UK Event Medical Services Limited

UK Event Medical Services Limited Sheffield

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

UK Event Medical Services Limited Sheffield is operated by UK Event Medical Services Limited. The company provides emergency and urgent care and a patient transport service. They also provide medical cover at public and private events. We did not inspect this part of the service as it is not currently a regulated activity.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 16 May 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.

The main service provided was patient transport services. Emergency and urgent services were a small proportion of activity; therefore we have reported our findings in relation to the urgent and emergency services in the patient transport services section.

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:

- Staff were committed to providing the best quality care to patients. Staff displayed a caring and compassionate attitude and took pride in the service they were providing.
- Staff checked patients' requirements prior to transporting them to ensure they were able to meet their needs.
- Staff followed evidence-based care and treatment and nationally recognised best practice guidance.
- The management team had taken action to improve governance and risk management systems within the past six months.
- There were effective policies and procedures for safeguarding issues to be identified and referred for investigation by relevant, external organisations.
- There were effective systems for reporting and investigating incidents; the provider learnt from incident investigations, for example, by making changes to equipment or care protocols.
- Vehicles and stations were visibly clean and tidy, with evidence of regular deep cleaning of vehicles.
- Relevant background checks had been carried out during recruitment processes. This included, for example, a full Disclosure and Barring Service and a driving licence check.
- We observed good multidisciplinary working between crews and other NHS staff when moving patients.
- The management team worked with local NHS providers to supply services which met the needs of local people.

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

- Our review of patient record forms on GP urgent care journeys found that the records were not always complete; the records did not always indicate what actions staff had taken to mitigate identified risks.

Summary of findings

- Some systems for identifiying and disposing of out-of-date stock and sharps waste, had not been fully implemented.
- Some staff were not able to recall the information provided to them as part of a training programme. For example, not all staff could recall having had training in the Duty of candour.
- The systems for storing medicines needed to be reviewed to confirm that medicines were kept safely at all times.
- The provider did not currently check that all relevant staff had been immunised with selected vaccines, such as Hepatitis B, which may be appropriate for their role.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

Ellen Armistead

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The main service was patient transport. Urgent and emergency services were a small proportion of activity. Where arrangements were the same, we have reported findings in the patient transport services section.

UK Event Medical Services Limited Sheffield

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Detailed findings

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Background to UK Event Medical Services Limited Sheffield

UK Event Medical Services Limited Sheffield is operated by UK Event Medical Services Limited. The service opened in 2002. It is an independent ambulance service in Sheffield in South Yorkshire. The service primarily serves the communities of the Sheffield, Rotherham, Barnsley, Doncaster and Hull, but does operate throughout the UK.

At the time of the inspection, UK Event Medical Services Limited Sheffield had a new team of directors who had been in post since September 2017. The service held a contract with an NHS provider for non-urgent transfers of patients from hospitals, home and care facilities. They also held a contract to move patients in urgent need of care, for example, from their home to a hospital, on the basis of GP referrals. They were in the process of establishing new contracts for patient transport services for other local NHS providers.

The service has had a registered manager in post since 2011. At the time of the inspection, the provider was in the process of registering a new manager who had recently been appointed to the board of directors.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector, and a specialist advisor with expertise in emergency and urgent care and patient transport.

Facts and data about UK Event Medical Services Limited Sheffield

UK Event Medical Services Limited Sheffield has an ambulance base in Sheffield, with administrative offices at a second location in Sheffield. There are 16 vehicles available for patient transport at the base.

The service employs 45 people in managerial, administrative and clinical roles. The employed staff are comprised of: five board-level directors, four office-based, administrative staff, two ambulance team leaders, one training manager, two ambulance lead drivers, one ambulance controller, five technicians and one trainee technician, three blue-light drivers and 21 ambulance care assistants. There are also three paramedics working on an casual, or non-contract, basis.

The service is registered to provide transport services, triage and medical advice provided remotely, and treatment of disease, disorder or injury.

The service's track record on safety for the current year, from September 2017 to May 2018 showed:

- No never events

Detailed findings

- 27 incidents
- No complaints

Since September 2017, an average of 860 patient journeys had been undertaken each month under a contract to provide non-urgent patient transport from hospitals, homes and care facilities; an average of 197 journeys had been completed each month under a contract to provide urgent patient transport based on a GP referral.

During the inspection on 16 May 2018, we visited the ambulance base and administrative offices. We spoke with ten staff including frontline ambulance crews and members of the management team. We spoke with two patients about the care they had received. We also spoke with one member of staff who worked at a local hospital and was involved in handing over care of patients from the hospital to the provider. During our inspection, we reviewed a sample of patient records. We checked two of the vehicles at the ambulance base.

The service was inspected for the first time in January 2013. It was subsequently inspected a further two times to check that specific standards had been met. The last inspection had been carried out in February 2014; the service was meeting all of the required standards of quality and safety it was inspected against at that time.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The main service was patient transport. Urgent and emergency services were a small proportion of activity. Where arrangements were the same, we have reported findings in the patient transport services section.

Summary of findings

We found the following areas of good practice:

- Staff were committed to providing the best quality care to patients. Staff displayed a caring and compassionate attitude and took pride in the service they were providing.
- Staff checked patients' requirements prior to transporting them to ensure they were able to meet their needs.
- Staff followed evidence-based care and treatment and nationally recognised best practice guidance.
- The management team had taken action to improve governance and risk management systems within the past six months.
- There were effective policies and procedures for safeguarding issues to be identified and referred for investigation by relevant, external organisations.
- There were effective systems for reporting and investigating incidents; the provider learnt from incident investigations, for example, by making changes to equipment or care protocols.
- Vehicles and stations were visibly clean and tidy, with evidence of regular deep cleaning of vehicles.
- Relevant background checks had been carried out during recruitment processes. This included, for example, a full Disclosure and Barring Service and a driving licence check.
- We observed good multidisciplinary working between crews and other NHS staff when moving patients.

Patient transport services (PTS)

- The management team worked with local NHS providers to supply services which met the needs of local people.

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

- Our review of patient record forms on GP urgent care journeys found that the records were not always complete; the records did not always indicate what actions staff had taken to mitigate identified risks.
- Some systems for identifiying and disposing of out-of-date stock and sharps waste, had not been fully implemented.
- Some staff were not able to recall the information provided to them as part of a training programme. For example, not all staff could recall having had training in the Duty of candour.
- The systems for storing medicines needed to be reviewed to confirm that medicines were kept safely at all times.
- The provider did not currently check that all relevant staff had been immunised with selected vaccines, such as Hepatitis B, which may be appropriate for their role.

Are patient transport services safe?

Incidents

- The service had an incident reporting policy that was available to all staff. Staff we spoke with were able to give examples of what constituted an incident and were aware of the incident reporting process. They were able to locate incident report forms and knew how to submit these. The service was also trialling an electronic recording system for reporting incidents at the time of the inspection.
- We reviewed incident reports that had been completed between September 2017 and May 2018. Twenty seven incidents had been recorded which covered a range of issues including equipment faults, patient complaints, and patient or staff injuries.
- We reviewed two incident reporting forms in more detail. We saw evidence that the incidents had been properly investigated and the learning shared with staff. We discussed examples of actions taken in relation to a specific incident with the director of care and quality. They showed us an example of a 'near miss' incident which had been investigated. Following the incident, staff who were directly involved were retrained in moving and handling protocols; lessons learned were also shared with all staff through a weekly newsletter.
- The director of care and quality showed us that they were also keeping a separate incidents register in relation to a specific contract for moving patients in response to an urgent GP referral. This had been in response to identifying a systematic problem in the booking process which had led to a number of occasions when the wrong type of crew had been requested. For example, an ambulance crew had been requested with only care assistants, but it was subsequently found that the patient required a higher-level of care and in fact needed to be moved with the help of a trained technician. Staff had been instructed not to move patients in these cases and report their concerns to the senior management team.
- The director noted that they had provided their ambulance staff with additional written guidance about what was within, or without their scope of practice, with

a view to minimising risks and maintaining safe levels of care. They were also working with the contractor to resolve and prevent the concerns identified with the booking process.

- The service had reported no never events or serious incidents in the past year. 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.
- Incidents were monitored by the director of care and quality, who demonstrated that each incident was risk assessed and prioritised for investigation. There was a bi-weekly directors' meeting where higher-risk incidents were reviewed to identify what further actions were needed.
- The management team told us that in the event of a joint investigation with a contracting service they provided information and received feedback, as required.The director of care and quality showed us how they communicated with the NHS provider that they held a contract with to ensure a flow of information across services.
- The service had a Duty of candour policy which had been reviewed and implemented in February 2018. The director of care and quality was responsible for ensuring compliance with the Duty of candour. The 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.
- Some, but not all, of the ambulance crew that we spoke with were aware of the duty of candour. Staff were introduced to the company's Duty of candour policy during their staff induction process. However, two of the staff that we spoke with could not recall having had training in the Duty of candour.
- The managers told us that there had been no incidents between September 2017 and May 2018 that had resulted in moderate, or above, patient harm that would trigger the Duty of candour process.

Mandatory training

- Mandatory training for all staff comprised: clinical scope of practice, incident reporting, whistleblowing, health and safety, fire safety, moving and handling, basic life support, infection prevention and control, safeguarding, dementia care, capacity and consent, end-of-life care and do not attempt cardiopulmonary resuscitation orders.
- The clinical director confirmed that the mandatory training was renewed on an annual basis.
- Intermediate care technicians completed annual clinical refresher training courses (First Response Emergency Care) to maintain their clinical skills and knowledge.
- We saw records of completed driver assessments, as part of a staff induction course, which was used to assess if staff were safe to drive the ambulances. The senior management team confirmed that it was expected that all staff would complete a further driver assessment on an annual basis to ensure that staff remained competent in their role.
- The provider also had three members of staff who had undergone additional response (blue light) training in case this was needed for their work.
- We spoke with the clinical director, who was in charge of training. They showed us how they kept oversight of staff training compliance. There was a training standards spreadsheet with records of compliance for each member of staff. The spreadsheet specified time frames for renewing different types of training.
- At the time of the inspection, all staff were either up to date with their training or were booked on to a relevant training course.
- The staff we spoke with told us that they had all been asked to complete new training at the start of their employment with the provider, regardless of prior experience.

Safeguarding

- The provider had an up-to-date safeguarding policy available to staff. The policy had been implemented in December 2017 following a reorganisation of the management structures.

Patient transport services (PTS)

- The policy included information for staff about how to report concerns within the organisation, as well as flow charts for how to escalate concerns to external organisations including social services and the police.
- The staff we spoke with gave us examples of what constituted a safeguarding concern and were able to describe the process for reporting these.
- We observed that there were safeguarding information booklets on the vehicles to support staff understanding of what constituted a safeguarding incident and how to escalate any concerns for investigation.
- We reviewed one incident record that had caused the ambulance crew to report their concerns within the organisation. Our discussions about this case with the senior management team confirmed that the issue had been reported appropriately to the relevant NHS provider's safeguarding referral process, for whom the patient transport work had been carried out under a contract. This showed that the safeguarding policy was in use and had been followed.
- Staff were aware of guidance related to specific safeguarding issues and there were policy documents that supported staff to follow identification and reporting protocols. For example, information had been provided to staff about the legal requirement for reporting incidents of female genital mutilation and staff had been made aware of the PREVENT strategy for identify and preventing radicalisation.However, we found that some of the staff that we spoke with were unaware of the PREVENT strategies.
- Frontline ambulance staff had all completed safeguarding training to level two. Training was renewed every year; all staff were up to date with their training at the time of the inspection. The training incorporated issues related to protecting both children and vulnerable adults.
- The director of care and quality and the clinical director had completed level four safeguarding training and were acting as the safeguarding leads within the organisation.

Cleanliness, infection control and hygiene

- The service had an infection, prevention and control policy that was available to all staff. The staff we spoke with were aware of their responsibilities related to infection, prevention and control.
- Infection, prevention and control training was delivered to all staff as part of their induction training and mandatory training updates.
- Personal protective equipment was available on all ambulances. This included, for example, disposable clinical gloves and aprons. Staff were aware of when these should be used and we observed that they were appropriately used.
- The ambulance base that we visited had store rooms and shelves for the use of the transport services. These were well organised, with all equipment and stock stored off the floor.
- Cleaning equipment was available at the ambulance base. A coding system was used which separated equipment that was to be used in different areas. For example, in ambulances and in non-clinical areas. There were also separate mops labelled for use in each vehicle. There were posters located next to all cleaning equipment to support staff in identifying the correct equipment to use.
- There was information available to determine which cleaning agents needed to be used, as required by standards for control of substances hazardous to health.
- We reviewed daily cleaning records for the station and vehicles. There was a schedule with a checklist for each of the vehicles, demonstrating that the correct tasks had been carried out.
- All vehicles had decontamination wipes which were within the manufacturer's expiry date. We observed ambulance staff cleaning down the equipment after the transfer of a patient to ensure that the vehicle was clean for the next patient. We observed that staff regularly used hand gel between patient contact as part of a routine of maintaining good hand hygiene.
- We spoke with both of the ambulance team leaders. They explained that there was a "deep clean" process for internal parts of the vehicles that was carried out by an external contractor. The urgent care vehicles were deep cleaned every 45 days and the lower risk patient

transport vehicles were deep cleaned every 90 days.We were shown documents with details of the date that this cleaning occurred; this included details regarding the extent of the "deep clean".

- The ambulance crew that we spoke with noted that they checked at handover points if patients had infections that would preclude them from either travelling with other patients on the vehicle or would require that ambulance needed to be deep cleaned after use.
- At the end of each shift, ambulance crews took clinical waste bags off the vehicles and these were placed in clearly identifiable, locked bins at the depot. These were emptied by a private contractor.
- There were sharps bins available and in use. On the day of the inspection we noted that there seven sharps bins awaiting collection from the private contractor and one of these was not correctly sealed. We asked the senior management team why these had not been collected in a more timely manner. They noted that they had been making changes as regards to the contract for the management of the clinical waste by an external contractor, but would now act promptly to ensure timely removal of sharps waste.

Environment and equipment

- The ambulance team leaders confirmed that there were 16 ambulances in use at the base. The ambulances could be fitted for a range of functions including bariatric ambulances, stretcher ambulances and multi-seat ambulances and wheelchair-carrying ambulances.
- We found the ambulance stations, including the garages and equipment storage areas, were clean and well laid out.
- Hazardous substances were stored in a locked room, or a locked cupboard. There were appropriate control of substances hazardous to health assessments in place.
- We observed that staff were responsible for completing a daily vehicle check before every shift. The daily vehicle checks were recorded on a form.This included checking if the vehicle was in a good state of repair and had the correct equipment available.
- There was one vehicle off the road on the day of the inspection; a vehicle check had identified a fault on the day prior to the inspection. The provider had an external contractor who maintained the vehicles. The fault was fixed and the vehicle returned in working order on the day of the inspection.
- During our inspection we found that the equipment was in good working order. This included, for example, carry chairs, wheelchairs, strapping and valve masks. There was also relevant equipment for paediatric and bariatric transfers. Any items that needed to be replaced periodically were labelled with a date. Relevant equipment had been serviced in line with the manufacturer's guidance.
- Consumable stock was stored on a number of shelves in store rooms or at the entrance to the vehicle garage. The level of stock was managed by the team leaders. The staff we spoke with told us there was never any problem replacing used consumables.
- However, in one of the ambulances that we checked we found some out-of-date stock in a paramedic bag. For example, there was an out-of-date drawing up needle and suction catheter. These items were disposed of on the day of the inspection. We discussed this with the senior management team; they noted that the paramedic bags were not currently in use due to the nature of the current contracts that they held. However, they would be instigating an audit of the bags to identify any other stock in need of replacement. The director of care and quality also showed us that there was a new online calendar system to prompt different members of the team to carry out audits.
- The Ministry of Transport test due dates, servicing schedules and insurance certificates were being monitored by the ambulance team leaders. They showed us that they had a noticeboard which displayed the different due dates for each vehicle. We checked the vehicle history for two of the ambulances. This confirmed that they had a current test certificate and the servicing was up to date.
- The vehicles used an radio handset and a satellite navigation system in the vehicle.All essential equipment in all the vehicles had been checked and safety tested.

Medicines

- The service had a medicines management policy.This was available to all staff.

Patient transport services (PTS)

- Medicine packs were stored in a stock room in a numerical-coded, locked cupboard.
- There was also a colour-coded tag system to indicate when a pack had been openedand required replenishing. Packs which needed renewing had a red tag; unopened packs had a green tag.However, these tags were not always properly secured to the packs and were instead next to the packs.
- There was a weekly medicines check to monitor stock levels, replenish packs and re-order supplies. The check included a drug count to check for any discrepancies between what had been ordered, what had been administered, and what was found to be held in stock.
- The provider also kept supplies of medical gases, including oxygen and nitrous oxide. Oxygen and nitrous oxide were stored in a separate, lockable facility, with cylinders stored off the ground. All of the cylinders we checked were in date.
- The clinical director showed us that they were in the process of training all staff in administering oxygen. More highly-skilled staff, such as technicians and paramedics, had already completed this training.
- Staff that had already been trained could administer oxygen based on a prescription recorded during the booking process for the patient journey. They could also administer oxygen that had not been prescribed, as necessary, based on their own assessment of clinical need.
- Staff we spoke with knew about their responsibilities when administering oxygen. The amount of oxygen that patients required was requested as part of the booking procedure and the relevant information was available on a hand held computer device for staff to review.Staff commented that, if they became aware that patients required oxygen, but this had not been shown on the hand held device, then they would contact the control room for the NHS provider for an accurate prescription and ask that it be recorded onto the hand held device.

Records

- Patient records were routinely kept for patients moved as part of a GP urgent request.
- The provider did not keep their own patient records for the patient discharge transfers, for example, when patients were moved from a hospital discharge lounge to their own home. However, the staff working on this service were required to use the NHS provider's own system for recording information about the patient's journey. For example, staff recorded, on handheld devices, the time the job was accepted, the time that they arrived and met the patient, the time that they set off on the journey and when they arrived at their destination.
- We asked the senior management team what staff on the patient discharge service would do if they needed to provide an unexpected level of care or treatment, for example, when oxygen was given outside of what was specified as part of the booking process. There were no arrangements in place for keeping patient records on these occasions. The staff that we spoke with confirmed that they could not record additional notes or text onto their hand held devices, but that they would contact the control room for additional advice and ask them to update the hand held devices.
- Information about special notes including do not attempt cardio pulmonary resuscitation orders, dementia or mental health diagnoses, and requirements related to end-of-life care, were included as part of the booking process. Staff understood the need to review all of the booking notes and to check for the presence of do not resuscitate orders. We observed staff carrying out relevant checks of information and patient notes prior to transporting patients.
- We reviewed a sample of five patient records kept for the GP urgent request contract. We found that there was limited evidence of staff acting in response to risk information recorded on the forms. For example, staff were not consistently recording actions taken in regards to high pain scores, or high early warning scores.
- The clinical director had audited the patient record forms within the past six months, in line with a request from the NHS provider with whom they held a contract. However, the audit requested had not included a review of these items.
- We discussed our findings with the senior management team; they confirmed that they would now be reviewing

their systems for recording patient information. This would include retraining staff in how to record actions taken and the appropriate response to different levels of early warning signs.

Assessing and responding to patient risk

- Risk information about patients was collected through the booking system of the NHS provider who the service held a contract with. This information was shared with the provider's staff when they were scheduled for a job.
- There had been a range of incidents in the past six months when the company had received inadequate booking information from the NHS provider. This had led to, for example, a crew being dispatched without the required levels of skill or training. This had specifically been in relation to the GP requests for urgent transfers.
- In these cases, the provider had acted in line with the contractor's request for their own staff to visit the patient and then request additional support at the scene. They confirmed that they did not move patients without having the correct level of staffing. For this contract, all staff completed a patient record for every individual that was being transferred; this included an assessment of risks.
- The director of care and quality had held a number of meetings with the NHS provider with a view to resolving the booking concerns.Some actions were now in place to improve the service and information exchange. For example, the provider's crews were now calling ahead to each patient they were transferring as part of the GP urgent request service. This allowed the patient to plan for their move, and also for crews to pick up any additional information directly before they arrived.
- The ambulance crews we spoke with had a clear understanding about what to do if a patient deteriorated during a journey. They told us they would call the NHS provider's control room to notify them of the change in the patient's condition; they would then proceed to either the nearest accident and emergency department or the ward from which the patient was discharged. Staff discussed a recent example where they had instigated this protocol.
- The ambulances used for patient transport services were equipped with automatic external defibrillators and oxygen that could be used in the event of an emergency. This equipment was checked daily by staff and we observed that they were in good working order on the day of the inspection.
- All staff received first aid training as part of their induction. This included providing cardiopulmonary resuscitation and the use of oxygen in an emergency situation.

Staffing

- On the day of the inspection 15 vehicles were in use. 13 vehicles were covering patient transport services from hospital discharge lounges in the local area and GP urgent care requests. The ambulance team leaders told us that they also typically scheduled two more ambulance crews who could be requested to work by other providers on an ad hoc basis. These crews were in use on the day of the inspection.
- We reviewed the staffing arrangements with the human resources administrator. They confirmed that there were both substantive and casual workers available to fill the shifts.
- The team leaders were in charge of organising the staff rota; they confirmed they had adequate numbers of staff to meet the current demand.
- We discussed staffing levels with the ambulance crews. They confirmed there had been sufficient staff to cover shifts but that this had sometimes been by relying on staff to provide flexibility and over time; they were aware of the need for additional staff recruitment to guarantee adequate cover.
- The senior leadership team had reviewed staffing levels as part of their performance monitoring. This had recently led to the additional recruitment of four more ambulance care assistants to ensure that they met the current demand for their service. These new members of staff were due to start within the next month.
- Staff worked on a 20-week rota. Full time staff were scheduled to work between 37.5 and 42 hours per week. The shifts were eight to eleven hours long. Breaks were half an hour and the frequency depended on the length of the shift.
- A new online, computer application had been launched in the company within the past three months to aid

scheduling shifts and booking staff holidays. At the time of the inspection, casual shifts were advertised on the application, but regular shifts were not yet scheduled on the system.

Anticipated resource and capacity risks

- The provider anticipated resource and capacity risks through the maintenance of a local risk register.
- The director of care and quality showed us that the risk register covered a range of items including financial risks to the business, for example, through loss of contracts as well as safety items, such as levels of staffing or outcomes of audits. We found that there were coherent action plans in place to mitigate potential risks.
- The risk register was reviewed at the bi-weekly senior management team meeting.

Response to major incidents

- A business continuity plan was in the process of development at the time of the inspection; the director of care and quality showed us how they were adding key elements to support the written policy, for example, with details of local suppliers, so that they could be operated in the event of an unexpected disruption to the service, including loss of premises, for example due to fire or flooding.
- The director of care and quality told us they had held discussions with their local NHS providers regarding supporting and assisting other services in the event of a major incident, but they had not been requested to develop a formal plan to aid in the response.

Are patient transport services effective?

Evidence-based care and treatment

- Staff followed national guidelines, which included the Joint Royal Colleges Ambulances Liaison committee guidelines.
- We saw evidence that the provider's internal protocols had been updated against recently published advice.
- The provider developed a range of policies and protocols to support patient-centred and safe care. This included for example a 'care to care' policy for supporting patients in a caring and empathetic manner and scope of practice documents to ensure staff were working within their level of skill and competence.
- The ambulance crew that we spoke with were aware of relevant protocols and guidance; they were working to implement the processes accurately. They were aware of which policies and protocols had recently been updated and cited examples.

Assessment and planning of care

- The patient transport service provided non-emergency transport for patients who required transferring between hospitals, transfers home or to another place of care. There was also a contract to provide urgent care transfers upon request from a GP. Staff had prior information about the patients they would be requested to transfer through a booking process.
- Key information about the patient was supplied during the booking process. Staff reviewed this information to ensure a safe transfer. For example do not attempt cardio pulmonary resuscitation orders were noted, as well as other special notes, such as the requirement for oxygen therapy.
- There had been some concerns about the quality of booking information received by ambulance crew prior to transporting urgent care patients on GP referrals. The management team were working with the NHS provider with whom they held a contract to provide this type of transport to resolve these concerns. Staff were also carrying out their own assessment of care and recording this on a patient record form for every patient being transferred as an 'urgent' case.
- We observed that staff held discussions with NHS staff at the discharging service, the patient or their relatives to help plan each journey and complete the transfer safely and with minimum discomfort to the patient.
- The ambulance crew were sensitive to patients' needs. For example, if a longer-distance journey was scheduled, the trip would be planned with stops to use the toilet and for refreshments. All of the ambulances held bottled water to give to patients, as required, during a journey.

Response times and patient outcomes

- The provider did not monitor response times for their service. The senior management team noted that the NHS provider with whom they held a contract to transport patients did monitor response times through the use of handheld device logging system.
- Data on response times was reviewed at monthly contract meetings. We saw that action logs were kept as a result of these meetings including whether the action was still required or had been closed or completed.
- An audit of patient care records had been carried out in line with the NHS provider's request under the contract. However, this had not systematically reviewed clinical outcomes for patients. Our review of the completion of patient record forms highlighted some areas for improvement, for example, around recording responses to risk and pain scores.
- The senior management team were responsive to our feedback in this area and confirmed that they would be reviewing their auditing systems to monitor patient outcomes more closely.

Competent staff

- There was a two-day induction training programme for all new staff. This consisted of both face to face and online training packages. Mandatory training was covered in the induction as well as moving and handling training, information governance, data protection, use of equipment, completion of patient records and the internal 'care to care' protocol.
- There was a driving competency assessment which was carried out as part of the staff induction.
- Staff started work upon completion of the induction and mandatory training courses. Staff we spoke with had completed the induction process in line with the policy.
- The clinical director told us that staff would be required to refresh their mandatory training on an annual basis.
- The human resources administrator completed driving licence checks when staff started working for the company. They reviewed these annually and were tracking the outcome as part of a new, human resources audit. The director of care and quality told us that staff with over six points on their licence were not allowed to drive the ambulances.
- A record was also kept in relation to staff members' professional registration with appropriate organisations. For example, paramedics' registration with the Health and Care Professions Council was checked and recorded.
- Formal staff appraisals were in the process of being completed at the time of the inspection. This was the first time that appraisals had taken place since the change in staffing and contracts in September 2017. Thirteen appraisals had been completed. We reviewed one of the completed appraisals and saw that they supported staff to identify career goals and further learning needs. One of the ambulance crew staff that we spoke with confirmed that they had had a recent appraisal and that it had been useful to identify how they could progress within the company. The operations director told us that they would be reviewing the staff appraisals to identify any company-wide concerns or training targets.

Coordination with other providers

- The provider had good working relationships with the NHS providers they worked with.
- We discussed the service provided with staff working in an NHS hospital discharge lounge where the ambulance staff collected patients. They told us they were satisfied with arrangements and that the provider worked hard to meet their needs.
- The director of care quality told us they held regular meetings with the NHS provider that they held contracts with to monitor the provision of care. The NHS staff we spoke with confirmed that they had held a recent meeting to review the quality of care provided; they commented that they had a positive working relationship with the provider and that they were proactive in resolving any concerns or issues as they arose.
- The ambulance crews that we spoke with commented that they found they had a good working relationship with NHS ambulance control room staff who co-ordinated the patient booking process.

Multidisciplinary working

Patient transport services (PTS)

- We observed good multidisciplinary team working between crews and other NHS staff when caring for patients. We saw co-ordinated care and transfer arrangements when crews were handing the care over to NHS staff.
- We observed that ambulance crews asked hospital staff appropriate questions to make sure that they understood the patients' needs prior to each transport.
- Staff checked that they had received the correct documentation and information on the handheld devices at handover points; they raised issues about the completeness of information, if necessary.

Access to information

- Staff had access to policies and standard operating procedures at the ambulance station. At the time of the inspection, the service was also in the process of implementing an online system which staff would be able to use to access relevant information about their working protocols and procedures.
- The ambulances were equipped with a satellite navigation system and an electronic tracker (global positioning system) to enable communication and monitoring of the vehicle whereabouts.
- Ambulance crews were provided with key information and special notes regarding care plans though the booking process. The booking information was transferred directly to their hand held devices. We also observed that relevant information about each patient was available on whiteboards in the hospital discharge service to support staff to understand each patient's transport needs.
- Staff were aware of the importance of do not attempt cardiopulmonary resuscitation orders, for example, in patients being transferred as part of an end-of-life care pathway. We observed instances where the crew checked this information was available and completed correctly prior to transporting patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service provided staff training on consent processes, as well as protocols for following the terms of the Mental Capacity Act (2005), through the induction training and annual mandatory training up dates.
- Staff we spoke with had good knowledge about the importance of understanding patients' mental capacity, how they could act in line with 'best interest' decisions, and the importance of involving patients in decisions about their own care, wherever possible.
- Staff also understood the requirements of Gillick competence. Gillick is a term used to describe if a child under 16 years of age is able to consent to their own medical treatment without the need for parental permission or knowledge.

Are patient transport services caring?

Compassionate care

- All of the staff that we spoke with during the inspection showed a commitment to providing the best possible care.
- We observed care being provided on patient journeys by one ambulance crew. Staff were respectful, kind and considerate towards the patient in their care. The crew introduced themselves and explained to the patient what was happening.
- Staff showed an awareness of the importance of maintaining patients' privacy and dignity, for example, by providing additional blankets or checking that patients were comfortable with what they were wearing.
- Staff were also careful about continuity of care after patients' transfers were completed. For example, they checked with patients and relatives about the availability of ongoing care and support after the transfer had been made from hospital to home. In one example, we observed staff transferring a patient into their own home with considerable care to minimise any distress; the patient was successfully transferred in a reclining chair in their home.
- We spoke with patients and relatives who had been transported by the ambulance crews. They noted that the staff had been caring, careful and helpful.

Understanding and involvement of patients and those close to them

- Staff demonstrated an awareness of involving patients, and their relatives or carers, in any decisions that were made about their care.

Patient transport services (PTS)

- The ambulance crew we observed were supportive of patients and remained committed to involving them in their care at all times. For example, we noted they explained what was happening as they were being moved and checked that patients were comfortable with what was happening. In one example, the crew offered a patient an option to sit up which was declined by the patient; the crew carried out the transport in line with the patient's request.
- The provider had a written 'care to care' protocol for staff to follow when providing care to patients. This included directions on providing adequate introductions, staff identification and information with a view to ensuring that patients understood what was happening at each stage of their journey. We observed staff providing information in line with the provider's policy.
- One of the patients we spoke with commented that the ambulance crew had been very good, explaining where they were going and what to expect.

Emotional support

- Staff understood the impact they could have on patients' wellbeing and acted to emotionally support their patients and relatives during transfers.
- We observed instances where the ambulance crew offered verbal reassurance during patient transfers. For example, in one episode in a discharge lounge where a patient was initially reluctant to leave the hospital. The crew patiently provided reassurance about the transfer process and were careful not to move the patient until verbal consent was obtained and the patient was ready to move.
- Staff consistently engaged patients with steady and light conversation as a way of helping patients through the transport experience.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- At the time of inspection the service held contracts with one NHS provider. This was to transport patients between hospital sites, homes and care facilities. There was also a contract to provide urgent transfer of patients from their homes to another provider under a GP referral. The contracts allowed for some bariatric patient support and paediatric transfers.
- Staffing levels, shift patterns and availability of vehicles had been planned in line with each contract's requirements.
- The ambulance team leaders told us that they regularly used between 13 and 15 vehicles each day to meet the demands of the NHS contracts. They typically scheduled two additional crews and vehicles than were booked on any given day to allow for a flexible approach to meeting demand. These additional crews could be requested as and when they were needed by NHS providers.
- The senior management team told us they held regular meetings with representatives from the NHS Trusts that they worked with to check that they were meeting their requirements and to plan for any additional work.

Meeting people's individual needs

- There were a range of measures to ensure staff could meet patient's needs.
- Information that had been received as part of the booking process was communicated to staff via their portable electronic devices. Additional conversations were held between staff from different services at handover points.
- A telephone interpreting service was available at all times and translation services could be arranged promptly for patients who did not speak English as a first language. Staff knew how to arrange the service.
- Staff told us, and we observed that, patient's requirements and preferences were discussed and practical adjustments were made, to meet individual needs prior to transporting patients. For example, longer journeys were planned with comfort breaks, both seated and stretcher vehicles were available, and 'same sex' crew members could be provided, where required.
- Staff understood do not attempt cardio pulmonary resuscitation orders and checked for the presence of these when working patients who were receiving end-of-life care.

Patient transport services (PTS)

- Staff were able to escalate concerns to the NHS or the provider's clinical director to access advice if a patient's health rapidly deteriorated during transfer so that an appropriate plan for management could be made.
- Staff had completed specific training in dementia care to support them to meet some patients' needs.
- The ambulance crews that we spoke with also confirmed that there were appropriate arrangements for moving patients with particular needs for example, bariatric patients or young children. This included the provision of additional equipment.

Access and flow

- At the time of the inspection, the average deployment per day was between 13 and 15 ambulances. There were a total of 16 ambulances available for use, thus ensuring that there was adequate service cover in the event of a vehicle breakdown. On the day of the inspection, there was one vehicle being repaired; this had been repaired within a one day turnaround and was back on the road at the end of the inspection day.
- Bookings were managed through an NHS provider's centralised dispatch centre; there were two ambulance team leaders who supported their staff's deployment from the provider's side.
- The centralised dispatch centre provided booking information to an individual staff member's electronic portable device so that they could review any information. They logged an activity on the device to confirm that the booking had been received and reviewed.
- We observed staff following these processes on the day of the inspection.
- The NHS providers that the service worked with reviewed information about performance, for example, in relation to the number of patients transported each day. They reviewed this with the service at contract review meetings.
- We asked staff in the discharge lounge about the flow of information between themselves, the centralised dispatch centre, and the provider's ambulance crews. They commented that the ambulance crews were responsive when they received the information.

Learning from complaints and concerns

- There was a formal complaints policy. Staff were aware of this policy and acted in line with it.
- We saw that the ambulance crew members carried business cards with them to give to patients so that they could provide the service with feedback directly, including about how to complaint.
- The NHS provider commissioning the service forwarded information about any complaints they received in relation to the service to the senior management team. If necessary, there was a process for joint investigation and learning across the different providers.
- The director of care and quality was responsible for monitoring and investigating any complaints. They collected evidence and statements from staff and compiled an internal report
- Complaints were reviewed at the bi-weekly directors' meeting to monitor for any trends, or identify any opportunities for shared learning across the business.
- There was an internal target for completing an investigation, and responding to any complainant in full, within 25 working days.
- The service had received two complaints in the past year through the NHS provider that they were contracted to work with; we saw that these had been dealt with in line with the provider's incident reporting and investigation policy as the responsibility for responding directly to the complaint lay with the NHS provider.
- We asked staff about how learning from complaints was shared to prevent a recurrence of the concerns raised. They noted that they were kept up to date with the outcome of any complaints, concerns or incidents through the staff news bulletins.
- The director of care and quality also noted that individual members of staff who were the subject of any complaint would be spoken with directly about their actions and either disciplined or offered retraining accordingly.

Are patient transport services well-led?

Leadership of service

Patient transport services (PTS)

- The senior management team consisted of on operations director, a clinical director, a specialist services director and the director of care and quality.
- The operations director, who had oversight of the operational ambulance crews and vehicles, was supported by team leaders, lead drivers and a controller. The clinical director, who had oversight of training, was also supported by a training manager.
- There had been a period of service transformation following the changes to the ownership of the business. This had led to a complete re-structure of the senior management team and the implementation of a range of new policies and protocols. There had also been wide-ranging changes to the staffing of the ambulance crews following changes to contracts awarded to the service by an NHS provider.
- The staff we spoke with were largely positive about the changes that had occurred since the change in ownership and management structure. They told us they were aware of the leadership team and their roles and responsibilities. They noted that the local management team were approachable and responsive when they had any concerns.
- There were appropriate staff reporting procedures to escalate concerns about co-workers and colleagues through the operation of a whistleblowing policy.

Vision and strategy for this this core service

- We discussed the vision and strategy for this service with the senior management team. They were committed to developing the business further and were in the process of establishing new contracts with other providers. New vehicles had been ordered, and additional staff had been recruited, to support a planned period of managed growth.The operational staff that we spoke with were aware of the plans to grow the business.
- The management team stressed the importance of caring for patients and supporting their staff. In the past six months, patient-centred care had been highlighted to staff through the 'care to care' policy and working protocols. Staff had been supported to engage in new training, had been given the opportunity to provide feedback through a staff survey and were now being engaged in a formal appraisal process.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- There had been a period of service transformation following the changes in ownership and management structures in September 2017.
- There was a governance framework in place with associated staff policies and protocols. It was evident that a number of new policies and protocols had recently been implemented.
- The implementation had been supported by investment in new computer software that was being trialled at the time of the inspection, for example, to aid with rotas and staff schedules as well as managing other governance-related processes such as incident management, complaints investigations and audit schedules.
- The governance frameworks and procedures were well understood by staff. This ensured, for example, the timely reporting and investigation of incidents and safeguarding concerns.
- We looked at the risk registers for ambulance operations. A range of items were managed through reviewing and updating the register. This included financial risks to the business and safety concerns.
- The register was up to date and included actions assigned to staff members to mitigate the risks highlighted. Progress against the actions to mitigate risks was recorded and up to date. The senior management team met on a bi-weekly basis and regularly reviewed progress with the risk register.
- The service undertook some audits to identify areas for improvement. These covered, for example, audits of medicines, patient report forms, and readiness of ambulances or vehicle defects.
- Audits were planned according to a schedule in an online calendar. Staff were prompted to complete new audits in a timely manner in response to computer-generated email reminders.
- The audits that we reviewed identified actions that could be taken to further improve the service. Actions that had subsequently been completed were noted.

- There was one example where we found that the auditing process had not effectively identified areas for concern. This was in relation to the completion of patient record forms. The management team were responsive to our feedback and assured us that they would review the audit questions and update them in light of our feedback. .
- The service engaged in monthly meetings with the NHS provider that it held contracts with to review their performance. They had also been inspected and audited by the NHS provider in March 2018 to check that they were meeting the required standards under the contract. Some actions had been identified at that time. We saw evidence that these actions had either been completed or were in progress at the time of the inspection.
- There was a recruitment policy for employing new staff. This included proof of identity, driving licence and enhanced disclosure and barring service checks. References and qualifications were also required. We reviewed the recruitment records for five staff members and found that relevant checks had been completed.
- Staff all completed a self-assessment in relation to their physical health. However, we found that the provider did not currently check that staff who had direct patient contact as part of their role had been immunised with selected vaccines, such as Hepatitis B, which may be appropriate for their role.
- We discussed this with the director of care and quality. They commented that they had recently reviewed the vaccines requirement for all staff and showed us a document outlining which vaccines were required for each role. They had identified that some vaccinations were required for all operational staff, such as Hepatitis B.However, they had not yet instigated a programme for assuring that all staff had been immunised; they were exploring options for working with an occupational health service to provide the required vaccinations.

Culture within the service

- There had been a period of organisational change starting in 2017. The structure of the senior management team had grown and there had been wide-ranging staffing changes, in terms of the ambulance crew staff, as a result in a change in contracts. The new management team had also rapidly implemented new policies and protocols.
- All of the staff we spoke with told us that the provider had been good at keeping them informed and had consulted with them on the changes.They found the management team to be responsive to their ideas and concerns.
- However, a staff survey in March 2018, which had been completed by 18 members of staff identified some dissatisfaction with the culture within the company. For example, some staff did not feel valued or felt there were communication issues.
- We found that the management team had been responsive to this feedback. They had provided staff with a full analysis of the survey and laid out written plans for improvement. This included actions to promote staff satisfaction, such as a pay review and staff recognition programme, as well as improvement to communication methods through staff bulletins and the ongoing implementation of online resources for staff.

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

- The senior management team showed us examples of how they had worked with other providers to make improvements to the service. For example, they had worked to improve the GP urgent care service by discussing protocol changes with the NHS trust that they held a contract with. This had led to changes in practice, for example, staff were now able to call ahead directly to patients to let them know when they would be arriving. This helped patients to understand the process and to be ready when the crew did arrive.
- The provider had recently instigated staff meetings to improve the flow of information between the senior management team and operational staff.These meetings were being held on a monthly basis. We reviewed the meeting minutes from the previous three months. We found that the meetings covered operational concerns around rotas and overtime, plans for business expansion as well as staff recognition, for

example through receipt of compliments and an 'employee of the month' scheme. There was a weekly staff bulletin which further supported efforts to communicate effectively with all staff.

- Staff told us that they enjoyed the staff meetings as there was also an 'informal' element; the senior management team took staff to a local restaurant and provided dinner.
- The provider was in the process of implementing a patient feedback system through the provision of standardised forms on the ambulances. We reviewed a prototype form and saw that it covered areas of patient satisfaction such as response times and caring attitudes.
- Ambulance crews were also carrying business cards to give to patients and inviting them to provide feedback directly to the company.

Innovation, improvement and sustainability

- The service had introduced an 'employee of the month' award based on feedback from internal and external sources. The winner was announced at monthly operations meetings and recognised through the receipt of a shopping voucher.
- The provider was investing in new software to provide staff with immediate access to the most up to date policies and protocols. Longer term plans for the system included using it for incident reporting with the aim of ensuring consistency of reporting and monitoring.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should further mitigate the risks to staff carrying out care and treatment by ensuring staff with direct patient contact had selected immunisations, such as Hepatitis B.
- The provider should check that staff understand relevant information required for assessing and responding to the risks to the health and safety of service users.
- The provider should review whether all staff understand their responsibilities under the Duty of candour regulation.
- The provider should review the implementation of systems for the safe management of clinical waste and stock.
- The provider should put in place a system to keep medicines safe at all times.
- The provider should improve their system for maintaining accurate patient records, including actions taken to mitigate risks in relation to the health, safety and welfare of service users, in particular for those where an unexpected level of care or treatment is required during a patient journey.