Western Medical (U.K.) Limited

Western Medical Ambulance Services

Quality Report

Airedale General Hospital
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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

Patient transport services (PTS)

Summary of findings

Letter from the Chief Inspector of Hospitals

Western Medical (U.K.) Limited provides patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 7 and 8 November 2017.

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 provider's stated aim was that the patient always came first. Staff were clear about the focus being the patient.
- The service was proactive in ensuring the vehicles were well maintained and equipment and consumable supplies were stored appropriately and available for use.
- Staff were employed and worked solely for the service. A sufficient number of staff were deployed in order to care for patients safely.
- The need to arrange food and drink for the patient in transit was considered. Staff completed an assessment of pain experienced by the patient and a pain score.
- Patient transport services (PTS) crew maintained the patient's privacy and dignity and demonstrated empathy and compassion. Staff were passionate about their roles and dedicated in providing excellent care to patients.
- For particularly vulnerable patients, such as those living with dementia or a disability, the service arranged for a relative or carer to accompany them while being transported. After transporting a patient home the crew frequently waited with a patient until the carer arrived.
- Emotional support was an integral part of the service provided by the PTS staff, particularly for end of life care patients.
- The patient's individual needs were taken into consideration when each request for patient transport was made. The requirements of patients with complex needs, including those with dementia, learning disabilities physical disabilities or mental health needs were assessed.
- Staff understood the reporting arrangements in this small service. The leadership operated through direct communication with staff. Staff told us that the leadership was very positive, supportive and approachable.
- Staff worked in a culture that was friendly and supportive. Staff felt valued and respected. Staff told us they were consulted about changes to the service and that managers were open to listen to any comments.

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

- No system was in place to manage risk which enables identifying, mitigating and controlling risks appropriately.

Summary of findings

- Reported incidents were not graded, to determine the level of patient harm. In addition, investigation of incidents was not robust and did not include learning to reduce the risk of similar incidents happening again.
- Staff were not aware of their responsibilities in relation to the duty of candour.
- Appropriate actions were not taken to identify, assess and minimise the risks associated with infection prevention and control.
- Training and competency records were not kept for each staff member who was responsible for providing care and treatment to patients.
- The required employment checks were not always undertaken or records kept of these, which would ensure compliance with the fit and proper person's employed requirement in full.
- Safeguarding training for adults was not evidenced in line with the Intercollegiate Document, 2016. This includes staff providing direct care and treatment to patients as well as the safeguarding lead.
- A policy and procedure for use of mental capacity, gaining consent, best interest and deprivation of liberty safeguards was not in place to support staff in complying with the requirements of these.
- A procedure for identifying, receiving, handling and responding to complaints from patients was not in place.

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 seven requirement notices that affected patient transport services. Details of these are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region), on behalf of the Chief Inspector of Hospitals

Western Medical Ambulance Services

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Detailed findings

Contents

Background to Western Medical Ambulance Services

Western Medical (U.K.) Limited commenced its current CQC registration in August 2011 and is an independent ambulance service based in Keighley, West Yorkshire. The nominated individual has been in post since 2011.

The service primarily serves the communities of Airedale, Wharfedale and Craven, although the service is able to undertake long distance journeys if required. It undertakes the transport of non-urgent patients between hospitals, homes and care facilities in a pre-planned and short notice (un-planned) work environment. It has a contract with one coordinating commissioner and primarily operates from one NHS acute hospital.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector as well as one other CQC inspector and a specialist advisor. The inspection team was overseen by Lorraine Bolam, Interim Head of Hospitals Inspection.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The service is registered to provide the following regulated activities:

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

The service operates from an acute NHS hospital and in addition to the two directors employs two or more part time members of staff. One of the directors also acts as one of the organisation's patient transport services drivers.

In the reporting period March 2017 to August 2017 there were 812 patient transport journeys

undertaken.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

The provider's track record on safety in the 12 months prior to the inspection was:

- No never events
- No serious incidents
- Seven reported incidents
- No healthcare-associated infection (HCAI) incidents
- No reported safeguarding concerns
- One formal complaint

The service has been inspected once previously in March 2014. This inspection found that the service was meeting all standards of quality and safety it was inspected against at the time.

During the inspection in November 2017, we visited the hospital site from which the service operates. We spoke with four staff including managers and patient transport drivers, one patient, two members of acute hospital staff who work with the service and a vehicle engineer who maintained the ambulance vehicles. We reviewed information that was provided by the service during and after the inspection including 88 of the most recent patient records.

Patient transport services (PTS)

Summary of findings

See the Letter from the Chief Inspector of Hospitals on page 2.

Are patient transport services safe?

At present we do not rate independent ambulance services. We found the following issues that the service provider needs to improve:

- The provider did not have a formal incident reporting policy or procedure to identify the type and seriousness of incidents or a policy for never events. Staff had little knowledge of the duty of candour requirements and did not understand their responsibilities in reporting any notifiable incident relating to the duty of candour.
- Staff did not have a full understanding of safeguarding and how to report a safeguarding incident. Safeguarding training certificates did not state training was for vulnerable adults' protection or that it was at the required level. This was not in line with the Intercollegiate Document, 2016.
- Mandatory training had not been aligned to the ambulance service.
- Environmental risk assessments were not undertaken that followed the format in the provider's own policy for assessing risk.
- No cleaning schedules or checklists were in place and the service could not provide assurances of when and how disinfecting and cleaning procedures were carried out. No schedule for deep cleaning vehicles was in place. The service did not have an internal deep cleaning procedure for staff to follow. Some staff involved in cleaning ambulances had not completed infection and prevention and control training.
- Not every item of equipment was identified to indicate when it was next due for service and staff were unable to confirm if equipment had been serviced prior to use. Some items of equipment were overdue for replacement.
- No formal medicines management policy was in place.
- We observed that transfer forms were not stored securely on the patient transport service (PTS) ambulance vehicle so that there was a risk patient confidentiality was not maintained. This was discussed with the provider on day one of the inspection and the provider took immediate steps to address our concerns.

Patient transport services (PTS)

- Arrangements for the provider's involvement in the acute hospital's major incident plan were specified in its contract with commissioners although we found this was not in place.

  However, we found the following areas of good practice:

- The service was proactive in ensuring the vehicles were well maintained and equipment and consumable supplies were stored appropriately and available for use. Oxygen was stored appropriately and securely and for patients using oxygen, the service followed a recognised procedure.
- Risk assessments were completed which were appropriate to the patients' needs.
- Staff were employed and worked solely for the service. A sufficient number of staff were deployed in order to care for patients safely.
- The service had in place a business continuity plan as part of its contract with commissioners.

Incidents

- An incident report form was used in the service and the provider was able to report on incidents that had occurred in the last 12 months. Although the provider did not have a formal incident reporting policy or procedure to identify the type and seriousness of incidents, the incident report form included brief guidance about reporting incidents or near misses involving patients being transported. The advice included identifying and reporting serious incidents.
- The service reported that there were no never events in the last 12 months. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. No policy was in place for never events.
- The service reported that there were no serious incidents, but seven reported incidents, in the last 12 months. The service was unable to show a record of incidents that had been reported. The service used an accident book although staff were not able readily to access it. Staff told us if there was an incident it would be reported to the nominated individual.
- Although few incidents occurred the requirement to record and report patient safety incidents was contractually specified by commissioners. However, the numbers and details of incidents was not recorded or reported to commissioners. No policy was in place for serious incidents or never events. We were not assured incident reporting procedures were embedded in the service. This meant that although concerns had been passed on, there was no formal record of the incident and it was unclear what actions, if any had been taken to reduce the risk of similar incidents happening again.
- The service had a policy in place for the duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff we spoke with had little knowledge of the duty of candour requirements. We observed that staff acted openly and transparently although they did not understand the duty of candour regulations or their responsibilities under duty of candour. Staff did not understand their responsibilities in reporting any notifiable incident relating to the duty of candour, although we found no evidence that incidents had occurred which would invoke a response under duty of candour. When we asked staff what happened if something went wrong they told us that they would apologise to the patient.
- The provider's contract with commissioners included a requirement to comply with duty of candour and to report incidents monthly as necessary. An 'incidents requiring reporting' procedure was included in the contract. We saw no evidence that incident recording and reporting was audited.

Cleanliness, infection control and hygiene

- No healthcare-associated infection (HCAI) incidents were reported in the last 12 months. The environment of the acute hospital which the service used was cleaned to a high standard.
- The service had an infection prevention and control policy which had been updated in September 2017. The policy stated staff should follow rigorous guidance on hand hygiene, personal protective equipment, body

fluid spillage, safe disposal of waste and handling of contaminated linen. However, we reviewed the policy and found that it did not contain the procedures that staff should follow.

- Staff had access to personal protective equipment such as gloves to reduce the risk of the spread of infection between staff and patients and were aware of when these should be used. Each staff member wore visibly clean uniforms and we observed that staff were bare below the elbow. Staff we spoke with told us a hand sanitiser was used after patient contact and we observed that hand sanitizer gel was used. However, the service informed us it did not complete hand hygiene audits. This meant the service could not be assured they were compliant with infection control practices.
- PTS staff we spoke with told us that they ensured their vehicle was fit for purpose, before, during and after they had transported a patient. The ambulance crew assigned to the vehicle each day completed the day to day cleaning of vehicles. Decontamination cleaning wipes were available on each vehicle.
- We checked three PTS ambulance vehicles for cleanliness. We observed that PTS ambulances were clean although not to a consistently high standard, as the vehicles were in use or undergoing maintenance. The interior and exterior of each PTS ambulance vehicle was cleaned weekly. No cleaning schedules or checklists with a record of when the vehicle was cleaned were in place.
- PTS staff we spoke with informed us that they used mops and buckets that were available at the hospital when required to clean the ambulance vehicle. The hospital was responsible for disinfecting or cleaning the mops to ensure effective infection control. The service could not provide assurances of when and how the disinfecting and cleaning procedure was carried out.
- A deep clean involves cleaning a vehicle to reduce the presence of certain bacteria. PTS staff we spoke with told us that deep cleaning was undertaken periodically, using PTS staff or an external contractor when this was deemed necessary. However there was no schedule for deep cleaning the vehicles or record that deep cleaning had been carried out. The service did not have an internal deep cleaning procedure for staff to follow.
- A policy for the safe disposal of clinical waste was in place which was updated in September 2017. Staff we spoke with told us that clinical waste was stored on the vehicle until it could be disposed of in the hospital's clinical waste. The vehicles we checked did not have clinical waste bags. There was no spillage kits provided on the vehicles. This meant the service was not complaint with its own infection control policy.
- There was no system in place to monitor cleanliness. The service did not have a system in place for infection control audits to be carried out to ensure that cleaning was effective, any contaminates were removed and appropriate action to reduce the risk of cross infection.
- Members of staff that we spoke with were aware of their roles and responsibilities for infection prevention and control although there was no evidence they had completed training in infection prevention and control.

Environment and equipment

- We visited the acute hospital where the service was based, as part of the inspection. The provider worked closely with the acute hospital and had the use of bathroom and kitchen facilities and arrangements were in place for use of the ambulance vehicle cleaning bay. These facilities were well maintained and secure. Clinical waste was removed by the hospital's waste contractor. PTS ambulance vehicles were parked in readiness in the outpatients' area.
- The service had a fleet of three vehicles which we were informed had each been converted to undertake PTS ambulance services. Each vehicle was more than five years old, which meant that there was some increased risk of faults and breakdowns, although the service was proactive in ensuring the vehicles were well maintained. Vehicle checks were carried out daily and the vehicles were regularly serviced. Reported faults were dealt with immediately and another ambulance vehicle was used to replace the faulty vehicle.
- We reviewed the vehicle records which confirmed that valid Ministry for Transport test certificates, maintenance records and vehicle insurance was in place. The provider made arrangements for the replacement of vehicles and we saw evidence of this. Each ambulance vehicle was covered for breakdown recovery.

Patient transport services (PTS)

- The contract with commissioners required national standards and regulations to be met for both vehicles and equipment carried on the vehicle. For example, vehicles carrying wheelchairs were required to be fitted with tail lift facilities and we observed this was the case. The contract provided for vehicles to be checked daily for defects and we received assurance that this was carried out.
- Two of the vehicles were fitted with blue lights, which we were assured were not used except when the vehicle was stationary. One vehicle did not have an external compressed gas sign fitted, which would identify that oxygen was carried on the vehicle in the event of an accident. The carpet fitted in the rear of one PTS vehicle did not meet cleanliness and infection control standards and the service took immediate steps to rectify this.
- Equipment and consumable supplies were stored appropriately and available for use. Some items of equipment were kept on the ambulance vehicles, such as defibrillators, and others, for example stretchers, we were informed were kept in the hospital. Not every item of equipment had a sticker attached to identify when it was next due for service and staff were unable to confirm if equipment had been serviced prior to use. On one vehicle a carry chair was stored which was not suitable for use, although we were informed that the chair was not used regularly. Defibrillator pads on two vehicles and certain consumable items were overdue for replacement and the service took immediate steps to rectify this.
- Each vehicle allowed patients to remain in their wheelchairs while being transported. We observed that the patient was secured for the journey using a four point harness and transferred in the wheelchair at the destination.

Medicines

- PTS staff we spoke with could describe the procedures to follow for the use and administration of medicines, although no formal medicines management policy was in place for the service. This meant that there were no procedures or guidance for staff to follow or have consideration to when handling patients' own medication, when administering a patients' own medication or when transferring a patient with medical devices in situ, such as a syringe driver. A syringe driver is used to give a patient medicines continuously over a period of time.
- PTS staff we spoke with were able to describe how they handled patients' own medicines during transfer and understood the importance of handing them over to nursing or medical staff correctly.
- For patients using oxygen, the service followed a recognised procedure. Staff we spoke with could describe the procedures they followed and were familiar with their responsibilities when administering oxygen.
- For patients with controlled medicines, the service followed a procedure agreed with the hospital. Controlled medicines accompanied the patient and were transported in a sealed package provided by the hospital department where the patient was collected. The identification for the member of PTS staff was checked and at the destination the package containing medicine was signed for. However, on the journey we observed where the procedure was used, the controlled medicines were not signed for at the destination although we observed the package of controlled medicine was handed over to the receiving service.
- No medicines apart from oxygen were stored on the ambulance vehicles as they were used only for the transport of PTS patients. We observed that oxygen was stored appropriately and securely on the PTS ambulance vehicles. However, the supplies of oxygen on two vehicles were out of date and the service acted immediately to replace these with in-date supplies prior to the second day of our inspection.

Records

- The service used a patient transfer form template throughout the hospital and copies of these forms were kept in each hospital department that used the service. The department requesting transport completed basic details about the patient so that this information was available for PTS staff when they arrived to collect the patient.
- We reviewed 88 of the most recent patient records for PTS transport provided between 20 October and 6 November 2017. Risk assessment information was completed which was appropriate to the patients'

needs and included information about equipment which was to accompany the patient or was required for the journey. Special notes such as do not attempt cardiopulmonary resuscitation orders (DNACPR) were included as part of the patient transfer record. The information recorded helped to ensure the provider was aware of any pre-existing conditions or identified safety risks so that the patient was kept safe during their journey on the PTS ambulance.

- We observed that transfer forms were not stored securely on the PTS ambulance vehicle so there was a risk patient confidentiality was not maintained. This was discussed with the provider on day one of the inspection and the provider took immediate steps to address our concerns as to data protection, by storing the patient transfer forms and accompanying information out of public view on the vehicle.
- Following a verbal handover, the PTS ambulance crew member checked the details completed by the hospital of the patient transfer form to ensure no discrepancy had arisen in transferring the information. We observed that staff undertook this checking procedure. Records travelled with the patient and were passed on to the receiving healthcare provider on arrival at the destination.
- The operations manager of the acute hospital reviewed the patient information for each patient transported to ensure the data compared correctly with hospital records. The patient's NHS number recorded on the transfer form was removed in the analysis of patient activity reported to commissioners, so that patient information was kept secure.
- We were informed that policies, procedures and administrative documents including the most recent patient records were kept securely at the providers registered address. We reviewed a selection of these documents at the hospital location.

Safeguarding

- The service had in place policies for safeguarding children and for protecting vulnerable adults from abuse which were updated in September 2017. The policies gave clear guidance to staff as to how to report urgent concerns. Although transporting children was included in the contract with commissioners, the nominated individual confirmed that the service did not transport children and had not done so in the previous 12 months.
- Staff we spoke with could describe the signs of abuse. Staff understood how to report suspected abuse, although this did not follow a formal process. We found evidence that staff knew how to report to the local authority safeguarding contact and some examples of this happening were given verbally although none of these were recorded.
- The service had a designated safeguarding lead; however, they had not undergone any extra training to complete this role. The nominated individual told us they were the safeguarding lead and we saw this was stated in the contract. We spoke with the safeguarding lead who we found did not have a full understanding of safeguarding and how the provider would report a safeguarding incident. The safeguarding lead did not explain how a safeguarding concern was raised with the local authority.
- The provider's contract with commissioners included provision for tackling violence against women and girls. Staff we spoke with were unaware of female genital mutilation (FGM). The safeguarding lead demonstrated a lack of understanding of their responsibility to prevent and report abuse including referral to other agencies as required. Reporting any recognised incidents of FGM is a legal requirement for all healthcare staff.
- The service had not reported any safeguarding concerns in the last 12 months. The safeguarding lead told us there had been reported safeguarding incidents in the last 12 months, however, they did not know how many because the incidents were not recorded. The safeguarding lead told us each safeguarding incident was reported to the hospital's safeguarding lead, although they could not provide evidence to show they received feedback from the hospital's safeguarding lead on the incidents reported.
- Safeguarding policies included contact information for the appropriate local authority safeguarding children team. The safeguarding adults' policy did not contain contact information for the safeguarding adults' team. This meant that we were not assured that staff could make an urgent referral when required.

Patient transport services (PTS)

- Safeguarding vulnerable adults and child protection was a part of mandatory training. Safeguarding training was undertaken in conjunction with acute hospital staff and evidence of this was seen. Each crew member had completed training in safeguarding. We received the provider's assurance that both adult and child training was undertaken although the training certificates did not state training was for vulnerable adults and child protection or that it was at the required level. The safeguarding lead could not provide assurance that training was at the appropriate level. This was not reflective of national guidelines for safeguarding, specifically the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document (2016).

Mandatory training

- The service had in place a training programme which included two training courses. Staff completed training in safeguarding and first aid, use of a defibrillator and oxygen. We checked staff training records and all staff were up-to-date with both training requirements, which were undertaken.
- We found evidence that training was undertaken in conjunction with acute hospital staff annually which provided some assurance that mandatory training took place although no specific mandatory training records were in place for the service.
- Mandatory training had not been aligned to the ambulance service. Staff had not completed training in moving and handling or how to undertake vehicles safety checks which would ensure staff were competent to undertake the vehicle checks required.

Assessing and responding to patient risk

- An initial risk assessment was undertaken by the service when the transport was requested. A patient risk assessment was undertaken of the patient's condition by the PTS ambulance crew and recorded on the patient transfer form at the time the patient was collected for transport. The risk assessment included pain, the patient's level of mobility whether they required oxygen, if they were confused or aggressive whether they had any special requirements, and whether the patient had an escort accompanying them.
- Crew members we spoke with described how they accessed clinical advice and escalated concerns if a patient's condition deteriorated during a journey. The nominated individual was contacted for advice, or the ward that the patient came from. Staff would return the patient to the ward or department if they assessed the risk of proceeding with the patient journey was unacceptable.
- The provider's contract with commissioners included the procedure to be followed to escalate to emergency services in a life threatening situation. PTS crew members we spoke with confirmed that this procedure was followed.
- If the service was requested to transport patients demonstrating violent or disturbed behaviour, an additional member of ambulance staff was used if necessary and an appropriately trained escort may also be requested from the acute hospital.
- The provider had a policy for risk assessment in place which included examples of risk assessments that should be carried out. Although the assessment and mitigation of risk was included in the provider's way of working, we found no evidence that risk assessments were undertaken which followed the format in the policy.This meant that the provider was not following its own policy for assessing risk.

Staffing

- Staff were employed and worked solely for the service. The nominated individual also worked as a PTS ambulance driver and two part-time staff were employed on zero hours contracts who worked variable hours according to demand. We were informed that an additional crew member was being recruited who was currently accompanying crew members for observation as part of the recruitment process.
- Patient transport was normally undertaken by one crew member. If an additional crew member was required the nominated individual told us this additional staff resource was provided to support the patient. For example, if a stretcher was requested, two crew members attended.
- The nominated individual told us the service was usually provided on an on-call basis and operated from 8am to midnight, with transport undertaken between 12

noon and 10 pm. A member of the management team was available 24 hours a day, seven days a week for support if needed and provided cover in the event of staff sickness.

- Staff break times were not fixed because of the nature of the on-call service. Staff took breaks in between jobs. Staff did not raise any concerns about access to time for rest and meal breaks.
- The service did not use agency staff but utilised the existing team of PTS drivers who worked additional shifts on overtime or flexibly where required to meet demand.

Anticipated resource and capacity risks

- The service had in place a business continuity plan as part of its contract with commissioners. The contingency arrangements set out in the plan for situations which may impact the service included plans for inclement weather. The plan included arrangements for the management team to liaise with bed managers at the hospital and with commissioners.
- The plan did not specifically describe how the service would function in the event of an emergency such as fire or an infrastructure incident.
- The provider described arrangements for service development which included the recruitment of additional staff to expand the service.

Response to major incidents

- The provider's role in the event of a major incident at the acute hospital was to assist in the removal of patients from the hospital site.
- Arrangements for the provider's involvement in the acute hospital's major incident plan were specified in its contract with commissioners although we found these did not take place.
- The provider undertook to liaise with the acute hospital as to its scenario training for major incident planning. Table top exercises are used to simulate a major incident, as well as the roles and responsibilities that individuals have during an incident.

Are patient transport services effective?

At present we do not rate independent ambulance services. We found the following issues that the service provider needs to improve:

- The service did not have a formal policy or a standard operating procedure for the use of mental capacity, gaining consent, best interest decisions or deprivation of liberty. Staff we spoke with were unsure about their responsibilities under the Mental Capacity Act (MCA) 2005 and did not understand the relevant consent and decision making requirements of legislation. No specific training was provided to staff in relation to the Mental Capacity Act or the deprivation of liberty safeguards.
- Staff were unable to access guidelines or protocols although the patient's needs were discussed with the hospital department where the patient was collected.
- The service was not compliant with its own recruitment policy. Recruitment appeared to be conducted informally and did not follow a recognised procedure. Records we reviewed did not contain the required evidence that recruitment checks were undertaken prior to employment.
- The competence of new staff was assessed by observation rather than formal assessment. Staff confirmed that a new crew member would participate in an introductory observational session but induction had not been recorded.
- Staff did not receive annual training updates. Training in first aid had previously been completed in 2015. Observational supervision was undertaken but this had not been recorded.
- Staff had not received a formal appraisal or other assessment of their learning needs. Staff had not completed an ambulance driver awareness course.

However, we found the following areas of good practice:

- The service followed local guidelines as agreed with the NHS hospital trust, for providing effective transport of patients. The patient's eligibility for transport was assessed when the transport was requested.
- The need to arrange food and drink for the patient in transit was considered and if needed for the journey a

snack box including a drink was prepared for the patient by the hospital ward or department they were leaving. Staff completed an assessment of pain experienced by the patient and a pain score.

- The patient pick-up time planned with the ward or department may have been up to three hours ahead, otherwise the service responded with one hour. The wards and departments we spoke with in the hospital confirmed the patient transport service (PTS) service usually arrived within an hour.
- The delivery of care and transport services was coordinated. We observed the coordinated working relationship between PTS ambulance and hospital staff. Staff in the acute hospital who worked with the provider daily spoke highly of the service they received.
- Staff were made aware of any special requirements the patient had for their journey in the PTS vehicle. The discharge information included essential details as to the patient's condition, for example advanced directives and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.

Evidence-based care and treatment

- The service confirmed that PTS transport was provided in line with local guidelines. The patient's eligibility for transport was assessed by the service when the transport was requested. A patient risk assessment was undertaken of the patient's condition by the PTS ambulance crew and recorded on the patient transfer form at the time the patient was collected for transport. The risk assessment included pain, the patient's level of mobility whether they required oxygen, if they were confused or aggressive whether they had any special requirements, and whether the patient had an escort accompanying them.
- We found that the service had limited knowledge of national guidance such as the National Institute for Health and Care Excellence (NICE) or the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). Staff were unable to access guidelines or protocols although the patient's needs were discussed with the hospital department where the patient was collected. For patients with medical needs, for example, the hospital provided an escort.

Assessment and planning of care

- An initial risk assessment was undertaken by the service when the transport was requested by the hospital, usually by a phone call to the provider. The hospital department requesting transport completed basic details about the patient using the service's patient transfer form template and copies of these forms were kept in each hospital department that used the service. This basic information to support assessment and planning of care was available for PTS staff to review when they arrived to collect the patient. Any special requirements, whether oxygen therapy was required, whether there were any special notes with the patient such as a DNACPR order of if the patient required any special equipment, wheelchair or trolley were considered.
- Following a verbal handover, the PTS ambulance crew member checked the details completed by the hospital of the patient transfer form to ensure no discrepancy had arisen in transferring the information. The need to arrange food and drink for the patient in transit was considered and if needed for the journey a snack box including a drink was prepared for the patient by the hospital ward or department they were leaving. For longer journeys, the PTS service planned additional stops for food, drink and toilet breaks.
- The risk assessment undertaken when the patient was collected by the PTS crew included an assessment of pain experienced by the patient and a pain score was completed. If the PTS crew were concerned about the patient experiencing pain during the journey, they diverted to the nearest emergency department.

Response times and patient outcomes

- The provider's contract with commissioners specified local quality requirements which stated that patients should be collected at the agreed pick up time in 95% of instances and that patients should receive the vehicle requested which is appropriate to meet their needs in 95% of instances. We were unable to confirm from the evidence we reviewed that this quality requirement was met.
- The service told us the patient pick-up time planned with the ward or department may have been up to three

hours ahead, otherwise the service responded with one hour. The wards and departments we spoke with in the hospital confirmed the PTS service usually arrived within an hour.

- The time the transport journey was requested by the ward or department and the time the patient left was included on the patient transfer form although we found this was not recorded consistently. The patient transfer form included an overall "quality control" response as to whether the transport, care and delivery of the patient was satisfactory or unsatisfactory but we also found the response was not recorded consistently. This meant that the service had potentially missed opportunities to improve performance.
- The commissioning contract included operational standards and national quality requirements which reflected NHS outcomes framework domains and indicators. For example, the contract included treating and caring for patients in a safe environment and protecting them from avoidable harm. Locally defined outcomes stated that patients with an identified medical need received a safe, professional and responsive high quality discharge transport service from hospital that met their needs.
- The service told us it offered flexibility by providing PTS transport on a call-off basis, particularly out of hours. This compared favourably with the service offered by the NHS ambulance service, which was confirmed by wards and departments we spoke with.
- The contract included an indicative activity plan for each commissioner's area and activity information was analysed from the patient transfer forms and monitored by the service. The number of journeys undertaken was reported to commissioners monthly. Where demand was in excess of indicative contract levels of activity, the provider was reimbursed.

Competent staff

- PTS ambulance staff we observed were experienced and competent in providing care and treatment for patients. The contract with commissioners included provision for recognised employment practices to be followed and for staff to have a range of competencies supported by training relevant to the care and movement of vulnerable patients. The contract set out that annual updates of training and records of training should be maintained.
- A recruitment policy was in place that set out the standards the service followed when recruiting staff. The policy stated relevant pre-employment checks such as identity and references would be obtained and held in the staff files. However, we found the service was not compliant with its own recruitment policy.
- Recruitment appeared to be conducted informally and did not follow a recognised procedure. Applications were received by telephone following local advertisement with no written application or records of interview. Records we reviewed did not contain the required evidence that recruitment checks were undertaken prior to employment. We saw records which showed appropriate criminal records checks although proof of identification and references had not been obtained.
- The nominated individual told us that each crew member had their driving licence and eligibility to drive vehicles checked prior to employment although the service could not provide evidence of these checks. One of the applicants had attended first aid training with other staff members. The nominated individual told us this applicant had been out on a vehicle to shadow an experienced crew member.
- The service had an induction policy and procedure which was updated in September 2016. The nominated individual told us staff undertook an induction programme that detailed the expectations and requirements of the role, the company and policies and procedures. However, we found the competence of new staff was assessed by observation rather than formal assessment. Staff confirmed that a new crew member would participate in an observational session. However, crew members had been employed two to three years previously and there was no evidence to show induction had been completed. The nominated individual told us the induction had not been recorded.
- There were no formal arrangements for ongoing checks of driver competence. We were informed observational

supervision was undertaken but this had not been recorded. Staff told us that if they had a concern about the standard of a crew member's driving they would inform the nominated individual.

- Staff we spoke with told us that whilst they regularly met with the nominated individual, they had not received a formal appraisal or other assessment of their learning needs. No checks on driver's driving competence were undertaken at the time of our inspection. Although we did not see evidence that staff had completed an ambulance driver awareness course, each member of the ambulance crew were experienced ambulance drivers.
- No registered professionals with formal requirements to maintain professional standards were employed in the service.

Coordination with other providers and multi-disciplinary working

- The contract with commissioners provided for the service to work in conjunction with other healthcare professionals. We spoke with wards and departments in the hospital that used the service and found the delivery of care and transport services was coordinated. We observed the coordinated working relationship between PTS ambulance staff and nursing staff in the hospital. Staff in the acute hospital who worked with the provider daily spoke highly of the service they received. We also spoke with the NHS ambulance service which was complimentary about liaison and multidisciplinary working with the provider.
- The provider held regular meetings with the hospital to monitor the service provision and with commissioners to monitor the contract, although we did not review minutes of these meetings. On arrival at care homes, the PTS service could encounter a difficulty in the care home accepting the patient. The service told us it discussed these issues with commissioners during meetings to monitor the contract.

Access to information

- Staff were made aware of any special requirements the patient had for their journey in the PTS vehicle. The discharge information included essential details as to the patient's condition, for example diabetes, advanced directives and DNACPR orders. The verbal handover to PTS staff given by the medical or nursing staff of the discharging ward or department included notes in a sealed envelope which were available for medical staff if required.
- The provider's PTS crew were supported by satellite navigation systems in the ambulance vehicles and shared information electronically on mobile devices. However, little information was available in accessible form about the provider's policies and procedures, which were not readily available to staff except by request to the nominated individual.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- When transporting patients staff operated on the basis of implied consent and this was not recorded. The provider explained to inspectors that it usually operated within a total contact time with the patient of no more than 35 minutes. If the provider identified unacceptable risks in undertaking to transport a patient, it refused to provide transport.
- The service did not have a formal policy or a standard operating procedure for the use of mental capacity, gaining consent, best interest decisions or deprivation of liberty. Staff we spoke with were unsure about their responsibilities under the Mental Capacity Act (MCA) 2005 and did not understand the relevant consent and decision making requirements of legislation. No specific training was provided to staff in relation to the Mental Capacity Act 2005 or the deprivation of liberty safeguards.
- Where patients were identified as having specific mental health needs, the commissioner used the NHS ambulance service rather than this provider.

Are patient transport services caring?

At present we do not rate independent ambulance services. We found the following areas of good practice:

- Patient transport services (PTS) crew maintained the patient's privacy and dignity and demonstrated empathy and compassion. Staff were passionate about their roles and dedicated in providing excellent care to patients.

Patient transport services (PTS)

- For particularly vulnerable patients, such as those living with dementia or a disability, the service arranged for a relative or carer to accompany them while being transported. After transporting a patient home the crew frequently waited with a patient until the carer arrived.
- The PTS crew introduced themselves to the patient and demonstrated an understanding of the patient's need for reassurance about the journey and the destination.
- Emotional support was an integral part of the service provided by the PTS staff, particularly for end of life care patients. When the patient appeared to become confused, the PTS staff were very calming.

Compassionate care

- We observed direct patient care during one patient discharge. The PTS crew maintained the patient's privacy and dignity throughout their contact with the patient, which included the transfer to the ambulance and particularly when escorting the patient through the public areas of the hospital and on arrival. Staff demonstrated empathy and compassion particularly when assisting the patient into a wheelchair. The patient warmly complemented the PTS crew for a smooth journey to the destination and overall for providing an excellent service.
- Staff we spoke with were passionate about their roles and were dedicated in providing excellent care to patients. Staff gave examples of how they took the necessary time to engage with patients and to communicate in a respectful and caring way, taking into account the wishes of the patient and to maintain patients' privacy and dignity. This was supported by our observation.
- Two patients had completed "Tell us about your care" comment cards ahead of the inspection which were both very complimentary about the caring attitude of staff and the support provided for patients in vulnerable circumstances. We did not see any evidence of dissatisfaction from the comment cards completed by patients who had used the service.
- We found that wherever possible, vulnerable patients, such as those living with dementia or a disability, the service arranged for a relative or carer to accompany them while being transported. The nominated individual told us that on the occasions where a patient was not accompanied the PTS crew waited with the patient until after their appointment. After transporting a patient home the crew frequently waited with a patient until the carer arrived.
- The PTS crew's role in supporting the patient on arrival and supporting them with their belongings was confirmed by the hospital staff we spoke with. The service made sure they were in the house with the patient and supported them.

Understanding and involvement of patients and those close to them

- We observed direct patient care during one patient discharge. The PTS crew introduced themselves to the patient and communicated constantly with the patient to keep them informed. Staff demonstrated an understanding and involvement with the patient's need for reassurance about the journey and the destination. The patient warmly complemented the PTS crew for the journey and overall for providing an excellent service.
- Staff we spoke with told us they provided clear information to patients about their journey and informed them of any delays. Staff showed an awareness of the needs of patients, relatives and carers and explained aspects of the journey in a way they could understand. This was supported by our observation.

Emotional support

- Emotional support was an integral part of the service provided by the PTS staff, particularly for end of life care patients. Staff understood the need to support family or other patients should a patient become unwell during a journey.
- Staff described how they would reassure a patient who became agitated during transport. Staff we spoke with told us they checked on the patient's wellbeing, in terms of discomfort, and the need of emotional support, during their journey. This was supported by our observation. When the patient appeared to become confused, the PTS staff were very calming.

Patient transport services (PTS)

Are patient transport services responsive to people's needs?

At present we do not rate independent ambulance services. We found the following issues that the service provider needs to improve:

- Patient information as to how to make a complaint was not available on the three PTS ambulance vehicles we checked. It was unclear to us how patients or their carers would make a complaint directly to the service if they wished to do so.
- No formal process was in place for sharing lessons learned from the investigation of complaints.
- Interpreting services were generally not available for patients whose first language was not English.
- The procedure for monitoring turnaround times was quite informal.
- The PTS service was facing some challenges in the volume of discharges received and on occasion a lack of communication as to individual patient's needs.

However, we found the following areas of good practice:

- Most patient journeys were arranged and delivered on the day of request. Staff in the hospital we spoke with told us they found the procedure for requesting transport easy to use. Patient transport services (PTS) transport ran promptly and they were kept informed about any disruption.
- The service liaised with commissioners and the acute hospital to maintain communication about patients' needs. The patient's individual needs were taken into consideration when each request for patient transport was made. The requirements of patients with complex needs, including those with dementia, learning disabilities physical disabilities or mental health needs were assessed.

Service planning and delivery to meet the needs of local people

- The main service was PTS which provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. This included those attending hospital, outpatient clinics or being discharged from hospital wards.
- The PTS service operated through a contract with one coordinating commissioner and mainly provided a transport service for patients discharged from one NHS acute hospital. The service undertook the transport of non-urgent patients between hospitals, homes and care facilities in a pre-planned and short notice (un-planned) work environment. Ward staff told us they could pre-book the PTS service at any time.
- The provider primarily served the local areas of Airedale, Wharfedale and Craven, although it also undertook longer distance journeys when required. The service provided an on-call service and workloads were planned around this. Each day, booking requests were received by telephone and were responded to promptly with an indicative timeframe for the PTS ambulance arrival. Ward and department staff we spoke with confirmed they found the provider's judgement was accurate and reliable. We observed effective communication between PTS crew members and office staff as part of service planning.
- The provider told us that the PTS service was facing some challenges in the volume of discharges received and on occasion a lack of communication as to individual patient's needs. Increasingly the service was asked to provide transport after 11pm and in the very early morning. The service had adapted its procedure for patient pickup to reduce delays by giving more lead time for the ward to ensure the patient was ready to leave when the transport arrived.

Meeting people's individual needs

- The patient's individual needs were taken into consideration when each request for patient transport was made. Staff we spoke with told us that when transport was requested the call taker asked about the patient and their needs. The individual requirements of patients with complex needs, including those with dementia, learning disabilities physical disabilities or mental health needs were assessed and the service also asked if the patient required a relative or carer to support them.

- The assessment of the patient's needs was confirmed by the PTS ambulance crew at the time the patient was collected for transport. The assessment included whether the patient was confused or aggressive and whether they had any special requirements, including whether they required an escort. PTS crew told us they would decline to transport the patient if they deemed it medically inappropriate and the decision was jointly agreed with the ward or department.
- The hospital confirmed that transport or patients with dementia was requested through the discharge hub, who liaised with the PTS service. The hospital ward said it would send an escort for patients with dementia or other mental health needs. Patients with dementia were also supported by deploying an additional crew member where the service assessed this was required.
- The contract with commissioners provided for patients to be treated without discrimination on the grounds of age, race religion or disability and for an equality and diversity policy to be in place. PTS staff were required to communicate in basic English. We were informed the PTS team included crew with knowledge of sign language and Urdu. However, the nominated individual told us interpreting services were generally not available for patients whose first language was not English. For the three PTS ambulance vehicles we checked we found there was no special equipment such as picture charts or other aids to assist communication with patients.
- The service was not required to transport bariatric patients. The hospital used the NHS ambulance service for bariatric patients.

Access and flow

- The service responded promptly to requests for PTS transport, so that any waits experienced by patients were minimal. Patients had timely access to an initial assessment of their suitability to use the PTS service. The service prioritised requests for transport for patients with the most urgent needs and also provided an on-call service. Most patient journeys were requested and delivered on the same day although PTS crew we spoke with confirmed that some patients were planned pick-ups which may have been requested several hours before the arrival time.
- Staff we spoke with in the hospital wards and departments that used the service told us they found the procedure for requesting transport easy to use. They said PTS transport ran promptly and they were kept informed about any disruption. The provider's small PTS ambulance fleet operated flexibly to ensure its vehicles and crew were where they needed to be and at the required time.
- The procedure for monitoring turnaround times was quite informal. The time the transport journey was requested by the ward or department and the time the patient left were included on the patient transfer form. The wards and departments we spoke with confirmed the PTS service usually arrived within an hour. We observed a patient journey which confirmed this procedure was used for PTS transport requests and operated in a timely manner.

Learning from complaints and concerns

- The service had in place a complaints policy which was updated in September 2017. The policy outlined the process for dealing with complaints initially by local resolution and informally. Where this did not lead to a resolution, complainants were given a letter of acknowledgement within two days of receipt followed up by a further letter within 28 working days, once an investigation had been made into the complaint.
- The complaints policy was also included in the contract with commissioners with provision for monthly reporting of complaints. We did not find evidence that complaints monitoring information was prepared or shared with commissioners.
- Complaints that were received were through the acute hospitals complaints procedure and forwarded to the PTS ambulance service. The nominated individual told us complaints were made to the hospital verbally and the hospital discussed the complaint with the complainant. The service subsequently provided a written response to the complaint.
- We reviewed the response to two complaints that were made through the hospital within the last 12 months. The complaints related to a patient's medication and to a delayed journey. We were informed that the complaints had been investigated to see if anything might have improved the patient's experience. The service also reported that one complaint was received in

the previous 12 months. The complaint was of a member PTS crew using a mobile phone while driving. The member of staff involved received a formal reprimand.

- Patient information as to how to make a complaint was not available on the three PTS ambulance vehicles we checked. It was unclear to us how patients or their carers would make a complaint directly to the service if they wished to do so. The complaints procedure was not readily available, and did not support patients not to identify themselves, if that was their choice.
- We requested documents relating to these complaints but none were provided. We found staff did not document complaints which meant the complaints process could not be monitored or audited effectively. The nominated individual told us the learning from complaints was discussed informally with staff. No formal process was in place for sharing lessons learned from the investigation of complaints.

Are patient transport services well-led?

At present we do not rate independent ambulance services. We found the following issues that the service provider needs to improve:

- There was no formal process for identifying and prioritising risks and recording measures implemented to mitigate the identified risks within the service. The service did not hold a risk register or have other similar systems to identify and monitor the highest risks to the organisation.
- Team meetings were not held and no process was in place for shared learning. There was no system in place to disseminate learning from incidents, safeguarding and complaint outcomes.
- The provider could not fully evidence how they were assured about the service. The service did not have a mechanism in place to measure the quality of the service delivered to the patient.
- The contract with commissioners identified the nominated individual as the governance and regulatory lead for a range of specific roles but we found no evidence of competency assessment having been undertaken to fulfil these areas of responsibility.
- Staff did not understand the duty of candour regulations or their responsibilities under duty of candour.
- Policies and procedures did not include dates that they had been implemented or when they should be reviewed.

However, we found the following areas of good practice:

- Managers of the service were well established and staff understood the reporting arrangements in this small service. The leadership operated through direct communication with staff. Staff told us that the leadership was very positive, supportive and approachable.
- The provider's stated aim was that the patient always came first. Staff were clear about the focus being the patient.
- Staff worked in a culture that was friendly and supportive. Staff felt valued and respected.
- Staff told us they were consulted about changes to the service and that managers were open to listen to any comments.

Leadership of the service

- Directors of the service were well established and staff understood the reporting arrangements in this small service. The managing director was the nominated individual and the leadership operated through direct face to face communication with staff or using mobile phones.
- The nominated individual told us the leadership style was an uncomplicated approach to running the service. Staff told us that the leadership was very positive and the nominated individual was supportive and approachable.
- The service had a policy in place for the duty of candour and the provider's contract with commissioners included a requirement to comply with duty of candour. However no incidents had occurred that required a response under the duty of candour regulations.
- The contract with commissioners identified the nominated individual as the governance and regulatory lead for a range of specific roles including for example information governance lead, information risk owner, accountable emergency officer and freedom to speak

up guardian. However, we found no evidence of competency assessment to fulfil these areas of responsibility. A further example was safeguarding, although we did not see evidence of the lead having the required level of training to fulfil this role.

Vision and strategy

- The nominated individual explained that its philosophy was that the patient always came first. The provider stated its aim and objective as providing a patient focused transport service which understood the needs of its patients and delivered high standards of care. The service ensured it was patient-led, reflected the need of local health providers and operated in accordance with national frameworks and standards.
- The provider's aims and objectives also included treating all patients with respect, courtesy and compassion and respecting their need for privacy, dignity and confidentiality. They also stated the service user would have their full attention and respond to any questions in an open and honest way.
- The aims and objectives included ensuring vehicles were clean, safe, comfortable and fit for purpose and doing everything possible to prevent delays and to explain reasons for delay when they did occur.
- The provider undertook in its aims and objectives to monitor feedback and to investigate any complaints in order to change practice which fell below accepted standards.
- When we asked staff about their understanding of the vision and values they referred us to the stated aims and objectives of the service. Staff were clear about the focus being the patient.

Governance, risk management and quality measurement

- The service had in place a risk assessment policy which was updated in September 2016. The policy stated that all risks and hazards should be identified and addressed. Risks should be recorded, reviewed and held in a central location so staff were aware. The service also had in place a number of operational policies and procedures which had been revised in September 2017. These included policies for infection prevention and control, manual handling and health and safety. The policies included procedures for the assessment and reduction of risk.
- We found the service had not implemented a formal risk management process so that risks to the service were not fully assessed. We asked the nominated individual for examples of risk assessments. We were informed risk assessments had not been undertaken. The nominated individual was unable to tell us what the current risks were relating to the service.
- The service did not hold a risk register or have other similar systems to identify and monitor the highest risks to the organisation, both clinical and non-clinical. This meant there was no formal process for identifying and prioritising risks and recording measures implemented to mitigate the identified risks within the organisation.
- Any formal meetings held were for training only and no process was in place for shared learning. Staff told us that team meetings were not held and they usually met individually with the nominated individual when needed. There was no system in place to disseminate learning from incidents, safeguarding and complaint outcomes.
- The directors' oversight of services included the number of patients who received transport which was reported to commissioners monthly. The contract with commissioners provided for a monthly activity and finance report of patient level data and we found this information was prepared and submitted. However, this was not supported by other recorded information.
- The contract also provided for a locally agreed service quality performance report to be submitted every six months detailing performance against operational standards, national quality requirements, local quality requirements, never events and the duty of candour. We did not see evidence that this performance information was prepared or submitted. The provider could not fully evidence how they were assured about the service.
- The service did not have a mechanism in place to measure the quality of the service delivered to the patient. The service did not carry out regular local audits to measure the quality and effectiveness of the

service delivered such as cleanliness and infection control. This meant there may be potential safety risks to patients and staff through a lack of monitoring of performance.

- Recruitment was conducted informally and did not follow a recognised procedure. Records we reviewed did not contain the required evidence that recruitment checks were undertaken prior to employment.
- Staff who worked remotely were supported by the management arrangements although the service did not have a policy related to lone working that underpinned this.

Culture of the service

- Managers told us they were committed to operating a caring and safe service from which patients received a prompt and reliable service and in which staff were rewarded for exceptional care.
- Staff worked in a culture that was friendly and supportive. Staff told us they were all here for the patient to be comfortable and safe. Staff were committed to ensuring patients received a caring and prompt service. Staff felt valued and respected.
- We observed that staff acted openly and transparently although they did not understand the duty of candour regulations or their responsibilities under duty of candour. When we asked staff what happened if something went wrong they told us that they would apologise to the patient.

Staff engagement

- Staff we spoke with told us that managers were open to listen to any comments. When anything needed a response, it was done virtually straight away. Staff we spoke with told us they were consulted about changes to the service.
- A whistleblowing policy was in place to provide assurance to staff who wished to provide feedback about aspects of the service. The policy was updated in September 2016 and described examples of the type of concerns to be raised. It contained information for external organisations to contact to escalate concerns.
- Managers we spoke with told us they held informal discussions with staff for example related to renewal of the contract with commissioners, and discharges to care homes. The nominated individual explained how the service took on board the views of staff for example, as to care homes not accepting patients after 5pm. However, there were no formal recording of these discussions.

Public engagement

- Two patients had completed “tell us about your care” comment cards ahead of the inspection which were both very complimentary about the caring attitude of staff and the support provided for patients in vulnerable circumstances. Patients said they felt the service provided a reliable and caring service to patients.
- We reviewed 88 of the most recent patient transfer forms, for patient transport services (PTS) transport provided between 20 October and 6 November 2017. A short quality control section was included in the form to assess the transport care and delivery of the patient and to award an overall satisfactory or unsatisfactory score. The information recorded helped to ensure the provider was aware of any situations identified about which the patient was less than satisfied so that action could be taken to address any concerns. For the 88 records we reviewed, the quality control indicator was satisfactory or in a few instances had not been recorded.

Innovation, improvement and sustainability

- The provider told us they considered that its approach to the resolution of issues which arose within the patient discharge process including its proactive approach with care homes represented innovative practice.
- The provider said it had begun to make informal plans to develop the service further in response to commissioner’s requirements. The provider said it was aware and shared with commissioners the need to take account of the impact on quality and sustainability when efficiency changes were being considered.
- Managers told us that staff were recognised for delivering exceptional care to patients who used the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there is a system in place to manage risk, which enables identifying, mitigating and controlling risks appropriately.
- Ensure that all reported incidents are graded, determining the level of patient harm. In addition, investigations of incidents must be robust and include learning to reduce the risk of similar incidents happening again.
- Ensure that staff are aware of their responsibilities in relation to the duty of candour.
- Take appropriate actions to identify, assess and minimise the risks associated with infection prevention and control.
- Ensure that an up to date training and competency record is kept for each staff member responsible for providing care and treatment to patients.
- Ensure that the required employment checks are undertaken, making sure that the service complies with the fit and proper person's requirement in full.
- Ensure that safeguarding training is evidenced in line with the Intercollegiate Document, 2016. This includes staff providing direct care and treatment to patients as well as the safeguarding lead.
- Implement a policy and procedure for mental capacity, consent, best interest and deprivation of liberty safeguards to support staff in complying with the requirements of these.
- Ensure a procedure for identifying, receiving, handling and responding to complaints from patients is implemented.

Action the hospital SHOULD take to improve

- Introduce a system of audit for reported incidents.
- Ensure each item of equipment is identified with its next date due for service.
- Introduce a formal medicines management policy
- Ensure that transfer forms are stored securely on the PTS ambulance vehicle so that patient confidentiality is maintained.
- Ensure contractual obligations as to involvement in the acute hospital's major incident planning are complied with.
- Ensure staff are able to access guidelines or protocols which support the patient's needs.
- Ensure interpreting services are available for patients whose first language is not English.
- Ensure there is a process in place for monitoring turnaround times which aligns with appropriate national guidance.
- Ensure there is a process in place to update policies and procedures in line with appropriate national guidance.

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 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met:** The service did not have a formal policy or a standard operating procedure for mental capacity, consent, best interest decisions or deprivation of liberty. Staff were unsure about their responsibilities under the Mental Capacity Act (MCA) 2005 and did not understand the relevant consent and decision making requirements of legislation. No specific training was provided to staff in relation to the Mental Capacity Act or the deprivation of liberty safeguards.

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 **How the regulation was not being met:** Staff did not have a full understanding of safeguarding and how to report a safeguarding incident. Safeguarding training certificates did not state training was for vulnerable adults' protection or that it was at the required level. This was not in line with the Intercollegiate Document, 2016.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Patient information as to how to make a complaint was not available on the ambulance vehicles and it was unclear how patients or their carers would make a complaint directly to the service. No formal process was in place for sharing lessons learned from the investigation of complaints.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider could not fully evidence how it was assured about the service. The service did not have a mechanism in place to measure the quality of the service delivered to the patient. There was no formal process for identifying and prioritising risks and recording measures implemented to mitigate the identified risks within the service. The service did not hold a risk register or have other similar systems to identify and monitor the highest risks to the organisation. The provider did not have a formal incident reporting policy or procedure to identify the type and seriousness of incidents or a policy for never events. It was unclear what actions, if any had been taken to reduce the risk of similar incidents happening again. No cleaning schedules or checklists were in place and the service could not provide assurances of when and how disinfecting and cleaning procedures were carried out. No schedule for deep cleaning vehicles was in place. The service did not have an internal deep cleaning procedure for staff to follow.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** Staff did not receive annual training updates. Observational supervision was undertaken but supervision was not recorded. Staff had not received a formal appraisal or other assessment of their learning needs.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** Recruitment was conducted informally and did not follow a recognised procedure. Records we reviewed did not contain the required evidence that recruitment checks were undertaken prior to employment.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met:** Staff had little knowledge of the duty of candour requirements and did not understand their responsibilities in reporting any notifiable incident relating to the duty of candour.