PTS-247 Limited

PTS-247 Limited

Quality Report

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

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

PTS-247 Ltd is operated by PTS-247 Ltd. It provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 30 January 2018.

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

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

Services we do not rate

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

We found the following areas of good practice:

- The majority of comment cards completed by service users which we reviewed gave positive feedback about the service and staff.
- Incidents were reported and investigated, with lessons learnt documented.
- We saw consistent documentation regarding the cleaning of vehicles.
- Vehicles were in good working order and well maintained.
- There was a low number of complaints compared to the number of journeys undertaken by the service.

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

- There was no policy or procedure relating to the duty of candour.
- No staff had received an appraisal within the last 12 months.
- The provider was in the process of putting staff through a care certificate qualification, which included multiple standards. However, in the interim period there was no clear way of having an overview of the percentage of staff that were up to date or had not completed their training.
- It was not clear from the certificates we saw what level of safeguarding training staff had attained. However, as the service did transport children, a minimum of safeguarding children level two was required.

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

Amanda Stanford

Deputy Chief Inspector of Hospitals (South).

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		The only core service provided was patient transport services. The service carried out approximately 3559 journeys each month, which equated to approximately 889 journeys a week. In the reporting period, April to December 2017, the service had carried out 35595 journeys.

PTS-247 Limited

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to PTS-247 Limited

PTS-247 Ltd is operated by PTS-247 Ltd. The service registered with the CQC in February 2017. It is an independent ambulance service in East Grinstead, Sussex. The service serves the communities of the Sussex area.

The service has had a registered manager in post since February 2017. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in February 2017.

Thirty-nine patient transport drivers worked at the service, with two administrative members of staff and one manager of the service, who was also the CQC registered manager.

The provider had a fleet of 40 vehicles that it used to carry out the regulated activity. These were all wheelchair adaptable vehicles that could each carry four passengers, or one passenger and one wheelchair.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a second CQC inspector and a specialist advisor with expertise in patient transport services.

The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

PTS-247 has one location, which is their head office in East Grinstead, Sussex. The main service is patient transport services. This service does not provide urgent and emergency transport services such as responding to 999 calls.

The service is registered to provide the following regulated activities:

- Transport services, triage, and medical advice provided remotely.

The service uses a total of 40 vehicles, all of which were wheelchair accessible.

During the inspection, we visited the headquarters in East Grinstead. We spoke with four members of staff including; a patient transport driver, two administrators and the registered manager. We also received 58 'tell us about your care' comment cards, which patients had completed up to, during and a week following our inspection.

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

Activity (April 2017 to December 2017)

- In the reporting period April 2017 to December 2017 there were 35,595 patient transport journeys undertaken.

Due to the previous service level agreement with the previous contractor, data was not submitted for the period January to March 2017.

Thirty-nine patient transport drivers worked at the service. Almost all journeys involved the transport of adult patients aged 18 and over. The NHS ambulance trust that subcontracted work to the provider held all patient data. Therefore, we were unable to obtain the exact numbers of children and young people the service had transported. However, the registered manager estimated that this amounted to approximately three journeys in the last 12 months.

Track record on safety

- The service reported no never events during the reporting period.
- The service reported 12 incidents.
- The service reported no serious injuries.
- The service had received and responded to 20 formal complaints.

PTS-247 delivered work which was sub-contracted from an NHS ambulance trust based in another region and this was the sole contract held by the provider. There was a previous contract in place that was being used as the basis for the service, but there was no formal contract with PTS-247.

Patient transport services (PTS)

Summary of findings

We found the following areas of good practice:

- The majority of comment cards completed by service users we reviewed gave positive feedback about the service and staff.
- Incidents were reported and investigated, with lessons learnt documented.
- We saw consistent documentation regarding the cleaning of vehicles.
- Vehicles were in good working order and well maintained.
- There were a low number of complaints compared to the number of journeys undertaken by the service.

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

- Only 50% of staff had received an appraisal within the last 12 months.
- The provider was in the process of putting staff through a care certificate qualification, which encompassed multiple standards. In the interim period there was no clear overview of the percentage of staff that were up to date or had not completed their training. However, after the inspection the provider submitted written evidence of an improved process to monitor training compliance.
- There was no policy on the duty of candour. However, following our inspection, the registered manager had created a policy, and was in the process of sharing this with all staff.

Are patient transport services safe?

Incidents

- The service reported no never events in the 12-month period before our inspection. Never events are serious incidents that are entirely preventable as guidance of safety recommendations providing strong, systemic protective barriers, are available at a national level, and should have been implemented by all healthcare services. Each never event type had the potential to cause serious harm and death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- The service had an 'Incident Reporting and Investigation Policy and Procedure' that was in date.
- The service reported twelve incidents since it registered with CQC in February 2017. The majority of these were related to patient collapse or vehicle collision. We reviewed the incident log, which was maintained in an electronic spreadsheet. Each entry had a reference number, along with the name of the reporter, name of the reviewer, investigations undertaken, date of incident, date of acknowledgment and any actions taken. However, whilst the incident description specified whether any harm was caused to staff or patient, the incidents were not given an impact or harm classification such as 'no harm', 'low harm', 'moderate' or 'severe', which meant the service may not have an overview of the impact of the incidents.
- There were no specific meetings to discuss incident learning, however the registered manager told us that when an incident was reported, they would speak to the staff member that reported the incident and gain further information if needed. We also saw that there was a 'lessons learnt' column in the incident spreadsheet, which detailed any actions taken.
- The duty of candour, Regulation 20 of the Health and Social Care Act 2008, relates to openness and transparency. This duty requires services of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Whilst there were no incidents during the reporting period that

triggered this duty, the service did not have a policy or procedure relating to the duty of candour, and we were not able to gain assurance that staff would be aware of this duty.

Mandatory training

- The provider had recently introduced 'care certificate' training for all members of staff. The care certificate is a training programme aimed at staff working within the care industry, consisting of 15 standards, including safeguarding adults and children, basic life support and awareness of mental health, dementia, and learning disabilities. However, as this was a relatively new process, not all staff had yet completed all 15 standards.
- The registered manager told us that prior to the care certificate being introduced to the service, all staff were expected to complete safeguarding children and adults, manual handling and emergency first aid. We reviewed five sets of staff records, and we saw that two members of staff did not have any evidence of safeguarding training within the last year, one had no evidence of emergency first aid training, and one did not have manual handling certificates present. This did not provide assurances that whilst staff were aiming to complete the care certificate, that they had other training to ensure they kept themselves and their patients safe.

Safeguarding

- We spoke to the registered manager who gave examples of where they had raised safeguarding concerns for adults at risk. Staff could report concerns to the registered manager, who reported the concern to the NHS ambulance trust for onward referral to the local safeguarding team where appropriate.
- Safeguarding training formed part of mandatory training provided by the service. We reviewed five sets of staff records and saw that three out of the five members of staff had a safeguarding training certificate dated within the last 12 months. However, at the time of inspection it was not clear from the certificates what level of safeguarding training this covered.
- The intercollegiate guidance document "Safeguarding Children and Young People: roles and competencies for health care staff" (2014) states, "All non-clinical and clinical staff who have contact with children, young people and/or parents/carers" require safeguarding children level two training.
- The provider was undergoing a change in the type of mandatory training provided to staff – because of this, it was difficult to determine the percentage of staff that had completed their safeguarding training.
- After the inspection, the provider submitted written evidence to CQC that showed all staff had completed safeguarding training at level 2.
- There was a combined adult and children safeguarding policy. National and local guidance were included as part of this and it had a review date. However best practice says that these policies should be separated to reflect the different legislation and processes required.

Cleanliness, infection control and hygiene

- There was a safe system of work relating to protective personal equipment and infection prevention and control that provided guidance to staff on the use of PPE and the cleaning of equipment. This stated the procedure for cleaning of vehicles was to wipe down surfaces with supplied antibacterial spray after each journey, ensure all vehicles had a weekly wash and valet, and a six-weekly deep clean with an ultra violet (UV) lamp or sooner if required. The UV lamp light can penetrate all surfaces and eliminate bacteria.
- Patients with infectious diseases such as Clostridium difficile (C diff) were permitted to travel on service vehicles but under the condition that they travelled with no other patients, and that the vehicle was deep cleaned following completion of the transfer. The vehicle would not be allocated any further work until deep cleaned.
- We saw the weekly cleaning schedule for January 2018, and evidence of this throughout 2017 on the computer records. The weekly clean was carried out at either the East Grinstead base or at designated car wash facilities in Brighton. If staff were unable to attend the designated cleaning sites, they could get the car cleaned locally and be reimbursed by the service for this. The clean included a clean of all areas on the outside of the vehicle, and a basic valet inside which include hoovering and a clean of all hard surfaces.

- In addition to the weekly clean, all vehicles had a monthly deep clean and we saw documentation demonstrating this had happened. This included an ultra violet (UV) light treatment, which is a type of light that can be applied to surfaces and will kill microorganisms or bugs that could potentially spread germs. The UV lamp was placed in the vehicle for 15 minutes for a routine monthly clean or for 30 minutes post contamination as per the PTS-247 Safe System of Work (SSN). As the lighting generated Ozone, the SSN stipulated that once the light has completed its cycle the vehicle could not be entered for a further 15 minutes to allow the ozone to disperse.
- Drivers sent photographs via an online messaging application of their completed compliance checks for their vehicles, and these were then kept in a folder at the office base. Spot checks were carried out by team leaders to ensure the checks were being completed consistently.
- We inspected one vehicle at the base. This appeared visibly clean and tidy. Hand cleansing gel was available as was personal protective equipment such as vinyl gloves.

Environment and equipment

- The provider's registered address and head office was based at an office in East Grinstead, West Sussex. There was a hand car wash service based on the same site, where the vehicles were cleaned. There was parking available for approximately 20 vehicles.
- The provider had 40 vehicles, all of which were wheelchair accessible. The vehicles were owned by PTS-247, but were kept at the assigned drivers home addresses across the locality. This allowed drivers to be allocated to jobs nearest to their home location.
- The provider held a contract for servicing and Ministry of Transport (MOT) testing with a garage in Crawley, West Sussex. We saw documentation showing where in the cycle all the vehicles were and what previous repair work had been completed or flagged at the servicing and MOT appointments. In addition to MOT and servicing dates, we saw that the spreadsheet also detailed key milestones in the vehicles life cycle, including cambelt changes, brake checks, clutches and battery changes, as well as recording when individual tyres had been replaced or worn. The vehicles ranged in age between 6 and 9 years old.
- We inspected one vehicle whilst on the base. This was visibly clean and tidy, and the condition of the exterior of the vehicle was good, with no obvious damage or dents.
- All staff were supplied with a uniform, including a t-shirt, trousers and safety shoes. High visibility vests were kept on the vehicles for transfers that may occur in the hours of darkness.
- First aid kits were available on all vehicles and we saw this on the vehicle that we inspected.
- Larger seatbelt straps were available for patients if required, and car seats for children were also available.
- Single use blankets were carried on every vehicle and there was a stock supply of these at the base. Once these had been used on a journey they would be handed to the hospital or clinic the patient had arrived to who would dispose of this.
- The vehicle we reviewed had a fire extinguisher on board. However, we found this was trapped in the door pocket, which meant it might not be easily accessible if needed in an emergency. We informed the manager about this who actioned this immediately. The manager told us that the fire extinguishers were bought in 2016 and yet had not been serviced, this may mean that they were not in a safe state to be used. Following the inspection, the registered manager told us that new extinguishers had been purchased.
- We saw a 'driver pack' on the vehicle which contained: a spill pack for urine and vomit, anti-bacterial cleansing wipes and multi surface spray; alcohol hand gel, bottled water, tissues, nitrile gloves, a sealed disposable blanket, sick bucket and patient experience forms.

Medicines

- The service did not stock any medicines at the base. Any medications that a patient needed to bring with them remained the responsibility of the patient. If a patient needed to transport medical gases such as oxygen with them, the driver would query this with the registered

manager and would check that the patient could self-administer and have enough for the journey. They could also access green 'medical gases' stickers to put in the car in the event of travelling with oxygen.

Records

- The service did not hold any patient records as the NHS ambulance trust that sub contracted the work retained all patient data. Drivers used personal digital assistants (PDA) which were a small, hand held device similar to a smart mobile phone. These devices allowed the secure transfer of data between drivers and the NHS ambulance trust. When the driver logged into their PDA at the start of their shift, they would have an overview of how many transfers they were doing, the name and address of the patients and the pick-up times set for these. As soon as the transfer was complete, the data was wiped from the PDA remotely. All drivers were allocated a PDA with a unique sign-on number and carried these with them for the duration of their shift.

Assessing and responding to patient risk

- Patients eligible for this service were triaged by the NHS ambulance provider according to their mobility, but would only be referred for transport from PTS if they were low acuity and could mobilise independently or with the assistance of wheelchair.
- We reviewed the services safe systems of work (SSW) documentation. SSWs are a procedural document that identifies risks and hazards of a specific event or procedure.
- The SSW for passenger and patient safety identified the risk of not accompanying patients to their door and offering assistance to get them safely indoors. It also recognised that if arriving in the hours of darkness, assistance should be offered to turn the lights on in the house. We saw one reported complaint where the service user had complained that the driver had not accompanied them to the door. We saw that the member of staff was reminded of the importance of escorting service users to the door.
- The SSW for possible collapse behind closed doors outlined possible scenarios that the drivers may come across during the course of their work such as arriving at the patient's home and there not being an answer when knocking at the door. The SSW advised to check that they were at correct address, make direct observations (such as whether staff can see a build-up of post or identify any unusual odours etc.), contact team leader or registered manager and dial 999. If staff could see that a patient had collapsed, they were advised to dial 999 and wait at the venue offering assurance until emergency services had arrived. We saw five incidents where staff had arrived to a patient collapse.
- If a patient became unwell on route, drivers were expected to safely pull over, call 999 and perform basic life support until emergency services arrived.
- All drivers had access to a national breakdown recovery company, and the registered manager told us that the recovery company is usually on scene within one hour. When a vehicle broke down there were three spare vehicles, and if they need another driver, they would cover this from within their own pool of staff.

Staffing

- There were 39 members of staff currently working for the service. The majority of these were employed by the service, with some opting to be self-employed contractors.
- Drivers worked from a weekly rota, with most drivers working the same shifts each week. The rotas were managed by a web-based application (app) on their personal mobile phone, and any changes to the rotas would initiate a notification to the relevant staff member's mobile phone.
- All drivers had a PDA allocated to them. They activated this on the days of their shift, and this would advise them of their journeys for the day.
- All staff members had access to a web-based HR application (app) on their personal mobile phones. We saw this app and it demonstrated that staff could book their leave and record sickness via this app. All company documents were also in the process of being loaded into this app so that staff could access SSWs/policies and procedures at any given time.

Anticipated resource and capacity risks

- The service currently had two spare vehicles at base that could be used to switch out with any that broke down or suffered a failure during a transfer, this meant there was limited impact to service delivery.

- There was a SSW for additional winter checks. This reminded staff to be aware of slip hazards and wet surfaces, both at pickups and drop off spots. The SSW advised that the base at PTS-247 would be gritted as would be most healthcare environments (such as hospitals) but to still exercise caution when transferring, adjust speed and distance and use fog lights when appropriate. We spoke to the manager who advised that there had never been an occurrence where a driver has refused to drive because of conditions or had to stop the service. During cold conditions, staff used a free messaging application on their mobile phones to advise drivers to be cautious in icy conditions.

Response to major incidents

- We reviewed the provider's Business Continuity Plan (BCP). This referred to business continuity scenarios such as staff absences, utilities and equipment failure, and vehicle breakdown. There was mitigation against these risks listed, including extending shifts or recruiting temporary staff, data backup systems and a minimum stock of spare vehicles. There was a key contacts section in the plan, which included contact numbers for the registered manager, team leaders and certain utilities suppliers. However, there were also gaps in this section, for example, the director on call, security alarm and fire alarm sections were left blank, meaning that staff needing to quickly invoke the BCP would not have the details for these key contacts quickly.

Are patient transport services effective?

Evidence-based care and treatment

- The provider carried out quality spot checks on both the drivers and their vehicles. Team leaders would locate the drivers in between jobs, intercept them and complete a checklist. We saw a 'driver inspection folder' that contained checklists and photographs of the drivers and vehicles. The checks included whether the driver was wearing their PTS-247 ID badge, whether the breakdown recovery card was within the vehicle, whether the vehicle appeared clean and tidy, and whether the tail lift was operational. We saw checks completed through 2017 but none had been commenced for 2018. The RM advised that they would be re-commencing these February 2018. The RM told us that the NHS ambulance provider also completed spot checks, but PTS-247 only received feedback if there were any issues that required addressing.

Assessment and planning of care

- We spoke to the registered manager about how staff are made aware of patients that have a do not attempt cardio resuscitation (DNACPR) in place. Drivers are informed of this when they receive the booking on their PDA, and will request to see the DNACPR certificate before commencing the journey.
- If drivers are transporting a patient with dementia, an escort or carer accompanies them. If they arrive to a pick up and a patient with known dementia does not have a carer or escort available, drivers will contact the NHS ambulance service through their PDA to check whether one is due.

Response times and patient outcomes

- The majority of data on number of journeys, response times and patient time on vehicles was held by the NHS ambulance provider that sub contracted the service. As such, we could not include data regarding performance and key performance indicators (KPIs) in this report. However, we spoke to the registered manager about how they know that they are meeting their KPIs, and we were told that if PTS-247 does not hit any of their KPIs, the NHS ambulance provider contacted them directly.
- KPIs that the service was monitored on included collection of renal patients within 30 minutes of appointment finish time, and collection of outpatients within 60 minutes of their appointment finish time.
- As the service was contracted by an NHS ambulance provider, the service was not responsible for monitoring the KPIs set.

Competent staff

- We spoke to the registered manager about staff appraisals. We were told that they were currently reviewing the appraisal process, and that no staff members had received an appraisal within the last 12 months. We were told that drivers often come into the office for informal chats but nothing was documented.

After the inspection, we were provided with assurance that 50% of the drivers had received an appraisal. This meant the provider was in the process of addressing the concerns we raised about staff appraisals.

- There was an in-date recruitment policy, which gave an overview of the steps taken when employing new members of staff. This included checking of relevant ID, right to work check, equal opportunities monitoring form and disclosure and barring service (DBS) checks. However the policy did not specify the procedure for checking driving licences. The registered manager told us that these were checked on application and then again on a 6 monthly basis. The maximum number of points on a licence was six, however these specifications were not referred to in the policy.
- We reviewed five sets of staff records. We did not see any DBS certificates within these records and discussed this with the registered manager. As the provider sends the DBS requests to a third-party organisation to complete the checks, the provider does not get a copy of the DBS document, only an email from the third-party provider informing them whether the check was clear or not. The registered manager showed us an electronic spreadsheet with all members of staff, their driving licence details, and their DBS certificate numbers, along with the date that this was completed. All of these had a DBS number other than two, which the registered manager informed us were new starters and not yet on the road.
- When a new member of staff joined the service, they had a period of shadowing an experienced driver on their journeys before transporting patients alone. We saw an induction presentation used for new members of staff; this gave an overview of the objective of the service and what training and support staff could expect whilst working for the company. However, there was no induction checklist within the staff folders we reviewed to provide a record of each staff member's induction. This meant the provider may not have assurances that new staff received a consistent induction.
- Training was completed via a web based application that could be accessed anywhere with a Wi-Fi signal. This allowed staff to access their training when they had gaps in between their journeys.

Coordination with other providers

- PTS 24-7 was sub-contracted by an NHS ambulance trust, and as such, the co-ordination of the transfers were triaged and placed by the NHS ambulance trust. We saw evidence of feedback from the NHS ambulance trust praising how one of the PTS 24-7 drivers worked with them to ensure journey that were tight on time and distance were completed and completed on time.

Access to information

- All staff had to sign for a driver pack on commencing their role. This contained information such as hard copied of safe systems of work, breakdown cover details, and patient experience forms.
- Part of the PDA was a satellite navigation system that drivers could use to navigate to their destinations. The registered manager had access to an overview of all drivers on the road via a live tracking system. The NHS ambulance provider also had access to this, although their version was not in real time and therefore not as accurate as the providers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Standard nine of the Care Certificate is awareness of mental health, dementia and learning disabilities. Within this framework, staff learn about mental capacity and consent, in line with relevant guidance and legislation. Additional evidence provided to CQC showed all staff had undertaken consent and mental capacity training.

Are patient transport services caring?

Compassionate care

- We were not able to observe any direct patient care whilst on site at the inspection.
- As part of the driver pack given to all drivers, a patient experience form was available for patients to complete. However, these went back to the NHS ambulance trust and the registered manager they rarely had the feedback shared with them.

Patient transport services (PTS)

- We received 29 'tell us about your care' cards that service users had completed. The majority of these were positive, with comments including 'staff treated me with dignity and respect', and 'considerate', 'caring' and 'polite'.

Understanding and involvement of patients and those close to them

- Whilst the service could not directly influence which drivers were assigned certain shifts, as most drivers had the same shift pattern each week, drivers were often assigned the same patient to transport. This was particularly common, the RM told us, where the patient had weekly transportation needs, such as renal dialysis patients. This meant that patients had a certain level of continuity of care and were able to build a rapport with the drivers, and one service user commented that the drivers were now their friends too. However, one comment card we reviewed stated that a service user would like to have more continuity of drivers.
- The service understood that certain types of patients such as those with dementia or learning disabilities required a carer or an escort to accompany them on their journeys and always accommodated this.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The service carried out 35,595 patient journeys since April 2017, which equated to 3995 per month. All patient transport work was sub contracted from an NHS ambulance trust. Although the NHS ambulance trust sub contracted the work to PTS-247, this arrangement took place outside of a formal contract.
- The service had met with the NHS ambulance provider twice since the contract began. The NHS ambulance trust was responsible for allocating journeys to the PTS-247 drivers and allocated journeys based on the drivers' home address postcode, where their vehicles were kept. This meant that drivers could be allocated straight to a transfer and would not need to use time and mileage attending a base before being allocated their first journey. The registered manager told us this had improved since past contracts.
- The service was available 5:30am to midnight seven days a week. Monday to Friday, the busiest days, were staffed with 39 drivers, Saturdays with 14 drivers, and the quietest day, Sunday, with three drivers.
- The service provided patient transport in wheelchair-adapted vehicles only. For patients that required any other type of transfer such as by a stretcher, the NHS ambulance trust would allocate this to a different service that could provide this.

Meeting people's individual needs

- The registered manager told us that a carer or escort generally accompanied patients with dementia or learning difficulties. On rare occasions where this had not occurred, staff knew to ring the NHS ambulance service to check whether an escort was needed or due.
- The registered manager explained how the care certificate training had a module for dementia and mental capacity, and this was felt to be important as they had one incident where a patient with dementia had travelled without a carer and had become confused whilst on route and the staff member had to report as an incident.
- We saw that drivers carried umbrellas to cover patients during transfer to or from vehicles in wet weather. All vehicles also carried water bottles for patients to use whilst on the journey if they chose to.
- We asked the registered manager what happened if patient's who did not speak English as a first language used the service. There was not a policy in place for this. This meant that needs of patients who did not speak English as a first languages needs may not be met.

Access and flow

- The service had a monitoring system that could track each driver and vehicle via a live satellite system. This system worked in real time and could identify whether the driver was stationery or travelling, whether they were speeding and monitor their overall safety score driving performance such as harsh breaking or cornering. The system also recorded and kept previous

driver journeys on the system, so that if there needed to be an investigation retrospectively, the registered manager could look up the journey on the system and 'play it back' and see the route taken and speeds at each point. If a driver was caught speeding, they would be liable for the fine and would have to attend a driver awareness course.

- Drivers' PDA allowed the collection of date to monitor pick up and journey times for all journeys. The sub-contracting NHS ambulance trust took responsibility for monitoring performance in this area. The registered manager said they only received feedback on performance if it was outside of their KPIs, which was rarely.
- When drivers began their shift, the PDA device allowed them 15 minutes prior to getting on the road to carry out safety checks on their vehicle. Tasks normally flowed from one pick up to the next but if there was a gap in the drivers schedule, they would go to the local hospital, speak with the NHS ambulance representative, and see if there are any local transfers that could be completed in between. This was monitored by the tracking system.

Learning from complaints and concerns

- All complaints came via the NHS ambulance organisation that contracted PTS 24-7. Any complaints that came directly to the driver or service would be reported to the registered manager who was responsible for informing the NHS ambulance organisation.
- Complaints were logged by the registered manager on an electronic database and included an outline of the complaint, investigations undertaken, and actions due. We saw that between April and September 2017 there were 23 complaints about the service. The majority of the complaints were regarding timeliness, (either arriving too late, or too early for an appointment) and complaints about driver skills or attitude whilst driving.
- The registered manager told us about a complaint where a patient had alleged that the driver was speeding. The registered manager explained how they were able to use the tracking system to be able to check the exact details of the journey and whether or not the driver had been speeding. They then were able to feed this back to the ambulance provider who would respond to the complainant.
- Another example of where a complaint had been dealt with and learned from, was when a driver had not escorted the patient to their door. The RM obtained a statement from the driver, had a one to one session with them and shared feedback on the web based messaging group. On the message, the RM reiterated that expectation is to accompany to door.
- There was an in-date complaint policy, which specified that complaints must be acknowledged within three working days and within 20 working days for a full response. Once the NHS ambulance provider had received a complaint, it would be shared with the registered manager at PTS-247, who would investigate and provide feedback to the NHS ambulance provider, who would then respond to the complainant.

Are patient transport services well-led?

Leadership of service

- Drivers reported to team leaders, who reported to the registered manager. The two administration staff also reported directly to the registered manager. Staff that we spoke with told us that the registered manager was supportive and well respected.
- The drivers and team leaders were home based and as such, did not regularly check in to the base apart from when their vehicles needed cleaning. As such, they kept in communication via a group messaging application on their mobile phones. If drivers had any queries they could ask the team on the chat room, contact their team leaders or go straight to the registered manager.

Vision and strategy for this core service

- PTS-247 delivered work which was sub-contracted from an NHS ambulance trust and this was the sole contract held by the provider. There was a previous contract in place that was being used as the basis for the service, but there was no formal contract with PTS-247.
- There was no written vision or strategy for the service, and the registered manager explained that this was due to the lack of a written contract and the uncertainty of

the future without this. However, they explained that the vision is expanding to capture primary medical service patients, and to provide a CQC standards led service for low acuity patients.

- There was also a company mission statement which stated the company aim as to provide a timely, safe, high quality, customer focused transport service to low risk patients.

Governance, risk management and quality measurement

- There was a low level of complaints compared to the number of journeys completed by the service. The NHS ambulance provider was responsible for monitoring the KPIs of the service. The NHS ambulance provider was responsible in informing the provider should the performance of the provider drop below the expected level.
- We saw a risk assessment log, which consisted of 16 risks. The five entries with the highest risk rating (this is the score given once controls or mitigations have been put in place) were general driving risk, maintenance of vehicles, moving and handling of patients and collecting patients from hospital and care home environments. There was also a risk regarding the use of non-crash tested wheelchairs and a risk related to the use of the UV lamp, demonstrating that the service had an overview of their potential risk, to both staff and members of the public.
- Separately to this, the manager told us that a specific risk to the company was the lack of a formal contract and how this directly affected the security of the business.
- There were no specific governance meetings. The registered manager told us that following any incident or complaint that had learning to be shared; this would be shared via the web-based messaging app. Whilst this appeared to be working well, there was no assurance that all drivers read all the messages, and the lack of face to face meetings to discuss governance issues meant that the registered manager could not be assured all team members were included.

Culture within the service

- Staff we spoke with described the service, being like a family and that they all look out for each other.
- There were no written values of the service, but the manager described their staff as having empathy, customer service, and an understanding that this is not 'just a taxi service'.
- There was a recruitment policy that referred to a risk based approach for allowing potential employees who had a prior criminal record to be given an opportunity to work for the company, taking into account the nature of the offence, the age at which it was committed and the relevance to the post in question. The policy also stated that this would be considered where there was clear evidence of rehabilitation, and where the risk was considered to be minimal or non-existent. This demonstrated that the service gave a fair opportunity of employment to people who may otherwise have been ruled out of employment. However, it was not clear from the policy what the threshold for prior criminal offences were, and what or how it would be assessed if a person with a prior conviction was a low or minimal risk.
- We saw a whistleblowing policy that described the steps staff could take should they have concerns. The period for acknowledging concerns raised was 5 working days, with a response and full report within three months.
- The CQC received no whistleblowing enquiries within the last 12 months.

Public and staff engagement (local and service level if this is the main core service)

- The service had a website but the information was out of date and no longer applicable. There was a booking form (suggesting that relatives could book the service themselves) and all contact was directed to an address registered with Companies House, not the providers registered address with the CQC. This may be confusing to members of the public.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The registered manager was attempting to create a 'virtual office' environment, where staff can feel part of the office environment without having to be physically in the office: "doesn't matter if 100 miles away or one mile away". We saw evidence of the web based applications being used, and saw the messaging group chat had daily, frequent use from the drivers on duty.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The provider must ensure that staff are trained to the appropriate level for safeguarding children in line with national guidance.

The provider must ensure that all staff undergo an appraisal.

Action the hospital SHOULD take to improve

The provider should ensure the governance provides oversight to ensure learning from incidents is communicated to staff.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (2) - Systems and processes must be established and operated effectively to prevent abuse of service users.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (2) A — Staff must receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.