Mr Warren Bolton

Medical Response Services

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

This report describes our judgement of the quality of care at this location. We based it on a combination of what we found when we inspected and from all information available to us, including information given to us from people who use the service, the public and other organisations.

Medical Response Services is an independent ambulance service provider based in Wigan, Lancashire. Medical Response Services is registered to provide patient transport services. Medical Response Services offers ambulance transport on an 'as required' basis and provides pre-planned transport. The service provides services on request from local NHS ambulance trust and Clinical Commissioning Groups.

The patient transfers included patients detained under sections of the Mental Health Act 1983 going to or from mental health units.

We inspected this service using our comprehensive inspection methodology. We carried out a scheduled comprehensive inspection on 14 November 2017. The service had one base which we inspected.

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

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

The main service provided by this service was patient transport.

Services 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 issues that the service provider need to improve:

- Although there were processes in place for reporting incidents, staff did not receive feedback and shared learning to prevent them from occurring again and to ensure the safety of people using the service.
- Staff did not receive the appropriate training, to enable them to carry out the duties they were employed to perform.
- The provider did not have robust safeguarding procedures and processes that made sure patients were protected. Staff did not receive safeguarding training that was relevant and at a suitable level for their role. We found no evidence that it was updated at appropriate intervals and enabled them to recognise different types of abuse and the ways they could report concerns.
- The provider did not ensure that staff had completed pre-employment checks completed prior to undertaking employment including fit and proper persons assessments for directors.
- Although, the provider had a duty of candour policy in place and were open and transparent, staff did not receive training in the duty of candour.
- We did not find robust systems to assess monitor and improve the quality and safety of the services provided.
- We found concerns regarding the governance and strategic risk management processes of the service. There were no effective governance arrangements in place to evaluate the quality of the service or to improve delivery.
- There was no formal risk register in place at the time of the inspection and therefore we had no assurance that risks were being tracked, managed or mitigated.
- A vision and strategy for the service had not been developed.

However, we found the following areas of good practice:

Summary of findings

- Staff were knowledgeable about how to report an incident and had access to incident reporting forms including whilst on ambulances. We saw evidence and examples of incident reporting.
- The service ensured a minimum of two staff were allocated to each patient transfer depending on risk and need. The staffing levels and skill mix of the staff met the patients' needs.
- All vehicles and the ambulance station were visibly clean and systems were in place to ensure vehicles were well maintained.
- All equipment necessary to meet the various needs of patients was available.
- Services were planned and delivered in a way that met the needs of the local population. The service took into account the needs of different people, such as bariatric patients or people whose first language was not English, and journeys were planned based upon their requirements.
- We observed good hand hygiene, and infection control processes.
- The service had a system for handling, managing and monitoring complaints and concerns.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North), 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 found the following issues that the service provider need to improve: • Although there were processes in place for reporting incidents, staff did not receive feedback and shared learning to prevent them from occurring again and to ensure the safety of people using the service. • Staff did not receive the appropriate training, to enable them to carry out the duties they were employed to perform. • The provider did not have robust safeguarding procedures and processes that made sure patients were protected. Staff did not receive safeguarding training that was relevant and at a suitable level for their role. We found no evidence that it was updated at appropriate intervals and enabled them to recognise different types of abuse and the ways they could report concerns. • The provider did not ensure that staff had pre-employment checks prior to undertaking employment including fit and proper persons assessments for directors. • Although, the provider had a duty of candour policy in place and were open and transparent, staff did not receive training in the duty of candour. • We did not find robust systems to assess monitor and improve the quality and safety of the services provided. • We found concerns regarding the governance and strategic risk management processes of the service. There were no effective governance arrangements in place to evaluate the quality of the service or to improve delivery. • There was no formal risk register in place at the time of the inspection and therefore we had no assurance that risks were being tracked, managed or mitigated. • A vision and strategy for the service had not been developed. However, we found the following areas of good practice:

Summary of findings

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Medical Response Services

Detailed findings

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Detailed findings

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Background to Medical Response Services

Medical Response Services is operated by Medical Response Services. The service opened in 2011. It is an independent ambulance service in Wigan, Lancashire. The service primarily serves the communities of Lancashire. However, patients are transported across the UK as required. The service predominantly provides patient transport services to adults only and transport for patients detained under the Mental Health Act (1983). The service also provides bariatric transport with all vehicles equipped with bariatric equipment.

The service provides medical patient transport services to NHS trusts and clinical commissioning groups. The service provided ambulance provision for event work; however this was a small portion of the work carried out.

The service is registered to provide the following regulated activities:

Diagnostic and screening services

Transport services, triage and medical advice provided remotely

Treating of disease, disorder or injury

We last inspected Medical Response Service in March 2014. Suitable arrangements were in place to ensure people using the service were provided with effective, safe and appropriate personalised care.

The service has had the same registered manager in post since 2011. This person is also the managing director.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection (North West).

Facts and data about Medical Response Services

During the inspection, we visited the registered location ambulance station in Wigan. The service was managed from this location. Ambulances and other vehicles were securely garaged at this location.

We spoke with four staff members of the management team. We conducted random spot checks on three vehicles and inspected cleanliness, infection control practices and stock levels for equipment and supplies.

During our inspection we looked at 10 patient records. We looked at three of the patient transport ambulances which were also used to transport patients with mental illnesses. We reviewed other documentation including policies, staff records, training records and call log sheets.

The CQC has not completed any special reviews or investigations of this service. The service has been

inspected once, and the most recent inspection took place in March 2014, which found that the service was meeting all the standards of quality and safety it was inspected against.

Activity (September 2016 to September 2017)

We requested information in relation to the number of patient transport journeys undertaken from the period of September 2016 to September 2017. However, this information was not kept by the provider.

Track record on safety

- There had been no never events reported by the organisation.
- There were no serious clinical incidents or serious injuries reported by the service.
- There were no complaints.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Medical Response Services was initially established in 2011 by the current managing director. . The company provides patient transport to meet the needs of NHS Hospital trusts. The company employs twenty patient transport services staff, and an additional five office and management staff, operating a fleet of 15 vehicles.

Summary of findings

We found the following issues that the service provider need to improve:

- Although there were processes in place for reporting incidents, staff did not receive feedback and shared learning.
- Appropriate recruitment checks were not completed for employees prior to commencing employment.
- Records confirmed staff were not up to date with mandatory training.
- Reliable safeguarding systems were not in place, to protect adults, children and young people from avoidable harm.
- Staff were not aware of the requirement to notify the CQC when there was an allegation of abuse concerning a person using the service.

However, we found the following areas of good practice:

- Staff were knowledgeable about reporting incidents and had access to incident reporting forms whilst on ambulances.
- Ambulances and the station were visibly clean and staff followed infection control procedures. Staff used hand gel in clinical areas to maintain good hand hygiene and used personal protective equipment.
- Systems were in place to ensure vehicles were well maintained with equipment to meet the needs of patients.
- Systems were in place to identify, assess and manage patients whose condition deteriorated.

Patient transport services (PTS)

- Staff carried or had access to a pocket guide with clinical information which was developed from the latest guidance.
- The service had systems and processes to monitor how the service was performing.
- Systems were in place for the planning of patient journeys and the care patients required.
- The service took account of the particular needs of patients and ensured flexibility, choice and continuity of care.
- The service had a system for handling, managing and monitoring complaints and concerns.
- Staff knew how to advise a patient if they wished to make a complaint.

Are patient transport services safe?

Incidents

- The service had an accident and incident reporting policy, which was updated in April 2017. The management team had introduced a new system for reporting and recording incidents. The policy described how accidents and incidents should be reported. It made reference to a company incident reporting form and that all incidents were to be reported within 24 hours.
- Staff were required to report and record incidents via a paper record and also called the office to log the incident. Each vehicle had a folder containing accident and incident reporting forms. Prior to the new system being introduced, staff recorded incidents as statements. The registered manager informed they had no recorded incidents. However, upon checking staff statements we identified three incidents which had taken place between October 2016 to March 2017 which concerned the safety of patients. No near misses were recorded.
- In the three serious incidents that we reviewed we did not see evidence how the service had investigated or reviewed them to prevent recurrence of a similar incident. There was no evidence of sharing of any lessons learnt following these incidents with the wider staff team.
- Staff we spoke with were able to describe the new procedures for reporting incidents. They stated they were confident to report any accidents, incidents or near misses.
- Staff who worked remotely could speak with the duty person at the control room and the services on-call manager.
- The service reported that there were no never events in the last 12 months. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

Patient transport services (PTS)

- Vehicle accidents and equipment defects were recorded on a separate defect report. From January to March 2017, 58 defects had been recorded. We saw examples of minor accidents, which managers had discussed with staff.
- The service had a Duty of candour policy (2016), which described their responsibilities under the Duty of candour legislation. Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for a registered person to ensure staff act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Staff did not receive training in duty of candour and not all staff were familiar with the term. Despite their lack of training, the registered manager told us they would be open and honest with people if things went wrong and would immediately seek support if a patient experienced avoidable harm.

Cleanliness, infection control and hygiene

- All the vehicles we looked at were uncluttered and visibly clean. The ambulance station was tidy and well organised. The floors were swept clean in the ambulance parking area and there was no excess equipment so the areas were not cluttered, making them easy to clean.
- Crews were required to ensure their vehicle was fit for purpose, before, during and after they had transported a patient. Decontamination cleaning wipes were available on all vehicles and we were informed that staff cleaned surfaces, seats and equipment after each patient.
- The crew assigned to the vehicle each day completed the day to day cleaning of vehicles. We found the daily cleaning sheet record on all vehicles had been completed consistently but vehicle cleaning standards had not been audited.
- Cleaning materials and chemicals were available for staff use. Different coloured mops and buckets were available for different areas; advice as to which mop should be used in which area was prominently displayed to prevent cross infection. The station room was divided into clean and dirty areas by signage.
- Staff followed infection control procedures, including washing their hands and using hand gel after patient contact.
- Hand washing facilities were available at the ambulance station.
- We saw no evidence of infection, prevention and control audits or hand hygiene audits within the service. This meant the service could not be assured staff were compliant.
- There were arrangements with the local hospitals for disposing of used linen and restocking with clean.
- The service followed operational procedures in relation to infection control. Staff told us that if a patient was known to be carrying an infection, they were not transported with another patient. The vehicle would be cleaned afterwards in accordance with infection control policy and procedures.
- Staff had access to personal protective equipment such as gloves and aprons to reduce the risk of the spread of infection between staff and patients. Crews carried a spills kit on their vehicles to manage any small spillages and reduce the infection and hygiene risk to other patients.
- Staff did not routinely have to manage clinical waste. However, clinical waste bags were carried on each ambulance and full bags were disposed at the hospital or at the ambulance station. The ambulance station had facilities for depositing and disposing of clinical waste through an external contractor.
- Staff were provided with sufficient uniform, which ensured they could change during a shift if necessary. Staff were responsible for cleaning their own uniform, unless it had been heavily contaminated and was disposed of as clinical waste.
- The ambulances we inspected were fully equipped, with disposable single use equipment stored appropriately and in-date.

Environment and equipment

- The premises were clean and tidy with adequate space to safely store the vehicles. In addition the unit provided a suitable environment for taking bookings and there was office space, facilities for staff, cleaning and separate storage areas.

- The keys for the vehicles were stored securely. There was secure access to the station building and within that to the offices. Staff attended the office to collect the designated vehicle keys. All vehicles were locked when unattended.
- Managers told us that all drivers had their driving licence and eligibility to drive vehicles checked prior to employment and on an ongoing basis by the Driver and Vehicle Licensing Agency. We saw evidence of these checks.
- Medical Response Services had 15 ambulances for the transport of patients. Systems were in place to ensure that all vehicles were maintained, serviced, cleaned, insured and taxed appropriately.
- Vehicles were covered by a current Ministry of Transport safety test certificates as required and a central log was kept at the station. Managers also ensured newer ambulance vehicles were covered by a first Ministry of Transport safety test certificates after 1 year as required in law. Records showed that drivers had the correct licence category, Category B for the weight of the vehicles driven.
- Where vehicles were off road awaiting repair, this was clearly displayed on the vehicle to prevent staff from using the vehicles. Vehicle defect report forms were provided on each vehicle, which included a description of the fault or defect, action taken to resolve, and further action required. Staff informed us they reported any defects directly to managers; we saw when staff had completed these.
- The records showed that vehicles had gone through a regular deep clean through a contract with an external company every four weeks. This included all fixtures and fittings internally including seats, interior lighting, grab rails, flooring and foot wells.
- There was a system for reporting equipment defects and staff had received appropriate training to use equipment safely. Some of the vehicles had an on-board wheelchair available for patient use and this was secured with fasteners. Equipment had been safety tested; stickers showed when the equipment was next due for testing and records were available to support their suitability for use. The seatbelts and trolley straps were in working order in the three vehicles we checked.
- We saw two items of consumables that were out of date in the stock room. For example, we saw a crepe bandage which was dated June 2015.
- Ambulances were all equipped with tracking devices and a mobile phone was provided in each vehicle where staff received messages from the control room duty manager.

Medicines

- Emergency medicines were not carried on the patient transport services ambulances and staff did not administer medicines. Patients or their accompanying carers were responsible for their own medicines administration whilst in transit. Staff would ensure medicines provided by the hospital for patients to take home would be stored securely in a bag on the ambulance.
- Oxygen cylinders were carried on vehicles. An appropriate health care professional had to prescribe the oxygen so staff could administer it or the patient had to have a home oxygen order form in place.
- Medical gases were managed properly. The service kept medical gas cylinders in a locked cage in a location outside. Storage of medical gases was secure and there were signs to alert staff and visitors to the flammable nature of the gases. Full and empty cylinders were appropriately segregated.
- Oxygen cylinders were appropriately stored on the ambulances. Oxygen stock was replaced frequently by a medical gas company.

Records

- Patient transpoert service drivers received work sheets at the start of a shift, which were completed by the duty manager in the control room and included the basic details of the journey to be completed. These included collection times and addresses. Patient specific information such as relevant medical conditions, mobility, and if an escort was travelling with the patient, patient's health and circumstances were assessed by the NHS Hospital trust and this information was given to patient transfer drivers during the handover process. A records management policy was not in place.
- The local NHS hospital trust provided ambulance crews with patient details such as 'do not attempt cardio pulmonary resuscitation information and any special notes or instructions, which stayed with the patient. This included their mental health needs and any potential

risks to staff. The booking process meant people's individual needs were identified and took into account the level of support required, the person's family circumstances and communication needs.
- Patient information was stored in the driver's cab out of sight, respecting patient confidentiality.
- Records were held securely in the station office. Storage was in locked filing cabinets and in a secure post box and through password protected computer systems.
- We reviewed journey records for mental health patients including patients detained under the Mental Health Act 1983 going to or from mental health units.
- There was a Mental Health Act and conveyance policy and procedure in place which referred to the completion of patient report forms and mental health conveyance risk assessment forms when transporting patients with mental health disorders. We found patient report forms were completed for these patients.

Safeguarding

- Reliable systems, processes and practices were not in place to protect adults, children and young people from avoidable harm and abuse. Although there were safeguarding alert forms available for staff to complete to record safeguarding concerns, which were given to the duty manager, we were not assured correct safeguarding procedures were followed. We discussed what staff would do if they were informed of a safeguarding concern. We were informed they would contact the hospital where the patient was transported from and seek advice, and if required would contact the police. However, the four managers we spoke with were not aware of their responsibility in making a safeguarding alert to the responsible local authority safeguarding team and were not aware of the legal requirement to notify the CQC.
- There was a safeguarding policy in place which was last updated in April 2017. However, the policy was not up to date with current legislation and did not include the ten categories of abuse. Internal safeguarding policies were not followed by staff.
- The provider had a policy relating to the use of restraint and informed us they do not use restraint. There was no recorded evidence to suggest staff had read the restraint policy and were aware of when to use restraint. We were not assured that staff knew what restraint was and knew when to use it.

Mandatory training

- The service had a comprehensive mandatory training programme. The majority of mandatory training was delivered by e-learning and training in restraint was delivered face to face. All staff were required to complete and record their mandatory training. Examples of training included; safeguarding, infection control, patient handling, fire safety, data protection, sharps, hand hygiene, health and safety and equality act training. Additional training consisted of control and restraint and handcuff training.
- We found that not all staff were up to date with their mandatory training. For example, we found that out of twenty five members of staff which also included the five office staff, only two members of staff had received up to date training in safeguarding. The three members of staff in the control room had not received up to date training. These staff were responsible for acting on any safeguarding concerns reported to them by frontline staff. We spoke to one of the directors who was also one of the control room staff. He informed us he had last received training in safeguarding over a year ago. The service had appointed the registered manager as the safeguarding lead who had completed online level three training in safeguarding. Although the safeguarding policy stated that 'staff were required to receive mandatory training safeguarding refresher training before the renewal date on their certificates,
- Not all staff had completed basic life support training. Out of the twenty members of frontline staff, seven members of staff had received up to date basic life support training.
- Not all staff were up to date with training in restraint. Two members of staff involved in an incident where they restrained a patient did not receive training in control and restraint nearly a year after the incident.
- The service had an induction policy in place and we were informed that staff completed an induction process, upon commencing employment with the service; we did not see completed induction documents for new members of staff. We were not assured that staff completed inductions.
- Patient transport services staff that drove the vehicles completed an in-house driving assessment on commencement of employment and would undertake a further assessment once they felt confident to transport

patients. The operations contract manager was the administrator for the organisation's driver training, and had qualified in May 2016 with the Royal Society for the Prevention of Accidents.

- Although senior management were able to review records to see the training staff had completed and when training was due for renewal, we were not assured that this was taking place as a high proportion of staff training was out of date.
- Staff, who worked as mental health crews, did not receive training in mental health awareness, mental health legal frameworks, de-escalation, prevention and management of violence and aggression and the use of handcuffs to equip them to work with and transport patients with mental health needs.

Assessing and responding to patient risk

- Medical Response Services staff requested detailed information on risks posed when transporting patients at the time of the booking. Basic risk assessment screening questions were asked at this time.
- When transporting patients the ambulance crew would use their first aid knowledge to assess if a patient's condition was deteriorating.
- Records showed that in each case for mental health patients, risk assessments were completed by the organisation requesting the transport. Information to evidence whether the patient was aware of the journey, current and past risks relating to physical and verbal aggression, the likelihood of the patient absconding or attempting to abscond, risks of self-harm and the current presentation of the patient was given to staff prior to the journey taking place.
- Ambulance crew had access to clinical advice from an on call member of staff or they would divert to a hospital. There was an escalation process in place for the management of deteriorating patients. They informed us they would stop the vehicle as soon as it was safe to do so, call the control room for advice and inform the organisation where the patient was collected from. They would then inform their managers and would support the patient as best they could until help arrived.

Staffing

- The service employed twenty members of staff, twelve of which were permanent and eight of which were bank staff. In addition there were five members of office and management staff.
- Recruitment systems did not ensure that staff had proper pre-employment checks prior to undertaking employment. For example, proof of identification, references and qualifications were not sought for all staff. We reviewed staff files. Out of the nine staff files we checked, one member of staff did not have evidence on file to ensure they had the right to work in the UK, five members of staff did not have two references on file and did not have a contract of employment on file.
- Fit and proper persons assessment were not robust. Both directors of the company did not undergo recruitment checks, although they both had a Disclosure and Barring Service check.
- All ambulance staff had valid enhanced Disclosure and Barring Service checks. We were able to see evidence that a check with the service had been carried out prior to staff commencing duties, which involved accessing patients and their personal and confidential information. This protected patients from receiving care and treatment from unsuitable staff.
- The registered manager had a level three certificate in first response emergency care and worked directly with patients and crew staff as required.
- The service used computer programmes to assist with shift rosters to plan shifts. Shortfalls in cover were shown on this system and staff could request to work additional shifts. The electronic rostering tracked sickness and holidays. If a short notice booking was received, the service would not accept if they could not supply two staff. We were informed that staff were allocated time for rest and meal breaks.
- There was a process in place for the ambulance crews out of hours and in case of emergencies. They had a direct number to the duty manager on call. Staff we spoke with knew how to escalate concerns when working out of hours.

Response to major incidents

Patient transport services (PTS)

- A major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services and would generally include the involvement, either directly or indirectly, of large numbers of people.
- As an independent ambulance service, the provider was not part of the NHS major incident planning. However management staff informed us they would be utilised when the NHS hospital trust had a major incident, to transport patients home.
- The provider assessed that current means of communication for instance mobile phones, land lines and other telecommunication was robust enough to allow partner agencies to make contact during a major incident.

Are patient transport services effective?

Evidence-based care and treatment

- Although the service had a set of up to date evidence based policies and procedures in place, they were not used to guide staff in their daily work. For example, we found the safeguarding policy had not been followed as an incident had not been reported to the local safeguarding authority. Policies were accessible as a hard copy for staff to readily access and on the computer system.
- The policies and procedures referred to best practice guidance including the department of health and the Joint Royal Colleges Ambulance Liaison Committee.
- Ambulance crew members carried their pocket book which was based on guidance from the Joint Royal Colleges Ambulance Liaison Committee clinical guidelines for pre-hospital care. Carrying a pocket book was in line with company policy.
- The NHS ambulance trust set or assessed patient's eligibility to travel on patient transport in line with the guidelines in the Department of Health 'Eligibility criteria for patient transport services' document. The eligibility criteria were set nationally and it was the responsibility of the providers booking patient transport to make sure it was used for patients who met the criteria.

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. During the booking process, basic journey information was gained regarding the collection address and discharge destination.
- Staff did not transport a patient if they felt they were not equipped to do so, or the patient needed more specialist care. The transport staff were not clinically trained, but did seek advice from clinical staff at the hospital as necessary or the manager on call for the service. If a patient was observed or assessed as not well enough to travel or be discharged from hospital, the ambulance care assistants made the decision not to take them.
- Where necessary, approved mental health professionals or mental health staff accompanied patients with mental health needs on the journey to or between hospitals to ensure they were transported safely and according to their individual needs.
- If distance or rural journeys were scheduled, the journey would be pre-planned with stops for toileting, refreshment food and drink. Ambulances held bottled water to provide for patients as required during a journey.

Response times and patient outcomes

- The provider did not benchmark and record the total of journeys they completed. We were not provided with information to identify the number of journeys undertaken in the reporting period September 2016 to September 2017 and could not establish how many repatriations and private transfers took place.
- The provider collected and monitored the performance of staff for the jobs that were assigned through the crew worksheets. Staff also called the control room to report any difficulties, so the duty controller was always aware of what issues were causing a delay.
- The operations contract manager met with local commissioners at least once a month. The provider had agreed with their contractors to complete journeys within one hour. The management team informed us that the service was currently answering calls within the desired response times, although no formal monitoring was taking place.
- Where booking staff recognised that they did not have the staff capacity or vehicles at the correct locations to

accept a job, they would refuse it and could suggest the referrer contact the local NHS ambulance service or other providers. The governance lead told us this rarely happened.

Competent staff

- Although, the service had an induction policy and procedure, all staff had not completed an induction programme that detailed the expectations and requirements of the role, the company and policies and procedures. The mandatory training followed the induction, which all staff were not up to date with. Some staff files contained certificates in restraint training, infection control and health and safety, but not all staff were up to date with this training.
- Driver and Vehicle Licensing Agency checks were completed prior to commencement of employment.
- The service had no arrangements in place for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor. The management team told us, that if they had a concern about the standard of a crew member's driving they would inform managers. Managers told us that any poor practice would be addressed. Any additional staff training or refresher training may then be identified.
- Appraisals had been carried out for 16 out of the 25 members of staff for 2015 to 2016. The service had recently introduced appraisals for staff. The governance manager showed us all staff had been scheduled to complete appraisals in November 2017. Following the inspection the provider informed us that these had been completed.

Coordination with other providers and multidisciplinary working

- Staff at the local NHS hospital trust reported good working relationships with ambulance care assistants, managers and the operations assistant. We observed effective co-operation between different providers to coordinate patients' transport around their care, treatment and discharge.
- We spoke with staff from the hospital discharge lounge who told us the service responded well to their requests for transport. They told us if they had any problems, the ambulance crews were very responsive and always provided assistance upon request.

Access to information

- Information was obtained from hospital staff and entered onto the patient journey forms. These included collection times and addresses.
- A 'live' satellite navigation system was provided for staff to track the ambulance journeys to ensure vehicles were reaching jobs as requested. Staff confirmed this was an effective system.
- Feedback from the hospital was that handovers between the ambulance and hospital staff were detailed, professional and appropriate. The management team reported they had a good working relationship with the hospital staff as generally visited the same wards and departments on a regular basis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Not all staff had not received training in the Mental Capacity Act 2005 and the Deprivation of Liberty standards. One member of the management team had completed training in mental capacity and the training was via eLearning.
- Although there was a policy in place covering the Mental Capacity 2015, we did not see any evidence to suggest that staff had read and understood the policy. We were also not assured that staff understood the principles set out in the Mental Capacity Act. The organisation's policy stated that 'if any person or carers refuse treatment whilst being transported to hospital, a vulnerable person's form must be completed and consideration must be given to the patient's mental capacity. The policy was not followed by staff.

Are patient transport services caring?

We did not inspect this key question.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The main service was a patient transport services 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, being discharged from hospital wards or referrals from care homes and private individuals.

- The service had two core elements, pre-planned patient transport services, and 'ad hoc' services to meet the needs of patients. Workloads were planned around this.
- The service worked with the NHS Trust to support them to meet demand by having regular telephone conversations. Medical Response Services could respond using four wheeled drive vehicles due to changing weather conditions as required.
- Patient transport services were provided to a number of NHS acute hospital trusts and Clinical Commissioning Groups. However, service level agreements were not in place for non-emergency and non-clinical patient transport. Journeys were provided on an ad hoc basis. The service supported hospital discharges across the Wigan region.
- The managers worked a rota at the station and managed all bookings from 8am to midnight. After midnight the office closed and the local NHS hospital trust allocated jobs directly to PTS crews who worked from 12am to 8am. This meant that if a call came through whilst on a journey, one PTS staff member would have to drive while the other staff member, who may be with a patient, took the booking. We raised concern over this practice as taking bookings whilst with patients did not ensure patient confidentiality and safe practice. We discussed the concerns with the registered manager and asked for additional staff members to be placed on call immediately to take bookings after midnight, to ensure patient care was not compromised. Following the inspection we were informed that staff were instructed not to take any booking calls if they were in process of transporting a patient to ensure the patient was their primary focus.
- On the day, bookings were responded to quickly via telephone. For the ad hoc on the day bookings, office based staff identified which drivers were available. We observed effective communication between drivers and office staff as part of service planning.
- All of the ambulances were equipped with tracking devices. The service had the ability to monitor the locations of its vehicles and to identify where they were.
- Meetings were held with senior managers and commissioners of the service to ensure the provision of the service remained satisfactory.

Meeting people's individual needs

- The ambulance care assistants ensured patients were not left at home without being safe and supported. Some patients were discharged from hospital and had a package of care to be arranged at home. If the support person or team had not arrived when the patient came home, the ambulance care assistants called the hospital to find out where they were. The patient would not be left alone until either the care team arrived, or the patient was safe in the care of their family or carer.
- Staff told us that at the time of booking the question was asked if the patient required a relative or carer to support them. Staff told us this service was put in place to meet the patient's individual needs and level of risk. This ensured that an appropriate vehicle was allocated to ensure seating arrangements were suitable. The provider's vehicles contained bariatric equipment to transfer patients who exceeded a certain weight. Staff confirmed they were competent to use this equipment, which was generally planned in advance so staff were aware of the patient's needs.
- The governance manager told us translation services were not currently available for patients whose first language was not English. However staff could access google translate via their phones.
- If distance or rural journeys were scheduled, the journey would be pre planned with stops for toileting, refreshment food and drink. Ambulances held bottled water to provide for patients as required during a journey.

Access and flow

- Patients could access their care and treatment in a timely way. The provider was able to ensure that resources were where they need to be at the time required. From taking a booking to providing the ambulance service, the provider aimed to be there within the hour. This was monitored by the duty controller. Patients were advised if there was a delay.

Patient transport services (PTS)

- The service was available 24 hours a day. Patient transport requests were received on an intermittent rather than a contractual basis and the service responded at short notice. Long journeys or night transfers were required to be pre planned.
- If a journey was running late, the driver would ring ahead to the destination with an estimated time of arrival and keep the patient and the hospital informed. Any potential delay was communicated with patients, carers and hospital staff by telephone.

Learning from complaints and concerns

- Staff knew how to advise a patient if they wished to complain and written information of how to make a complaint was present on the ambulances.
- The service had a system for handling, managing and monitoring complaints and concerns. The policy was updated in April 2017 and 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 followed up by a further letter within 28 working days, once an investigation had been made into the complaint.
- The service had not received any complaints from patients within the last 12 months.

Are patient transport services well-led?

Vision and strategy for this this core service

- A written statement of vision, strategy and guiding values had not been developed. The management team informed us their strategy was to stabilise, develop and sustain the business. They outlined they wanted to improve staffing and the quality of the service provided and to provide the best possible service to patients across the country.
- Staff we spoke with told us they did not know what the vision and strategy for the service was.
- Managers had a good understanding of the commercial aspect of the patient transport services, ensuring they remained competitive. This was demonstrated by the service trying to secure new contracts.

Governance, risk management and quality measurement

- There was no formal risk register in place at the time of the inspection and therefore we had no assurance that risks were being tracked, managed or mitigated. The provider was unaware of the high risk areas in their service due to a lack of audits.
- Internal audits looking at practices, system and process were not completed by the service. Therefore, areas of non-compliance or areas for improvement were not identified and action could not be taken to make improvements.
- We observed no evidence of governance meetings taking place prior to the announcement of the inspection. Since the announcement two senior management meetings had taken place in October and November 2017 to discuss operational issues.

Leadership / culture of service

- The leadership team consisted of the managing director who is the CQC registered manager, second director, office manager, operations contract manager and an office administrator. They were responsible for the planning of the day to day work. Some of the management team also formed part of the operational staff for public events.
- The company structure was clear and showed clear roles and responsibilities within the senior management team. Staff knew which manager would provide them with the necessary guidance and support.
- The managing director and the operations contract manager went out on transfer cases as required. This allowed them to maintain their practice.
- We saw records which showed that some crew had additional qualifications and had developed their leadership skills. The managing director had completed a First Response Emergency Care level three qualification and operations contract manager had completed a qualification to administer driving training to the staff team.
- Staff team meetings were not held. There were limited opportunities for staff to make suggestions on how the organisation could improve the services.
- The managing director told us learning was cascaded to staff. All staff members had a work email account. The service had introduced a bulletin which was printed and placed in the staff pigeon hole, informing staff of developments with the service and practice issues. The first bulletin was published in November 2017.

- We saw information that showed us the directors had not been appointed in line with the fit and proper person requirements. Although both directors of the company had a Disclosure and Barring Service check they did not undergo another recruitment checks. Checks on the directors' qualifications, competence, skills and experience were not completed. Proof of identity, a full employment history, information about any physical or mental health conditions relevant to a person's capability were not in place.

Public and staff engagement

- The service's publicly accessible website contained information for the public in relation to what the service was able to offer.
- The provider informed us they had not completed any patient surveys and were introducing these. The provider's website had opportunities for the public to give feedback about the service.
- Staff were able to access information such as policies and procedures electronically and duty rotas.

Innovation, improvement and sustainability

- There was genuine positivity about the future of the service with a hope and plans to help the service expand.
- Senior managers considered the sustainability of the service during contract negotiations.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure staff receive the appropriate training, to enable them to carry out the duties they are employed to perform. This includes safeguarding training that is relevant and at a suitable level for their role, updated at appropriate intervals and enables them to recognise different types of abuse and the ways they can report concerns.
- The provider must ensure they have robust safeguarding procedures and processes that make sure the patients are protected.
- The provider must ensure that staff undergo checks prior to undertaking employment to ensure they only employ 'fit and proper' staff who are able to provide care and treatment appropriate to their role.
- The provider must ensure systems and processes are in place to implement the statutory obligations of Duty of candour and ensure all staff are trained and understand it.
- The provider must have effective governance, including assurance and auditing systems or processes.
- The provider must ensure that directors undergo checks prior to undertaking employment to ensure they are 'fit and proper' to undertake their role.

Action the hospital SHOULD take to improve

- The provider should ensure that all learning from incidents is shared to prevent them from occurring again to ensure the safety of people using the service.
- The provider should that there is a system in place to assess, monitor and improve the quality and safety of the services provided.
- The provider should introduce team meetings.
- The provider should review its process for operational issues within a strategic overview or central risk register.
- The provider should introduce infection prevention control audits.
- The provider should develop a vision and strategy for the service and ensure this is embedded across the organisation.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17: Good governance. Care Quality Commission Regulations 2014 (Part 3) **How the regulation was not being met:** The provider had not ensured that there was effective governance, including a risk register, assurance and auditing systems or processes in place. These must assess, monitor and drive improvement in the quality and safety of the services provided. **This was breach of regulation** Regulation 17(2) (a)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18: Staffing Care Quality Commission Regulations 2014 (Part 3) **How the regulation was not being met:** The provider had not ensured staff has received that appropriate training, to enable them to carry out the duties they are employed to perform and received safeguarding training that is relevant and at a suitable level for their role, updated at appropriate intervals and enabled them to recognise different types of abuse and the ways they can report concerns. **This was breach of regulation**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
	Regulation 18 (2)(a)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13:Safeguarding service users from abuse and improper treatment Care Quality Commission Regulations 2014 (Part 3) **How the regulation was not being met:** The provider had not ensured they had robust safeguarding procedures and processes that made sure the patients were protected. This was breach of regulation Regulation 13 (2)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19: Fit and proper persons employed Care Quality Commission Regulations 2014 (Part 3) **How the regulation was not being met:** The provider had not ensured staff had had pre employment checks completed prior to undertaking employment including fit and proper persons assessments. **This was breach of regulation:** Regulation 19 (2)(a)(b)(3)(a)(b)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulation 5: Fit and proper persons: Directors

Care Quality Commission Regulations 2014 (Part 3)

How the regulation was not being met:

The provider had not ensured directors had satisfied the requirements of the regulation.

This was a breach of regulation:

Regulation 5 **(3)(a)(b)(d)(e)**