Private Ambulance Service Ltd

Private Ambulance Service Ltd

Quality Report

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

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection visit on 2 August 2016 and an unannounced inspection on 12 August 2016.

Our key findings were as follows:

- On our announced inspection we found many safety concerns regarding infection control and hygiene; equipment and medicines management. There were also poor governance and leadership arrangements owing to a lack of registered manager; fit and proper persons checks not being carried out, contrary to regulation 19; and a poor culture among some operations managers. These findings are detailed in the report. However, when we returned for the unannounced it was clear that these issues had been resolved and systems and processes had been introduced to prevent these issues reoccurring. We were impressed with how quickly and effectively the service had addressed the problems.
- Staffing levels were sufficient to meet patient needs.
- Staff were confident in assessing and managing specific patient risks and processes were in place for the management of deteriorating patients.
- The concerns regarding infection control, equipment and medicines had all been resolved when we conducted a subsequent unannounced inspection.
- The service coordinated well with the local NHS ambulance provider to meet patients' needs
- We spoke with six patients and one relative. All patients told us that staff were kind and caring.
- The service was planned to meet the needs of its contractual arrangements with health service providers. The service utilised its vehicles and resources effectively to meet patients' needs.
- There was unanimously positive feedback from staff regarding the support and availability of the managing director

We saw several areas of good practice including:

- Safeguarding adult and children training to level two was completed to a high rate of over 99%.
- The culture amongst the staff we spoke with was good, and they liked working for the service.
- Mandatory training rates were good and staff were automatically booked onto refresher training courses when they were due for renewal.
- Staff were competent in carrying out their responsibilities and felt they received appropriate training and support for this.

However, there were also areas of poor practice where the location needs to make improvements.

The location must:

- Ensure that incident reporting procedures to ensure staff report all incidents and 'near misses'; and implement systems for sharing learning and feedback with all staff following incidents and investigations to reduce the risk of incidents reoccurring.
- Ensure that governance processes and quality assurance measures and processes improve to provide effective oversight of all aspects of the service, in accordance with regulation 17.

The location should:

- Improve the governance systems within the service.

Summary of findings

- Ensure that staff always receive adequate rest time between shifts, to reduce the potential risk of becoming fatigued.
- Have a registered manager in post. The service had not had a CQC registered manager in post for more than six months; although one had been appointed at the time of their inspection, they had not yet commenced work and were therefore not registered with CQC.
- Implement robust processes for risk assessing the vehicles for the transport of mental health patients, as this forms a significant part of the work of the service.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Overall we have not rated patient transport services at Private Ambulance Service Ltd because we are not committed to rating independent providers of ambulance services at the time of this inspection. We found that there was clear evidence of effective learning from the feedback we had given the service relating to the issues around medicines management, equipment and infection control. When we returned for our unannounced inspection we found actions had been taken to ensure these issues did not reoccur. Staff used information provided by the cleric booking system to help them plan patient journeys effectively. The service coordinated well with the local NHS ambulance provider to meet patients' needs. The service was active across the independent ambulance sector and had close links with other local providers to help them understand growth and demand. The patients we spoke with gave consistently positive feedback on the care from and interactions with staff. Staff were responsive to specific patient needs. Staff were positive about the support from and visibility of the managing director and enjoyed working for the service. There was limited learning from incidents and staff reported they did not receive feedback from incidents. However, during our unannounced inspection we observed a new process for sharing learning from incidents with staff, which staff were aware of. There were cleanliness concerns for the vehicles during our announced inspection. However, during our unannounced inspection we found that all vehicles inspected were cleaned thoroughly and all cleaning procedures had been changed and updated. However, we found that there were areas where the provider could make improvements. Specifically that the staff did not always receive adequate rest time between shifts, which meant they were at greater potential risk of becoming fatigued. Also that the service had not had a CQC registered manager in post for more than six months.

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Detailed findings

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Background to Private Ambulance Service Ltd

Private Ambulance Service Ltd was established in 2012 and provides patient transport services. They also supply first aid services to public events.

The service holds contracts with three NHS trusts, as well as a range of private contracts across Essex and London. All management functions for this service are managed from the Essex head office location.

Whilst Private Ambulance Service Ltd employs emergency response trained staff and has 10 rapid response vehicles and 28 intermediate tier vehicles, the service does not directly provide emergency response services. Private Ambulance Service Ltd provides staff and vehicles to support the fleet of NHS ambulance trusts as part of ongoing contracts and service level agreements (SLAs). The terms of the agreements mean that the staff work on the NHS rota alongside the NHS crews where needed.

The service is registered for transport services, triage and medical advice provided remotely.

At the time of our inspection there was no registered manager in post. The service had appointed a new manager by the time of our unannounced inspection and this individual would go through the registered manager process following commencement of employment with the service.

Our inspection team

Our inspection team was led by:

Inspection Manager: Leanne Wilson, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a governance specialist, a nurse and a paramedic.

How we carried out this inspection

This inspection was a scheduled inspection carried out as part of our routine schedule of inspections. The inspection was an announced inspection and took place on 2 August 2016.

We spoke with 14 members of staff, four managers of the service, spoke with six patients and one relative about their experience of using the service, and spoke with the management team. We also reviewed a range of information and documents provided by the service.

Detailed findings

Facts and data about Private Ambulance Service Ltd

Private Ambulance Service Ltd started the company in 2012 with six vehicles and 20 staff. In 2016, the service has 126 vehicles. The service now employs 300 people.

Our ratings for this service

Our ratings for this service are:

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

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Private Ambulance Service Ltd was established in 2012 and provides patient transport services. They also supply first aid services to public events.

Private Ambulance Service Ltd started the company in 2012 with six vehicles and 20 staff. In 2016 the service has 77 patient transport vehicles and 29 emergency response vehicles. The service now employs 300 people.

The service holds contracts with three NHS trusts, as well as a range of private contracts across Essex and London. The service also operates a small satellite base in the west Midlands for a contract in the Birmingham area. All management functions for this service were managed from the Essex head office location.

Whilst Private Ambulance Service Ltd employs emergency response trained staff and has 29 emergency response vehicles, the service does not directly provide emergency response services. Private Ambulance Service Ltd provides staff and vehicles to support the fleet of NHS ambulance trusts as part of ongoing contracts and service level agreements (SLAs). The terms of the agreements mean that the staff work on the NHS rota alongside the NHS crews where needed.

The service is registered for transport services, triage and medical advice provided remotely.

There was no registered manager in post. The service had not had a CQC registered manager in post for more than six months. One had been appointed at the time of our inspection but they had not commenced employment at the time of our inspection.

Summary of findings

Overall we have not rated patient transport services at Private Ambulance Service Ltd because we are not committed to rating independent providers of ambulance service at the time of this inspection.

We found that:

- There was clear evidence of effective learning from the feedback we had given the service relating to the issues around medicines management, recruitment, governance, equipment and infection control. When we returned for our unannounced inspection we found actions had been taken to ensure these issues did not reoccur.
- Staff used information provided by the booking system to help them plan patient journeys effectively. For instance they had access to information about patient phobias, preferences of staff, nutritional needs and beliefs.
- The service coordinated well with the local NHS ambulance provider to meet patients' needs. The service was active across the independent ambulance sector and had close links with other local providers to help them understand growth and demand.
- The patients we spoke with gave consistently positive feedback on the care from and interactions with staff.
- Staff were responsive to specific patient needs. For example staff told us about how they worked to maintain the dignity of a house-bound bariatric

Patient transport services (PTS)

patient in a difficult living situation by parking the vehicle close to the door and covering the vehicle entry whilst the patient was transferred to the vehicle.
- Staff were positive about the support from and visibility of the managing director and enjoyed working for the service.
- Governance systems were not effective and did not link well throughout the service. However, we were assured that the provider's plan for governance would be taken forward and improved.

However we found that there were areas where the provider could make improvements:

- Staff did not always receive adequate rest time between shifts, which meant they were at greater potential risk of becoming fatigued.
- The service had not had a CQC registered manager in post for more than six months.
- There were no processes for risk assessing the vehicles for the transport of mental health patients, despite patients with mental health concerns being transported.

Are patient transport services safe?

We did not rate the service for safety because we were not rating independent ambulance service providers at the time of the inspection:

We found that:

- Mandatory training rates were good and staff were automatically booked onto refresher training courses when they were due for renewal.
- Staffing levels were sufficient to meet patient needs.
- Staff were confident in assessing and managing specific patient risks and processes were in place for the management of deteriorating patients.
- The concerns regarding infection control, equipment and medicines had all been resolved when we conducted a subsequent unannounced inspection.
- Safeguarding adult and children training to level two was completed to a high rate of over 99%.
- The vehicles were maintained to a good standard.

However we also found areas where improvements could be made:

- Staff did not always receive adequate rest time between shifts in line with government guidance recommending a minimum of 11 hours between shifts. This meant staff were at greater potential risk of becoming fatigued and making mistakes.
- There were no processes for risk assessing the vehicles for the transport of mental health patients, despite patients with mental health concerns being transported.
- No staff had been trained at safeguarding children level three, which would be required for those staff transporting and treating children.
- No exit interviews or formal debriefs were being conducted with staff leaving the service, which could have helped the service improve awareness of the reasons for staff turnover.
- There was no clear business continuity plan or risk assessment to manage demand in situations such as extreme weather.

Incidents

- Between February and July 2016 there had been 55 incidents including three which had been graded as having a significant impact.

Patient transport services (PTS)

- At the time of our inspection, the service was recording combined incidents and complaints data using an IT-based system. The service was considering ways of separating the recording of complaints and incidents into two systems to ensure that data could be analysed effectively.
- We spoke with four members of staff who all told us they knew how to report incidents by filling in an incident form which were kept in the general corridor area in sealed black boxes and escalating it to their manager.
- There was limited learning from incidents and staff reported they did not receive feedback from incidents. However, during our unannounced inspection we observed a new process for sharing learning from incidents with staff, and staff were aware of this.
- The managing director told us that messages were communicated through the online staff forum and two staff members confirmed that they used this.
- The managing director told us it was difficult to encourage staff to consistently report 'near misses' and was considering ways of improving this in order to prevent avoidable incidents in the future. Two members of staff we spoke with confirmed there was an under-reporting of 'near misses'.

Mandatory training

- The training lead and education and development manager told us that training completion rates should essentially be at 100% or very close to it at any given time. This was because all training was covered during induction and staff were booked into refresher sessions as soon as they were due renewal on specific training modules.
- We were provided with data following our inspection which showed high compliance with mandatory training targets. For example, mandatory training in fire safety level one was up-to-date for 96.8% of staff and this was the lowest rate of all the modules. Also, during our inspection we saw lists of staff names with the dates on which they would be due refresher training.
- All vehicle drivers were required to undertake a driver review on an annual basis to ensure that they were suitable to drive vehicles.

Safeguarding

- A dedicated safeguarding lead for both adults and children had recently been appointed and staff we spoke with were aware they could contact them if they were concerned about safeguarding risks, for example at a patient's home.
- We asked three members of staff what they would do if they were concerned about a potential safeguarding risk. All three told us that if they became concerned about potential risks, for example when visiting a patient's home, they knew to call the single point of contact to escalate the concern or receive guidance.
- During our unannounced inspection the managing director shared with us a safeguarding concern that had been raised by staff in respect of a patient. This was raised and escalated internally appropriately by the team and in the best interest of the patient.
- Safeguarding adult level two training rates were at 99.2%.The safeguarding lead had completed East of England Ambulance Service Trust (EEAST) accredited safeguarding level two training and the service was planning to roll this out to all staff. We reviewed this training course and found it to be comprehensive in explaining what staff should do in the event of a safeguarding concern.
- Safeguarding training was not clearly identified in levels. There was no data for the service on safeguarding children specifically as the data provided was for combined training at level 2 which showed that 99.2% of staff had been trained.
- No staff had been trained at safeguarding children level three, which would be required for those staff transporting and treating children.

Cleanliness, infection control and hygiene

- There were cleanliness concerns for the vehicles during our announced inspection. We checked five ambulances including three frontline vehicles, one patient transport vehicle and one secure patient transport vehicle and found issues with cleanliness and infection control in all five. However, during our unannounced inspection we found that all vehicles inspected were cleaned thoroughly and all cleaning procedures had been changed, updated and were now being monitored.

Patient transport services (PTS)

- In one vehicle we found a bag containing antiseptic solution for blood spills, which appeared to have bodily fluid stains on it. Other equipment in the vehicle, including the strap on a trolley and a suction catheter, also appeared to be stained.
- There was also a dirty sheet in the vehicle's clean linen cupboard and the 'Airflow' machine cushion appeared to have bodily fluid on which we were able to wipe away. A manager confirmed that this vehicle had been used the previous day and that it should have been cleaned at the end of the shift. This was not in accordance with the service's own policy which specified "it is essential that all blood and body fluid spillages are cleaned and disinfected as soon as is practicable".
- In the secure transport vehicle there were significant blood stains on the glass in the secure area where a patient would sit. The managing director told us this vehicle had not been used for "some time" but acknowledged this was unacceptable.
- In three of the vehicles we found holes in the trolley mattresses. This meant they could not be properly cleaned. This was a recognised fault with the mattresses; the company that manufactured them were contacted and were providing replacement mattresses for all vehicles affected.
- The lid of a bin in one vehicle was visibly unclean with an unknown substance on it.
- On two vehicles there was no alcohol hand gel in the dispensers.
- In one of the frontline vehicles we checked, there was a used clinical waste bag tied to the hand rail which was from the last patient who had been transported. Crew members told us the last patient on the vehicle had diarrhoea and that a deep clean should have been done but only the trolley had been cleaned. Three members of staff confirmed this vehicle was in service at the time we checked it. We raised our concerns about this vehicle to the managing director, who confirmed it was policy for ambulances to be deep cleaned after transporting a patient with diarrhoea and acknowledged the lack of thorough infection control was unacceptable and stopped the vehicle from going back out on the road.
- However, on the subsequent unannounced inspection we checked five frontline ambulances and two patient transport vehicles and found that the concerns regarding hygiene and infection control had been resolved in all of them. All ambulances inspected were visibly clean on the outside, and exceptionally clean on the inside. We could see all ambulances in the station were clean visibly from the outside.
- The processes for cleaning the ambulances had been completely overhauled. The managing director had appointed two compliance officers to oversee the cleaning and maintenance of the vehicles. We spoke with one of these officers during our inspection who took us through the changed processes. They were positive about their new roles and the impact this was having.
- Staff were now being performance managed as a result of the first inspection and any concerns were being escalated to the managing director. We were satisfied that robust systems had been introduced to ensure that these issues will not reoccur.

Environment and equipment

- We found out of date equipment in three of the five vehicles we checked during the announced inspection. This included oxygen piping, an oxygen supply and a blood pressure cuff. Other equipment including ambu bags (used for resuscitation) and masks did not have expiry dates so we could not be assured they were in date.
- In three vehicles, we found the lids of sharps bins were open and one was filled over the safe limit.
- One of two oxygen cylinders in a vehicle was below the fill level and on another vehicle we found the oxygen cylinder was not stored securely.
- A member of staff told us that one of the vehicles we checked had just been taken off the road because the crew had reported a technical fault; however there was no sign to alert staff to the fact the vehicle should not be used.
- In the store room we found two paramedic bags containing out-of-date equipment including a carbon dioxide detector and cannula. One of these bags also included incomplete intubation equipment with only one available size of laryngoscope blade and no batteries for the laryngoscope handle. This meant a clinician would be unable to view the anatomy of a patient's airway to safely place an endotracheal tube. The store room manager told us that the paramedic bags containing this equipment were not in use however they appeared stocked and accessible and

there was nothing to clearly indicate they should not be used, meaning an increased likelihood of a staff member picking up the bags and potentially using out-of-date equipment.

- We spoke to a member of staff working in the store room who confirmed there was no formal system to ensure that equipment coming into the store room for repair or maintenance was free from contaminants such as bodily fluids.
- During our unannounced inspection we found that all procedures for the updating of equipment in the store room had been updated and implemented. We looked at a range of equipment that was identified as a concern on the first inspection and found no concerns.
- An emergency care assistant (ECA) told us the blood glucose monitoring machines on all vehicles had not yet been calibrated as this would be done annually and the machines were five months old.
- During our unannounced inspection we found that there was now a process for the calibration of blood glucose machines, two we checked worked appropriately. Whilst there was no record of these checks, which were to take place monthly, we were informed one would be put in place.
- All vehicles were fitted with a bariatric stretcher as bariatric patient transport formed a significant proportion of the service's work. There were also specialist bariatric ambulances with bariatric stair climbers. The service routinely provided back up for NHS ambulance crews transporting bariatric patients as they had access to more specialist equipment to preserve patient dignity.

Medicines

- We discussed medicines management with the medicines lead, managing director and five other members of staff and found a lack of safe and robust medicines management processes during the announced inspection. However all processes for the management and storage of medicines had significantly improved when we undertook our unannounced inspection.
- The only medicines stored on vehicles and on the premises were technicians' medicines as there was only one paramedic employed by the service, who would take their own kit, for which they were solely responsible, if they were doing a paramedic shift under the service level agreement with the East of England Ambulance Service NHS Trust.
- The service held an account with the local pharmacy for the supply and disposal of medicines.
- One member of staff was responsible for the regular checking of medicines and stocking up red medicine boxes for frontline ambulances. We checked two of these boxes, which were locked securely. However, in one box we found paracetamol that went out of date in 2005. We informed the medicines lead immediately, who disposed of it. These boxes were supposed to be checked daily so it was clear that thorough checks were not being undertaken.
- During our unannounced inspection, the service had adapted their processes for the checking of medicines, all out of date medicines had been replaced and there was now a monitoring and auditing process for medicines in place to minimise the risk of further concerns developing.
- We also found that medicines, including ibuprofen solution, paracetamol tablets and aspirin, were missing from the boxes we checked when compared to the checklist of what should be included. The checklist did not indicate the exact amount of each medicine that should be included and in each box there were varying amounts of medicines. The medicines lead acknowledged this was an error and would address this. During the unannounced inspection, we checked two medicines boxes and all medicines were accounted for.
- A member of staff who worked in the storeroom was on site at all times and had access to the red medicine boxes and distributed to ambulance technicians as required.
- The service medicines lead audited stock drugs at least once monthly. We looked at local audit records for the period between 20 June 2016 and 1 August 2016, which showed that no medicines were missing. Whilst red boxes were not audited at the time of our announced inspection, a process for auditing them was in place by the time our unannounced inspection took place.
- The service medicines lead was responsible for overseeing medicines management, ordering medicines, checking medicines in stock and making up the red boxes. We asked what happened when they were on annual leave or off sick. They said that they never went on leave for longer than a week so this had

never been considered, and that if they were not on site for a week they would call one of the emergency care support workers who would restock and make up red boxes as required. We spoke with the relevant emergency care support worker who confirmed they did this, however more robust cover arrangements were required and this was agreed with the managing director.
- We checked the safe containing spare technician medicines and found they were all in date. Only the clinical lead and the managing director had access to the keys to this safe.

Records

- Frontline crews carried NHS patient report forms which would be completed and handed over at the patient's destination.
- On collection of a patient the ambulance crew would be provided with a bag containing the patient's records of care. The records of care would be transported with the patient and handed over to the service on arrival. The service ensured that this was handed over to a recognised person in the service.
- On long transport journeys the service maintained their own records of care and needs to be met for the patient. This included rest stop breaks, food required, personal needs and medicines needs.

Assessing and responding to patient risk

- Staff were confident in knowing what to do in the event of specific patient risks. For example, an ambulance controller we spoke with gave a recent example of a patient with severe depression and anxiety who they did not feel could be left alone so the crew members called for extra assistance and waited with the patient to ensure there was always someone with them.
- Staff told us that, as there was not usually a paramedic present for the patient journeys the service carried out, they would call 999 in the event of a patient's condition significantly deteriorating. This was the service policy.
- If a patient's condition had started to deteriorate they would divert their transport and take the patient to the nearest hospital. The crew would notify the hospital of their impending arrival by phone and also their operations centre about the change to the journey.
- Of all staff employed to work on patient services 99.2% had received basic life support (BLS) training.

Staffing

- We were concerned that staff were not receiving adequate rest time between shifts. Two emergency care assistants told us that on a '12pm shift' they would have to start at 10am to allow for one hour to complete checks on the vehicle and equipment and another hour to make their way to the Bedfordshire/Hertfordshire control area to provide emergency cover. They told us shifts routinely overran owing to the nature of ambulance work and they were required to clean the vehicle after their shift ended, which took about 30 minutes.
- The service worked with contracted partners to flex the start times of the shifts the following day to meet the demand of the service needs. However there was the potential for staff to not adhere to the minimum rest requirements recommended by the government between shifts, which is 11 hours.
- We spoke with the managing director about these concerns who spoke with one of the operations managers about the rest times between shifts. The numbers provided did not match the service procedure. The service procedure would also not allow for sufficient rest between shifts. The managing director informed us that they would commence a review into this.
- During our unannounced inspection we were informed that a meeting had been held and a consultation on staff working hours was being drafted to be rolled out for feedback. There would then be a process followed to change the shift rota pattern to increase rest times. However due to the nature of human resource changes and consultation, this process would take time.
- The service employed 10 ambulance controllers who were responsible for the day and night function of controlling personnel and vehicles to ensure demand and key performance indicators (KPIs) were met. They liaised with patients and hospitals when concerns arose in relation to patient transfer. We observed staff in the control room. Controllers were split into London contracts and 'ad hoc' services and during our observations staffing levels were sufficient to manage services, which staff confirmed.
- Data provided by the service showed they employed 70 emergency care assistants (ECAs) who conducted East of England Ambulance Service NHS Trust frontline duties within their scope of practice and any other

duties in support of company requirements. A further 180 ambulance care assistants (ACAs) were responsible for carrying out patient transfers within their scope of practice and any other duties in accordance with company requirements.

- The service regularly reviewed staffing levels to ensure they were meeting patient needs and told us that one of their major challenges was employing sufficient numbers of suitably qualified people at the exact time they are required. To address this, the managing director said the service would over-recruit if high grade personnel had applied for vacancies.
- Between June 2015 and June 2016, the service had a staff turnover rate of 15% which the managing director acknowledged was high. The service leads thought this was mainly due to staff starting in a role to work out whether they were suited to it and deciding they were not. However, there was no evidence that exit interviews or formal debriefs were being conducted with staff leaving the service to confirm this, which could have helped the service improve awareness of the reasons for staff turnover.
- There were four specialist mental health staff to carry out mental health transfers within the training standards. Mental health staff were the only members of frontline staff trained in restraint and mental health training was delivered by the managing director.
- The service did not use agency staff but utilised an internal bank of staff who worked additional shifts on overtime or flexibly where required.

Anticipated resource and capacity risks

- The service carried out a significant amount of 'ad hoc' work so would assess resource requirements and capacity on an individual basis when requested.
- The service undertook monthly reviews on their performance, capacity and demand requirements within the service. The managing director was fully aware of where the challenges were for delivery within the service. This included two specific contracts where they were aware delivery would not be achievable. As a result of their reviews the service had initiated contract processes to withdraw their service provision.
- Examples were provided to us where on two occasions staff sickness had impacted upon the delivery of a contract. The provider was able to speak with the contract owners and alternative arrangements were made by that provider to meet the patient need. This demonstrated that the processes of monitoring capacity and risks were thorough.

Response to major incidents

- There was no specific major incident policy for the service, which would not necessarily be required for a service of this type.
- In the store room there were two major incident bags that we saw to be full and ready for use. These would be provided to staff who would support front line services in the event of a major event.
- The education and development manager told us the service did not conduct major incident rehearsals, but staff who supported front line NHS crews received training through the NHS ambulance services.
- We asked what would happen in the event of unexpected severe weather conditions, for example, and there was no clear business continuity plan or risk assessment to manage demand in such situations, although the managing director told us there had never been a time when services were unable to run for these reasons.
- The managing director told us about when the service was affected by a power cut. The service responded by cutting down services to the operational hub to prevent any further delays in fixing the problem and the managing director told us that because services were largely 'ad hoc', they had flexibility to make alternative arrangements with different care providers under the individual service level agreements.

Are patient transport services effective?

We did not rate the service for its effectiveness because we were not rating independent ambulance service providers at the time of the inspection:

We found:

- Staff were able to plan appropriately for patient journeys using the information provided by the IT-based booking system.
- Staff were competent in carrying out their responsibilities and felt they received appropriate training and support for this.

- The service coordinated well with the local NHS ambulance provider to meet patients' needs.
- The service was active across the independent ambulance sector and had close links with other local providers to help them understand growth and demand.
- Staff could access the information they needed to meet specific patient needs such as nutritional, behavioural or physical needs.

However we also found areas where improvements could be made:

- Coordination under service line agreements with hospital trusts was not always clear and effective.
- The service was not meeting all key performance indicators (KPIs) for patient journeys under its contractual arrangements with London NHS trusts, though the trusts had not formally raised contract queries on performance.
- There was no specific mental capacity awareness training.

Evidence-based care and treatment

- People had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice. Eligibility for patient transport reflected Department of Health guidelines and was monitored by the control centre staff at point of booking. The service used clear criteria for the assessment at booking.
- There was no formal environmental risk assessment for the secure transport vehicles for patients who may have mental health problems. This is recommended in accordance with evidence based best practice from the National Institute for Health and Care Excellence (NICE), quality standard QS34 published in June 2013 specifically Quality statement 5: Safe physical environments.
- The service undertook a limited number of local audits. Local audits included vehicle cleanliness and hand hygiene.
- There was guidance in place in relation to oxygen administration, with managers advising us that it would have been taught during each member of staff's first person on scene (FPOS) course.
- There was no medical gas policy in place at the time of our inspection, however one had been written and implemented by the time of our unannounced inspection.

Assessment and planning of care

- Three staff members told us the booking system provided them with sufficient information to plan for their patients accordingly, although occasionally hospitals did not give them accurate information meaning a booking would be delayed or cancelled, for example if the service had not been informed there would need to be space for an escort. However, responsibility for this would lie with the hospital or service who had filled in the details for the booking. The managing director confirmed this. We saw examples of bookings on the booking system and were satisfied they provided adequate information for staff to make appropriate arrangements.
- The service had secure vehicles for transporting patients detained under section 136 of the Mental Health Act. Staff who used these vehicles were trained in mental health awareness with 99.2% of all staff receiving up to date training.
- Staff transporting patients in a secure vehicle carried handcuffs and wore knife-proof vests to protect themselves. We were told that the number of staff used for these journeys would depend on the risk assessment for the particular patient, for example some patients would require a driver and two nurse escorts, and others would require a six-person crew to mitigate the risk of harm. The service provided 24-hour seven days per week cover for secure transport.
- Staff were made aware of any patient mental health problems through the booking system in advance of accepting a booking so they could plan accordingly. Bookings for patients with mental health problems were separate from other bookings to ensure that only mental health-trained staff responded to these bookings.

Nutrition and hydration

- Staff carried bottles of water in the vehicles in case of delays with the journey to ensure patients could stay hydrated.
- Specific nutrition and hydration needs were communicated via the booking system.
- Where a patient needed to stop or wanted to stop for food or hydration on long journeys this would be arranged by the crews.
- We asked patients if they could access fluid or food on the transport during long journeys. Most patients took a

drink or a light packed lunch with them on the transport, especially if they knew they were going a long way. One patient described this as a "pack out". One patient said, "We don't expect anything on the transport, that's not their job, but I am sure if we needed anything they would get it for us."

Patient outcomes

- The local audit outcomes were not escalated to a higher level, shared with staff or reported on at any staff meeting. For example we shared the cleanliness of vehicles audit with the managing director who was not aware that the audit results were poor.
- We reviewed a key performance indicator (KPI) report from June 2016. In June the service undertook 7,337 patient journeys. There were a further 1,984 escort journeys. There were 308 aborted journeys and 2,639 cancelled journeys.
- The service followed KPIs to monitor patient outcomes which were set by the individual providers with whom they had contracts. The managing director told us the service had difficulty meeting the KPIs set by one NHS trust largely because with London traffic the KPIs for transport and response times were unrealistic. The managing director told us they were currently reviewing the contractual arrangements because of these difficulties.
- The service was still in the developmental stages of its KPI arrangements within the London North West area. The trust set a KPI for 90% of patients to arrive between 45 minutes and 10 minutes prior to their appointment times. Private Ambulance Services ltd (PAS) achieved 72.1% against this KPI, which was worse than the trust target.
- The NHS trust set a KPI of 90% of patients to have departed the trust within 60 minutes of booking; the service achieved 80.5%, which was worse than the trust target though the NHS trust had not reported concerns about performance on the contract. The trust also set a KPI of 90% of patients within local zones to spend 60 minutes or less on the vehicle from the pick-up time to the time of delivery; PAS achieved 82% against the KPI, which was worse than the trust target. The locality director for London sent a weekly report on outcomes to the managing director.

Competent staff

- We asked four members of staff about induction and all four said it had prepared them well for the job. One ambulance controller told us that they covered hypothetical call-handling scenarios which they said "helped a lot in knowing how to deal with patients". Another said that while staff "could always do with more training", they felt they had all the necessary support and training to carry out their role.
- The education and development manager told us, and training records confirmed, that the service did not provide specific training on bariatric patients, but staff said they were confident in calling for support, for example when additional crew members were required.
- Appraisals were done on an annual basis and one of the emergency care assistants we spoke with confirmed these were regular and helpful in supporting them. However this member of staff voiced frustrations that there career progression to become a paramedic was very limited within the service. There was only one paramedic employed by the service.
- Progression opportunities were available upon request of staff. However, there were some delays due to the changing guidelines around independent ambulance services. One member of staff voiced their frustrations to us regarding a lack of progression to paramedic training. The managing director said this was available and would be based on the individual and other performance with the service. The service were also planning training on response driver training, as well as further educational qualifications once the outcome of regulation changes were known.

Coordination with other providers

- The majority of the service's work was in London under contracts with three NHS hospital trusts. However the service was unable to provide exact proportions of its work due to the varying nature of its 'ad hoc' work. The service also provided patient transport services to two NHS ambulance trusts, and two NHS mental health trusts (for ad hoc mental health services).
- The service had monthly review meetings, to assess KPIs, and quarterly patient user group meetings with one NHS Trust.
- Under the London North West contract the service conducted weekly and monthly meetings to review all aspects of the contract.
- Under the ambulance frontline contract, the service sent patient report forms to Basildon Ambulance

Station weekly. The ambulance trusts conducted audits on these, and we were told that any issues were escalated to the operations manager for review. The service liaised with a dedicated point of contact at the ambulance trusts who was responsible for liaison and inspection of all private companies that support frontline services.

- The managing director told us, and staff confirmed, that coordination was good with the ambulance services but more variable with hospitals.
- The service and the managing director was active across the independent ambulance sector and had close links with other local providers to help them understand growth and demand.

Access to information

- Staff accessed the information needed for specific patient journeys via the booking system and reported that this worked well. Staff were reliant on other providers inputting all the relevant information.
- A member of staff told us that if something had not been communicated via the booking system and they did not feel they were competent to carry out a journey because of something that became apparent on arrival, they would not carry it out without further guidance or back up (for example if it appeared a patient had a mental health problem which had not been communicated).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In the event that a patient required a mental capacity assessment while under the care of the service, staff would call for paramedics from the NHS ambulance trust as emergency care assistants were not qualified to make mental capacity assessments under the Mental Capacity Act (2005). However, the need for this was rare owing to the type of service staff were carrying out.
- Mental Capacity Act was not included as part of mandatory training or staff induction because staff would not be expected to carry out these assessments on patients. Whilst it was briefly raised as part of safeguarding training there was no specific mental capacity awareness training. It would have been valuable for the service to include it as they regularly transported patients with mental health problems.

Are patient transport services caring?

We have not rated the patient transport service for caring because we were not rating independent ambulance service providers at the time of the inspection:

We found:

- We spoke with six patients and one relative. All patients told us that staff were kind and caring.
- All patients and the relative said they were a reliable service that always came on time, so they were not left waiting for long periods.
- Emotional support for patients and families were provided to a good standard, especially for patients at the end of their life.
- Staff respected the needs of patients, promoted their wellbeing and respected their individual needs.
- Patient dignity, independence and privacy were well respected by staff in the service.

Compassionate care

- We spoke with six patients and one relative of a patient, who used the service. All said that the staff were kind, caring and that they felt safe in their care.
- One patient told us they used a wheelchair and had poor eyesight. They told us the driver always came to the house and let them know the service had arrived. The patient said, “I know it’s them, as they come at the same time, and I know their names.” We were also told, “They always make sure I am strapped in and safe before they take me anywhere.”
- A patient told us they were having chemotherapy and had to travel for a long time, “The staff know I may be ill, it’s not easy being in an ambulance for three or four hours at a time”. “They do their best to make me comfy, and they are really nice to me.”
- One patient told us that the transport driver always helped them to walk to the vehicle, “Sometimes I am sat down for a long time, or use a wheel chair, but the driver helps me to walk, it’s only a bit, but its lovely to stretch my legs and means a lot to me.”
- Staff gave an example of a bariatric patient who they were transporting in order for them to go on holiday. The patient was house bound and mobility severely limited. The patient was concerned as local people had looked in their windows and mocked them due to their

physical condition and they wanted to ensure no one saw them leaving their home. The staff managed to get the transport close to the patient's home, and cover the vehicle entry with blankets whilst the patient transferred to the vehicle in order to protect the patient's dignity.
- Staff often took the same patients to familiar journeys, which enabled them to get to know the patient and family members or carers well. This enabled staff to meet the patient's individual needs, for example by using a male or female driver or escort, as they knew about routines or patterns of behaviour that may need require specific support.
- Two of the patients we spoke with told us that the staff got along with the patients, encouraged people to talk and look out for each other during the journey.

Understanding and involvement of patients and those close to them

- All patients and the relative said they were a reliable service that always came on time, so they were not left waiting for long periods. One patient said, "If they are going to be late they let you know, they always check I am alright and if I need anything while I am waiting, they are really nice."
- Staff kept patients and their families informed as part of the eligibility process. If the patient did not meet the eligibility criteria, alternative arrangements were then considered and guidance provided to the patient on why they had not met the eligibility. Patients were fully consulted through their booking process on their eligibility either by the NHS trust or by Private Ambulance Service Ltd directly.

Emotional support

- In the event that the service would transport a patient who was nearing or at the end of their life, the hospital the patient was being treated by would inform the team that the patient was for end of life care.
- We spoke with three members of staff in the service about what they would do in the event they were informed that a patient was for end of life care. They all responded with answers that considered the emotional wellbeing of the patient and the family. The staff would ensure that all aspects of the journey would be communicated with the patient and the family and would ensure that the dignity of the patient was maintained at all times.
- The staff we spoke with provided us with an example of a patient transport to a hospice. The family were distressed by the events and they worked to reassure the family and the patient that they would help and get them to their destination as soon as possible, to meet their needs.
- In the rare event of a patient death during the journey, the ambulance team would drive the patient to the nearest hospital to be seen and confirmed as deceased by a doctor. The crew would notify the control room who would try to contact the family to request they go to the hospital. The staff we spoke with could only recall one occasion where this had happened, because end of life care was often planned and organised in advance and families were very aware of the possibility during transport.

Supporting people to manage their own health

- Staff told us they felt it was important to empower those who used the service and support them with independence.
- Patients were encouraged wherever possible to use their own mobility aids when entering or leaving the vehicle.
- Staff asked each patient whether they required assistance with walking, sitting and standing at the beginning and end of each journey.
- Staff provided us with examples of when they had liaised with local general practitioner (GP) services, the police and fire services to ensure patients were transferred safely between services, for example bariatric patients, or patients with mental health needs.

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

We have not rated the patient transport service for responsive because we were not rating independent ambulance service providers at the time of the inspection:

We found:

- The service was planned to meet the needs of its contractual arrangements with health service providers. The service utilised its vehicles and resources effectively to meet patients' needs.

- Staff were able to plan appropriately for patient journeys using the information provided through the booking system.
- Staff had access to communication specialist equipment, pictorial guides, and language services to meet patients' individual needs.
- Ambulance crew staff had training to support people with dementia or mental health problems to meet their individual needs.
- Staff and patients were aware of and knew how to access the service's complaints and compliments system.

Service planning and delivery to meet the needs of local people

- The service delivery was based on a set of predetermined contracts with a number of health service providers who require patient transport services and purchase these directly from Private Ambulance Service Ltd. Business growth and diversity of the service was therefore managed successfully by attracting new contracts or extending existing services to increase its business revenue.
- The service had two core elements, core patient transport services, and 'ad hoc' services to meet the needs of local contracts. The 'ad hoc' services allowed the service the flexibility to expand or retract this element of it service based on local contract demands.
- The managing director of Private Ambulance Service Ltd actively liaised with locality directors and directors of operations for services across London, Cambridge and Essex. They were also active on independent ambulance service forums to engage with the contract market place and establish how its competitors were performing whilst seeking to establish new or extend service contracts.

Meeting people's individual needs

- Fleet vehicles were all designed to meet the needs of bariatric patients and had been specifically adapted to provide additional space. There was dedicated equipment; for example, bariatric patient trolleys and winch systems to enable safe access to transport.
- The service worked under contracts with external services, the majority of patient needs were registered at the time of transportation being booked by a hospital or other provider. The control room staff were therefore made aware of any specific patient needs at the time of the booking being made.
- We saw examples where transport was allocated based on specific needs, for example, transport had been booked by a hospital for a patient to attend a local hospital appointment without notifying staff that the patient's escort was bariatric. The service liaised with the local hospital to make changes to the transport services required, to ensure the patient and escort were safely transported to the hospital.
- We spoke with three staff who told us that training provided to them covered meeting the needs of individuals. Staff gave examples of how they were trained to provide services to patients living with dementia, by offering more time and ensuring that escorts were in place where possible.
- One staff member told us that special needs and learning disabilities were covered at induction and that they could request further advice or training via continual professional development days.
- Transport crews had access to a simple pictorial communication guide, which gave a range of symbols and signs used to communicate with people who may be cognitively impaired, lack speech or may have English as a second language.
- Staff could access a language line via a local NHS ambulance service to support patients whose first language was not English.
- Staff supporting patients with specific mental health conditions were offered training in physical intervention and restraint techniques, including where necessary the use of hand restraints. At the time of inspection, three ambulance care assistants and two emergency care assistants were trained to support patients with these specific techniques, which we were assured met the needs of the service.

Access and flow

- Patients' eligibility for the service was assessed at the point of booking through the internal system. The eligibility criteria was based on a range of circumstances including the medical need for transport, patient's physical needs, specialist equipment required, whether an escort was needed and any other patient needs.
- The service delivery was based on a set of predetermined contracts with a number of health

service providers who required patient transport services and purchased these directly from Private Ambulance Service Ltd. Bookings were therefore made directly by a hospital in 'real time' via the electronic booking system. The control room staff then allocated vehicles based on need. The two control room staff we spoke with told us the systems worked well and enabled them to manage flow through the service.

- Portable hand held devices carried by staff provided them with accurate journey information including name, pick up point, destination, mobility requirements and any specific notes based on individual needs.
- Vehicles were tracked in 'real time' to enable control room staff to deploy vehicles to the correct location, on time and redeploy any vehicles or staff that can be used for alternative journeys, if a journey was aborted or cancelled.

Learning from complaints and concerns

- We spoke with six staff during our inspection; all of them knew about the complaints and compliments system in place.
- Staff knew that feedback forms were available in the ambulance station and on vehicles used to record a complaint or to gain positive feedback in relation to the services provided.
- Responses from staff were mixed in relation to feedback on complaints or compliments. One staff member told us that they only got feedback from complaints if it was generally in relation to their performance; others told us they got feedback via newsletters and managers in relation to complaints. Feedback was also shared via the online staff portal, which we were shown. Staff confirmed they used this regularly to receive updates.
- Signs in the vehicles we inspected displayed information on how to provide feedback including how to raise a complaint or provide a compliment.
- The ambulance station had a wall of fame dedicated to positive feedback from patients and family members; this contained positive feedback in letters, thank you cards and local press newspaper cuttings. There were no displays showing staff how the business was performing in relation to complaints or concerns.

Are patient transport services well-led?

We have not rated how well the service was led because we were not rating independent ambulance service providers at the time of the inspection:

We found:

- There was clear evidence of effective learning from the feedback we had given the service relating to the issues around medicines management, recruitment, governance, equipment and infection control. When we returned for our unannounced inspection we found actions had been taken to ensure these issues did not reoccur.
- There was unanimously positive feedback from staff regarding the support and availability of the managing director.
- The culture amongst the staff we spoke with was good, and they liked working for the service.
- There was a positive strategy for the service over the next two years, though this was not formally documented.
- There were positive processes in place for staff and public engagement. The service was seeking feedback to improve the quality of services wherever possible.
- The managing director was a strong leader, who was passionate and dedicated to their business which was positive.

However we also found areas where improvements could be made:

- Governance systems were not effective and did not link well throughout the service.
- The service had not had a CQC registered manager in post for more than six months.

Vision and strategy for this service

- The managing director spoke of the vision and strategy for the service for the coming two years. Whilst this was not written down they were clear about what they wanted to achieve and that this had been communicated to staff using the staff forum page.
- The strategy for the service was to stabilise the service and sustain the work they currently had. The service has

expanded significantly during the last 18 months, showing a 312% increase in revenue. The strategy was to stabilise and sustain the business and develop and improve the staff and quality of service provided.

- There were no plans for service expansion at the time of the inspection because the service had achieved all targets set out in their business plan from when the company started four years ago. The focus was now to be able to consistently achieve and deliver an outstanding service.
- The service routinely monitored the key performance indicators (KPIs) for delivering an effective patient transport service, with each indicator reviewed by the managing director on a weekly basis. The managing director was clearly very knowledgeable about all the metrics and KPIs within their service.

Governance, risk management and quality measurement

- There was a limited governance system within the service. The managing director had identified that governance of the service was their top risk at the time of our inspection and had a plan in place to address the issues.
- An audit was commissioned in May 2016 on the governance system which identified many areas for improvement including, incidents, complaints, risk assessments, policies, board meetings and the risk registers all needing to work together effectively to identify and manage risk in a timely way.
- We reviewed the risk register for the service which identified 18 risks in the service, all related to the governance processes such as policies, procedures and audits in the service.
- The risk register was new and only implemented as a working document in June 2016. The service was due to take it to the first board meeting for review by the board in August 2016. The service was planning to discuss the risk register as well as any other significant quality issues at each board meeting going forward.
- The policies and procedures for the service were well written, however they did not link well to each other identify where a policy should be read or implemented in conjunction with another policy or procedure. This was an identified risk on the risk register and was a task that would be completed by the new manager following their appointment.
- The policy on working hours for staff was not clear, and it was evident that there was confusion at all levels regarding how many rest hours a driver should have before going back out on the road. The managing director agreed that this was a problem and would review it as soon as possible to ensure working hours of staff were appropriate.
- The quality of meeting minutes at board level was poor. There was limited detail and information recorded on items discussed. The managing director had just appointed a full time executive administrator with experience of writing professional minutes. This person would ensure that the minutes from the August board meeting going forward were more detailed.
- Remote lone workers were risk assessed as being suitable to work alone. The work they were undertaking was assessed to ensure that the risk was as low as possible. There were GPS tracking systems on the vehicles, which would alert the control room if a person was stationary for too long. The staff would then contact the individual for a welfare check.
- The contracts that staff signed were very detailed and explained all the terms and conditions of employment with the service. This had been raised as a concern to us prior the inspection that employees were unaware of what was expected of them. However, we found that the staff had signed the contracts and all required information was clearly explained within them regarding terms of employment.
- The service did not have process in place for the fit and proper persons (FPPR) employed under regulation 19 or fit and proper persons (FPPR) for directors under regulation 5. We examined six staff records and four director files and found that the required FPPR checks were not in place and therefore these regulations were not being met.
- We were also concerned about the quality of some references being accepted by the service, and information the application form that did not support that they were the suitable candidate for the role.
- There were limited risk assessment processes in place, in accordance with FPPR in taking people on with criminal records. Whilst it was entirely acceptable to take people on to work in accordance with the Rehabilitation of Offenders Act we were concerned that the risk assessment around the roles people worked was limited.

- The process for internal recruitment in roles required improvement. Where a person was promoted internally there was little evidence of how this was processed in personnel records. This meant that we were not assured from the records how the person was the most suitable for the role.
- We raised all of these FPPR and HR issues this with the new HR lead and the managing director who assured us this would be immediately addressed. During our unannounced inspection we found that improvements had been made to the recruitment processes internally. There was also a policy and procedure for fit and proper persons employed and for directors. We were assured by the improvements made on recruitment.

Leadership of service

- At the time of the inspection the service did not have a registered manager with the CQC in post. The previous manager, who was not registered, had resigned. The managing director was seeking recruitment through a specialist recruitment agency to find a more suitable candidate for the role. Interviews were due to take place the week of the inspection. By the time of our unannounced inspection a registered manager had been appointed.
- The service was run by the managing director in the absence of a registered manager. The managing director was exceptionally knowledgeable about the service, knew all the staff by name, and was clearly passionate and dedicated to their business.
- Staff all knew who their managers were and felt that they were visible and accessible. There were dedicated managers on each shift who staff could speak with at all times. The senior management team were available and on call when required over the seven day period.
- The service had a clinical director, who was a registered paramedic. They worked with the service at least two days per week. Their roles and responsibility included the safe management of medicines. However we identified that there was no contingency in place should they be unavailable for a period of time. This placed the management of medicines at risk. The managing director informed us that they would resolve this issue as soon as possible.
- The managing director was supported by operations managers, other directors, and team leaders. Whilst we found some were dedicated to their roles there was a concern with regards to the team leaders and operations managers of the ambulance fleet. The ambulances were found to have cleanliness and infection control issues during our inspection. We reviewed audits completed by the managers from December 2015 to April 2016, which identified that cleanliness of the ambulances was a concern. However, the managers did not take any action on the results or escalated any concerns to the senior management team. This did not demonstrate good leadership from the management team.
- We raised our concerns about the condition and cleanliness of the ambulances to the managing director on the day of our inspection. The managing director provided us with assurances that these issues would be dealt with swiftly. We were assured by their response and allowed them time to resolve the issues identified during the inspection prior to our unannounced inspection.
- On our unannounced inspection we found that the concerns identified at the first inspection had begun to be resolved, the actions taken by the provider were positive and we were assured that these improvements were sustainable.

Culture within the service

- All staff we spoke with spoke very positively about the managing director and their open approach to management. All said they could speak to them and raise any concerns that they may have about the service. For example, one emergency care assistant told us that “management are really supportive and open. I enjoy coming to work”. Another told us about a recent traumatic incident they had witnessed and said that the managing director had spoken to them straight away to offer them direct support and counselling services, and gave them the following day off with full pay.
- There had only been one incident where duty of candour was required. This was a joint incident with an NHS ambulance trust. The service did not undertake duty of candour themselves as this was completed by the NHS service; however, the provider was aware that it had been undertaken.
- Staff had received communication on what duty of candour was through the staff forum. The provider was issuing information to staff on duty of candour prior to staff receiving formal training.

- There currently was no policy for duty of candour or staff had not been trained in duty of candour at the time of the inspection.
- The operations manager for each service monitored the contracts for their locality. The KPI performance of each locality was reported weekly to the managing director. Any concerns regarding KPIs and performance were to be escalated to the managing director as soon as possible.
- There was a notably poor culture around pride in keeping the ambulances clean by staff. There was also a poor culture from the management team who were checking the ambulances but did not address the issues of cleanliness prior to the vehicles going out on to the road. The managing director assured us that these issues would be dealt with immediately following our inspection and had called all managers to an urgent meeting as soon as we left the premises. When we returned we were pleased that significant improvements had been made to the cleanliness of the ambulances.

Public and staff engagement

- The service did not hold specific staff meetings due to shift patterns worked and staff availability. The service utilised a staff forum, which all staff could access from their systems, phones or personal digital assistants (PDAs). All staff had a log in for this system. The forum was updated weekly with messages on the business and messages from the management team. All staff we spoke with spoke about the forum page and got their updates though this.
- On the staff forum page there was an 'ask' page, which was where the staff could ask the managing director any question and they would answer it. We saw examples of where they had responded to staff questions and could see that this page was utilised well by staff. The most common question the managing director received was if they were going to sell the company. This was a rumour that had started out of a news article, which incorrectly said that the company was going bust. This was not the case and staff were reassured that this was an error and the company was not changing owners.
- The service had recently started an 'ambassador scheme' where members of staff were appointed by other staff to bring any issues raised by the staff body to board meetings. We spoke with one of these 'ambassadors' who told us they felt privileged to be engaged with the service in this way.
- The service sought feedback from patients in a variety of ways. They utilised comment cards, patient feedback forms, feedback through the website, and patient surveys. The service also took part in the NHS Friends and Family Test for the NHS PTS contracts they held in the London area. Data provided by the service supported that they sought feedback from patients through as many avenues as possible.
- The operational management team for the service attended the patient and public forums for the NHS trusts where they had NHS patient transport contracts. These were held monthly and the service regularly attended to seek feedback and engage with people who used their services. We reviewed two sets of minutes for these meetings, which supported what we were told.
- The service had listened to public feedback through engagement work and were in the process of implementing a new alert system for patients who were being collected for their journey. The feedback was that whilst they had a timeslot for their journey they wanted to know when their drivers were nearby. The service was introducing a GPS system, which would generate a text message to the patient, when the driver was nearby, to say that their driver would be there within them within 30 minutes. This system was in place, though had not been launched at the time of the inspection as the system used was still being adapted to support this new alert.

Innovation, improvement and sustainability

- The focus of the service over the next two years was to deliver a sustainable service that was stable prior to expanding. The service had many opportunities to expand further but chose not to go down this route, but to provide a higher quality service for the patients they currently conveyed. Once the service was stable the provider would then review their position in two years' time.
- The service provides routine contracts as well as an ad hoc service with an on call system. This enabled the service to deliver regular work but also provide additional services to support others when needed. For example, the service provided support and second

Patient transport services (PTS)

crews to NHS ambulance services when they needed support. This could be one vehicle or 25 vehicle support on a daily basis. The service was established to be able to flexibly support demand when required.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that incident reporting procedures to ensure staff report all incidents and 'near misses'; and implement systems for sharing learning and feedback with all staff following incidents and investigations to reduce the risk of incidents reoccurring.
- Ensure that governance processes and quality assurance measures and processes improve to provide effective oversight of all aspects of the service, in accordance with regulation 17.

Action the hospital SHOULD take to improve

- Improve the governance systems within the service.
- Ensure that staff always receive adequate rest time between shifts, to reduce the potential risk of becoming fatigued.
- Have a registered manager in post. The service had not had a CQC registered manager in post for more than six months; although one had been appointed at the time of their inspection, they had not yet commenced work and were therefore not registered with CQC.
- Implement robust processes for risk assessing the vehicles for the transport of mental health patients, as this forms a significant part of the work of the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 (1) and (2)(a) Reporting of incident and near misses required improvement. Sharing, learning and improving from incidents was not robust. Governance processes and quality assurance measures are not robust and were not providing effective oversight of all aspects of the service, in accordance with this regulation.