Outdoor Medical Solutions Limited

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Outdoor Medical Solutions Limited is operated by Outdoor Medical Solutions Limited. The service provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 1 August 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.

The main service provided by this service was patient transport services. Where our findings on urgent and emergency care services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the patient transport service core service.

Our rating of this service improved. We rated it as good overall.

The provider had made good improvements since the last inspection. We found governance arrangements, systems and processes functioned effectively. Policies and procedures had been reviewed and updated.

The provider was able to demonstrate that staff had the skills, knowledge and experience to deliver effective care and treatment. There was an effective process to monitor mandatory and statutory and other staff training. Arrangements for appraising, supporting and manging staff performance had improved, with a calendar of annual appraisals.

The service had suitable premises and vehicles and looked after them well.

Staff completed and updated risk assessments for each patient. They kept clear records.

Nigel Acheson

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Good 	The main service provided was non-emergency patient transport services. Where arrangements were the same, we have reported findings in the non-emergency patient transport services section. The service provided medical cover for events such as motor racing, festivals and film sets, which we do not regulate. However, the service provided or intended to provide emergency and urgent care when patients were transported from events, festivals and film sets to urgent or emergency care providers, for example minor injury and illness units. The service also carried out transfers between hospitals and between hospital and home where the patient sometimes required skills and competencies above that of basic first aid.
Patient transport services	Good 	The service provides a patient transport service, commissioned by and on behalf of NHS and independent ambulance services, NHS hospital trusts and primary care providers. This includes some high-dependency transfers, where a paramedic is required.

Summary of findings

Contents

Good

Outdoor Medical Solutions Limited

Services we looked at
Emergency and urgent care; Patient transport services;

Summary of this inspection

Background to Outdoor Medical Solutions Limited

Outdoor Medical Solutions Limited is operated by Outdoor Medical Solutions Limited. It is an independent ambulance service based in Lydney, Gloucestershire. The service primarily serves the community of Gloucestershire but also works for other providers in England and Wales.

The service provides non-emergency patient transport. The service also provides medical cover for events, such as motor racing, festivals and film sets, which we do not regulate. However, the service did provide emergency and urgent care (between 15 and 20 journeys per year) when patients were transported from events to urgent or emergency care providers such as minor injury units.

The service also carried out transfers between hospitals and between hospital and home where some patients required skills and competencies above that of basic first aid.

The service began trading in March 2010 as a provider of event medical cover to film sets based in Wales. In 2012 they began to provide patient transport support to the NHS in Wales and extended this into England, so requiring CQC registration. They acquired premises at Tetbury in Gloucestershire and a registered manager was appointed in December 2013.

In April 2016 the service relocated to support the further expansion of services and acquired an office, training suite and vehicle garage at Aylburton Business Centre in Lydney Gloucestershire. They began trading from there in July 2016.

Our inspection team

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

Information about Outdoor Medical Solutions Limited

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the headquarters and ambulance base in Lydney. We spoke with three staff including managers. We did not speak with patients or relatives, as the service was not doing any patient transports on the day of the inspection. During our inspection, we reviewed 10 sets of patient records.

The service has had one prior inspection since registration with CQC, which found that the service was not meeting all standards of quality and safety it was inspected against. We issued a warning notice, relating to fit and proper persons, staffing, and good governance. We found that sufficient progress had been made in the areas identified in the warning notice.

Activity (November 2018 to July 2019)

- There were 15 emergency and urgent care patient journeys undertaken.
- There were 509 patient transport journeys undertaken.

Summary of this inspection

The registered manager employed four staff including the medical director. They used 21 bank staff to meet shift requirements on an intermittent basis including four registered paramedics and four ambulance technicians and other staff for patient transport.

Track record on safety

- No never events
- No clinical incidents
- No serious injuries
- No complaints

We inspected two ambulance vehicles which were used for patient transport services.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse.
- The service controlled infection risk well. Staff kept vehicles, equipment and premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and vehicles and looked after them well.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and stored securely.
- The service had systems to ensure the safe and proper use of medicines. Medicines were stored in secured locked cupboard in a locked room, with access restricted to authorised staff. Each ambulance contained a tamper-evident medicine box.

Are services effective?

We did not have sufficient evidence to rate this key question.

- The service did monitor care and treatment to make sure staff followed best practice guidelines.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided informal supervision to provide support and monitor the effectiveness of the service.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

However,

- Information about response times was not routinely collected in a meaningful way. Although the service recorded the time a booking was received and the time the ambulance crew arrived

Summary of this inspection

at the collection, the data was not captured in a way that demonstrated whether key performance indicators (KPIs) were being met. The provider had not been requested to provide this information under any of the contracts they had.

Are services caring?

We did not have sufficient evidence to rate this key question.

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Managers told us that they involved families and carers in decision making, to establish what drinks patients liked, and to work together to give the patient a safe and comfortable journey.

Are services responsive?

Good

We rated responsive as **Good** because:

- The provider did not have any fixed contracts with the NHS but supported acute hospitals as required.
- Patients' individual needs were established at the time of booking, and details were recorded on the booking form. Further assessment of needs took place during handover from healthcare professionals.

Are services well-led?

Good

We rated well led as **Good** because:

- Leaders had the skills, knowledge, and experience they needed. The service was led by the registered manager, and a further manager who took the lead on all aspects of governance.
- The service had a vision for what it wanted to achieve, although this did not translate into a strategy or business plan.
- The service had systems in place to provide assurance of quality and safety. The governance framework ensured that all quality, performance and risks were understood and managed. Staff records were complete, patient feedback was gathered, and patient clinical records were audited.
- The service had a formal system for identifying risks, planning to eliminate or reduce them, and coping with the expected and unexpected.
- The service was taking steps to improve engagement with patients, staff, the public and local organisations to plan and manage appropriate services. The service collaborated with partner organisations effectively.

Good

Emergency and urgent care

Safe	Good
Effective	
Caring	
Responsive	Good
Well-led	Good

Information about the service

See information under this sub-heading in the patient transport services section.

Summary of findings

See information under this sub-heading in the patient transport services section.

Good

Emergency and urgent care

Are emergency and urgent care services safe?

Good

We rated safe as **good.**

See information under this sub-heading in the patient transport services section. In addition to the findings in Patient Transport Services, we found:

Mandatory training

- The service ensured staff were appropriately trained to drive under blue lights and non-emergency driving, all staff received the appropriate driver training for their role. The provider confirmed at recruitment staff had completed this training.
- Paramedics had basic and advanced life support training, which was confirmed at recruitment. The service then reconfirmed that all training was up to date for paramedics every quarter.
- The service provided evidence of staff C1 driving licences to drive vehicles of maximum authorised mass between 3.5 and 7.5 tonnes.

Environment and equipment

- **The service had suitable premises and vehicles and looked after them well.**

- Emergency equipment kept on vehicles, such as oxygen cylinders and defibrillators, were tested and calibrated yearly through an external company. Paramedics were responsible for checking defibrillators prior to each shift.
- The provider had three ambulances. On the date of the inspection two ambulances were on site. We checked both vehicles which appeared to be in good working order. There was no visible body work damage and doors and lights were working properly. All essential equipment was available and there was evidence this had been safety-tested. There were suitable harnesses and belts to safely transport passengers, including children.
- We also saw that there was some specialist equipment for children, including child defibrillation pads, on held on vehicles. However, if a child was being transported from an NHS site, the hospital would supply any specialist equipment the child required.

Medicines

- The paramedics would stock medicine bags, and it was the responsibility of the paramedic to check they had full and in date stock before signing out to take on the vehicle. Medicines were held securely on vehicles. First aid bags were held on patient transport vehicles.
- Guidance for medicines had been produced by the service's medical director to allow staff to administer medicines. This was under the medicines administration protocol. This protocol outlined which staff were competent to administer medicines to patients. They were signed by the relevant healthcare professionals to show they have read and understood them. Stocks of medicines were accounted for, stored securely and only accessible by authorised persons on the vehicle.

Assessing and responding to patient risk

- Managers told us staff identified and responded appropriately to changing risks to people who used services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenged. Paramedics assessed patients against Joint Royal Colleges Ambulance Liaison Committee (JRCALC) protocols.
- Resuscitation training for adult and paediatric patients was delivered at the induction. Emergency care assistants and ambulance care assistants were resuscitation trained for basic life support, and paramedics advanced life support.
- Managers confirmed that crews could access specialist clinical advice through the main site management team if required on scene or in transit.

Safeguarding

- The service had a process to identify if a protection plan was in place for a patient they were attending. Information was shared by local ambulance trusts with the service which ensured, due to patient confidentiality, only information relevant to the transport would be shared. Ambulance crews discussed this with relevant family and healthcare professional.

Staffing

- Paramedic registration with the Health Care Professional Council (HCPC) was checked on recruitment and every two years when registration

expires and was renewed. The staff record included the registration number. We reviewed the paramedic files and saw evidence of their qualification and registration with the HCPC and confirmed there were no notes or restrictions to practice.

Are emergency and urgent care services effective?
(for example, treatment is effective)

We did not have sufficient evidence to rate this key question.

See information under this sub-heading in the patient transport services section. In addition to the findings in Patient Transport Services, we found:

Evidence-based care and treatment

- Policies and procedures were formulated and updated in line with relevant and current evidence-based guidance, standards, best practice and legislation. The service was provided in line with NICE guidelines and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. We saw policies referred to relevant national guidance and legislation, for example, National Institute for Health and Care Excellence (NICE), Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health and Social Care Act 2008, Medicines and Healthcare Products Regulatory Agency (MHRA) and Health and Safety Executive (HSE).

Competent staff

- Paramedics received a one day induction, which included demonstration of equipment, basic life support, and manual handling training. They were also introduced to policies and procedures and the online training system. We saw that all staff were 'signed off' by a supervisor as being competent following an assessment shift.

Are emergency and urgent care services caring?

We did not have sufficient evidence to rate this key question.

See information under this sub-heading in the patient transport services section.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

Good

We rated responsive as **good.**

See information under this sub-heading in the patient transport services section.

Service delivery to meet the needs of local people

- The provider did not have any fixed contracts with the NHS but supported acute hospitals with emergency transport when requested. They also provided emergency medical cover at events where, on occasion, patients were transported from the event to hospital.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- The managers could describe how they would support people with complex needs or those in vulnerable circumstances. Patients' individual needs were established at the time of booking, and details were recorded on the booking form for NHS patients being transported at then requested of an NHS hospital.

Access and flow

- **People could access the service when they needed it.** The emergency patient transport service was available 24 hours a day seven days a week.

Are emergency and urgent care services well-led?

Good

We rated well led as **good.**

See information under this sub-heading in the patient transport services section.

Good

Emergency and urgent care

Culture within the service

- Due to the unannounced nature of this inspection there were no staff we could talk with about the culture of the service. However, we spoke with the registered manager about the challenges associated with managing a remote and scattered workforce. The recent recruitment of two team leaders has helped improve mechanisms for staff to raise concerns, and a staff meeting was planned for September 2019.

Vision and strategy for this service

- **The service had a vision for what it wanted to achieve, although this did not translate into a strategy or business plan.** Managers told us they wanted to develop the business through gaining formal contracts with NHS hospitals, and expand the events covered.

Governance

- **The service had systems in place to provide assurance of quality and safety.**
- At the last inspection we found that governance arrangements were not operating effectively to ensure that all quality, performance and risks were understood and managed. However, we found governance arrangements had significantly improved.
- The governance framework ensured that all quality, performance and risks were understood and managed. In order to maintain assurance, staff records were completed, and patient clinical records were audited.

Management of risk, issues and performance

- **The service had a formal system for identifying risks, planning to eliminate or reduce them, and coping with the expected and unexpected.**
- There was a risk register which included operational risks, including patient safety risks, health and safety risks, and staff safety risks. Risks included those relating to faulty equipment or failure of essential equipment; and ensuring medicines were stored safely and at the correct temperature.

Good

Patient transport services

Safe	Good
Effective	
Caring	
Responsive	Good
Well-led	Good

Information about the service

The main service provided by this ambulance service is non-emergency patient transport. Where our findings on non-emergency patient transport – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the non-emergency patient transport section.

Outdoor Medical Solutions (OMS) began trading in March 2010 as a provider of event medical cover and provider of medical support to film sets based in Wales. In 2012 they began to provide patient transport support to the NHS in Wales and extended this into England so requiring CQC registration. They acquired premises at Tetbury in Gloucestershire and became registered with the CQC 2 December 2013.

In April 2016 they relocated to support the extension of services of OMS and acquired an office, training suite and vehicle garage at Aylburton Business Centre in Lydney Gloucestershire and began trading from there in July 2016.

CQC only regulates activity that is or should be registered. OMS were registered to provide

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

They did this through

- Patient transport support to hospitals which we regulate.
- Transport of patients from events such as motor sport or festivals,

How we inspected this service:

We visited the headquarters which comprised office accommodation for booking staff, assessment and training facilities and the vehicle depot. We inspected premises, equipment and two vehicles and patient and staff records.

- We spoke with the registered manager, and two other managers for the service.

Good

Patient transport services

Summary of findings

We found the following areas of good practice:

- The provider had made good improvements since the last inspection. We found governance arrangements, systems and processes functioned effectively. Policies and procedures had been reviewed and updated.
- The provider was able to demonstrate that staff had the skills, knowledge and experience to deliver effective care and treatment. There was an effective process to monitor mandatory and statutory and other staff training. Arrangements for appraising, supporting and manging staff performance had improved, with a calendar of annual appraisals.
- The service had suitable premises and vehicles and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records.

However,

- On the day of the inspection the provider could not assure us the drivers had the correct driving license for one of the vehicles

Are patient transport services safe?

Good

We rated safe as **good.**

Incidents

- **The service managed patient safety incidents well.** Staff recognised incidents and reported them appropriately. Managers investigated incidents and took appropriate remedial action when required. When things went wrong, staff apologised and gave patients honest information and suitable support.
- There was an incident reporting policy which set out staff's responsibility to report incidents and how to do this. It stated that all incidents would be investigated by a senior manager or supervisor and signed off by the registered manager.
- Staff were required to complete an incident form which was submitted and reviewed by a manager. Incident forms were kept by the manager. We noted that there had only been four minor incidents in the previous twelve months. There had been no serious or untoward incidents in the 12 months to 29 March 2018. Due to the low numbers of incidents reported no themes had emerged, which led to changes and shared learning. However, the forms used to collect incident data were comprehensive. We reviewed the incident forms and saw staff received feedback on all incidents raised. We saw examples of incidents and action taken. These included an incident relating to a patient who fell, which led to a review of staff manual handling training.
- The provider issued any new or updated patient safety alerts to staff using a social media app. Through this the service could monitor that staff had received the update, but not whether it had been read.
- Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable incidents' and provide reasonable support to them. There was a duty of candour policy which set out the organisation's responsibilities to be open and transparent with patients when mistakes occurred. There was a checklist to prompt managers to take appropriate steps to comply with the regulation. The service had not

reported any incidents where duty of candour applied. However, they demonstrated an understanding of the principles of openness and honesty when mistakes occurred. Duty of candour also formed part of annual mandatory training.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- At the previous inspection we found the provider was not able to demonstrate all staff had the skills, knowledge and experience to deliver effective care and treatment. There was not an effective process to monitor mandatory, statutory and other staff training because staff records were incomplete. At this inspection we found that the provider had made significant changes to processes and record keeping.
- All staff received induction training on employment. The provider employed staff who were employed by both the NHS and other independent ambulance providers. This was a day programme, which included documentation completion (including patient report forms and DNACPRs); infection control; hand hygiene; CPR; and vehicle familiarisation and inspection. It also included safeguarding, duty of candour, and whistleblowing. An induction checklist was completed by a senior manager at the induction training day, which had to be completed within one moth of employment.
- Following the induction day, new recruits also had an online training course covering 30 key modules to work through over a six-month period.
- The statutory and mandatory training policy did not set out the training required for each job role. However, we saw there were 30 modules covered during induction, and these were refreshed every, 18, 24 or 36 months. A database would flag up when refresher training was due, and time periods for recompletion were assessed. The mandatory training covered:

- Infection prevention and control
- Moving and handling
- Safeguarding of children and vulnerable adults (level 2)
- Incident reporting
- Basic life support and resuscitation
- Fire safety awareness
- Equality and diversity
- Capacity to consent and Duty of Candour
- Correct completion of forms

- A training matrix was maintained by a manager and identified when staff were due to refresh their training. All staff were up to date with mandatory training. The registered manager told us staff were released for one day to complete refresher training.
- We looked at a random selection of staff files and saw evidence that staff completed the necessary induction and assessment. There was also evidence that their driving licence had been checked on employment and six-monthly thereafter.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse.**
- The service provided safeguarding training to all staff. Staff were trained to level three for both safeguarding adults and children, and records showed all staff were up to date with this training. In addition, the service's registered manager was trained to level four. The provider's safeguarding policy required staff to complete safeguarding training every 18 months.
- Safeguarding processes were clear. We were told any safeguarding concerns would be escalated verbally by the crew to a supervisor or manager and an incident form would be completed. The supervisor or manager would then raise the concerns with the referring organisation, for example the NHS hospital, so they could report them through their processes.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept vehicles, equipment and premises clean. They used control measures to prevent the spread of infection.**
- Staff received training in infection prevention and control as part of their induction and this was refreshed annually. All staff were up to date with this training.
- Deep cleaning of vehicles was undertaken every month, or if an infectious patient had been transported, and we saw records that confirmed these had taken place.

- We also saw records that a local garage carried out vehicle safety checks every 10 weeks. Medical devices were checked, maintained and replaced every three months, or as required, by a third party, and electronic and paper records were kept.
- There was guidance on hand hygiene contained in the infection prevention and control policy. There was personal protective equipment available on vehicles, including gloves and aprons, and there were hand cleansing gel and decontamination wipes for cleaning internal surfaces and equipment.
- There was a clinical waste disposal policy which described the procedure for waste disposal. There were sharps bins and clinical waste bags on the vehicles we inspected, and these were closed. We saw clinical waste was disposed of at the ambulance base in a secure marked bin and collected every three months by a waste contractor.
- Linen was visibly clean, and the provider had a system to provide fresh linen for each patient. When a patient was taken to hospital or nursing home, any used linen stayed with the patient. The destination organisation provided the service with fresh linen as a replacement. There was no official linen exchange agreement in place due to the range of destinations the provider transported patients to. The service bought single-use, disposable linen to use at large events when the exchange option was not available.
- An infection control audit had taken place in May 2019, which covered the garage area, each vehicle, equipment stores, waste management, patient equipment and hand hygiene. The provider had set a compliance level of 85% of above, and had attained this in all areas, and had achieved 100% in nine out of the total 14 areas. The report also had a commentary at the end of the report, but no action plan to help the provider further improve its results.

Environment and equipment

- **The service had suitable premises and vehicles and looked after them well.**
- The ambulance depot was in a small unit on an industrial park. The environment was secure and suitable for the storage of ambulances and equipment. There was an office with access to a small kitchen and a toilet for staff, with hand washing facilities. Store rooms were secure and were well organised, so equipment and consumables could be easily accessed. We inspected the store room and found stored items we checked had expiry dates clearly displayed, and all of these were in date.
- The provider had five vehicles, including three ambulances, and two four-wheel drives. On the date of the inspection two ambulances were on site. We checked both vehicles which appeared to be in good working order. There was no visible body work damage and doors and lights were working properly. All essential equipment was available and there was evidence this had been safety-tested. There were suitable harnesses and belts to safely transport passengers, including children.
- Medical gases were safely secured and were in date. Sterile supplies, such as dressings, were appropriately stored, packaging was intact, and they were in date.
- Managers told us they had access to enough equipment to undertake their roles safely. If equipment became damaged or defective, there were processes to report this to management and to obtain replacements. If a replacement item was not available, the crew would only be tasked to jobs which they were equipped to deal with. For example, if a carry chair was defective, the crew would not be tasked to any jobs requiring a carry chair.
- Spare equipment we inspected was clearly marked with service and portable appliance testing stickers to confirm they were in-date with these checks. We noted that some equipment was not in service, and these were clearly marked with 'not in use' signs.
- A manager carried out weekly checks of equipment and consumables and we saw records of these checks.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient. They kept clear records.**
- All bookings were risk assessed by managers to ensure a suitably trained and experienced crew were dispatched. Managers told us staff undertook their own risk assessment and could seek clinical advice via an on-call manager 24 hours a day. In the event of a deteriorating patient, staff would call for emergency support (via 999), record patients' observations and commence treatment in accordance with their level of training. All staff were trained in basic life support.

- Patients were monitored during transport. We were told by the registered manager that the risks to patients and people who used the service were assessed and recorded on patient report forms. Staff recognised and responded to patients' changing conditions during their journey and updated the patient report form. We saw this on the patient report forms we reviewed.
- We were assured of the processes in place that supported staff to manage the risk of a deteriorating patient. There was a documented escalation process for deteriorating or seriously ill patients. The registered manager told us that staff could either contact the registered manager or the emergency services and ensure that the patient was transferred to the appropriate urgent or emergency care department, in line with the policy.
- There was a policy in place to support the care and treatment of patients who may be violent or aggressive. There was online conflict resolution training to be completed after induction.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**

- Staffing levels and skill mix were planned and reviewed by the registered manager when they received a request for transport or as part of the planning to cover an event where they may have to transport patients to another facility. There was no staff rota as the demands on the service varied week to week.
- The registered manager told us new staff completed an induction programme and worked with them before working with other members of staff. The provider kept records of appraisals and observations carried out during the induction phase.
- In total, the service had access to 21 bank staff. The majority (13) were ambulance care assistants. There were four emergency medical technicians and four paramedics.
- In the event of unexpected absence, the register manager filled any gaps if possible. If necessary, staff would be asked if they could swap shifts or cover on overtime.
- We reviewed the rotas for November 2018 to July 2019 and found they were fully staffed.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and stored securely.**

- Staff provided a clear explanation of the expectations regarding the recording of patient care, which were consistent with the PCF [patient care form] Guidance Policy (last reviewed in November 2018.) This stated a PCF should be completed for every patient contact, whether they were treated or not. This applied to patients who were admitted to hospital, inter-hospital transfers and GP transfers. During routine discharge journeys, only patients' names, addresses and journey timings were recorded.
- Records were returned to the base depot where they were securely stored.
- We reviewed 10 patient care forms. All records were complete, legible, signed and dated. Where observations were required to be completed, these were recorded clearly, and more than one set was documented where needed.
- The provider undertook a regular audit of patient records, and we noted that feedback was given to staff, both when improvements were needed, and when a member of staff had done a good job of completing the record.
- The administration of oxygen was recorded correctly and clearly. Details included the time at which it was started, the rate at which it was being administered, the route of administration (nasal, face mask), and a signature of the administering crew member.
- Records given to ambulance staff travelling with the patient and those created by the provider were passed to the relevant carer or other staff at a receiving provider.
- The service had an information governance policy which included a process for managing confidential patient information.

Medicines

- **The service had systems to ensure the safe and proper use of medicines.**

- Medicines were stored in secured locked cupboard in a locked room, with access restricted to authorised staff. Medicines were signed for when taken out in sealed boxes, and it was well documented when medicines

were used. Controlled drugs were not used by the service. We were told that medicines were checked each month by the registered manager for expiry dates and damage and additional stocks were ordered where replacement was needed. All the medicines we saw were within their expiry date. Medicines and gases were locked and stored securely within the garage unit. Oxygen and oxygen/nitrous oxide cylinders were stored safely on vehicles in canvas bags and were within their expiry dates.

- Each ambulance contained a tamper-evident medicine box. This box was sealed with a unique number label and a log of this number was kept in the station office. If this seal was broken, due to patient use or when it was checked, contents were replaced, and it was resealed with a new, logged tag. Medicines stocks on the vehicle were tailored to specific events. For example, motor sports and horse racing association organisations provided guidance on what was required for each ambulance providing a service at these events.
- Guidance for medicines had been produced by the service's medical director to allow staff to administer medicines. This was under the medicines administration protocol. This protocol outlined which staff were competent to administer medicines to patients.

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

We did not have sufficient evidence to rate this key question.

Evidence-based care and treatment

- **The service did monitor care and treatment to make sure staff followed best practice guidelines.**
- Staff had access to policies and clinical guidance, which was kept at the vehicle depots; and we found patient care forms were reviewed to assure the service that staff provided care and treatment in accordance with national guidelines and good practice.
- The service did not review eligibility for non-emergency patient transport to ensure that transport was provided in line with local guidelines as this was the responsibility of the commissioning services.
- The service had a comprehensive range of policies. Some policies referred to Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines, for example medicines management.
- There was a medical director employed by the organisation, who was a GP. They provided advice and guidance regarding policy, medicines management, records systems and incidents. Managers told us the medical director had good availability and was able to provide timely advice and support.
- Patients who used the service were assessed and care and treatment was delivered and this was recorded on patient report forms. We saw evidence of weekly patient reports audits and annual patient report form audits completed by the medical director. Managers demonstrated trends in patient report forms were identified and dealt with immediately following the weekly review. Patient report form discrepancies were automatically raised with the appropriate staff member and if necessary training was offered and an incident report form completed.
- There were 509 non-emergency patient transport journeys undertaken. None of these were patients from events who were transported to hospital. In the same reporting period the registered manager estimated that they had transported 10 to 15 patients who were from events and transported to hospital needing emergency and urgent or other care.

Response times / Patient outcomes

- **Information about response times was not routinely collected in a meaningful way**. Although the service recorded the time a booking was received and the time the ambulance crew arrived at the collection, the data was not captured in a way that demonstrated whether key performance indicators (KPIs) were being met. The provider had not been requested to provide this information under any of the contracts they had.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided informal supervision to provide support and monitor the effectiveness of the service.**

Good

Patient transport services

- New staff received a one day induction, which included demonstration of equipment, basic life support, and manual handling training. They were also introduced to policies and procedures and the online training system. We saw that all staff were 'signed off' by a supervisor as being competent following an assessment shift. We also saw a new comprehensive individualised training manual for each staff member due to be introduced to all members of staff in September 2019.
- The training policy described an annual training needs analysis and a range of methods available for managers to identify training needs, including workplace assessments and performance appraisal.
- Supervisors worked alongside staff and provided advice and support where needed.
- Performance appraisals had been introduced in September 2018. These were undertaken by the registered manager, and the operations manager. A spreadsheet was maintained to show how many staff had received a performance appraisal. Managers had plans to complete the rest of the appraisals by 1 September 2019. These were to be completed over the telephone due to the geographical base of staff, some of whom lived over 200 miles from the ambulance base.
- We checked staff records and found that all relevant staff had a Disclosure and Barring Service (DBS) check and a Driver and Vehicle Licensing Agency (DVLA) check every two years. There was a record of which drivers were licensed to drive C1 vehicles (vehicles weighing between 3,501 and 7,500 kg, which is approved for the carriage of no more than eight passengers in addition to the driver).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care**.
- Staff had received training, which covered the fundamentals of consent and capacity. Managers told us that where a patient lacked capacity, this had been assessed by the clinicians making the transport booking. All decisions in relation to transport and care while being transported were discussed with hospital staff before a patient was conveyed.

Access to information

- **Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment**.
- Staff had access to the information they required to ensure they could provide safe transportation, care and treatment. Information was provided by third parties so there was no direct contact with patients at the booking stage. Further information was shared by NHS providers when patients were handed into the care of ambulance staff.
- Up to date satellite navigation systems were used to enable staff to plan transport routes.
- When patients were transferred to their destination the information needed for their ongoing care was shared via a patient report form. The registered manager told us that staff requested up to date 'do not attempt cardio pulmonary resuscitation' information, where relevant, when transferring patients.

Are patient transport services caring?

We did not have sufficient evidence to rate this key question.

Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness. The provider requested feedback form patients, families and carers, through feedback cards placed on the ambulance and through feedback forms on their website. The provider had not received many completed forms, but those they had were positive. We saw that staff were being encouraged to ask patients for feedback.
- We were not able to speak directly with patients; however, the supervisor was able to share examples of where staff had 'gone the extra mile'. We were told that staff would stop at a local shop to buy some basic provisions such as milk and bread for patients on their journey home for hospital and make them a drink when they arrived. They also told us about a staff member who took a patient's washing inside from where it had been hanging on a line outside.
- The management team told us that looking after patient's dignity started from meeting the patient in

their hospital bed to the moment they had been safely transported to their destination. They talked of the importance of ensure patients were covered by blankets to maintain dignity.

- Managers told us staff were encouraged to stay as long as it took to ensure patients were comfortable. Staff would ensure that a telephone and television remote control were in reach of the patient before they left.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Managers gave us examples of the effect that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. We were given an example of where a patient had died on a patient transport journey. Staff arranged for flowers to be delivered to the patient's family.

Understanding and involvement of patients and those close to them.

Staff involved patients and those close to them in decisions about their care and treatment.

- Managers told us that they involved families and carers in decision making, to establish what drinks patients liked, and to work together to give the patient a safe and comfortable journey. They described planning breaks on long journeys and gave us an example of a patient they transported regularly, who liked to stop at a particular place for dinner which they accommodated.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- The provider did not have any fixed contracts with the NHS but supported acute hospitals as required. They also worked as a sub-contractor providing patient transport to several other organisations. Services were planned and delivered to meet the needs of patients by the registered manager who allocated staff based on patient details provided by the requesting body.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- The service took some steps to support people with complex needs or those in vulnerable circumstances.
- Patients' individual needs were established at the time of booking, and details were recorded on the booking form. Further assessment of needs took place during handover from healthcare professionals. Senior staff told us patients living with dementia or those with learning disabilities would always be conveyed with a two-person crew. All staff had received awareness training to help them support people with dementia, learning disabilities or mental illness.
- Most patients transport needs could be met. For example, there were vehicles with seats or with stretchers and seats so that patients could be transported appropriately. The provider took account of the needs of different patients and people close to them, including those in vulnerable circumstances. Patients were able to have their relatives travel with them which would help to support their complex needs.
- Harnesses were available on ambulances to ensure patients were safely secured whilst being conveyed to hospital. Ambulances were also equipped to convey bariatric patients. They had clamp fittings on the floor of ambulance for transporting patients in wheelchairs. Restraints, for example seat belts and baby seats, ensured patients were safely restrained when being conveyed.
- Each vehicle was equipped with a translation card for multiple languages and sign language for deaf people. This enabled staff to show or use common phrases to find out what problems the patient was experiencing. Staff could use a telephone translation service if further language support was needed.

Access and flow

- **People could access the service when they needed it.**
- The service worked with various NHS and non-NHS providers for the provision of patient transfers. They

worked on an ad-hoc basis providing vehicles and staff when other providers did not have capacity. They met with these commissioners on a regular basis but did not formally report on their performance in terms of their responsiveness.
- The non-emergency patient transport service was available 24 hours a day seven days a week.
- Patient transport was prioritised by the requesting organisation and the provider informed them if they could meet the priority or not. The telephone bookings for transport were received up to 24 hours in advance by the registered manager and then staff who were available were allocated to the work.

Learning from complaints and concerns

- **The service treated complaints and concerns seriously, investigated them and responded to complainants in a timely fashion.**
- There was a complaints policy which set out the organisation's commitment to take complaints seriously and use them as opportunities to learn and improve the service. The registered manager had overall responsibility for the management of complaints.
- Leaflets on how to complain or provide feedback were accessible to patients on vehicles. Patients, carers and families were also able to leave feedback through the service's website.
- Complaints, whatever their source, were recorded as incidents and investigated in the same way (see Incidents above). The registered manager told us there had been no complaints in the last year.

Are patient transport services well-led?

Good

We rated well led as **good.**

Leadership of service

- **Leaders had the skills, knowledge, and experience they needed.**
- The service was led by the registered manager, and a further manager who took the lead on all aspects of governance. The registered manager was responsible for liaising with clients, taking bookings, scheduling and planning. They also investigated complaints and incidents and were responsible for staff recruitment, supervision and appraisal. They were the named safeguarding lead for adults and children. At the last inspection we found the provider did not maintain their own or other staff files appropriately including evidence of disclosure and barring (DBS) checks, ensure that appraisal and supervision took place or carry out audit described in their policies. However, on this inspection we found the managers had made the necessary improvements.
- There was a medical director employed by the organisation, who was a GP.
- The registered manager understood the broad challenges to good quality care such as being asked by organisations to provide transport that might be inappropriate due to skill level. They were able to speak about what was needed to address them such as reviewing patient transport requests sometimes in person. The registered manager told us they ensured they worked several shifts with different staff to maintain contact and visibility for staff.
- There was a recently appointed supervisor, who was responsible for monitoring safety and quality standards. This included vehicle and equipment maintenance and cleaning.

Vision and strategy for this service

- **The service had a vision for what it wanted to achieve, although this did not translate into a strategy or business plan.**
- The service had a vision: 'to supply excellent, patient focused experience that is greater than the expected values of our customers. With concentrations of safety, training and infection control we are able to offer incomparable levels of patient care guaranteeing that the patient is at the middle of everything we do'.
- The service did not provide us with a strategy or a business plan. The service operated in a competitive market and its future was dependant on maintaining existing relationships. The registered manager was keen to expand the service by securing further contracts and worked hard to maintain good working relationships with commissioners and build a good reputation for providing safe and responsive services.
- The service committed to consistently monitor and audit performance through customer and employee

feedback, and regulatory audits. They intended to respond positively to complaints and criticisms in line with the complaints procedure and were fully committed to equal opportunities in the workplace.

Culture within the service

- Due to the unannounced nature of this inspection there were no staff we could talk with about the culture of the service.
- However, we spoke with the registered manager about the challenges associated with managing a remote and scattered workforce. There was a formal policy about lone working and they were able to demonstrate that staff safety and welfare was a priority. The policy covered the protection of staff and sub-contractors from the risks of lone-working.

Governance

- **The service had systems in place to provide assurance of quality and safety.**
- At the last inspection we found that governance arrangements were not operating effectively to ensure that all quality, performance and risks were understood and managed. However, we found governance arrangements had significantly improved.
- The governance framework ensured that all quality, performance and risks were understood and managed. Staff records were complete, patient feedback was gathered, and patient clinical records were audited.
- There was a range of comprehensive policies, supported by clear processes and measurable standards so that performance could be monitored.
- We reviewed the recruitment policy and procedure. This set out the service's commitment to promote equality in employment and avoid discriminatory practices. It also set out a list of pre-employment checks, and described the recruitment procedure in full, including how compliance with the policy would be monitored. It also included the requirement for job descriptions, a job application, a selection interview, completion of a health questionnaire or a driving assessment.
- We reviewed a random selection of six staff files. These included a checklist in each file to prompt managers to complete recruitment tasks, including pre-employment checks. We found that checks were taken in line with the provider's own policy.
- Other policies we reviewed included the health and safety policy, incident policy, and complaints policy. We found that they had all been updated within the last 12 months.

Management of risk, issues and performance

- **The service had a formal system for identifying risks, planning to eliminate or reduce them, and coping with the expected and unexpected.**
- There was a risk register. This had last been reviewed in July 2019. It included operational risks, including patient safety risks, health and safety risks, and staff safety risks. Risks were rated red, amber or green, and managers were able to tell us about mitigating actions in place, and the current position of the risks.
- The service held senior management meetings every three months, and we saw written minutes of these meetings. It was attended by the register manager and the medical director, as well as two supervisors. The agenda included medicine management and policy review, handling of controlled drugs, record systems and patient confidentiality, business expansion and serious untoward incidents (of which there were none). The risk register was also reviewed and updated at these meetings.

Information Management

- **The service did not collect, analyse, manage and use information well to support all its activities. Secure electronic systems with security safeguards were used.**
- The service did not use information to actively monitor performance in a holistic way. While response times were recorded, these were not monitored or used to review performance.
- The provider kept electronic information secure. Mobile applications were password-protected so they could only be accessed by authorised persons, as were the mobile phones themselves. Electronic data was stored on an encrypted server.

Public and staff engagement

- **The service was taking steps to improve engagement with patients, staff, the public and local organisations to plan and manage appropriate services. The service collaborated with partner organisations effectively.**

Good

Patient transport services

- The service continued to find it challenging to capture patient feedback, given the transient nature of the service. There were feedback forms held on ambulances and staff were encouraged to share these with patients. We saw emails and messages to staff to encourage them to obtain patient feedback. However, patient feedback was minimal.
- Staff engagement was also challenging but the service had taken steps to improve this. Messages and updates through secure social media applications had been introduced.
- The service engaged well with NHS providers and commissioners, and feedback from them indicated there were good working relationships.

Innovation, improvement and sustainability

- The registered manager told us they were hoping to take some patient transport staff on to payroll, rather than staff continuing as sub-contractors to support improvements in availability and response to transport requests.
- Sustainability was supported through offering a service as sub-contractors to larger companies, non-regulated events work and training for other organisations.