties which we are contracted to complete”. This included stopping at road traffic incidents or when flagged down by members of public who may be injured. For example, if stopped at a road traffic incident to provide first aid whilst renal patients were on board. Staff advised that one staff

member stayed with renal patients whilst another attended to the patient. The ambulance staff contacted the NHS ambulance provider dispatch system to inform them and stayed with the patient until emergency services arrived on scene.

- The service promoted supportive practice that avoided the use of restraint. There was a policy to guide staff on what to do in the event of patients becoming agitated or aggressive. The use of self-defence and restraint policy advised that staff must always look for alternatives to force in any situation and cited de-escalation and seeking assistance from the police where applicable. We saw that there were eight incidents relating to violence and aggression from patients over a six month period between July and December 2018. Most transfers were completed with two-man crews, but there were some single crew vehicles. The registered manager advised that they would only use experienced ambulance care assistants for these journeys, and showed us that the PDA system had an alarm button that staff could use if they encountered violence and aggression.
- The service did not routinely transfer patients sectioned under the Mental Health Act. The relevant policy stated that restraint by staff not under the direct command of a mental health professional, must only be undertaken by staff who have undertaken a suitable qualification on restraint, which Elite staff members did not have. Transfers of sectioned patients would only be accepted where a suitable mental health professional was an escort but this was not common practice.
- The service transfer data provided to us showed several ‘high dependency transfers’. We queried this with the directors as this would require a higher level of care and training. The directors advised us that this was an inherited term from a previous contract and did not actually refer to the conveyance of higher dependency patients. It generally referred to bariatric transfers, or transfers where the patient required a high level of oxygen to travel with them.
- All drivers had access to a national breakdown recovery company should they have an issue with the vehicle whilst transferring patients. The registered manager advised us that they had recently switched breakdown providers due to a poor response time previously. The service also had resilience vehicles available that could get to most places in the geographical area covered within 30 to 45 minutes.



# Patient transport services (PTS)

## Staffing

- The service had 72 members of staff. Most staff employed were on a full or part-time contract, with some staff electing to work on a zero hours contract basis. The registered manager told us that they were trying to phase out zero hours contracts but that some staff preferred the flexibility that these contracts offered.
- Most staff who completed patient transfers were ambulance care assistants. There were three members of paramedic staff available but these were generally used for event work which was outside the scope of this inspection as the CQC does not regulate event work. There was also a make-ready team of three members of staff, who were based at the station and were responsible for ensuring vehicles were ready for use each day.

## Response to major incidents

- Following the inspection, the provider sent us a copy of their business continuity plan. This contained basic steps for staff to take in the event of a major incident or continuity issue and provided mobile numbers for the two company directors who formed the Business Continuity Management Team. There was reference to team leaders taking a key role in planning the emergency meetings but the name and contact details for the team leader were not included in the plan. There were further gaps in the plan where it required updating. For example, the 'list of key customers, suppliers, third parties and their contact details' which read: 'to be added in', and sections where the action was to 'contact phone supplier', but no contact details were listed. There was a section titled: contacts for internal and external agencies to support the recovery efforts – however this listed a first name and part of a company name, with no further details or contact information. There was also no reference to the sub-contracting ambulance or contact details listed as part of the cascade, who would require to be updated in the event of a business continuity incident.
- We spoke to the registered manager who told us that there was a 24 hour on call system held between the two directors. Staff or the contracting ambulance service could call through to this number if there were any concerns regarding work the next day or concerns

about staffing. The registered manager told us that the night before our inspection, the contact at the ambulance provider had been in touch to discuss the prediction of cold weather and snow the next day.

- The registered manager was able to provide examples of planning for adverse weather such as having grit on site at the station, and taking grit on the vehicle when picking up from remote or rural locations where they anticipated roads may not be gritted.
- The PDAs were the main hub for staff completing their transport journeys. Occasionally the batteries on these ran out or the devices failed. To mitigate this, on a daily basis the service transferred the job details onto paper which was held at the base. Should there be an issue with the PDAs on route, staff could call into the base where the job sheets could be reviewed to ensure continuity to the service and transfers. We reviewed the job sheets for the day of the inspection and saw that these contained information including the category of the job, number of escorts, the patient's mobility and there was no personal identifiable information recorded.

## Are patient transport services effective?

Not sufficient evidence to rate

## Evidence-based care and treatment

- **All staff could access all policies and procedures through an app they could download to their mobile phones.** There was an extensive folder of policies and procedures. The clinical director was responsible for the updating and maintenance of these policies. The policies were version controlled and had last been updated in February 2018.
- Where policies were subject to national guidance, we saw that these were referenced in the policy document. However, we saw on the adult and child protection policies that the guidance quoted had been superseded by more recent guidance which would need to be updated.
- The medical director was a registered doctor who attended the service quarterly to provide support and guidance. The clinical director was a registered paramedic who worked and supported the service weekly.

# Patient transport services (PTS)

- There was a limited amount of auditing carried out by the service. The service had a third-party organisation who completed spot checks on the effectiveness of the cleaning of vehicles and completed hand hygiene audits. However, no other audits were undertaken.
- There were key performance indicators (KPI) set by the contracting ambulance provider. These were in place to ensure a timely service for patients accessing their outpatient appointments, renal appointments and when being discharged from acute services. The service had to meet these targets in order to maintain their contract and regular contact with the contracting ambulance provider ensured that the registered manager was kept up to date and informed if performance fell below the required targets.
- Whilst staff did not make decisions about care or treatments for patients being transported on the service, we saw that equality and diversity training was part of the mandatory training that staff completed.
- We spoke to the registered manager about how staff are made aware of patients that have a do not attempt cardio resuscitation in place. Drivers are informed of this when they receive the booking on their PDA and we saw an example of this.

## Response times and patient outcomes

- **Information was collected and monitored on the number of journeys and response times relevant to the eight key performance indicators set by the sub-contracting ambulance service. The service monitored, and generally met, agreed response times so they could facilitate good outcomes for patients.**
- The majority of data on the number of journeys, response times and patient time on vehicles was collected by the PDA and held by the sub-contracting NHS ambulance provider. The provider reviewed this data when sent to them on a monthly basis by the sub-contracting ambulance service. The registered manager told us they received regular feedback on their performance from the sub-contracting ambulance provider and that issues could be discussed at quarterly meetings with the sub-contracting ambulance service. We reviewed the data from October to December 2018 and saw that the service was meeting six out of the eight KPIs set.
- Patients eligible for this service were triaged by the NHS ambulance provider according to their mobility. Staff

told us that if their mobility was worse than indicated on the transfer form, they would contact the dispatch team to advise and if necessary, request a different vehicle type better suited to the patient.

- The service reported two deaths of patients whilst in the service. Both were related to discharges of patient who were at the end stages of their life and during the handover of the patient to the ambulance staff the patients deteriorated and the transfer was aborted.

## Competent staff

- **The service made efforts to ensure staff were competent for their roles but did not always ensure staff had the right training to undertake their roles. Staff did not receive a yearly appraisal. Induction plans were in place, but there was no record that staff had completed these.**
- The provider employed three paramedics, two technicians and 61 ambulance care assistants. We saw that the three paramedics were registered by the Health and Care Professions Council (HCPC). The HCPC keeps a register of health and care professionals that meet the standard for their training, professional skills and behaviour.
- We looked at five sets of staff records and saw that only one of these had an appraisal documented. The registered manager estimated that only 10% of staff had an appraisal in the last 12 months. They recognised that this was something that required improvement and they were developing a new appraisal system that they were starting to roll out.
- During our inspection, we looked at five records and saw all records had been checked within the last six months, and included a copy of the photographic driving licence.
- There was a staff induction policy which stated that each member of staff should have an induction plan which will be signed off by a senior member of staff. However, we reviewed five staff files and found that none of these had induction checklists in. The registered manager informed us this was because this process had only begun in January 2019. We spoke to staff who told us that the induction process involved completion of key mandatory training, an introduction to the company policies and procedures and third-manning on patient transport journeys for a period of three days.

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- Following the inspection, the provider also sent us examples of six staff members' probation meeting minutes. These gave new staff an opportunity to discuss any further training needs or aspirations, if they had any concerns and what they were proud of.

## Coordination with other providers / Multi-disciplinary working

- **The service was sub-contracted by an NHS ambulance trust, and as such, the co-ordination of the transfers were triaged and placed by the NHS ambulance trust.**
- The registered manager of the service reported a good interaction and positive relationship with the contracting ambulance provider. The service had a contact in the organisation that they could get in touch with if they had any concerns or issues about the service. An example was given where the service had been updating their contact late the previous evening due to predicted inclement weather.
- The registered manager and director attended bi-monthly meetings with the NHS ambulance provider, where they could raise any issues or discuss other relevant information. There were however no minutes available from these meetings.
- We saw examples where the service had worked with a discharging hospitals staff to ensure a patient who was at the end of their life was appropriately managed. Although the team had been sent to collect the patient, when they arrived it was felt by the hospital that the patient was no longer fit to travel and staff helped to ensure the patient was transferred back to the hospital bed.
- The contracting ambulance provider issued a standard operating procedure to the service. This covered various aspects of their contract including the expectations for patients care, health and safety and communication.

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

- There was training available for staff regarding patients who may be subject to the Mental Capacity Act, however at the time of our inspection this was not mandatory and the service reported only 50% of staff had completed this module.

## Are patient transport services caring?

Good



## Compassionate care

- We were not able to observe any direct patient care whilst on site at the inspection.
- **Feedback from patients and service users was consistently positive, however the response rate was not monitored by the service which meant that it was not possible to assess what percentage of the patients transported had given their feedback.**

We were not able to observe any direct patient care whilst on site at the inspection. The provider kept no records in relation to patient's personal details following transportation, however we contacted the contracting ambulance trust who were able to provide us with the contact details for patients who had used the service in the last six months.

We contacted six patients via the telephone. All patients we spoke with told us that staff were polite and respectful, with one patient stating that they saw them regularly and "were like friends".

Staff gave us an example where a staff member had gone above and beyond to help a patient who had been incontinent on their journey home. Staff stayed with the patient and helped them put their clothes in the washing machine and ensured they had clean clothes before leaving them.

- We saw a range of compliments from patients and relatives who had contacted the service by letter or email. Comments included: "What was expected to be a difficult and uncomfortable journey turned out to be anything but, thanks to your staff". We were "grateful for the manner our relative was treated and the care taken". We "appreciate the kind help that they provided" when a member of the public had fallen.

We looked at the patient feedback form folder. This combined both Elites' own feedback forms and the contracting NHS Ambulance forms. We looked at a sample of five of these from within the last 12 months, and saw that four out of five feedback forms selected 'excellent' in response to whether they received a professional service; were shown respect and felt safe;



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did staff take measures to meet their needs and to rate overall service received. The fifth card rated all of the above as good. Many of the feedback forms in the folder we were unable to use as they were not dated.

Some of the additional comments included on the feedback forms included: “very good”; “crew lovely”; “very pleased with the service”; “excellent crew”; “first class” and “great staff”.

The service collected feedback via forms but these were not always dated and were not given to patients on every journey. We fed this back to the provider who sent us a further 45 feedback forms that had been dated and completed since our inspection. For the question ‘would you recommend this service’, the majority of patients scored ‘extremely likely’ or likely’.

There was a dignity, privacy and patient involvement policy. This outlined the responsibility of staff to treat patients with respect including introducing themselves to the patient, addressing them by their name rather than a diminutive and respecting their privacy where needed. Patients we spoke with told us they felt the way they were addressed was respectful.

## Understanding and involvement of patients and those close to them

- The eligibility for the transport service was decided by the contracting NHS ambulance provider. However, 13% of journeys involved an escort, either for medical reasons or to provide continuity of care to a patient which ensured that patients had the right support available to them when they travelled.
- Patients we spoke with told us that they felt supported and encouraged, and that when needed they received additional support such as getting in and out of wheelchairs. One patient told us about a recent fall whilst transferring from their wheelchair and told us that the staff helped him and made sure they were ok.
- The feedback forms provided to us following the inspection included the question ‘Did staff escort you to the reception of your destination and inform staff that you had arrived?’ and we saw that out of the 45 feedback forms, the majority (39) said yes, with the remainder saying either not required (5) or no (1).

## Are patient transport services responsive to people’s needs?

Good



### Service planning and delivery to meet the needs of local people

- **Whilst the service was not responsible for planning to meet the needs of the people using the service, it made sure it had the right staff and resources to meet the demand set by the contracting NHS organisation.**
- The service carried out 29,344 patient journeys between February 2018 and January 2019, which on average came to 2445 journeys per month. There were sufficient staff levels and vehicles to meet the requests from the contracting NHS organisation. Less than 1% of these journeys were cancelled by the contracting ambulance trust, and 7% were aborted by Elite staff. All patient transport work was sub contracted from an NHS ambulance trust.
- The service worked seven days a week, with the first transfer leaving at approximately 6:30am and the last journey finishing back at the base for 11:30pm.
- The service provided a range of different vehicles depending on patient needs and could provide stretcher vehicles, or multi-seater vehicles for transferring more than one patient at a time. For example, to outpatient or renal appointments.
- Staff did not always work the same shifts, so continuity of staff could not always be guaranteed for regular patients such as those who went for weekly dialysis appointments.

### Meeting people’s individual needs

- **The service had informal processes in place to make sure that patient’s needs were met.**
- Patients who may be disorientated or distressed by travelling could have the continuity of care of a familiar face to travel with. Of the 29344 journeys made by the service, 3763 (13%) included journeys with escorts for patients. These could either be family members for children, carers for patients living with dementia or

# Patient transport services (PTS)

patients who needed a nurse or healthcare assistant to travel with them. This meant that patients who may be disorientated or distressed by travelling could have continuity of care or a familiar face to travel with.

- The service did not have access to an interpreting service for patients whose first language was not English. The registered manager told us that they could access a language line to allow translation where needed.
- The service had communication aids to support patients who were unable to speak due to their medical condition or who had complex needs. The vehicles we looked at had communication cards available. These contained pictures and words that they could point to or look at when being asked questions.
- Dementia training was available for staff but this was not a mandatory module. Equality and diversity training was part of the mandatory training for staff and we saw that 75% of staff had completed this training.
- Bottled water was kept on all vehicles in case patients required hydration whilst travelling.

## Access and flow

- **People could access the service when they needed it and received the right care in a timely way. Key performance indicators such as turnaround times and pick up times were set and monitored by the NHS ambulance provider.**
- The NHS ambulance provider set targets for three distinct journey types: outpatients, renal outpatients and discharges from acute trusts. The subcontracting NHS ambulance trust took responsibility for monitoring performance in this area and the registered manager informed us that they were provided with regular feedback regarding their performance. As this performance and data was managed by the subcontracting NHS ambulance, we cannot include these figures in this report, however, six of the eight key performance indicators were being met between October and December 2018.
- Three patients who used the service told us that the service was generally on time, and if they were delayed, would apologise and explain why.
- All bookings for patients were managed by the subcontracting NHS ambulance provider. All bookings, once made, fed through to staff personal digital assistants (PDA).

- Less than 1% of patient journeys were cancelled over the reporting period. Cancellations could only be made by the subcontracting NHS ambulance service.

## Learning from complaints and concerns

- **Complaints were jointly investigated and managed by the contracting NHS organisation, however the service were unable to give us accurate numbers of complaints received.**
- The service did not have an adequate process that made sure people's concerns and complaints were listened to and used to improve the quality of care. Any complaints that came directly to the driver or service would be reported to the registered manager who was responsible for informing the NHS ambulance organisation. However, there was no system for the service to log and have an overview of these which meant that they may not be able to identify themes and trends related to complaints. The registered manager gave us an example of a complaint where a patient's relative felt that a patient had been injured by staff during a transfer. The service advised the NHS ambulance organisation and suspended the members of staff involved from duty until the investigation had been completed. This meant that the service took complaints seriously and mitigated the risk of further harm until an investigation had been completed. We contacted the sub-contracting NHS ambulance for confirmation of how many complaints had been made about the service. They confirmed that the service had received seven complaints between January and December 2018. This equated to
- We did not see leaflets on the vehicles we looked at advising patients how to make a complaint. This meant that patients may not know how to raise a concern or complaint. However, the service website had a feedback form and contact form that patients and members of the public could use.

## Are patient transport services well-led?

Requires improvement



## Leadership of service

- **There was a clear management structure for the organisation and leaders were visible and**

# Patient transport services (PTS)

**approachable.** The service had two directors, one of whom was the registered manager. There was also a HR manager and an office manager who worked from the office base. One medical director visited once per quarter, and one clinical director attended one day per week. There was one team leader who had operational responsibility for the ambulance care assistants. However, this meant that when the team leader was sick or on annual leave, one of the two directors were required to cover their role. There were ongoing discussions about the possibility of recruiting a second team leader.

- Leaders were visible and approachable. The directors told us they liked to ensure an “open door policy” for staff. Staff we spoke to told us that they received good positive management support when required.

## Vision and strategy for this this core service

- **There was no written vision or strategy for this service.** However, the directors explained that their vision was to provide a manageable high-quality service to the patients they served. They were committed to the NHS contract they currently held and wanted to grow in a staged and managed way to ensure a stable service.

## Governance

- **There were governance processes in place but the reviews and outcomes were not regularly documented. There was a limited amount of auditing in the service.** It was not clear how trends and themes from incidents and complaints were shared with staff.
- The service held governance meetings quarterly, however, these had not been minuted until after our inspection. We reviewed the minutes of the governance meeting the day after our inspection and saw that the two directors, the medical director and the clinical director were present. We saw that complaints and incidents were listed as being discussed but there was no overview of numbers per quarter or any themes.
- The directors told us that whilst there were not any other documented or minuted meetings, the directors shared an office and spoke daily about any foreseen issues or incidents.
- Prior to our inspection there had not been any local investigation or feedback following incidents as this was sent directly to the contracting NHS ambulance. This had now improved with feedback and comments being

completed locally prior to being sent to the NHS ambulance organisation. However, other than a messaging system on staff phones, there was no evidence of how any themes were shared with staff following incidents or complaints as there were no staff meetings.

## Management of risk, issues and performance

- **The service had systems for identifying corporate level risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However operational risks were not included on this.**
- We looked at the service risk register which was split into four sections: governance, sales and business development, finance and human resources. The likelihood and the impact of the risks were considered and the likelihood and impact to the service if the risk occurred. All risks had controls put in place to reduce the likelihood of the risk occurring.
- The highest scoring risks were the possibility of both directors being absent at the same time and the possibility of the contracting ambulance service increasing the demand on the service without providing a contract to support the purchase of further vehicles. We saw that the risk register was discussed at the governance meeting following our inspection, however there was limited detail on the discussion held.
- Whilst the provider had a risk register it only had risks relating to the company as a whole and not individual risks which could have an impact on every day activity such as vehicle breakdowns or injury to staff through manual handling.
- There was a business continuity plan that contained basic steps for staff to take in the event of a major incident or continuity issue. However there were significant gaps in contact details and key information in the plan which meant it may not be robust in the event of a major incident or continuity issue.
- The service did not have a written business continuity plan or policy. This meant that whilst the registered manager was able to talk through some practical steps to be taken in the event of inclement weather and how they managed when the PDAs failed, this was not documented anywhere.

# Patient transport services (PTS)

- The service was not responsible for monitoring their own performance and this was managed by the contracting NHS ambulance.

## Information Management

- Information about the service including performance and patient information was controlled and monitored by the contracting NHS ambulance organisation. Staff had access to training about information governance and protection.
- The contracting NHS ambulance organisation monitored the key performance (KPI) data for the targets it set. The service met with the ambulance organisation quarterly where they could discuss any perceived issues with the quality of the data. However, we did not see any minutes from these meetings. The registered manager did not report any issues with the reported performance data.
- We saw that information governance training formed part of the mandatory training programme and that 72% of staff had received this training.
- Staff showed us how they accessed information on their PDA. Each member of staff had a unique pass code to use the system, ensuring the information was kept secure.

## Culture within the service

- **Staff had effective working relationships with each other. There were clear staff support networks and all staff we spoke to felt supported by their colleagues.**
- We spoke to four members of staff who told us that this was a supportive environment to work in and that they enjoyed the job. Whilst we did not get any direct feedback about the challenge culture, we heard an example where staff had raised concerns about the behaviour of an individual and that this had been acknowledged and dealt with.

## Public and staff engagement

- **The service collected feedback about the service.** People could give feedback via their website but this was newly implemented and at the time of our inspection no feedback had been received through the site. The service also received feedback through the contracting NHS ambulance provider and through feedback forms that were given to patients on journeys. However, the feedback forms were not always dated or consistently given to patients so it was not clear whether the feedback given was a full picture of the service experienced.
- The service did not have regular staff meetings and so utilised technology such as closed messaging groups and apps to keep in touch with their colleagues. The directors and team leaders told us they had an open-door policy and that staff could approach them at any time. There was a 24 hour on call system that staff could use if they had concerns or issues that needed urgent resolution.
- The service had set up a closed messaging group that all staff members could access from their phones to keep in touch with their colleagues. The clinical director also produced a quarterly newsletter for staff which we saw.
- The registered manager told us about a counselling service available to staff through the contracting NHS ambulance organisation. Some staff had used this service following distressing incidents.
- There was a staff notice board in the staff room. This had various forms and information on it including the contracting NHS ambulance contact numbers, blank incident forms, upcoming weather warnings and information regarding safeguarding and duty of candour.

## Innovation, improvement and sustainability

- The service was changing the way it completed appraisals. It was incorporating a career pathway for staff who wished to train to a level three certificate in First Response to Emergency Care.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital **MUST** take to improve

- The provider must ensure that governance processes are robust and clearly documented.
- The provider must ensure that all staff have an appraisal and a documented induction process.

### Action the hospital **SHOULD** take to improve

- The provider should ensure the safeguarding policies reflect the process that staff take when identifying a safeguarding concern.
- The provider should ensure that all staff receive mandatory training and that this is kept up to date.

- Mental capacity Act training should form a part of the mandatory training programme.
- The provider should ensure that a robust business continuity plan and process is available.
- The provider should ensure that they keep a record of key information such as number and themes of complaints.
- The provider should ensure that they monitor the amount of feedback cards given to patients to be able to provide an accurate response rate.

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

Transport services, triage and medical advice provided remotely

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Staff must receive such appropriate support, training, professional development, supervision and appraisals as necessary to enable them to carry out the duties they are employed to perform.

#### Regulated activity

Transport services, triage and medical advice provided remotely

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The service must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. They should assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.